OFFICE OF THE INSPECTOR GENERAL

ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES

ANNUAL REPORT TO THE GOVERNOR

&

THE GENERAL ASSEMBLY

FISCAL YEAR 2023

JULY 1, 2022 TO JUNE 30, 2023

ANN MCINTYRE

INSPECTOR GENERAL

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

December 2023

To the Governor and Members of the General Assembly:

I respectfully submit the Fiscal Year 2023 Annual Report of the Office of the Inspector General (OIG) for the Department of Children and Family Services.

This Report contains the investigative summaries and recommendations from the **24** investigative reports submitted to the Director of DCFS in FY 2023 and details the Department's responses and implementation plans for the **89** recommendations issued. Recognizing the complexities of the child welfare system, the OIG issues both case specific and systemic recommendations to strengthen and reform the child welfare system. In response to the 89 recommendations made by the OIG, the Department has demonstrated a commitment to improving the system charged with protecting our most vulnerable children and families. The OIG will continue to monitor the Department's implementation of the recommendations issued in FY 2023 as well as the pending recommendations from prior fiscal years (see Department Update on Prior Recommendations, page 199).

The OIG investigations completed in FY 2023 highlight the many challenges faced by child welfare professionals that impact their ability to effectively intervene and provide services to families. Many families that come to the attention of DCFS have complex histories and contend with poverty, housing and employment instability, substance use, violence, and mental health issues. Additionally, child welfare professionals must navigate multiple systems including healthcare, legal, law enforcement, and a myriad of community providers that often compound the difficulty of serving families. Limited resources to address underlying issues and long delays in access to services prevent families from obtaining essential services. Several investigations conducted this year call attention to the critical need for communication and collaboration among multiple entities. The Department, while charged with protecting children, cannot alone ensure the well-being of our most vulnerable children and families (see Appendix). Along with multifaceted family dynamics and the navigation of multiple external systems, child welfare professionals also encounter obstacles from within the Department such as high turn-over, understaffing, finite resources, and a need for enhanced training and support. In FY 2023, the OIG issued 16 recommendations for training individual employees and 13 recommendations addressing agency wide training needs.

Several of these identified training issues are being addressed through the OIG's Error Reduction Training (ERT). The independent, in-depth investigations conducted by the OIG uniquely position us to identify the challenges and complexities child welfare professionals face, as well as patterns and practice errors. In 2008, the statutory mandate of the OIG expanded to include Error Reduction Training whereby investigative findings inform training curriculum for the field. These Error Reduction Trainings provide essential feedback to support and strengthen child welfare practice. In FY 2023, the OIG developed a training curriculum for supervisors and administrators focused on supporting and guiding frontline workers. The OIG has initiated the statewide trainings for supervisors and managers on a regional level. Response to these trainings has been overwhelmingly favorable and the OIG will continue to deliver this training in FY 2024 (see Error Reduction Training, page 195).

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Notwithstanding the obstacles presented, in FY 2023, the OIG issued 13 recommendations for disciplinary action, including 4 recommendations for discharge, in response to substantiated allegations of employee misconduct. Additionally, as the primary liaison between the Department and the Illinois State Police, the OIG assisted the Illinois State Police and the FBI leading to the indictment of a Department employee and 14 other persons on federal charges for allegedly participating in a scheme to fraudulently obtain $3.2 million of state funds intended for childcare services. In FY 2023 the OIG, also assisted the Illinois Attorney General's Special Litigation Bureau to secure a settlement agreement with a vendor for a $1 million fine to be paid to the state of Illinois and abstention of participation in state contracts based on a FY 2022 OIG investigation (see Coordination with Law Enforcement, page 217).

This Office will continue to hold Department and contracted agency employees accountable for instances of misconduct. However, recognizing the many challenges of a complex and demanding child welfare system, I also want to acknowledge the dedicated child welfare professionals throughout Illinois who work tirelessly every day, at times with risk to their own personal safety, to ensure the safety of children and provide services to families.

I am grateful to the Governor for the opportunity to serve as the Inspector General of the Department of Children and Family Services and it is with heartfelt appreciation that I recognize my team for their unwavering commitment to the mission of this Office and the children and families of Illinois.

Respectfully,

Ann McIntyre
Inspector General

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

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INTRODUCTION

The Office of the Inspector General (OIG) of the Illinois Department of Children and Family Services (DCFS or the 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 the OIG is to investigate misconduct, misfeasance, malfeasance, and violations of rules, procedures, or laws by DCFS employees, foster parents, service providers and contractors with the Department (20 ILCS 505/35.5 – 35.7). To that end, the OIG conducts investigations and makes recommendations to protect children, uncover wrongdoing, improve practice, and increase professionalism within the Department.

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

INVESTIGATIVE PROCESS

The 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 Child Welfare Employee License investigation.

In FY 2023, the OIG opened 768 general investigations and 160 investigations of child deaths, and conducted 7,276 searches for criminal background information. Requests for investigation and notices of deaths or serious injuries are screened to determine whether the facts alleged suggest possible misconduct by a Department employee, private agency employee, foster parent, service provider, or identify a need for systemic change. If an allegation is accepted for investigation, the OIG will conduct a full investigation pursuant to 89 Ill. Admin. Code 430. The Inspector General reports to the Director of the Department and to the Governor with recommendations for discipline, systemic change, or sanctions against private agencies. The OIG monitors the implementation of accepted recommendations.

The OIG may refer complaints 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, when appropriate.

ADMINISTRATIVE RULES

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

CONFIDENTIALITY

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

Reports issued by the 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, the OIG prepares several reports redacting confidential information for use as teaching tools for private agency and Department employees. Redacted reports are also shared with other entities that interact with, or are involved in, the child welfare system.

IMPOUNDING

The OIG is charged with investigating misconduct "in a manner designed to ensure the preservation of evidence for possible use in a criminal prosecution" (20 ILCS 505/35.5(b)). In order to conduct thorough investigations, while ensuring the integrity of records, IG investigators may impound files by immediately securing and retrieving original records.

INVESTIGATION CATEGORIES

DEATH AND SERIOUS INJURY INVESTIGATIONS

According to DCFS Rule 430, the Inspector General investigates deaths or serious injuries in foster homes, child welfare institutions, independent living programs and other facilities licensed by the Department, as well as deaths or serious injuries when there was an open child welfare service case or child protection investigation by the Department 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. The 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. The 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. When further investigation is warranted, records are impounded, subpoenaed, or requested, and a review is completed. When necessary, a full investigation, including interviews, is conducted. The 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 2023:

FY 2023 CHILD DEATH CASES REVIEWED	
INVESTIGATORY REVIEWS OF RECORDS	**143**
FULL INVESTIGATIONS	**17**
CHILD DEATHS IN FY 2023 MEETING OIG CRITERIA FOR REVIEW	**160**

Summaries of death investigations where a full investigative report was submitted to the DCFS Director in FY 2023 are included in the Investigations Section of this Report. Later in the same section, there are summaries of all child deaths reviewed by the OIG in FY 2023.

GENERAL INVESTIGATIONS

The OIG responds to and investigates complaints filed by the state and local judiciary, Department and Child Welfare Contributing Agency (CWCA) employees, foster parents, biological parents, the public, referrals from the Office of Executive Inspector General (OEIG), and referrals pertaining to Child Welfare Employee Licensure (CWEL). A preliminary review is conducted on all complaints received. After preliminary review, a complaint may be closed, opened for further investigation, or referred for review by Department management, the Office of Affirmative Action, Labor Relations, or the Advocacy Office for Children and Families. 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. Summaries of General Investigations where a full investigative report was submitted to the DCFS Director in FY 2023 are included in the investigations Section of this Report. Investigations yield both case-specific recommendations, including disciplinary

recommendations, and recommendations for systemic changes within the child welfare system.

In FY 2023, the OIG received 612 requests for investigation, 103 OEIG referrals, and 53 CWEL referrals totaling 768 complaints, a 16% increase from FY 2022. The OIG screened 792 telephone inquiries through the OIG General Intake line, a 14% increase from FY 2022.

FY 2023 COMPLAINTS	
REQUESTS FOR INVESTIGATION	**612**
OEIG REFERRALS	**103**
CWEL REFERRALS	**53**
TOTAL COMPLAINTS RECEIVED	**768**

CHILD WELFARE EMPLOYEE LICENSURE (CWEL) INVESTIGATIONS

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees. The CWEL system permits centralized credentialing and monitoring of all persons providing direct child welfare services, whether 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 the 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). The OIG investigates and prosecutes CWEL complaints.

When a CWEL investigation is completed, the 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 2023, 53 cases were referred to the OIG for CWEL investigations.

FY 2023 CWEL INVESTIGATION DISPOSITIONS	
PENDING INVESTIGATION	**6**
PENDING, OIG MONITORING	**1**
CLOSED, MONITORED ONLY	**25**
CLOSED, NO ADVERSE LICENSURE ACTION	**10**
CLOSED, CWEL VOLUNTARILY RELINQUISHED	**9**
PENDING AHU	**2**
FY 2023 CWEL INVESTIGATION REFERRALS RECEIVED	**53**

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 the OIG meets the definition of a criminal justice agency in the Department of Justice Regulations on Criminal Justice Information Systems (Title 28, Code of Federal Regulations, Part 20, Subpart A) the OIG, unlike the Department, has access to criminal history

outside of Illinois 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. The OIG provides technical assistance to the Department and private agencies in performing and assessing out of state criminal history inquiries for the purpose of child safety in emergency placement. The 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 does not include disposition information, the 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 2023, the OIG's six LEADS operators conducted 7,276 searches for criminal background information.

The OIG serves as the primary liaison between the Department and the Illinois State Police. In the course of an investigation, if evidence indicates that a criminal act may have been committed, the OIG shall notify the Illinois State Police. The OIG may also investigate the alleged act for administrative action only.

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

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.

The 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, the OIG will consider comments received and may revise the report accordingly.

The 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.

RECOMMENDATIONS

The 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.

The 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. Ideally, discipline should have an

accountability component as well as a constructive or didactic one. It should educate an employee on matters related to their 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 they have simply violated an arbitrary rule with no rationale behind it. In addition, the OIG will determine whether the facts suggest a systemic problem or an isolated instance of misconduct or bad practice. If the facts suggest a systemic problem, the OIG may investigate further to determine appropriate recommendations for systemic reform.

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 the OIG to discuss the report and recommendations.

The 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, the 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.

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

OIG HOTLINE

Pursuant to statute, the 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
- General questions about DCFS and the OIG

The OIG Hotline is an effective tool that enables the OIG to communicate with concerned persons, respond to the needs of Illinois children, and address day-to-day problems related to the delivery of child welfare services. The following chart summarizes the OIG's response to calls received in FY 2023.

CALLS TO THE OIG HOTLINE IN FY 2023	
INFORMATION AND REFERRAL	**454**
REFERRED TO SCR HOTLINE	**72**
REQUEST FOR OIG INVESTIGATION	**191**
TOTAL CALLS	**717**

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2022 to June 30, 2023 (FY 2023). The Investigations section is four parts. Part I includes summaries of full child death and serious injury investigations submitted to the Director of DCFS. Part II contains aggregate data and case 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. Part IV contains the OIG Error Reduction Training Implementation Plan based on findings of the Inspector General's investigations.

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 implementation plan to the recommendations follow.

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS

DEATH AND SERIOUS INJURY INVESTIGATION 1

DEATH

A 17-year-old medically complex youth, with diagnoses of developmental disabilities, cerebral palsy, and epilepsy, had a seizure while staying at his stepfather's home. When the seizure lasted longer than usual, the youth's stepfather called for emergency services, which took the youth to the hospital where doctors pronounced the youth deceased. The cause of death was attributed to complications of haemophilus influenzae pneumonia and acute bacterial cystitis with prostatitis. Significant contributing conditions to his death included cerebral palsy and epilepsy. The Department indicated the stepfather for death by neglect (#51) and medical neglect (#79) and indicated the youth's mother for medical neglect (#79). Six months prior to the youth's death, the Department closed and unfounded a child protection investigation involving the youth and his mother.

INVESTIGATION

In September 2019 and October 2019, the Department initiated two child protection investigations involving the youth's youngest maternal sibling, the youth's mother, and the mother's paramour, who was the father of the youth's two youngest maternal siblings. The Department indicated the paramour for neglect in the first investigation and unfounded the mother and the paramour for neglect in the second investigation. In December 2019, the Department opened an intact family services case and a private agency provided the family with services. The youth's mother and her paramour completed parenting classes. The paramour also consistently completed drug tests and reported to the caseworker that he began an intensive outpatient treatment program. In April 2021, the private agency closed the family's intact services case, noting that the youth's mother and her paramour completed all the requested services.

In October 2021, less than six months after the family's intact services case closed, the Department initiated a child protection investigation after the 17-year-old youth attended school with bruising on his arm. According to the hotline reporter, the youth had multiple diagnoses including physical and cognitive disabilities, was non-verbal, required a wheelchair, and completely depended on others for all his basic needs. The next day, the assigned child protection investigator met with the youth and school personnel at the school. The child protection investigator documented observing three circular bruises in varying stages of healing on the youth's arm. School personnel also showed the investigator the youth's leg that appeared to have a gouge injury in the

process of healing. School personnel stated they noticed the injury after the youth returned from summer break two months earlier.

After leaving the school, the child protection investigator went to the youth's home and interviewed the youth's mother. The mother stated the youth exhibited self-harming behaviors since infancy, and the youth sustained the arm bruises from biting himself. The mother reported the school knew the youth had a history of biting himself. The mother also reported the youth sustained the injury on his leg when he tried to roll off the bed, and his leg got caught between the mattress and the bedframe. While at the home, the child protection investigator interviewed the mother's paramour, who was the father of the youth's two youngest siblings. The paramour corroborated the mother's statement that the youth caused the bruises on his arm. The paramour also stated the injury on the youth's leg occurred during a visit with his stepfather, who was also the father to the youth's two oldest siblings. The youth's stepfather, who was also in the home during the child protection investigator's visit, reported that he had visitation with his children every other weekend, and that he included the youth in the visitations because he was a father figure to the youth. The stepfather confirmed the youth's leg injury occurred at his residence when the youth got caught between the mattress and the bedframe. While in the home, the investigator documented observing the youth hit himself on the arm. The child protection investigator interviewed the youth's four siblings at the home, who confirmed the youth displayed self-harm behavior and that everyone in the home helped take care of the youth.

The child protection investigator told IG investigators that she did not observe the stepfather's residence because the youth did not live there. The child protection investigator also stated the leg injury occurred months prior to the hotline call, and the family reported they fixed the bed. However, DCFS Procedures 300.60. *Reports of Child Abuse and Neglect: Scene Investigations and Time Lines* requires child protection staff to observe the environment where the alleged maltreatment occurred.

Seven weeks after the hotline call, the child protection investigator spoke with a nurse at the family's primary care physician's office, who reported all the children had been seen in the last 18 months and had up to date immunizations. The OIG obtained the youth's medical record, which noted the youth's last well-child visit occurred in 2018, and the youth had an assessment for injuries in July 2021, following a motor vehicle accident. The child protection investigator told IG investigators that during investigations, nurses typically provided information to the child protection investigator, and that the treating physicians rarely provided the information themselves. The child protection investigator stated she typically asked nurses when the children had last been seen, immunization history, and if there were any concerns noted in the chart. The child protection investigator stated she generally did not ask the reason the doctor saw a child. When asked about any additional steps or information sought when a child had medical complexities or required ongoing medical treatment, the child protection investigator told IG investigators that she followed her supervisor's instructions, but there was "no reason to look" further regarding the youth's medical issues.

The child protection investigator entered the majority of her investigatory contact notes in SACWIS two months after making the contacts, despite the supervisor's multiple instructions to enter contact notes into SACWIS. The supervisor told IG investigators that the child protection investigator performed her job effectively, but consistently had issues entering contact notes in SACWIS. The supervisor stated the delay in entering contact notes made it difficult for the supervisor to follow the investigator's progress and ensure the child protection investigator made required contacts. The child protection investigator entered most of the contact notes for the investigation involving the youth two days prior to the investigation's due date. The child protection investigator's supervisor had scheduled benefit time on the investigation's due date, and a temporarily assigned child protection supervisor provided final supervision on the investigation.

On the same day she was assigned as the temporary supervisor to the investigation, the temporarily assigned supervisor approved the closure of the investigation and documented that due to insufficient evidence, the mother would be unfounded for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the youth.

The temporarily assigned supervisor waived the required contact "Physician(s) – Treated Current Condition" and noted: "no current condition- spoke with nurse at PCP." The temporarily assigned supervisor also waived the required contact for the "Primary Care Physician," noting the investigator spoke with the nurse instead of the doctor. The temporarily assigned supervisor told IG investigators that these two required contacts were often used interchangeably. When asked about the procedural requirement to have a medical provider examine a child during investigations involving allegation #11, the temporarily assigned supervisor told IG investigators that the medical exam would typically happen in the initial stage of the investigation and did not know why it was not requested during initiation of the youth's investigation. The temporarily assigned supervisor also stated she did not require a medical exam prior to approving the final finding because she did not believe the exam would provide any additional information, as it was already determined that the injuries were self-inflicted, and the child protection investigator observed the child engaged in self-harm behaviors.

DCFS Procedures 300.100. *Reports of Child Abuse and Neglect: Medical Requirements for Reports of Child Abuse and Neglect* requires a medical exam for certain allegations, including allegation #11 and states that the exam "cannot be waived" when the child is an infant, non-verbal, or has a developmental delay. Additionally, DCFS Procedures 300.75.b. *Reports of Child Abuse and Neglect: Area Administrator Requirements, Cases Requiring Area Administrator Review* requires investigations be staffed with an area administrator involving children who are non-verbal, medically complex, or have severe developmental delays. The temporarily assigned supervisor told IG investigators that she did not know about this requirement. The child protection investigator's supervisor and the temporarily assigned supervisor separately told IG investigators that the Department did not provide formal training for child protection investigators that are temporarily assigned to supervisory positions.

RECOMMENDATIONS

1. The OIG reiterates the following recommendation (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 6. See also: Department Update on Prior Systemic Recommendations) should be incorporated in Procedures 300: In the absence of the Public Service Administrator, only a 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 Office of Child and Family Policy will incorporate the following procedural requirement in Procedures 300, "In the absence of the Public Service Administrator, only a Child Protection Advanced Specialist or Area Administrator can approve a Child Endangerment Risk Assessment Protocol, approve a critical decision regarding protective custody and provide a Final Supervisory Decision."

2. The Department should develop and require training for Temporarily Assigned Supervisors who are currently employed as Child Protection Specialist Workers and Child Protection Advanced Specialists.

The Department agrees. The Department's child protection leadership team is in the process of developing a training module for Child Protection Specialist Workers and Child Protection Advanced Specialists who are temporarily assigned as supervisors.

3. The Department's new data system, IllinoisConnect (formerly known as CCWIS), should include prompts for required investigative contacts that cannot be waived and prompts when a waiver is required.

The Department agrees. The recommendation will be incorporated in the new system.

4. This report should be shared with the child protection investigator's current supervisor for training purposes.

The Department agrees. The report was shared with the current supervisor.

5. The child protection investigator should receive an oral reprimand for her failure to enter investigation notes in a timely manner in the October 2021 child protection investigation, as supported by a documented history of a delay in entering contact notes.

The Department agrees. The employee was issued an oral reprimand.

6. A redacted copy of this report should be shared with the child protection investigator's supervisor from the October 2021 investigation and the temporarily assigned supervisor for training purposes.

The Department agrees. The report was shared with the involved staff for training purposes.

DEATH AND SERIOUS INJURY INVESTIGATION 2

DEATH

A 24-year-old mother found her 4-year-old medically complex child unresponsive, and an ambulance transported the child to the hospital, where medical staff pronounced the child deceased. The pathologist reported the child had cocaine in her system, and the amount was more than twice the dose that would be fatal for a healthy adult. The medical examiner's report determined the cause of death as cocaine toxicity and ruled the manner of death as homicide. The medically complex child could not have ingested the cocaine herself, as she required feeding through a tube and lacked the motor skills to put the substance in her mouth. The child's mother and the mother's paramour tested positive for cocaine the day of the child's death, and the mother and the paramour were held without bail in jail on charges of first-degree murder and drug-induced homicide. The Department indicated the mother and the paramour for death by abuse (#1) and substance misuse by abuse (#15). Six days prior to the child's death, the Department initiated an investigation against the mother for medical neglect (#79) and environmental neglect (#82) to the child that remained open at the time of the child's death.

INVESTIGATION

In October 2018, the then 9-month-old child first came to the attention of the Department after she was brought to the hospital and medical staff determined she had a hypoxic brain injury. The reporter told the DCFS hotline that a metabolic disease could have caused the injury, or it could be from oxygen cut-off or shaking. The OIG obtained the child's medical records, in which physicians documented the following diagnoses: hypoxic ischemic encephalopathy, status epilepticus-generalized convulsive, obtundation, hypoglycemia, acute respiratory failure, and an altered mental status. Almost two months later, the hospital discharged the child to her mother and father. The following week, the Department unfounded the mother and father for head injuries by neglect (#52) because medical staff ruled out abuse by the parents and reported the child ingested medicine that caused the brain hypoxia. The day prior to the child's hospital admission, a family friend watched the child for the parents, and the parents believed the child may have ingested the family friend's diabetes medication. As a result of the incident, the child sustained permanent and severe brain damage, and the child required a wheelchair, was non-verbal, and depended on others for all her basic needs.

Six days prior to the child's death, the DCFS hotline received a report that the 4-year-old medically complex child required tube feedings and lost a lot of weight in the prior two weeks because of difficulty with child's feedings. The reporter stated the child had a fever, had been vomiting for a week, and had a rash all over her face. The reporter stated the mother had not taken the child to the doctor, and that the reporter attempted to call the mother that day, but the mother did not respond. The reporter also stated that it did not appear that the child bathed regularly, the mother and child previously smelled of marijuana, and the child came to school with the

same clothes on that she wore the day before, with vomit still on her clothes. The Department opened the investigation for allegations of medical neglect (#79) and environmental neglect (#82) against the mother.

The same day as the hotline call, the assigned child protection investigator attempted to see the mother and child at their home, but no one answered the door. The investigator called the mother, and they discussed the child's condition, to which the mother stated that the child had trouble with feedings the prior week and vomited, but had no fever. The mother reported she contacted the child's dietitian, who replied via email with recommendations and a plan of action. Without prompting, the mother stated that she planned to take the child to the clinic the following day. The mother agreed to contact the child protection investigator to confirm she brought the child to the clinic. The mother also agreed to forward the dietitian's email to the investigator, which the mother did later that day.

The day after the hotline call, the child protection investigator exchanged a series of text messages with the mother to confirm that the mother took the child to the clinic. The mother confirmed that an advanced practice registered nurse saw the child at the clinic and the mother provided the nurse with the investigator's contact information. The child protection investigator contacted the nurse, who verified she saw the child at the clinic. The nurse stated she discharged the child to the mother due to no outward signs of abuse or neglect. The child protection investigator discussed the medical neglect allegations, and the nurse responded that the mother appeared active in caring for the child since the mother seemed well informed about the child's condition. The child protection investigator told IG investigators that he discussed the child's weight loss with the nurse, who reported the child's illness and vomiting could have possibly caused the weight loss. When asked if he attempted to see the child during the medical exam, the child protection investigator told IG investigators that he did not discuss it with the mother, and that she had taken the child to the clinic outside his working hours.

Following the communications with the nurse, the child protection investigator staffed the investigation with another child protection investigator who was temporarily assigned as a supervisor, as the permanent supervisor was on vacation. The temporarily assigned supervisor instructed the investigator to see the child in person on their next scheduled workday, two days later. The temporarily assigned supervisor told IG investigators that given that the medical professional saw the child, she thought it was sufficient to delay the requirement to observe the child in-person. The temporarily assigned supervisor reported basing the decision on the facts that the report was not coded as an emergency response, the family had no prior reports of environmental neglect, and the concerns about the child's presentation came from someone that had never been in the home.

The temporarily assigned supervisor told IG investigators that she never followed up with the child protection investigator about seeing the child when the investigator returned to work two days later because the temporarily assigned supervisor no longer had temporary assignment as the supervisor. In a separate interview, the child protection investigator told IG investigators that he did not see the child in person due to responding to a report on a different investigation in a different city. The child protection investigator's permanent supervisor separately confirmed to IG investigators that the child protection investigator had initiated two newly assigned investigations that day, as the field office was understaffed. The permanent supervisor told IG investigators that she did not recall when she reviewed the investigation involving the medically complex child after her return from a 10-day vacation, and she had to review all the investigative reports assigned to her team from that time period. The permanent supervisor told IG investigators that child protection staff should not have gone two days without trying to see the child in person. The permanent supervisor also stated that currently there was no real time way for supervisors to know if an investigator saw the child or attempted to see the child until the investigator entered their contact notes in SACWIS. The permanent supervisor stated she relied on meeting with the child protection investigators to determine if a child had been seen.

Six days after the Department initiated the investigation, the DCFS hotline received a report of the child's death. In those six days, the child protection investigator did not contact the hotline reporter, observe the child or the home environment, interview the mother in person, or contact the child's physicians or specialists. The child

death investigator interviewed the child's primary care physician, who worked at the same facility as the nurse who evaluated the child five days prior to her death. The primary care physician informed the child death investigator that the child needed to be seen every month for a weight check, but the mother did not comply with the weight checks, and the mother did not respond to the physician's calls or letters to their residence. The OIG obtained the child's medical records, which documented the child weighed 23.8 lbs. the week prior to her death, a weight loss of 7 lbs. from the last documented weight check two months earlier of 30.42 lbs.

The child death investigator also interviewed the child's school nurse, who reported she had regular contact with the child's physician and dietician because of the mother's lack of cooperation. The school nurse stated that two months prior to the child's death, the mother sent the child to school without enough formula for her feeding. The child's teacher also told the child death investigator that the mother ran out of formula about a month and a half earlier, and the school provided the child with formula which she did not tolerate well. The teacher stated that the school staff had concerns about the child's hygiene and weight loss.

Less than two months after the hotline call regarding the medically complex child's weight loss, the Department indicated the mother for medical neglect (#79) and environmental neglect (#82). According to the rationale, the child's primary care physician completed the CANTS 65-B, Evaluation of Medical Neglect of a Child and documented medical neglect of the child which contributed to her worsening condition and placed the child at risk for a serious outcome.

RECOMMENDATIONS

1. A copy of this report should be shared with the child protection investigator, the temporarily assigned supervisor, and the permanent supervisor for training purposes.

The Department agrees. The report was shared with the involved staff and used as a training tool.

2. The Department should explore technology that provides real time information for better oversight and coordination for child protection supervisors to ensure children are being seen in a timely manner. This data should allow for a distinction between when a child is physically seen and when a good faith attempt was made but the child was not seen.

The Department agrees. The Department of Child Protection and the Department of Information and Technology (DoIT) are committed to exploring technology with the ongoing development of IllinoisConnect that will provide greater oversight and coordination for child protection supervisors. This technology will enhance current data provided through PowerBI, which provides a distinction between victims seen and documented and victims not seen and/or documented.

3. This report will be redacted and used by the OIG in Error Reduction trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

4. A redacted copy of this report should be shared with the clinic where the child was seen prior to the death.

The report was shared with the administrators of the clinic.

DEATH AND SERIOUS INJURY INVESTIGATION 3

DEATH

A 19-month-old child was transported by ambulance to the hospital after she was found bleeding from the mouth and unresponsive while in the care of her father's 20-year-old paramour. Hospital personnel observed bruising on the side of the child's face and body in various stages of healing. Two days later, the DCFS hotline received notification of the child's death. The coroner's office ruled the child died from blunt force injuries of the head. The father's paramour was charged with first-degree murder and aggravated battery to a child. The criminal case remains pending. The Department indicated the paramour for death by abuse (#1) and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). One month prior to the child's death, the Department initiated a child protection investigation against the child's father and his paramour for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child which was pending at the time of the child's death.

INVESTIGATION

The child first came to the attention of the Department as a 2-month-old after the DCFS hotline received a report that a registered sex offender lived in the home with the child, the mother, the father, and the child's then 4-year-old and 6-year-old paternal siblings. During the child protection investigation, the mother and father denied they knew their roommate was a registered sex offender. The father also stated the roommate only stayed at the home for a few days and was never alone with the children. Two months later, the Department closed the investigation and unfounded allegations of substantial risk of sexual abuse-sex offender has access (#22a) against the mother and father. The Department indicated the roommate for substantial risk of sexual abuse-sex offender has access (#22a) to the three children.

The Department initiated a child protection investigation 16 months later after the mother and maternal grandmother brought the then 18-month-old child to the emergency department with multiple injuries that she reportedly sustained while visiting her father's home. The child sustained bruising on both cheeks, nose, upper lip, left eyelid, forehead, and left buttocks. The hospital released the child to her mother, but she needed follow-up X-rays to determine if the child's arm had a buckle fracture at the top of the humerus.

An OIG review of the call to the hotline revealed that the reporter provided information that the call floor worker did not include in the hotline narrative, and therefore, the information was not provided to the child protection staff. This included information that the father and his paramour gave multiple explanations to the mother and maternal grandmother about the child's injuries and that the father and paramour's explanations were not consistent with the child's injuries.

The same day as the hotline call, the assigned child protection investigator went to the mother's residence to observe the child. The investigator photographed the bruises and injuries on the child's face, neck, and back. The mother told the child protection investigator that she and the father separated during the summer, but she recently allowed the child to have visits with the father. The mother reported the father's paramour watched the child and the child's paternal siblings while the father worked. The mother stated the paramour sent a text message to the mother, explaining that the 18-month-old child got hurt after the 5-year-old paternal sibling ran through the door, which hit the child, knocking her to the ground. The paramour reported the child held a sippy cup at the time, which caused the marks to the child's face. The child protection investigator explained to the mother that it would be inappropriate to allow the child to go to the father's home until the Department assessed the home and the mother agreed. IG investigators separately interviewed the assigned child protection supervisor and the area administrator, who both reported frequent communication about the investigation, and they understood that the mother would not allow the child to go to her father's home before additional investigative work was done to assess if the child would be safe at her father's home. The supervisor told IG investigators that the child protection investigator reported the mother appeared very protective of the child and that the father did not have court ordered custody or visitation.

The Department assigned a parallel child protection investigator and supervisor to the investigation, as the father and parental siblings lived in a different jurisdiction than the child and mother. The day after the hotline call, the parallel child protection investigator spoke with the child's 5-year-old and 8-year-old paternal siblings at their school. The siblings did not disclose any concerns about the paramour or the father, and they confirmed the door hit the child in the face at their father's home. The siblings reported that at the time of the injury, the paramour cared for them while their father worked. The parallel investigator also contacted the paternal siblings' mother, who reported no concerns regarding the father or the paramour.

The following day, the parallel investigator spoke with the father at his residence, and he stated neither he nor his paramour used physical abuse or corporal punishment with the children. The parallel investigator also contacted the paramour, who repeated that the 5-year-old paternal sibling ran through the door, which hit the child and knocked her over. The paramour reported the child also fell off the bed that evening. The paramour stated she did not notice any issues with the child's arm until the next morning, when the child did not move her arm. The parallel investigator notified her supervisor and the primary child protection supervisor and investigator that she conducted the interviews and uploaded photographs to SACWIS of the door that reportedly hit the child.

Procedures 300 Appendix B, *Allegation of Harm, cuts, bruises, welts, abrasions, and oral injuries, #11/61* requires child protection staff to conduct a reenactment. The parallel child protection investigator told IG investigators that she did not conduct a scene investigation or reenactment because the primary investigative team did not request these tasks. The parallel child protection investigator also told IG investigators that she did not interview the paramour in-person because the paramour was not available when the investigator went to the home, and the primary investigative team did not request for her to return and meet with the paramour in-person. In a separate interview with IG investigators, the area administrator reported ongoing issues with tasks related to parallel assignments, as many parallel workers waited for the primary staff to direct them to conduct a scene investigation. The area administrator also reported instances in which parallel investigators did conduct scene investigations because they knew it should be done in a physical injury investigation. Procedures 300.50(n), *Parallel Investigations* documents the process for assigning parallel investigators but provides little guidance on the work required of the parallel investigator.

Two weeks after the hotline call, the mother sent a text message to the primary child protection investigator to ask for an update regarding the investigation, as the father requested visitation with the child. The investigator documented in SACWIS that she called the mother to explain that the father's home had not yet been assessed but there was no current evidence to suggest that the child would be in immediate harm. The investigator stated the mother should not send the child to the father's home if she did not feel the child would be safe there. The primary child protection investigator told IG investigators that the mother reported the father pressured her to send the child to his home. The primary investigator told IG investigators that she explained to the mother that the investigation remained ongoing, and they did not have all the information yet to determine if the child would be safe at the father's home. The primary investigator stated she informed the mother that the mother would be responsible if something happened to the child while at the father's home. The primary investigator told IG investigators that the mother gave the impression that she sought advice and that the mother did not give any indication that she would send the child to the father's home. The primary investigator also told IG investigators that she did not discuss the conversation with the mother with her supervisor.

The same day that the mother sent the text message to the primary investigator, the paramour called the parallel investigator to inquire if the child could visit her and the father that weekend. The parallel investigator asked the primary supervisor for guidance, and the primary supervisor stated that they did not have urgent and immediate cause to say that the child could not go to the father's home. The parallel investigator then spoke to the paramour and provided the primary supervisor's response. In her interview with IG investigators, the primary supervisor reported that she could not recall what she specifically told the parallel investigator, but the

primary supervisor informed IG investigators that they would not have urgent and immediate cause unless the child went to the father's home.

Less than three weeks later, the child died from blunt force injuries of the head. The Department placed the primary child protection supervisor and investigator on desk duty for 72 days. The Department reassigned the pending child protection investigation and indicated the paramour and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

RECOMMENDATIONS

1. This report should be shared with the area administrator, the primary child protection supervisor, the primary child protection investigator, and the parallel child protection investigator. The area administrator should use this report in a case discussion with the involved staff for discussion purposes.

The Department agrees. The report was shared with the involved child protection staff.

2. State Central Register (SCR) administrators should review the audio recording of the hotline call and the hotline narrative from the January 2022 child protection investigation to provide additional training to the call floor worker.

The Department agrees. SCR administrators reviewed the audio recording and provided additional training to the call floor worker.

3. This report will be redacted and used by the OIG in Error Reduction trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

4. The Department should revise Procedures 300.50(n) *Parallel Investigations* to clarify expectations of child protection staff when parallel investigators are assigned.

The Department agrees. A practice memo was issued to all child protection staff clarifying expectations surrounding parallel assignments.

5. As previously recommended (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 11. See also: Department Update on Prior Systemic Recommendations), the Department should develop written protocol for the use of restricted duty status. The Department should review the practice of placing staff on indefinite desk duty after the death of a child and explore the use of increased supportive supervision in lieu of desk duty, when appropriate.

The Department continues to collaborate with staff, the union and across divisions to develop a written protocol related to restrictive duty status that will work effectively for various divisions and their respective job assignments. The restrictive duty status will allow for increased supervision when discipline may be pending. The updated protocol will be released later in FY 2024.

DEATH AND SERIOUS INJURY INVESTIGATION 4

SERIOUS INJURY

A 14-year-old mother brought her 2-month-old infant to the hospital for a fever and vomiting. Medical examination revealed the infant sustained significant injuries that included multiple bone fractures, bruises, a brain bleed, eye hemorrhage, torn frenulum, liver lacerations, occipital skull fracture, and swelling to the neck. The mother did not provide an explanation for the infant's serious injuries and reported the infant had been in the care of the 15-year-old presumed father the day prior. The Department took protective custody of the infant and placed the infant with a relative. The Department indicated the mother for head injuries by abuse (#2); bone fractures by abuse (#9); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the infant. The Department unfounded the mother for medical neglect (#79), but the allegation rationale recommended this allegation be indicated because the infant was in the mother's care for eight hours before the mother took the infant to the hospital to be evaluated. The Department had a pending child protection investigation involving the presumed father for allegations of substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the infant at the time of the serious injury report.

INVESTIGATION

From 2010 to 2015, the Department conducted three child protection investigations involving the mother as a minor, one of which was indicated. Between 2016 and 2017, the Department completed 10 child protection investigations involving the presumed father as a minor. The Department unfounded all the investigations.

The Department received a call after the 14-year-old mother gave birth to the infant, and the mother stated the 15-year-old presumed father raped her. The Department determined the report as an ineligible event and took the report as information only.

Less than two weeks prior to the infant's serious injuries, the Department initiated a child protection investigation after the mother and the maternal grandmother brought the then 1-month-old infant to the hospital for crying, fussiness, and not eating. The caller to the DCFS hotline reported concerns about abuse towards the infant and noted the mother showed signs of postpartum depression. The caller also reported the mother and grandmother disclosed that the infant began exhibiting these symptoms two days earlier, after returning from a visit at the presumed father's home. The reporter stated the hospital planned to discharge the infant to the mother later that day.

The same day as the hotline call, the child protection investigator spoke with a hospital social worker and the maternal grandmother. The hospital social worker reported that the infant had subconjunctival hemorrhages in both eyes. The child protection investigator told IG investigators that according to the hospital social worker, it was inconclusive if the infant's subconjunctival hemorrhages were a result of physical abuse or excessive crying. The social worker also reported the infant's skeletal survey and MRI exams appeared normal. The child protection investigator told IG investigators that she previously spoke with the social worker during other investigations and that she did not speak with the treating physician during this investigation because she obtained sufficient information from the hospital social worker. The child protection investigator told IG investigators that it was common practice in their field office to obtain medical information from hospital social workers because of the difficulty in reaching treating physicians.

The maternal grandmother reported that two days prior to bringing the infant to the hospital, she left the infant at the presumed father's home for a visit. The maternal grandmother stated the presumed father called later that day to report the infant vomited blood, and the maternal grandmother reported that the infant had not thrown up blood prior to visiting the presumed father. The maternal grandmother stated the presumed father returned the infant to the mother that evening, even though the presumed father planned to care for the infant for two days. The maternal grandmother told the child protection investigator that a week earlier, the infant returned from the presumed father's home with a blood clot in her eye which the presumed father explained happened

after the infant scratched herself. The maternal grandmother reported she did not believe the explanation. The child protection investigator told IG investigators that she never discussed the alleged rape with the mother or the maternal grandparents.

The same day as the report to the hotline, the child protection investigator went to the home and observed the infant, who lived with her mother, maternal grandparents, and other maternal relatives. The investigator documented that the infant appeared fussy and hoarse from crying. The child protection investigator told IG investigators that she did not observe any injuries to the infant, including blood clots in her eyes. The child protection investigator interviewed the mother, who did not remember the doctor's discharge instructions for the infant. The child protection investigator told IG investigators that she explained the discharge instructions to the mother, however the child protection investigator did not document observing the infant's discharge paperwork, and the investigative file did not contain the infant's medical records. The child protection supervisor could not explain to IG investigators why the investigative file did not contain the medical records. The child protection investigator also interviewed the maternal grandfather, who confirmed that the infant came home from the visit with the presumed father early and the infant usually spent the night with the presumed father. The maternal grandfather reported instructing the maternal grandmother to take the infant to the hospital because the infant had not eaten nor had a bowel movement. During interviews with the mother and maternal grandparents, the child protection investigator did not obtain a timeline of events documenting the time between the infant's return from the presumed father's home to two days later when the infant went to the hospital.

While at the home, the child protection investigator completed a home safety check list and noted the home appeared safe with operable utilities. The investigator did not document an attempt to observe the presumed father's residence, where the maternal relatives reported the infant sustained the injury. DCFS Procedures 300.60, *Reports of Child Abuse and Neglect: Scene Investigations and Time Lines* provides detailed guidance for child protection staff to account for the events leading up to the injury and to conduct a scene investigation of the environment where an incident of child abuse or neglect is alleged to have occurred. However, the child protection investigator consulted with her supervisor the day of the hotline call, and they assessed the infant as safe. The child protection investigator told IG investigators that she had initial concerns because of the parents' young ages and that the infant had multiple caregivers and family members at both homes. The child protection investigator stated she assessed the infant as safe with maternal relatives because the mother took the infant to the hospital and the maternal grandparents expressed concerns for the infant's safety. The child protection investigator told IG investigators that she did not consider a safety plan because the mother and maternal grandmother assured they would not allow the presumed father to care for the infant. During the investigation, the child protection investigator never interviewed the presumed father or any of his household members to confirm the timeline provided by the maternal family. The supervisor instructed the child protection investigator to follow up with the presumed father, but the supervisor told IG investigators that the maternal family only provided the presumed father's phone number, and that the child protection investigator could not locate his address.

The supervisor told IG investigators that she assessed the infant as safe during the initial investigation due to the child protection investigator's conversation with the hospital social worker, in which medical staff concluded the infant's hemorrhaging was due to excessive crying and not physical abuse. However, the supervisor and the child protection investigator separately told IG investigators that they did not review the infant's medical records until after the infant returned to the hospital with serious injuries. The OIG obtained the infant's hospital records from the initial visit, which stated it was inconclusive if physical abuse caused the infant's hemorrhages and follow-up was needed. The doctor provided the mother with discharge instructions to follow up with a child protection medical team at the hospital two weeks later for the infant to undergo additional medical tests. The initial medical records also contained the social worker's interview with the mother, in which the social worker documented the mother did not respond when asked if she felt safe in her home and if she feared anyone in her home. The maternal grandmother was present during the interview. The

social worker also documented that the mother had a history of postpartum depression and postpartum mood and anxiety disorder, and that the social worker provided the mother with referrals for treatment.

DCFS Procedures Section 300.100.c.6.A. Reports of Child Abuse and Neglect: Medical Requirements for Reports of Child Abuse and Neglect, Obtaining Second Medical Opinions requires child protection staff to obtain a second medical opinion when a treating physician is unable to offer an opinion regarding the cause of the injury. The supervisor informed IG investigators that she believed it was unnecessary to obtain a second medical opinion during the initial investigation because the child protection investigator told her the medical staff determined abuse did not cause the infant's initial injuries, despite the medical records documenting the cause as inconclusive. The supervisor also stated there were no additional child abuse medical teams besides the one at the hospital that discharged the infant with no concerns of abuse, however there were additional medical teams in the region, including the board-certified child abuse pediatricians that the Department contracts with to assist child protection staff in determining abuse or neglect injuries. The supervisor stated she had no knowledge of this medical entity in the region.

The child protection investigator did not complete any investigative activities for two weeks, between the day after the hotline call and the initiation of the second investigation after the infant returned to the hospital with serious injuries. The child protection supervisor reported no specific reason for the gap in investigative activity to IG investigators. The supervisor told IG investigators that they based the decision to indicate the presumed father for the injuries on the maternal relatives' reports that the infant got injured while in the care of the presumed father, and the new evidence of additional injuries supported that the infant was physically abused. The Department indicated the father on the initial investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10) and for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

RECOMMENDATIONS

1. This report should be shared with the child protection investigator and the child protection supervisor for training purposes.

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

2. The child protection investigator and the child protection supervisor should participate in the Medical Aspects of Child Abuse training. After training completion, the DCFS Medical Director or designee should facilitate a discussion with the child protection investigator and the child protection supervisor about applying knowledge learned to child abuse and neglect investigations.

The Department agrees. The child protection investigator and supervisor have enrolled in the training. Once the staff have completed the training the DCFS Medical Director will meet with the staff to facilitate a discussion.

3. This report should be shared with the Executive Deputy Director, Deputy Director of Child Protection, and Deputy Director of State Central Registry to review the child protection investigation into the infant's serious injuries for the lack of adding the presumed father as an alleged perpetrator and the finding to unfound Allegation #79 – Medical Neglect due to the rationale stating that the allegation should be indicated.

The Department agrees. The report has been shared with the Deputy Directors to review the child protection investigation.

DEATH AND SERIOUS INJURY INVESTIGATION 5

DEATH

A mother left her 4-year-old child in the care of her paramour while the mother went to work. Late that evening, the paramour called 911 and reported the child fell out of the bed and stopped breathing. An ambulance transported the child to the hospital, where doctors pronounced the child deceased. Medical staff subsequently reported the child's death was due to abusive injuries, and the medical examiner documented 37 injuries to the child's body, including contusions, lacerations, hemorrhages, and multiple teeth traumatically absent. The Department indicated the mother for death by neglect (#51) and the paramour for death by abuse (#1). Law enforcement also charged the paramour with first degree murder. At the time of the child's death, the Department had a pending child protection investigation against the mother and paramour for burns by abuse (#5).

INVESTIGATION

Two weeks prior to the child's death, the Department initiated a child protection investigation after the mother brought the 4-year-old child to the hospital with unusual burn patterns to her hands and feet. The reporter told hotline staff that the burns looked substantial and voiced concern about the delay in seeking care, and stated that the mother disclosed the injuries occurred a few days prior. An on-call child protection investigator interviewed the mother at the hospital, who reported she gave the child a bath while she was cooking. The mother stated she left the child in the bathtub to check on the food and then heard the child scream. The mother reported the child turned on the hot water, and the mother removed the child from the bathtub and did not observe any injury to the skin. The mother stated she Googled how to treat the burns, but when the burns did not improve, she brought the child to the hospital. The on-call investigator observed the non-verbal child and photographed the injuries. The on-call investigator told IG investigators that she did not complete a body chart at the hospital because she did not have the necessary form. The on-call investigator also stated the child's grandfather lived at the home and was reportedly present at the time of the incident, but the on-call investigator did not interview the grandfather.

The on-call child protection investigator enacted an out-of-home safety plan, and the mother identified her paramour to care for the child and monitor the safety plan, however the on-call investigator told IG investigators that she did not ask the mother or the paramour about the extent of their involvement with one another. The on-call investigator called the placement clearance desk to initiate the safety plan, which reported the paramour was negative on CANTS and positive on LEADS. LEADS results indicated two arrests that were not prosecuted. On the same evening as the hotline call, the on-call child protection investigator conducted a walkthrough of the paramour's home but did not complete the required home safety checklist. The on-call investigator interviewed the paramour, who agreed to not allow the mother any unsupervised contact with the child.

The next day, the Department assigned the primary child protection investigator to the investigation, who told IG investigators that she received three to four cases that day, and that a transfer staffing did not occur with the on-call investigator, nor did the primary investigator receive any supporting documents at the time of the new assignment. That same day, the primary investigator contacted the paramour, who reported that she would continue to care for the child. The investigator also called the mother and explained that the investigator needed to speak with the treating physician before terminating the safety plan.

Four days later, the child protection investigator met with the paramour and observed the child, who could not tell the investigator how the burn occurred. The paramour reported cleaning the child's wound and showed the investigator the first aid products. The paramour also told the investigator that she or the child's father provided care for the child while the mother worked, although the father was no longer involved; however, the investigator did not obtain additional information about the father during the investigation. The investigator documented no new injuries or signs of abuse to the child, but the child protection investigator told IG investigators that she did not observe the child undressed, did not complete a body chart, and her supervisor did not instruct her to complete those tasks. Both the child protection investigator and her supervisor reported to

IG investigators that upper management pressured staff to terminate safety plans within two weeks and required a staffing with the supervisor and area administrator if a safety plan went longer than two weeks.

One week into the investigation, the child protection supervisor instructed the investigator to meet with the mother to complete a scene investigation, educate the mother on bathing safety, and to send the child's medical information to the Multidisciplinary Pediatric Education and Evaluation Consortium (MPEEC) to obtain a second opinion. MPEEC consists of board-certified child abuse physicians who provide expertise regarding questions of inflicted or accidental injury during pending child protection investigations.

The next day, the child protection investigator spoke with the treating physician, who expressed concern about the unusual burn pattern and noted the child's injuries did not align with the mother's explanation. The physician also reported the mother should have brought her child to the hospital immediately due to the severity of the injuries. The physician would not provide a definitive opinion regarding whether the injuries should be considered abuse or neglect, and the investigator did not request that the treating physician complete a CANTS 65-A Referral Form for Medical Evaluation of a Physical Injury to a Child directed by Procedure 300. In her interview with the OIG, the child protection investigator stated she did not recall why she did not have the doctor complete the form.

Ten days after the hotline call, the child protection investigator documented seeing the child at the paramour's home and noted the child had healing bruises but no additional marks. The investigator did not describe the bruising nor document observing the child's burns. Later that day, the child protection investigator told her supervisor that the treating physician reported he could not classify the burns as abuse or neglect, but the physician had some other concerns with possible supervision. The child protection supervisor instructed the investigator to meet with the mother to complete a scene investigation and send the child's medical information to MPEEC for a second opinion. The supervisor then terminated the safety plan prior to the investigator interviewing the mother about the injuries. The child protection supervisor told IG investigators that she gave the mother's lack of history with the Department significant weight in deciding to end the safety plan. The supervisor also reported the mother and child lived with family who would ensure the child's safety, however, the child protection investigator never documented interviewing household members or assessing the home. The supervisor reported she did not ensure the investigator submitted the MPEEC referral or completed a scene investigation. The child protection investigator told IG investigators that she forgot to complete the MPEEC referral because she was overwhelmed with her other cases.

The child protection investigator contacted the paramour and the mother to inform them that the safety plan was terminated and the child could return to her mother's care. The investigator scheduled a visit with the mother at her residence in three days and did not discuss the allegations during the call. The child protection investigator did not complete any additional investigative tasks prior to the child's death. At the time of the child's death, the child protection investigator never met the mother in person, never observed her home, and did not speak with household members despite allowing the child to return to her mother's care. The investigator also had not documented any discussion of whether the child had received follow up medical care that the hospital recommended at discharge from approximately ten days earlier.

Three days after the termination of the safety plan, the Department received notification of the child's death after the child was brought to the hospital in an unresponsive state. The Department transferred the pending investigation for burns to the child protection investigator investigating the child's death. The child death investigator spoke with the mother at her home, where she lived with the child's maternal grandfather and uncle. The mother told the investigator she met the paramour online approximately five months earlier and began spending the night at the paramour's home with her child two months later. The mother reported she began allowing the paramour to care for the child the following month while the mother worked. The investigator interviewed the mother regarding the timeline of the child's burns, and the mother reported she left the child in the paramour's care about three weeks prior to taking the child to the hospital. The mother reported the

paramour called her while at work and stated she left the child in the bathtub and walked out of the room. The paramour stated she heard the child scream and removed her from the bath. The paramour told the mother that when she wiped the child's face with the towel, skin came off, and the paramour sent her photographs of the burns. The mother reported she was too scared to take the child to the hospital and believed she could treat the burns using A&D ointment on the child's face and feet. The injuries to the child's face were not reported in the initial hotline call to the Department. The mother took the child to the hospital three weeks later after the uncle expressed concern that the child's foot appeared swollen. The mother told the investigator she did not believe the paramour's story about the bathtub and that the paramour did not have extremely hot water in her home. The mother also reported a prior incident of domestic violence in which the paramour tried to choke the mother with her hands because the paramour did not like the way the mother talked to her.

The child death investigator also spoke with law enforcement, who obtained the mother's phone as evidence, and found multiple messages that documented the paramour caused the child's burns. According to law enforcement, it appeared that the mother protected the paramour when initially interviewed about the burns. Approximately one month after the child's death, the Department indicated the mother and the paramour for burns by abuse (#5) to the child and closed the investigation, noting the mother continued to allow the paramour to care for her child after knowing the paramour caused the child's burns.

RECOMMENDATIONS

1. The primary child protection investigator and child protection supervisor should participate in the Medical Aspects of Child Abuse training. After training completion, the DCFS Medical Director or designee should facilitate a discussion with the child protection investigator and supervisor about applying knowledge learned to child abuse and neglect investigations.

The Department agrees. The child protection investigator and supervisor are enrolled in the Medical Aspects of Child Abuse training. Once they have completed the training, the DCFS Medical Director will facilitate a discussion with the employees.

2. The primary child protection investigator should be counseled regarding her failure to complete a scene investigation, assess the home, determine and interview household members and seek an expert medical opinion.

The Department agrees. The child protection investigator was issued a counseling.

3. The child protection supervisor should be counseled for not ensuring the investigator had visited the environment to complete a scene investigation and determine household members before approving termination of the safety plan; not ensuring the investigator referred the case to MPEEC.

The Department agrees. The child protection supervisor was issued a counseling.

4. This report should be shared with the on-call child protection investigator for educational purposes.

The Department agrees. The report was shared with the on-call child protection investigator for educational purposes.

5. This report will be redacted and used by the OIG in Error Reduction trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

6. The Department should share this report with the Medical Director and Statewide Medical Consultation Providers (MPEEC, MERIT, PRC and CMRN) for use in on-going training of direct service staff.

The Department agrees. The report was shared with the Medical Director. A redacted copy of the report will also be shared with Statewide Medical Consultation Providers for use in ongoing training.

7. The Department, in collaboration with the DCFS Medical Director and Statewide Medical Consultation Providers, should develop training materials and posters to educate the field on burns. Materials should include but not be limited to, differentiating between accidental and inflicted injuries; prevalence and risk factors associated with inflicted injuries; and mechanism of injuries.

The Department agrees. The DCFS Chief of Nursing, in collaboration with the DCFS Medical Director completed the development of the training materials. The training materials are currently with the Office of Communications to develop the final materials.

DEATH AND SERIOUS INJURY INVESTIGATION 6

DEATH

An 8-year-old child was found cold and unresponsive by his mother, who called 911. Emergency services transported the child to the hospital, where a doctor pronounced the child deceased. Medical staff noted the child appeared malnourished and weighed only 38 lbs. The forensic pathologist found the cause of death to be failure to thrive secondary to chronic malnutrition for physical neglect and abuse. The Department took protective custody of the child's 12-year-old sibling and placed him with a relative. The child's mother and father were convicted of first-degree murder and are awaiting sentencing. The Department indicated the mother and father for death by abuse (#1); tying/close confinement (#14); torture (#16); cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); and failure to thrive (#81) to the child and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child's sibling. At the time of the child's death, the Department had a pending child protection investigation involving the child and sibling for allegations involving abuse and neglect, and the Department unfounded the parents in a separate investigation less than five months prior to the child's death.

INVESTIGATION

In December 2013, the Department initiated a child protection investigation after a report that the child tested positive for opiates at birth and received methadone treatment in the neonatal intensive care unit for withdrawal symptoms. In February 2014, the Department took protective custody of the then 6-week-old child upon his discharge from the hospital. The Department also took protective custody of the child's then 3-year-old sibling and placed the children with their maternal aunt. The Department closed the investigation and indicated the mother for neglect to the child and sibling.

A private agency provided case management services for approximately three years. During the first year of placement, the agency moved the children to the home of the paternal grandmother. The parents initially participated in recommended services to address issues of substance use, mental health, and domestic violence. While the court granted and the agency implemented unsupervised visitation between the children and parents, the agency learned of reports of continued domestic violence, and visitation returned to being supervised. The parents later reported they no longer wanted to participate in services and requested that the paternal grandmother obtain guardianship of the children. The placement case remained open for the completion of the subsidized guardianship process and the court entered a finding of fit for unsupervised visitation. The assistant

state's attorney at the time of the hearing told IG investigators that the judge's order of fitness allowed for the agency to approve unsupervised visits if appropriate.

The children's juvenile case originated in the county where the parents resided at the time the children entered foster care. Because the grandmother lived in a different county, probate court in the grandmother's county granted guardianship to the grandmother. That same day, the original county court closed the children's juvenile case, and the Department closed the placement case.

Eight months after the grandmother obtained guardianship, the Department initiated a child protection investigation after the then 4-year-old child sustained a large bruise on his buttocks which the child attributed to his mother spanking him. The grandmother reported she saw the child's injury the morning after the children returned from a visit with the parents and contacted the father, who denied he knew what happened. The grandmother took the child to the doctor and stated she would no longer allow the parents to visit the children. The child protection investigator met with the father, who denied he knew how the injury occurred. The mother refused to be interviewed. The child's doctor told the investigator that the bruise appeared abusive. The Department closed the investigation and indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child. The children continued to reside with their grandmother.

Approximately two years later, the Department initiated an investigation after the grandmother brought the then 6-year-old child to the hospital with significant bruising, a swollen forehead, and bilateral black eyes. According to the reporter, the parents cared for the child at the time of his injuries. The child said he sustained the injuries when he wrestled with his then 10-year-old sibling and struck his face on a piece of furniture. The child protection investigator spoke with the grandmother, who stated she left the children with the parents because she required hospitalization. The investigator separately interviewed the child and sibling, and they both reported the child received the injuries while they wrestled. The children reported they lived with their grandmother but stayed with their parents when their grandmother went to the hospital.

The mother told the child protection investigator that three days before the grandmother picked up the children, the child sustained injuries while wrestling with the sibling. The mother stated the child's nose and forehead appeared red and swollen, and bruising appeared the next day. The mother reported she treated the injuries. The father reported he was at work when the injury occurred and confirmed the mother treated the injury. The father stated he did not take the child to the hospital because he did not think the injury required medical treatment.

The Department closed and unfounded the investigation for allegations of cuts, bruises, welts, abrasions, and oral injuries by neglect (#61); medical neglect (#79); and inadequate supervision (#74) to the child. The rationale cited that the sibling caused the injuries and the treating physician did not believe the parents' actions qualified as medical neglect.

In the year preceding the child's death, the Department initiated a child protection investigation after the parents refused to return the then 7-year-old child and the 11-year-old sibling to the grandmother, their legal guardian. According to the reporter, the father threatened to flee the state with the children and the parents' home had environmental concerns. The grandmother told the child protection investigator that she allowed the 11-year-old to return to the parents care one year earlier because of behavior issues and aggression towards the 7-year-old child. The grandmother then stated that one month earlier, she needed to travel out of state for a family emergency and left the child with the parents and sibling. The grandmother reported that when she returned to Illinois, the parents refused to return the child. The grandmother stated that when she went to the parents' home that day, the mother became aggressive and threatened her. The day after the report, the child protection investigator attempted to see the children and parents at their home and at the father's place of employment, but did not locate the parents or children. During the pending investigation, the child protection investigator learned that the parents took the children out of state.

The child protection investigator requested assistance from the state's attorney's office in the county of the parents' current residence, to either obtain a protective warrant or receive guidance on court involvement. The county of residence differed from the county where the children's juvenile case originated, and differed from the county that granted the grandmother guardianship of the children. The assistant state's attorney from the parents' county of residence instructed the child protection investigator to send a petition request and to obtain the juvenile orders from the originating county to ensure the juvenile court had not restored the parents' fitness. That same day, the investigator requested court records from the originating county and the grandmother's county. The child protection investigator also made additional good faith attempts to the parents' home over the next two days, but no one responded. After the second attempt, the father called the investigator and reported he left the state with the children and had no plans to return to Illinois. The child protection investigator told IG investigators that the police characterized the situation as a civil custody dispute, not something that required law enforcement intervention.

During the child protection investigation, staff from the originating county state's attorney informed the investigator that, according to records, the juvenile court terminated wardship and granted guardianship to the paternal grandmother. The supervisor documented consultation with the child protection investigator in SACWIS and waived daily attempts to see the children. The supervisor told IG investigators that the child protection investigator reported that the juvenile court found the parents fit, but the supervisor did not know how the investigator verified the information. The child protection investigator told IG investigators that she believed she reviewed the guardianship order from the probate court in the grandmother's county but did not recall specific details other than the parents remained fit in the originating county's juvenile court. The child protection investigator reported safety concerns about the children in the parents' care based on their extensive history with the Department, but the issue of the parents' fitness continued to impact the decision not to request a petition or a child protective warrant. The supervisor told IG investigators that he did not recall reviewing the guardianship order but remembered discussing it with the child protection investigator but did not instruct the child protection investigator to submit a referral to the state's attorney's office. The supervisor stated they did not have the grounds to file a petition because the parents took the children out of state, the court found the parents fit, and the child protection investigator could not observe the home environment.

Less than five months before the child's death, the Department unfounded the parents for environmental neglect (#82) to the children due to a lack of evidence, and the parents refused to cooperate and moved out of state without providing an address. The Department closed the investigation and neither child protection staff nor law enforcement saw the children.

Three months after the Department closed the investigation, the Department opened an investigation after an anonymous caller reported the 8-year-old child had two black eyes and the father explained the child sustained the injuries after the child fell down the stairs. The reporter expressed suspicions about the explanation after the father stated he punished the child for eating in the middle of the night. The reporter also stated the children had not attended school for a year, the sibling sustained an injury while accompanying the father at his work, the children appeared small for their age, and the reporter did not know how often the parents fed them. The reporter stated the sibling disclosed the mother frequently locked the child in the basement, and the reporter had concerns the mother used drugs.

The next day, the child protection investigator spoke with the investigator from the previous investigation, who reported the court records from the originating county juvenile court documented that the court found the parents fit. Later that same day, the child protection investigator attempted to see the children at the parents' home, but no one answered the door. The father called the investigator later that day and denied harming and neglecting his children or using the sibling for free labor at work. The father reported the family returned to Illinois about a month earlier and he tried to file for guardianship of the children to enroll them in school. The father told the investigator that he and the mother completed services during the previous placement case and

the court found them fit. The father agreed to allow the child protection investigator to see the children at the home four days later.

The next day, the Department received a related information call, and according to the reporter, the father stated the mother refused to answer the door to the child protection investigator because the child still had two black eyes. Over the next several days, both the investigator and supervisor attempted to see the children at the family's home, but no one answered the door. The day of the scheduled appointment, the father stated they forgot about the appointment and rescheduled for four days later. The supervisor waived required daily attempts to see the child until the next scheduled appointment under the belief that continued attempts to see the children were unnecessary because the family rescheduled the meeting.

Eight days after the Department initiated the investigation, the child protection investigator saw the children and home for the first time. The sibling told the investigator he felt safe in the home and enjoyed going to work with his father, who did not force him to work. The sibling reported the father took him to the hospital to get stitches after he injured his finger at work. The investigator photographed the sibling's finger and noted it appeared to be healing.

The child protection investigator interviewed the child in his bedroom and documented he appeared clean but sickly and thin. The investigator observed multiple snacks on the child's shelves, and the child stated he ate all the time but did not gain weight. The child denied anyone hurt him and stated he felt safe in the home. However, during the OIG interview, the child protection investigator stated the parents and sibling came in and out of the bedroom and interrupted the interview. The child protection investigator told IG investigators that she did not ask the family to stop interrupting because she wanted to balance obtaining as much information as possible with not upsetting the parents, due to their history of non-compliance. The child protection investigator photographed the child but did not document discussion of the specific injuries reported to the hotline. The child protection investigator told IG investigators that she did not ask the child about the injuries because the child reported he felt safe. The investigator also reported she observed the child did not have black eyes as reported to the hotline but acknowledged the bruising could have faded in the time elapsed between the hotline report and the visit to the home. The child protection investigator told IG investigators that the child remained in his bed dressed in a hoodie with his legs under a blanket during the entire interview. She reported that she did not examine the child's body for injuries only observing the parts of his body visible outside of his hoodie because the child was verbal. The child protection investigator stated if the child was non-verbal, she would have had him remove his clothes as required by policy, though the investigator could not cite a specific Department policy.

During the investigator's visit to the home, the parents requested to be interviewed together. The child protection investigator documented discussing concerns about the child being very thin and appearing unhealthy. The mother responded the child ate all the time but did not gain weight. The investigator discussed the possibility of medical issues, such as a metabolic disorder, and the father stated that they wanted to have the child medically examined but cited the guardianship issue for not being able to access medical care. The investigator documented a plan to assist the parents in obtaining guardianship of the children to remediate the issues. The child protection investigator told IG investigators that she did not seek medical care for the child because she did not have the necessary consent for the child to be medically evaluated and did not believe she had enough evidence to take protective custody. The child protection investigator stated she knew the child needed medical care, and therefore, she focused on assisting the parents in obtaining guardianship of the children so the children could get medical care.

The child protection investigator assessed the children as safe and wrote that the parents previously completed services and the court found them fit. The child protection investigator told IG investigators that she based the safe assessment on the home's clean appearance, the children's reports that they felt safe, and the court's finding of fitness. The child protection investigator stated she relied on the father's self-report of service completion

during their placement case and did not review placement case records. The child protection investigator documented contacting the state's attorney's office in the originating county but told IG investigators that staff there did not respond to verify the juvenile court finding of parental fitness. The child protection investigator told IG investigators that she believed she reviewed the court orders from the originating county but did not recall reviewing the guardianship order from the county probate court where the grandmother lived. The child protection investigator stated she never received training on guardianship issues and could not recall if her supervisor provided direction regarding obtaining or applying the order. The supervisor of the child protection investigator approved the assessment of the children as safe. The supervisor told IG investigators that the child protection investigator did not report any concerns about the child's appearance and made no indication the child needed urgent medical care. The supervisor did not recall viewing the child's photo in SACWIS prior to his death. The supervisor told IG investigators that she did not review the family's placement case nor consult with the state's attorney's office in any of the counties involved with the family.

The following week, the child protection investigator contacted the grandmother and asked her to sign temporary guardianship of the children to the father so he could enroll the children in school. The grandmother reported she did not think returning guardianship to the parents was a good idea but agreed to sign the paperwork because she no longer wanted to fight with the father. The child protection investigator told IG investigators that she did not obtain specifics from the grandmother about why she did not support the parents obtaining temporary guardianship.

Six weeks after the Department initiated the investigation, the Department received notification of the child's death. The Department reassigned the pending child protection investigation to another child protection investigator who spoke with medical providers who treated the sibling's finger injury. The nurse reported they had no record of the parents attempting to access medical care for the deceased child, but the parents brought the sibling for follow up appointments. The Department closed the investigation and indicated the mother for allegations of human trafficking of children by neglect (#90) to the sibling and malnutrition (#83) to the child. The Department indicated the father for allegations of human trafficking of children by abuse (#40) and cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) to the sibling, and malnutrition (#83) to the child.

RECOMMENDATIONS

1. The child protection investigator in the February 2022 investigation should be disciplined for conducting an inadequate investigation and for her failure to seek immediate medical care for the child.

The Department agrees. The employee was issued an oral reprimand.

2. The child protection supervisor in the February 2022 investigation should be disciplined for her failure to ensure an adequate investigation was conducted and for allowing a delay in seeing the child given the report of injury, the report that the parents were actively avoiding DCFS, the violation of the guardianship order, and the family's DCFS history.

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

3. The child protection supervisor in the August 2021 investigation should be counseled for relying on a 2015 court finding of fitness for visitation only and failure to consider the violation of the guardianship court order in assessing safety of the children.

The Department agrees. The employee was issued a counseling.

4. The child protection investigator and supervisor in the February 2022 investigation should participate in the Medical Aspects of Child Abuse training. After training completion, the DCFS Medical Director

or designee should facilitate a discussion with them about applying knowledge learned to child abuse and neglect investigations.

The Department agrees. The DCFS Medical Director will facilitate a discussion once the child protection investigator and supervisor complete the Medical Aspects of Child Abuse training.

5. This report will be redacted and used by the OIG in Error Reduction trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

6. This report should be shared with the DCFS Office of Legal Services. The Office of Legal Services should provide training on guardianship, fitness, and protective custody for the purpose of obtaining medical care to child protection supervisors, area administrators, and regional administrators in this region.

The Department agrees. The Office of Legal Services and Child Protection will collaborate to develop the training.

7. As DCFS encourages and expands the utilization of guardianship as a permanency option, per the April 6, 2022, D-Net Announcement, the Department must educate staff and community partners on the parameters and expectations of guardianship orders.

The Department agrees. The Department is working with the Office of Communication to deliver a robust campaign strategy to expand utilization of guardianship as a permanency option. In addition, a two-day Adoption, Legal and Subsidy Training was developed by the Office of Legal Services and portions of the training address guardianship.

8. This report should be shared with the DCFS Guardian, in light of the parents' pending criminal trial, given the child's sibling remains a youth in care.

The Department agrees. The report was shared with the DCFS Guardian.

DEATH AND SERIOUS INJURY INVESTIGATION 7

DEATH

A 2-year-old child was found unresponsive in the home by her father's paramour. Emergency services personnel arrived at the home; found the child naked, unresponsive, and covered in bruises; and subsequently pronounced the child deceased. The postmortem examination determined the child's cause of death as blunt force trauma due to physical abuse and ruled the death a homicide. The autopsy documented the child had multiple bruises, lacerations, severe organ damage, patterned marks on almost every area of the body, and deep tissue damage on her arm and back. The Department indicated the father for death by abuse (#1); head injuries by abuse (#2); internal injuries by abuse (#4); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The father remained in jail awaiting trial for charges of first-degree murder. Eight months prior to the child's death, the private agency returned the child and her siblings to their mother's care, with approval of the court. The following month, the judge ordered the private agency close the placement case without after care services. The mother later became homeless and took the children to live with their fathers.

INVESTIGATION

In 2015, the Department unfounded and subsequently expunged three child protection investigations involving the mother. In October 2016, the Department

initiated a child protection investigation after the child's then 9-month-old sibling required hospital admission for possible malnutrition as the then 19-year-old mother did not follow the feeding plan for the sibling's severe food allergies. Two weeks into the child protection investigation, the Department opened an intact family services case. The mother did not cooperate with the intact caseworker, and in December 2016, the Department took protective custody of the child's then 1-year-old and 2-year-old siblings due to ongoing concerns related to missed doctor's appointments, failure to feed the sibling properly, failure to have necessary medicine on hand, not following through with early intervention when both siblings were delayed, and not cooperating with intact family services. The Department closed the investigation and indicated the mother for neglecting both siblings.

In December 2016, the Department opened a placement services case, and a private agency provided the family with services. In October 2018, the mother gave birth to her third child, who remained in the mother's care, while the two older siblings remained in their foster home. The placement supervisor noted the mother corrected the original safety issues and participated in unsupervised visits with her children, but the mother needed stable housing and to address her pattern of relationships with partners that placed her children at risk, including a past history of domestic violence. In March 2019, the Department initiated a child protection investigation after the DCFS hotline received a report that the mother allowed unsupervised contact between her third child and his father, despite the father being a registered sex offender. The assigned child protection investigator contacted law enforcement, who stated the father could be unsupervised around his own child but needed to be supervised by an adult around other children. Prior to closing and unfounding the investigation, the child protection investigator verified the sibling's father enrolled in a sex offender treatment course.

In September 2019, the Department initiated an investigation after the mother gave birth to the child, as the mother had an open placement case. The assigned child protection investigator spoke with the hospital staff, who stated the child was born full term and healthy and that the mother appropriately cared for the child. The placement caseworker told the investigator that the mother had unsupervised visits with the two oldest siblings, worked towards return home, completed parenting classes and attended counseling weekly. The hospital discharged the child to the mother, and the Department unfounded and closed the investigation. The placement caseworkers attempted to involve the child's father with the placement case; however, he never cooperated and had no involvement in the case.

In December 2019 and May 2020, the Department initiated two child protection investigations into allegations that the mother allowed inappropriate individuals to watch the children, but the Department unfounded and closed both investigations.

In August 2020, the court granted the private agency discretion to return the 4-year-old and 5-year-old siblings to the mother's care. The agency returned the siblings in September 2020, and the placement case remained open to provide after care services. Two days after the siblings returned home, the Department initiated a child protection investigation after the DCFS hotline received a report that a person was shot at the mother's home in the presence of her children. The mother told the child protection investigator that the children were asleep at the time of the shooting and that she knew the shooter and the victim. The mother denied being in a relationship with either of them but reported allowing them to visit the home. The Department took protective custody of the children and placed the then 11-month-old child and the siblings in a traditional foster home. The court provided the private agency with discretion to determine whether the mother's visits would be supervised or unsupervised. The Department closed the investigation, indicating the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

In January 2021, the court removed the private agency from the family's placement case due to the agency's high staff turnover, as the judge ruled the turnover impacted the private agency staff in earning the mother's trust. Management from the private agency told IG investigators that the court advocated for unsupervised visits after the Department took protective custody of the children in September 2020. The private agency

management stated they disagreed with unsupervised visitation because of ongoing safety concerns. The private agency management told IG investigators that throughout the placement case, the mother allowed men in her life who had violent backgrounds or were sex offenders. The private agency management reported that the mother did not honestly provide information about who she allowed around the children, which posed an ongoing safety concern. The mother also had a history of not allowing the private agency staff in her home. The private agency management stated that the staff and the mother's therapist had multiple meetings with the mother to address these concerns. In addition, the private agency management told IG investigators that the mother did not have stable housing for any length of time, and the private agency staff assisted the mother with Norman funds to help pay for a deposit on an apartment, but the mother moved frequently.

At the end of January 2021, the family's placement case transferred to the second private agency. During the transitional staffing, the mother continued to reside in the home where the shooting occurred, and the mother declined other housing options from the original private agency. The second private agency later met with the mother, who stated she felt safe in the home and there had been no other incidents. The mother agreed to continue counseling. The mother also reported receiving unemployment assistance after being laid-off, and she began seeking new employment.

In late March 2021, the second agency permitted the mother to have unsupervised visits with her children. The family's caseworker told IG investigators that the visits went well, and that the court supported returning the children home. In May 2021, the court granted the second private agency the discretion to return the children home to their mother, and the agency returned the 6-year-old child three days later. Two weeks later, the agency also returned the 5-year-old, almost 3-year-old, and 20-month-old siblings to the mother.

In July 2021, the second private agency submitted a status update to the court for the permanency hearing that recommended no additional services, but the family would benefit from the agency conducting at least five to six months of aftercare monitoring. The court found that the children achieved permanency through reunification with the mother, and the court terminated wardship, appointed the mother as the children's guardian, removed the Department as the children's guardian, and closed the permanency case.

The family's caseworker told IG investigators that at court, the judge denied the caseworker's request to discuss after care services and ordered the case closed. The family's caseworker reported she wanted to provide the mother with support since she went from having no children in her care to four young children. The caseworker stated she planned to work with the mother to ensure enrollment of the school-aged children in school in the fall and enrollment of the younger children in childcare. Additionally, the caseworker reported she planned to assist the mother with housing and monitor medical appointments.

Following the closure of the placement case in July 2021, the family had no involvement with the Department for over six months until the child's death was reported to the DCFS hotline. The child's father told law enforcement that the child's mother became homeless about three months after the placement cased closed, and the mother left the 2-year-old child in his care. The father's paramour confirmed to law enforcement that the child had been staying with the father and paramour for the past three months. The paramour also stated the father previously used his hand to hit the child, but the paramour did not believe it worked as discipline and gave the father a belt to hit the child.

In 2019, the Department issued Policy Guide 2019.04, *Requirements for Reunification and After Care Services*, which directed and clarified that Department and private agency staff were "to provide services to the family for at least 6 months following return home of each child from substitute care…" On January 1, 2020, 20 ILCS 505/7.8 became effective, which required the Department or the private agency to provide a minimum of six months of after care services to each child after a court determines that a child should be returned to the custody or guardianship of a parent or guardian. The Department issued Policy Transmittal 2020.21, Procedures 315.250, *Reunification, Planning for After Care and Termination of Services,* in response to the enacted law on

December 28, 2020. DCFS Procedures 315 does not currently address what permanency staff can do if the court denies or does not support after care services.

The caseworker from the second private agency told IG investigators that the court frequently denied after care services for her placement cases. In separate interviews, management at the second private agency told IG investigators that it was not common for the court to reject the agency's recommendation for additional after care services, but it happened. The management stated that they understood that once the court closed the family's case, the agency had no authority to provide services. The private agency management also reported that they believed the private agency had never requested assistance from DCFS legal to appeal the court's decision.

IG investigators interviewed DCFS legal staff from the involved county, who reported that the court did not always value after care services and that the court did not always support after care services when the parent met minimal parenting standards and the court found the parent fit. In a separate interview, a DCFS legal administrator told IG investigators that if a court ordered closing of a family's case without after care services, permanency workers could request DCFS Legal to file a motion for reconsideration of after care services. The DCFS legal administrator stated she believed Department staff knew about the requirement of after care services but did not know how familiar judges, assistant state's attorneys and the guardians ad litem were with the requirement.

RECOMMENDATIONS

1. When a case is closed in court prior to the completion of the six months of required after care services in violation of Illinois law, the assigned caseworker and supervisor should contact the Office of Legal Services for assistance. Office of Legal Services is encouraged to request the court to keep the case open during the six months of after care services. This recommendation should be incorporated in Procedures 315.250 and the Department should provide education to the field regarding this issue.

The Department agrees. The recommendation will be incorporated into Procedures 315.250. The Department will issue a Policy Guide to detail the changes. Additionally, the Office of Legal Services will communicate this change to the field via targeted emails to Regional Counsel, Regional Administrators and Area Administrators.

2. The Department should collaborate with the Administrative Office of Illinois Courts (AOIC) to provide training and education on the procedural and statutory requirements of after care services to court personnel statewide. A redacted copy of this report should be shared with the AOIC and Office of Legal Services to assist with the training.

The Department agrees. The Office of Legal Services will share a copy of the redacted report with the AOIC and work with the Assistant Director of the AOIC's Courts, Children and Families Division to determine how best to provide training on this information to court personnel statewide.

3. The Office of Legal Services should convene meetings with local state's attorneys to discuss the procedural and statutory requirements of after care services.

The Department agrees. The Office of Legal Services will work with the AOIC to identify avenues for providing training on the requirements of aftercare to local state's attorneys, including emphasizing the importance of supportive after care services in terms of achieving and maintaining permanency.

4. The report should be shared with the DCFS Office of Legal Services.

The Department agrees. The report was shared with the Department's Office of Legal Services.

5. This report should be shared with the involved Area Administrator for the purpose of future case planning.

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

6. The OIG will share a redacted copy of the report with the second private agency that provided case management for the family's placement case.

The Inspector General's Office shared the report with the private agency.

7. The OIG will share a redacted copy of the report with the first private agency that provided case management for the family's placement case.

The Inspector General's Office shared the report with the private agency.

8. The OIG will share a redacted copy of the report for training purposes with the involved county's state's attorney's office, and the involved circuit's chief judge.

The Inspector General's Office shared the report with the involved county state's attorney's office, the involved guardian ad litem, and the involved circuit chief judge.

DEATH AND SERIOUS INJURY INVESTIGATION 8

DEATH

A 14-year-old youth was found unresponsive by her mother. Emergency services responded to the home and found the youth in the mother's bedroom, wedged between the wall and the bed. The youth had no observable injuries, but emergency services noted environmental issues with the home. The autopsy determined the cause of death as heroin and fentanyl intoxication and ruled the manner of death as accidental. The Department placed the youth's 7-year-old and 5-year-old maternal siblings with their father under a safety plan. The Department indicated the mother for death by neglect (#51) to the youth and environmental neglect (#82) and substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) to the maternal siblings. In the year prior to the youth's death, there were four unfounded child protection investigations involving the youth's family.

INVESTIGATION

In 2019 and 2020, the Department unfounded two child protection investigations involving the mother for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

In June 2021, the Department initiated the C-sequence investigation after receiving an anonymous report that the mother's addiction to opiates and stimulants caused her to neglect her children. According to the reporter, the maternal sibling appeared malnourished, and the mother allowed a 20-year-old neighbor to corporally punish the children. The reporter also stated the mother occasionally sold prescription drugs from the home and the live-in boyfriend had substance use issues. The hotline report listed the maternal grandmother as an other person with information (OPWI) and provided her contact information.

The day after the hotline report, an on-call child protection investigator made a good faith attempt to visit the home, with no response. Two days later, the assigned child protection investigator conducted a walk-through of the mother's home and noted adequate food and that the children appeared free of visible injuries. The mother denied any substance use issues and reported she ended her relationship with her paramour. The investigator documented an interview with the 14-year-old youth and the then 4-year-old and 7-year-old maternal siblings,

who all reported they felt safe in the home. The assigned investigator also interviewed the family's neighbor, who reported no concerns about the mother and denied any knowledge of drug use in the mother's home.

In July 2021, three weeks after the Department initiated the C-sequence investigation, the Department initiated the D-sequence investigation after receiving a report that the children lived in unsanitary conditions at the mother's home, including rodents, open food containers, and a putrid smell. The Department assigned the investigation to the same child protection investigator.

IG investigators listened to the recording of the hotline call, in which the D-sequence reporter stated they witnessed the mother use drugs believed to be opioids, but the call floor worker did not document the reported drug use in the hotline narrative. The call floor worker opened the investigation for an allegation of medical neglect (#79) against the mother to the three children, but the reporter made no allegations related to medical neglect. The call floor worker did not include allegations addressing either the living conditions or the mother's reported drug use. The call floor worker also incorrectly documented the reporter's relationship to the family, which resulted in child protection staff contacting the incorrect reporter during the D-sequence investigation.

In August 2021, three weeks after initiating the D-sequence investigation, an anonymous caller reported to the DCFS hotline that while in the family's home, they had observed straws hidden throughout the home as well as several plastic bags that contained a white powdery residue. The anonymous reporter stated the mother engaged in domestic violence in the home, but the children never witnessed the incidents, as they were outside. The Department took the call as related information to the pending D-sequence investigation and added allegations of inadequate supervision (#74) and environmental neglect (#82) against the mother to the three children.

Two days after the related information call in the sequence D investigation, the hotline received a report that law enforcement responded to an altercation between the mother and her former paramour at his residence. Prior to leaving the residence with the children, the mother told law enforcement that the paramour pushed her against the wall and spit in her face. The assigned child protection investigator documented in SACWIS that she spoke with law enforcement twice via telephone and once in person. IG investigators determined the child protection investigator used benefit time on the day she documented speaking to law enforcement in person. IG investigators reviewed the child protection investigator's phone records and did not identify any calls between the child protection investigator and law enforcement.

Two weeks after the Department received the hotline call regarding the domestic incident, the Department closed the C-sequence investigation and unfounded the mother for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). IG investigators reviewed the child protection investigator's notes and found that the child protection investigator entered her C-sequence documentation into SACWIS on the last day of the investigation, approximately four hours after the supervisor entered the final supervisory consultation note into SACWIS. The child protection supervisor told IG investigators that he based his supervisory note on the child protection investigator's verbal report of her investigative activities and read the written SACWIS investigation report just before approving the investigation for closure. The supervisor informed IG investigators that the child protection investigator had a history of not completing SACWIS documentation in a timely manner, and that the child protection investigator became combative when the supervisor attempted to address documentation issues.

IG investigators reviewed the child protection investigator's SACWIS notes for the C-sequence and D-sequence investigations and found numerous inconsistencies in the child protection investigator's documentation including contacts with the children, the former paramour, and the maternal grandmother. The child protection investigator documented two identical phone conversations with the former paramour in June and July 2021, however IG investigators found the child protection investigator's phone records did not include any contact with the former paramour. The child protection investigator documented an interview with the maternal grandmother on the last day of the C-sequence investigation, who denied the mother used drugs and had no

concerns for the children in the mother's care. IG investigators spoke to the maternal grandmother, who denied speaking with the child protection investigator. Furthermore, the maternal grandmother told IG investigators that she would have reported her concerns about the mother's ability to parent, the children's home environment, and the mother's drug use. The child protection investigator documented in SACWIS for the C-sequence investigation that the mother tested negative for the toxicology screen, but IG investigators found no evidence that the child protection investigator referred the mother for a drug test during the C-sequence investigation or prior to the reassignment of the D-sequence investigation.

In October 2021, the Department reassigned the D-sequence investigation and placed the child protection investigator on desk duty for allegedly falsifying case records in an unrelated investigation. The initial investigator documented that two different medical providers shared the children's medical information, but the reassigned child protection investigator documented speaking with both providers, who denied they had records of the children as patients. IG investigators subpoenaed the medical providers and confirmed neither medical provider had records for the children at any of their network facilities.

In November 2021, the reassigned child protection investigator met with the mother and documented no concerns at the residence. The mother provided the reassigned investigator with toxicology results from the mother's drug test from August 2021, stating she completed the drug test per the initial child protection investigator's request. The reassigned child protection investigator uploaded a photograph of the mother's test result, which showed the mother completed the toxicology screen the day the Department closed the C-sequence investigation, and the results were not available at the time of investigation closure. The mother's toxicology results were "Negative Dilute," which meant the mother consumed a large quantity of water before providing the urine specimen. The reassigned child protection investigator documented in SACWIS that the results were negative and told IG investigators that she had not seen a "Negative-Dilute" result before and believed it was the same as a negative result. The reassigned child protection investigator also told IG investigators that the mother refused to take another drug test, citing she already completed the required screen. The reassigned child protection investigator told IG investigators she did not push for a second test because she thought the mother tested negative.

Four days after the reassigned child protection investigator met with the mother, the Department closed the investigation and unfounded the mother for inadequate supervision (#74), environmental neglect (#82), and medical neglect (#79) to the three children. According to the rationale, the children denied they were left home alone, the children's primary care physicians reported no concerns for medical neglect, and the child protection investigators witnessed no safety hazards in the home.

Two days after the investigation closed, law enforcement arrested the mother for an outstanding warrant and possession of a controlled substance after they found her her unconscious in a car at a gas station, with drugs in the car. The youth's father petitioned the court for an emergency modification of parenting and testified that the youth did not regularly attend school and the mother used heroin and cocaine. The court granted the father temporary legal custody of the youth.

On the same day the youth's father filed the custody petition in November 2021, the hotline received a report alleging the father did not provide the youth with adequate food, the youth did not attend school, and the father left the youth unsupervised for long periods of time. The next day, the Department received a related information report from an anonymous person who stated the youth did not feel safe with her father and said the father tried to enter the bathroom while she showered. The reporter stated the father had a history of violence, substance use, and mental illness. That same day, a child protection investigator interviewed the father at his home and observed the father had adequate food. The father denied the allegations and reported he worked with the school social worker to enroll the youth in school. The investigator spoke with the youth, who stated she felt safe in the home and that she had plenty to eat. The investigator also spoke with different family members who reported no concerns with the father, including the maternal grandmother, who stated she

watched the youth at her residence after school. The investigator made multiple attempts to contact the mother, but she never answered or returned the calls.

Before closing the investigation, the investigator confirmed with the school social worker that the youth attended school. Two weeks after the Department initiated the investigation against the youth's father, the Department closed the investigation and unfounded the father for inadequate food (#76) and inadequate supervision (#74).

During the pending investigation against the youth's father in November 2021, the Department initiated the E-sequence investigation after receiving a hotline report regarding the mother's arrest at the gas station. The reporter stated that law enforcement found drug residue in the mother's car, which she used to regularly transport the children. The day after the hotline report, a child protection investigator went to the mother's home and spoke with the 7-year-old and 5-year-old maternal siblings, who reported they felt safe with their mother. The investigator did not document asking the children about drug use but noted observing no evidence of substance use or environmental neglect. The mother told the child protection investigator that she borrowed the car from a friend and was arrested after police found cocaine in the car. The mother denied any substance use issues and stated she tested negative on the drugs screens she completed through court. The mother initially agreed to complete a drug test for the child protection investigation, but never followed through.

The same day the Department initiated the E-sequence investigation, the siblings' father filed an emergency petition to restrict and modify parental responsibilities. Two days later, the court granted him physical care and control of the two siblings. The siblings remained in their father's care for six weeks. Two days later, the youth died while the three children were at the mother's home. The E-sequence investigator did not document any investigative activity in those six weeks, such as referring the mother for a drug test, asking the mother about law enforcement finding her unconscious in the car, speaking to the arresting officers, or attempting to obtain court documents regarding parental custody.

Two weeks after the youth's death, the Department closed the E-sequence investigation and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the two siblings. The Department cited that there was no evidence that the children were exposed to drug use.

RECOMMENDATIONS

1. The Department should develop a policy addressing toxicology results detailing guidelines for accepted providers, inconclusive results and testing timeframes to be used by frontline staff.

The Department's Behavioral Health Division will revise and update the drug testing protocol, policy, and informational transmittal for frontline staff.

2. The Department should share this report with the Deputy Director for State Central Register for training and discussion purposes with the call floor worker for the D-sequence investigation hotline report.

The Department agrees. The report was shared with the Deputy Director and additional training was provided to the call floor worker.

3. The Department should share this report with the area administrator for review with the reassigned child protection investigator to the D-sequence investigation, the child protection supervisor for the C-sequence and D-sequence investigations, and the child protection supervisor for the E-sequence investigation.

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

4. The OIG will pursue CWEL licensure action against the initial child protection investigator for the C-sequence and D-sequence investigations.

Charges were filed against the employee's CWEL license. IG attorney's prosecuted charges and are awaiting a final decision by the CWEL board.

DEATH AND SERIOUS INJURY INVESTIGATION 9

DEATH

A 3-month-old infant was found unresponsive by the 32-year-old maternal aunt after she co-slept with him and his twin sibling. Emergency services transported the infant to the hospital, where doctors pronounced him deceased. The Department took protective custody of the infant's twin sibling and placed her in a traditional foster home. The medical examiner ruled the cause and manner of death as undetermined, in part because the sleep environment or other external factors may have contributed to the infant's death. The Department indicated the maternal aunt for death by neglect (#51) to the infant and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's twin sibling. At the time of the infant's death, the Department had a pending child protection investigation on the infant's 32-year-old mother for inadequate shelter (#77), substance misuse by neglect (#65), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infants.

INVESTIGATION

The Department initiated a child protection investigation on the 32-year-old mother after she gave birth to the infant and his twin sibling and reported she used cocaine and marijuana during her pregnancy. According to the reporter, the mother tested negative for drugs at the time of delivery, but the results of the twins' drug tests remained pending at the time of the report to the Department. The reporter also stated the mother had a history of domestic violence and housing instability.

The same day as the hotline call, the child protection investigator observed the twin infants at the hospital and noted they appeared healthy and awake. The investigator spoke with the mother at the hospital, who reported she used cocaine during her pregnancy, but the investigator did not document any information regarding the timing of her last drug use. The mother also answered yes to several questions on the Adult Substance Abuse Screen, which required a referral for an assessment; however, the investigator and supervisor never ensured the mother received a referral for substance use disorder services.

While at the hospital, the child protection investigator confirmed with the relative that the mother and infants could stay in her home until the mother obtained housing, although the investigator did not document discussions to assess the relative's home or a discharge plan with the mother, the relative, or hospital staff. The child protection supervisor told IG investigators that she called the child protection investigator several times regarding the status of her assessment of the family, but the investigator never answered her phone or discussed a critical decision with the supervisor as required. The supervisor also told IG investigators that she instructed the child protection investigator to complete an out-of-home safety plan during initial supervision; the investigator never completed the plan in SACWIS but did enter a contact note that documented the assessment of the twins as safe in the hospital. However, according to *DCFS Procedures 300. Appendix G Requirements for Use of the Child Endangerment Risk Assessment Protocol*, the safety assessment of a child in a hospital should be based on the child's return home. The child protection investigator resigned from the Department prior to the OIG interviews.

During the child protection investigation, the hotline received five related information calls. A reporter contacted the hotline requesting information about the discharge plan as the mother and the infant's sibling would be ready for discharge. The infant would remain in the neonatal intensive care unit for observation.

According to the reporter, the mother had diagnosed mental health issues and reported substance use during her pregnancy. In the second related information report, the reporter again requested a discharge plan for the mother and infant sibling. The reporter stated the mother tested positive for cocaine at a prenatal visit two months prior to the twins' birth. The mother reported housing issues following the death of the maternal grandmother two months earlier. The hotline worker coded the call as action needed, which required the child protection investigator and supervisor to review the report within 60 minutes to determine the necessary action and establish a time frame for action according to *DCFS Procedures 300.30.f. Reports of Child Abuse and Neglect: Content of Child Abuse and Neglect Reports, Report Response Codes*. However, child protection staff never documented responding to the action needed report. The child protection supervisor told IG investigators that due to her flex schedule, she did not see the emails regarding the hotline calls for discharge planning in a timely manner. During the pending investigation, the child protection investigator also did not obtain information nor request documentation regarding the mother's mental health diagnosis. The child protection supervisor did not ensure that the child protection investigator issued subpoenas or obtained consents for the release of the mother's mental health records also required in DCFS procedures, as the information was essential to determine service provision.

The day after the action needed report, the child protection investigator contacted a hospital social worker who stated the twins and mother's drug tests were negative, and they were all healthy and cleared for discharge. The OIG obtained the hospital medical records that documented the hospital discharged the infants to the mother the next day, with follow-up care scheduled for three days later, but the mother never brought the infants to the appointment.

Over the next two weeks, the child protection investigator did not document any investigative activity with the family. The supervisor told IG investigators that the child protection investigator reported that the day after the infants' discharge, she went to the home where the mother had been staying. The child protection investigator told her supervisor that she initiated a safety plan with the mother and the man she lived with, but the child protection investigator did not enter the plan or document the visit in SACWIS. The supervisor told IG investigators that the child protection investigator had difficulty completing documentation in SACWIS as required, and that the supervisor addressed the issue with the child protection investigator and discussed it with the area administrator.

The Department received a fourth related information call approximately two weeks after initiation of the child protection investigation. The reporter expressed concerns about the infants due to the mother's risky behavior that included reports of sex work and mental health issues. Three days later, upon the area administrator's direction, the supervisor instructed the child protection investigator to assess the mother and infants immediately, initiate an out-of-home safety plan until the mother began mental health and substance use disorder services, refer the mother for a drug test, contact the prior reporters, offer the mother intact services, and complete other investigative tasks. The investigator made two unsuccessful attempts to call the mother and did not document an attempt to see the mother in person that day. The supervisor contacted the reporter from the fourth related information call, who reported the mother entered a substance use disorder treatment center two months before the twins were born but left after three days. The reporter also stated the mother lived with a man she met at a bus stop.

Later that evening, because the investigator had not contacted the mother, the supervisor requested that after-hours staff visit the mother's home, assess the twin infants, and initiate a safety plan. The after-hours child protection investigator went to the mother's residence, observed the infants, and noted no signs of abuse or neglect. The twins slept in their car seats because the mother did not have cribs. The after-hours investigator discussed the need for an out-of-home safety plan with the mother, and the mother agreed to a safety plan with the infants' maternal aunt, who later came to the home. The mother and aunt agreed to the safety plan that included no unsupervised contact between the mother and infants and the mother would engage in services. That same evening, the after-hours investigator completed a home assessment at the aunt's home and provided

her with a second crib to ensure both infants had safe sleep arrangements. The after-hours investigator observed formula, diapers, and clothing for the infants, and she discussed safe sleep practices with the aunt, explaining the infants must sleep in their own crib and not co-sleep with her in the bed. The after-hours investigator entered the unsafe Child Endangerment Risk Assessment Protocol (CERAP), which the primary supervisor approved. According to DCFS Procedures 300. Appendix G. *Requirements for Use of the Child Endangerment Risk Assessment Protocol,* the child protection investigator is responsible for providing the responsible caregivers with their rights and responsibilities of the care plan, including how to obtain medical care. However, child protection staff never provided the aunt with information on how to obtain medical care for the infants.

Five days after initiating the out of home safety plan, the supervisor instructed the primary child protection investigator to re-assess the infants' safety, refer the mother for a drug test, and refer the family for intact family services. That same day, the investigator visited the aunt, who requested formula because the mother did not provide her public aid benefits. The investigator entered an unsafe CERAP in SACWIS but did not add any new information to the document, including requirements to end the safety plan. Later that day, the investigator spoke to the mother about engaging in services to address mental health and substance use issues, parenting, and housing assistance. The mother agreed to participate in services and provide the aunt with the public aid benefits for the infants, however, the investigator did not document providing the mother with any referral information for services. The child protection investigator entered weekly unsafe CERAPs over the next six weeks and continued to use the information from the initial assessment completed by the afterhours child protection investigator. The child protection supervisor could not explain to IG investigators why the child protection investigator never updated the unsafe CERAPs. The child protection supervisor stated that the child protection investigator had difficulty using SACWIS, needed reminders to complete tasks, and had difficulty with follow-up in investigations.

One month after the Department initiated the child protection investigation, the supervisor emailed the area administrator to request an intact referral for the family, and the area administrator sent the email request to the Department Intact Referral mailbox later that day. The supervisor could not provide a reason to IG investigators for the delay in referring the family for intact services despite the identified need at the outset of the investigation.

About three weeks after initiating the out of home safety plan, the aunt reported issues with the mother and required the mother to visit the infants in the community and not in her home. The investigator did not update SACWIS to reflect the changes to the visitation plan. The following week, the area administrator instructed the child protection supervisor to ensure that the investigator updated the CERAP, terminated the safety plan unless they planned to take protective custody of the infants, and followed up with the intact service referral. The supervisor and investigator did not terminate the safety plan or follow up with intact services over the next two weeks.

Two months after the initial hotline call, the Department received a fifth related information call after law enforcement responded to the aunt's home. According to the reporter, the aunt stated she could no longer care for the infants after having them in her home for almost six weeks. The aunt stated she wanted the child protection investigator to provide assistance or remove the infants. The child protection investigator contacted the law enforcement officer, who reported the infants appeared safe during the visit. The law enforcement officer also confirmed that the aunt requested that the Department remove the children from her home by the next day, but the child protection investigator did not contact the aunt within this timeframe.

Two days after the fifth related information call, the child protection supervisor documented discussing the investigation with the child protection investigator and noted the mother had cooperated. The supervisor told IG investigators that she based the level of the mother's cooperation on the fact she reported being willing to engage in intact services. The mother identified additional relatives to care for the infants and the child protection investigator subsequently completed CANTS/LEADS for the identified relatives. The child

protection supervisor instructed the child protection investigator to terminate the current safety plan and complete a care plan and home safety checklist. The child protection supervisor told IG investigators that the field used care plans in place of a safety plan, which consisted of a verbal agreement for a caregiver to care for a child and did not require weekly monitoring. DCFS Rules and Procedures do not define or provide instructions for the use of care plans in child protection investigations. That afternoon, the child protection investigator contacted the aunt, who agreed to continue to provide care for the infants because the aunt did not want the infants to enter the Department's custody. The child protection investigator did not document any discussion with the aunt regarding what support she needed to continue to care for the infants, despite the information provided by law enforcement.

Two days later, the area administrator again instructed the child protection staff to follow up with the referral for intact services submitted four weeks prior. The Intact Family Recovery (IFR) program supervisor, who received the referral from the general intact family services supervisor, requested additional information prior to accepting the referral, including referring the mother for drug testing and additional background information. The IFR supervisor told IG investigators that she typically responded to referrals within one day, but she missed this referral in her inbox which led to a delay in assigning an IFR provider for almost one month. The child protection supervisor told IG investigators that this investigation was the first time she referred a family to the IFR program. At the time of this OIG investigation, DCFS Procedures 302.388.e.2. *Services Delivered by the Department: Intact Family Services, Case Opening and Initial Case Assignment* did not include the requirements for IFR referrals and criteria for services. The IFR supervisor told IG investigators that she did not routinely provide training to field staff about referring cases to the IFR program.

The child protection supervisor instructed the investigator to refer the mother for a drug test, but the mother failed to appear for the test. Two weeks later, the IFR program rejected the mother for services, in part due to the mother's failure to cooperate with a drug test. The child protection supervisor instructed the investigator to screen the case at court. The infant died two days after the IFR program rejected the mother for services.

Approximately one month after the infant's death, the Department closed the investigation and indicated the mother for substance misuse by neglect (#65), inadequate shelter (#77) and substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) to the infant twins. According to the rationale, the mother had a history of housing instability, lived with a man who posed a risk to her children, the twins' meconium tested positive for cocaine, and the mother tested positive for cocaine during a prenatal visit.

RECOMMENDATIONS

1. The Department should discipline the child protection supervisor for her failure to ensure required tasks were completed in the child protection investigation regarding the twin infants.

The Department agrees. The employee was discharged.

2. This report will be redacted and used by the OIG in Error Reduction Trainings.

The redacted report has been shared with IG training staff for inclusion in OIG Error Reduction Trainings. See also, Part IV: Error Reduction Training.

3. The Department should incorporate guidance for field staff on the Intact Family Recovery Program in DCFS Procedures 302.388 e) 2) Case Opening and Initial Case Assignment.

The Department agrees. The current Intact Family Recovery (IFR) manager completed a training with child protection staff and other stakeholders on the referral process for IFR. The IFR manager will also conduct training on the referral process for child protection investigators, supervisors and area administrators on a

quarterly basis. In addition, the Intact Family Recovery brochure was updated and will be posted on the D-net. Guidance for field staff will be incorporated in procedures.

4. The Department should ensure that the intact referral process is incorporated into IllinoisConnect (formerly known as CCWIS) to allow for tracking, follow-up, and initiation of services.

The Department agrees. The recommendation will be incorporated in the new system.

5. The Department should use this report in training staff on the new SAFE model. This training should specifically address assessing the safety of children in the hospital and use of informal care plans.

The Department agrees. Child Protection leadership will work with the SAFE Model developer to create teaching cases that will address this issue to be used when the SAFE Model is implemented with staff, supervisors and managers.

6. Expanding on a prior OIG recommendation (from January 2022 Annual Report, Death and Serious Injury Investigation 4. See also: Department Update on Prior Systemic Recommendations), the Intact Family Recovery coordinator should conduct ongoing training for the region's child protection investigation supervisors and area administrators to ensure the field is educated about the Intact Family Recovery 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 current Intact Family Recovery (IFR) manager completed a training with child protection staff and other stakeholders on the referral process for IFR. The IFR manager will also conduct training on the referral process for child protection investigators, supervisors and area administrators on a quarterly basis. In addition, the Intact Family Recovery brochure was updated and will be posted on the D-net.

PART II: CHILD DEATH REPORT

Pursuant to Illinois Register at 89 Ill. Admin. Code 430, the Inspector General investigates deaths or serious injuries in foster homes, child welfare institutions, independent living programs and other facilities licensed by the Department, as well as deaths or serious injuries when there was an open child welfare service case or child protection investigation by the Department within the preceding 12 months. The death of a child is always tragic. For that reason, the OIG reviews the Department's involvement with that family. The OIG review is based upon the work even beyond the contributory path to the death. Problems not truly connected to the death could come to light. A death is not always a reflection of errors on the part of Department or private agency workers.

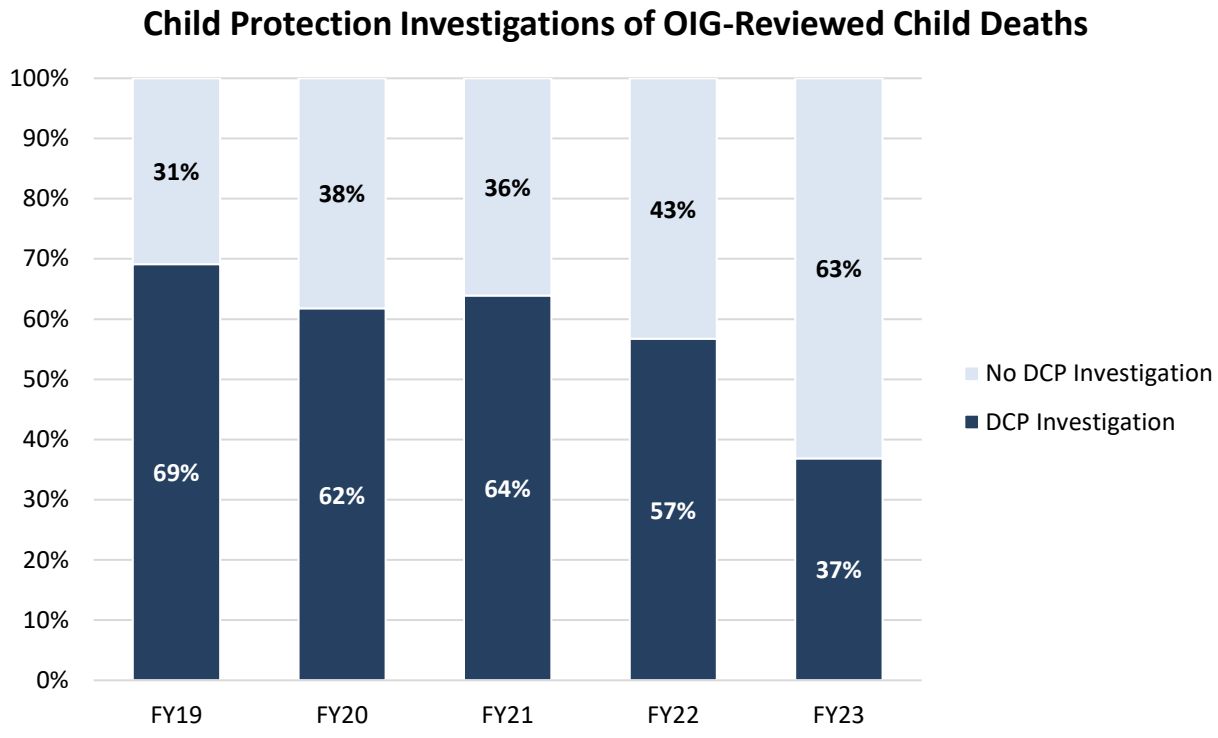
OIG staff receive notification of the death of a child mainly from the Illinois State Central Register (SCR). This year the OIG learned, from the Child Death Review Team, of additional deaths that had not been reported to SCR. OIG staff investigate the Department's prior involvement with the deceased and their family when (1) the child was a youth in the care of DCFS within a year of their death; (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.

Notification of a child's death initiates an investigatory review of records. IG investigators review the death reports and information available through the Department's computerized records. The investigator then obtains additional records, including the child's death certificate and autopsy reports when available. Records may be requested, impounded, or subpoenaed. The majority of cases involve an investigatory review of DCFS and private agency case records.

Those reviews which identify malfeasance or misfeasance of Department and private agency employees, as well as systemic problems and errors, may move to a full investigation. The issues identified may or may not relate to the death itself. As part of a full investigation, additional records – often including social service, medical, police, and school records – may be requested and interviews conducted. A full investigation may result in a report to the Director of DCFS.

In Fiscal Year 2023, IG investigators completed an investigatory review of 160 deaths of children who died between July 1, 2022, and June 30, 2023. A description of each child's death and DCFS involvement is included in this Annual Report. IG investigators determined 17 deaths required full investigations. Comprehensive summaries of death investigations reported to the Director in FY 2023, which may include deaths that occurred in earlier fiscal years, are included in Part I: Death and Serious Injuries Investigations.

Of the 160 child deaths reviewed by the OIG, the Department conducted a child protection investigation for allegations of death by abuse or neglect in 59 (37%) of the deaths. Of those 59 deaths, the Department indicated a perpetrator for death by abuse or neglect in 26 deaths (44%) and unfounded an alleged perpetrator for death by abuse or neglect in 26 (44%) deaths; 7 child protection death investigations (12%) remain pending at the time of this report. Of the 59 deaths investigated by the Department for death by abuse or neglect, 14 of the deaths were ruled homicide in manner, 12 had an undetermined manner, 15 had a manner of accident, 13 had a manner of natural, and one had a manner of suicide. Autopsy results have not been released for four of these deaths.


Child Protection Investigations of OIG-Reviewed Child Deaths
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
31%
38%
36%
43%
63%
69%
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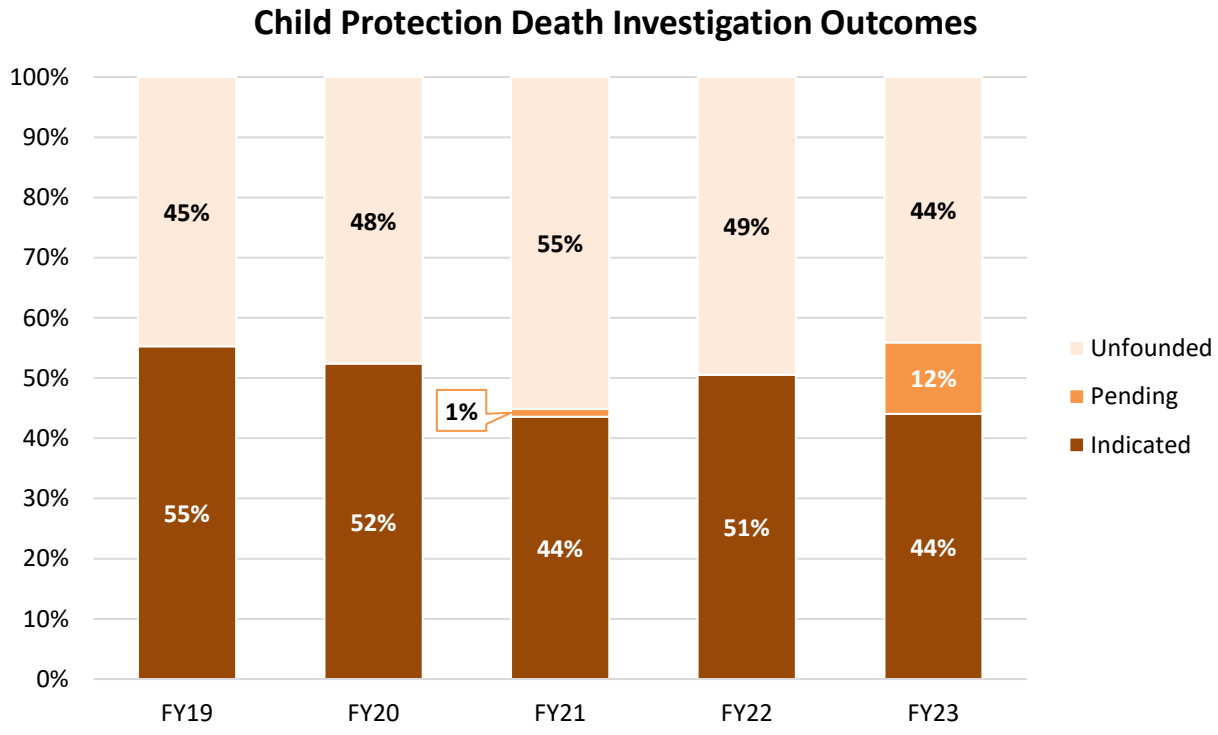
FY23
No DCP Investigation
DCP Investigation


Child Protection Death Investigation Outcomes
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
45%
48%
55%
49%
44%
55%
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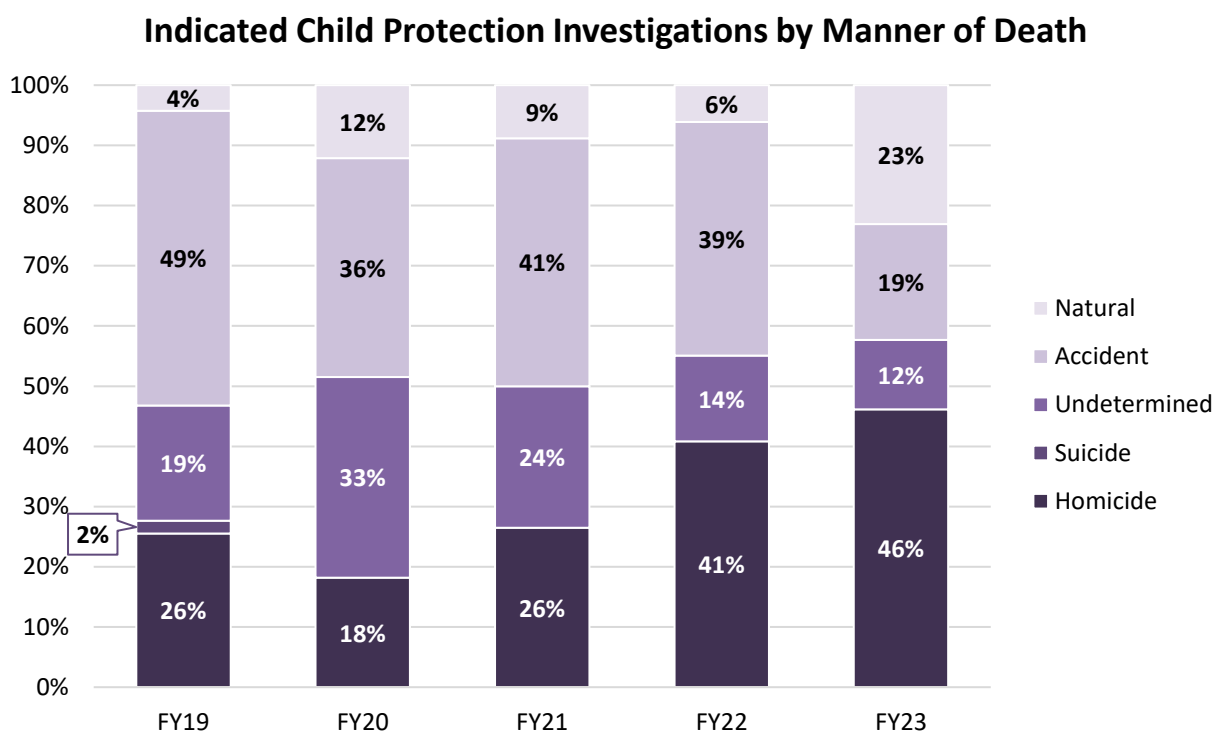
Unfounded
Pending
Indicated

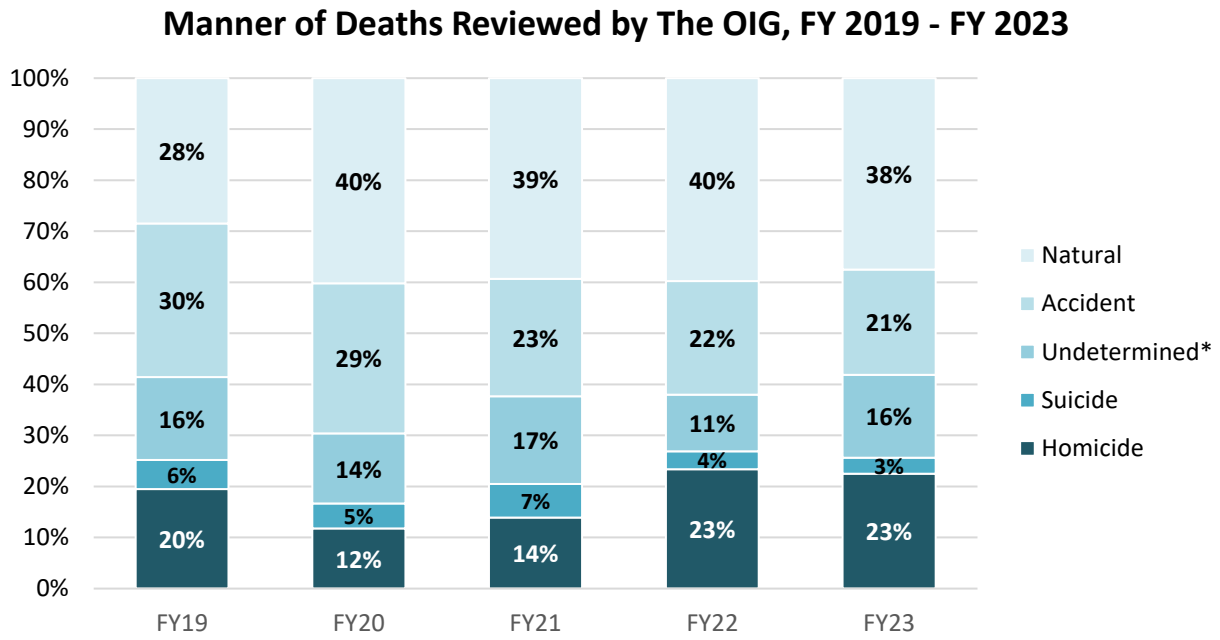

Indicated Child Protection Investigations by Manner of Death
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
4%
49%
19%
2%
26%
12%
36%
33%
18%
9%
41%
24%
26%
6%
39%
14%
41%
23%
19%
12%
46%
FY19
FY20
FY21
FY22
FY23
Natural
Accident
Undetermined
Suicide
Homicide

STATISTICAL SUMMARY

The following is a statistical summary of the 160 child deaths reviewed by the OIG in FY 2023. 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. This year there are nine deaths for which autopsy results have not yet been released and thus this report has a list of deaths classified under a 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 (see Table 2)

Youth in Care	Deceased was a Youth in Care.
Unfounded DCP	Family had an unfounded child protection investigation within a year of child's death.
Pending DCP	Family was involved in a pending child protection investigation at time of child's death.
Indicated DCP	Family had an indicated child protection investigation within a year of child's death.
Child of Youth in Care	Deceased was the child of a youth in care, but not in care themselves.
Open Intact	Family had an open intact family services case at time of child's death.
Closed Intact	Family had an intact family services case 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/Closed Placement	Deceased or sibling(s) returned home to parent(s) from foster care within a year of child's death, or siblings of deceased adopted within a year of child's death.
Child Welfare Services Referral	A request was made for DCFS to provide services, but no abuse or neglect was alleged.
Former Youth in Care	Child was a youth in care within a year of their death.



** Undetermined category includes autopsies that were ruled an undetermined manner as well as autopsies pending at time of this publication*

TABLE 1: CHILD DEATHS BY AGE AND MANNER OF DEATH

CHILD AGE		HOMICIDE	SUICIDE	UNDETE-RMINED	PENDING	ACCIDENT	NATURAL	TOTAL	
Months of Age	At birth				2	1	2	5	3%
	0 to 3	1		7		5	10	23	14%
	4 to 6	1		3	1	3	3	11	7%
	7 to 11	2		2	2	1	3	10	6%
	12 to 24	2				1	3	6	4%
Years of Age	2	1		1		1	3	6	4%
	3	2					3	5	3%
	4	1				1		2	1%
	5					1	4	5	3%
	6						3	3	2%
	7	1		1		2		4	3%
	8	1		2			1	4	3%
	9	1					2	3	2%
	10				1			1	1%
	11	1					1	2	1%
	12					2	3	5	3%
	13	2		2			4	8	5%
	14		1			1	3	5	3%
	15	6	1			4	4	15	9%
	16	2	1		1	3	2	9	6%
	17	10	1		1	3	6	21	13%
	18 or older	2	1			4		7	4%
TOTAL		36	5	18	8	33	60	160	100%

TABLE 2: CHILD DEATHS BY CASE STATUS AND MANNER OF DEATH									
REASON FOR OIG INVESTIGATION*		HOMICIDE	SUICIDE	UNDETE-RMINED	PENDING	ACCIDENT	NATURAL	TOTAL	
DCP	Pending	6	1	4		4	8	23	14%
	Unfounded	15	1	1	1	15	22	55	34%
	Indicated	2		5		2	5	14	9%
Youth in Care		7	1	1	4	8	9	30	19%
Former Youth in Care							1	1	1%
Return Home/ Closed Placement								0	0%
Open Placement/ Split Custody		2	1			1	2	6	4%
Open Intact		3		3	2	3	8	19	12%
Closed Intact		1		2	1		4	8	5%
Child of a Youth in Care				1				1	1%
Child Welfare Services Referral			1	1			1	3	2%
TOTAL		36	5	18	8	33	60	160	100%

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

TABLE 3: CHILD DEATHS BY REGION OF RESIDENCE AND MANNER OF DEATH								
REGION	HOMICIDE	SUICIDE	UNDETERMINED	PENDING	ACCIDENT	NATURAL	TOTAL	
Central	5		3		6	26	40	25%
Cook	24	2	9	3	13	20	71	44%
Northern	3	2	6	2	9	6	28	18%
Southern	4	1		3	5	8	21	13%
TOTAL	36	5	18	8	33	60	160	100%

TABLE 4: CHILD PROTECTION DEATH INVESTIGATIONS BY RESULT AND MANNER*								
FINAL FINDING	HOMICIDE	SUICIDE	UNDETERMINED	PENDING	ACCIDENT	NATURAL	TOTAL	
Indicated	12		3		5	6	26	44%
Unfounded	1	1	8		9	7	26	42%
Pending	1		1	4	1		7	14%
TOTAL	14	1	12	4	15	13	59	100%

**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.*

TABLE 5: CHILD DEATHS BY COUNTY OF RESIDENCE AND MANNER OF DEATH								
COUNTY	HOMICIDE	SUICIDE	UNDETE-RMINED	PENDING	ACCIDENT	NATURAL	TOTAL	
Adams						2	2	1%
Bond						1	1	1%
Boone			1				1	1%
Cass						2	2	1%
Champaign						4	4	3%
Clark						1	1	1%
Coles	1						1	1%
Cook	24	2	9	3	13	20	71	44%
Douglas						1	1	1%
DuPage			1			1	2	1%
Franklin						1	1	1%
Fulton						1	1	1%
Hamilton						1	1	1%
Henry						1	1	1%
Jackson					1	1	2	1%
Jefferson						1	1	1%
Kane					2		2	1%
Kankakee					1	1	2	1%
Knox			1			1	2	1%
Lake		1		1	2		4	3%
LaSalle						2	2	1%
Livingston						1	1	1%
Logan						1	1	1%
Macoupin	1		1				2	1%
Madison					1	1	2	1%
Marion					2	1	3	2%
McDonough					1	1	2	1%
McHenry						1	1	1%
McLean					2		2	1%
Montgomery			1				1	1%
Peoria	2				2	1	5	3%
Richland					1		1	1%
Rock Island						1	1	1%
Saline		1					1	1%
Sangamon					1	1	2	1%
Scott						1	1	1%
St. Clair	4			3		1	8	5%
Stephenson					2		2	1%
Tazewell						2	2	1%
Vermilion	1					1	2	1%
Warren						1	1	1%
Will	2	1	2		1	3	9	6%
Winnebago	1		2	1	1		5	3%
TOTAL	**36**	**5**	**18**	**8**	**33**	**60**	**160**	**100%**

FY 2023 DEATH CLASSIFICATION BY MANNER OF DEATH

HOMICIDE

Thirty-six deaths were classified as homicide in the manner of death.

CAUSE OF DEATH	NUMBER	PERCENT
Drowning	1	3%
Drug toxicity	1	3%
Gunshot wound(s)	27	75%
Physical abuse	6	17%
Starvation	1	3%
TOTAL	**36**	**100%**

HOMICIDE CATEGORY	NUMBER	PERCENT
Child Abuse	12	33%
Street Homicide	21	58%
Other	2	6%
Unsolved	1	3%
TOTAL	**36**	**100%**

ALLEGED PERPETRATOR INFORMATION*

PERPETRATOR	NUMBER	PERCENT
Mother	5	14%
Father	1	3%
Stepmother	1	3%
Stepfather	1	3%
Mother's paramour	2	6%
Babysitter	1	3%
Unknown caregiver	1	3%
Sibling	2	6%
Unsolved	1	3%
Youth's boyfriend	1	3%
Sibling's boyfriend	1	3%
Unrelated (street homicide)	5	14%
Unknown (street homicide)	16	44%

**Some deaths have more than one perpetrator*

SUICIDE

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

CAUSE OF DEATH	NUMBER	PERCENT
Drug Toxicity	2	40%
Hanging	3	60%
TOTAL	**5**	**100%**

UNDETERMINED

Eighteen deaths were classified undetermined in the manner of death.

CAUSE OF DEATH	NUMBER	PERCENT
House Fire	3	17%
SUID* or undetermined–sleep related	12	67%
Undetermined	3	17%
TOTAL	**18**	**100%**

** Sudden unexpected infant death*

ACCIDENT

Thirty-three deaths were classified as an accident in the manner of death.

CAUSE OF DEATH	NUMBER	PERCENT
Drowning	5	15%
Drug toxicity/drug related	8	24%
Hypoxic injury/suffocation	4	12%
Motor vehicle accident related	9	27%
Sleep related	7	21%
TOTAL	**33**	**100%**

Sixty deaths were classified natural in the manner of death.

CAUSE OF DEATH		NUMBER
Cancer	6	10%
Complications of multiple medical complexities	31	52%
Congenital heart condition	2	3%
Diabetes complications	1	2%
Neurological condition complications	4	7%
Pneumonia, sepsis, viral infection, or bacterial infection	5	10%
Prematurity complications	9	15%
Respiratory complications	1	2%
TOTAL	**60**	**100%**

HOMICIDE

Child No. 1	DOB: 10/2006	DOD: 07/2022	Homicide
Age at death:	15 years		
Cause of death:	Gunshot wound of chest		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Child was a youth in care; 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: Fifteen-year-old was shot at a public park by an unidentified individual. Police responded to the scene and the teen was transported to the hospital, where he was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In the year before his death, the teen was in the care of his maternal grandmother under subsidized guardianship. In May 2021, DCFS received a report that the then 14-year-old teen was brought to the hospital for an evaluation but did not meet the criteria for admission. The grandmother initially refused to allow him to come home because of his behavior problems, but later picked up the teen from the hospital. The grandmother denied to the CPI that she refused to pick him up from the hospital. The next day, DCFS received a second report that the teen disclosed a domestic violence incident with his mother. The teen's mother stated the grandmother called her to get the teen, but the teen became combative and refused to leave with her. She denied she attacked the teen. DCFS unfounded the maternal grandmother in the first investigation for lock-out (#84) and unfounded the mother in the second investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In February 2022, the grandmother reported to a community-based agency that she arranged for the teen's 17-year-old sister to live with her girlfriend and the teen to live with the mother's paramour. The grandmother reported she had concerns about the sister's mental health, and the girlfriend's family was not addressing these concerns. DCFS initiated an investigation against the grandmother for inadequate supervision (#74), and against the sister's girlfriend for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10), and for mental injury by abuse (#17). The grandmother told the CPI that the sister was legally in her care but was living in the home of her girlfriend's father. The CPI visited the girlfriend's home, observed the sister to be safe, and the sister reported she was doing well in the home. The CPI discussed with the girlfriend's father the process for him to become the sister's legal guardian. DCFS indicated the grandmother for inadequate supervision by neglect (#74) and unfounded the girlfriend for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and mental injury by abuse (#17). At the same time, DCFS initiated an investigation against the mother's paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substance misuse by abuse (#15) after the teen disclosed that he fought with the paramour and the paramour gave him marijuana. The grandmother told the CPI she no longer wanted to be the teen's legal guardian and had made a verbal agreement with the paramour to care for him, though the teen was currently living with his great-aunt. In March 2022, the maternal grandmother reported the teen was back in her care again because the great-aunt could not care for him. The paramour denied he gave the teen marijuana. He reported they argued about the people the teen associated with, the argument escalated, and the paramour stated he had to hold the teen down. DCFS unfounded the mother's paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substance misuse by abuse (#15). In April 2022, DCFS received a report that the father of the sister's girlfriend hit the 17-year-old sister. The sister denied the allegations, no injuries were observed, and police had no reports of calls to the home. The investigation remained pending at the time of the teen's death. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). In May 2022, a probate court judge granted the

grandmother's request to vacate her guardianship of the teen and his 17-year-old sister, and they came back into DCFS care. That month, the teen was placed with his paternal grandmother. The placement worker last visited the home one week before the teen's death. The paternal grandmother noted the teen had been behaving well, and the teen reported he was attending therapy.

Child No. 2	DOB: 05/2015	DOD: 07/2022	Homicide
Age at death:	7 years		
Cause of death:	Massive head injury due to gunshot wound to the head		
Alleged perpetrator:	Unknown – street homicide		
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: Seven-year-old was pronounced deceased at the hospital. The family reported they were on the way home from visiting relatives in a neighboring state when someone shot at their car. DCFS investigated the child's death and unfounded the mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In February 2021, DCFS received a report that the child's then 7-year-old and 10-year-old siblings reported that the mother's paramour was abusive toward their mother, and the children were afraid of him. The mother told the reporter the paramour had moved out of the home, but the children reported he had not. The mother reported verbal altercations but denied any physical violence. The family lived with the children's maternal grandmother, who corroborated the mother's report. The mother agreed to intact family services. DCFS opened the intact family services case and indicated the mother and paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact family services worker recommended domestic violence services, mental health services, drug and alcohol assessments, and family counseling for the children. The mother was cooperative with services, but the paramour was not. The intact worker made regular visits to the family's home and noted no safety concerns. The intact case remained open at the time of the child's death.

Child No. 3	DOB: 08/2004	DOD: 07/2022	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound of right thigh		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was sitting outside with her boyfriend when a drive-by shooter shot her in the thigh. She was taken to the hospital by ambulance, where she died several hours later. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In 2019, the teen and her siblings came into DCFS care, and the teen's 2-month-old son was also taken into DCFS care. In the year before her death, the teen was living in a traditional foster home with the goal of independence. The siblings returned home to their fathers. In July 2021, DCFS closed her siblings' placement cases, and the teen's siblings have had no further involvement with DCFS. The teen was employed, enrolled in driving classes, graduated high school, and planned to attend state college on a full-tuition scholarship. The teen's son remained in placement with his paternal relatives.

Child No. 4	DOB: 04/2007	DOD: 07/2022	Homicide
Age at death:	15 years		
Cause of death:	Gunshot wound to head		
Alleged perpetrator:	Brother		
Reason for review:	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: Fifteen-year-old was in a bedroom with her 20-year-old brother when a gun discharged and shot the teen in the head. The teen's 17-year-old brother told police he heard the gunshot and saw the 20-year-old running away with the gun. The 17-year-old began CPR while the mother called 911. The teen was transported by ambulance to the hospital, where she was pronounced deceased. Police arrested the 20-year-old brother, who reported he was assembling a ghost gun and accidentally touched the trigger. He stated he did not believe the gun was functional because it was not fully assembled. The brother was charged with felony involuntary manslaughter. DCFS indicated the brother for death by abuse (#1).

Reason for Review: In August 2021, DCFS received a report that the teen's father sexually assaulted the then 14-year-old teen, and the reporter had also seen the father provide and smoke cannabis with the teen. The CPI spoke with the father, who denied the allegations and stated the teen primarily lived with her mother. The mother stated the teen had never disclosed sexual abuse to her. The CPI attempted to meet with the teen multiple times and eventually located her at school. She denied the allegations. DCFS later unfounded the investigation for sexual penetration (#19) and substance misuse by abuse (#15). In September 2021, DCFS received a report that the teen's parents assumed the role of caregivers for two friends of the teen who had eloped from their own homes. The reporter stated the teen's father trafficked them and provided them with drugs and guns. A CPI attempted to see the family at home. The CPI spoke with one of the friends at school. The friend denied anything inappropriate happened in the teen's home and denied the teen's parents provided them drugs or a firearm. Throughout the investigations, the CPI made numerous attempts to locate and interview the teen, her friends, and her parents without success. In October 2021, DCFS received a related information report that the teen was visibly dirty, and her hair looked like it had not been combed in months. An allegation of environmental neglect was added to the investigation. A CPI eventually located the teen at school who appeared well groomed and denied issues at home. DCFS later unfounded the September 2021 investigation for substance misuse by abuse (#15) and by neglect (#65), sexual penetration (#19), human trafficking of children by abuse (#40), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and environmental neglect (#82). In November 2021, while both the August and September investigations remained pending, DCFS received a report that the teen was intoxicated at school and DCFS initiated a separate investigation. The CPI contacted the mother who told the CPI she knew of the incident but denied the teen had an alcohol problem. The family did not make themselves available at the home, despite the CPI scheduling visits. The CPI met with the teen at school and observed no signs of abuse or neglect. The teen reported her brother left alcohol at home, she took it without permission, and she understood what she did was wrong. DCFS unfounded the November 2021 investigation for substance misuse by neglect (#65) and inadequate supervision (#74). In January 2022, DCFS received a report that the mother used drugs with the teen and encouraged her to assault people and vandalize property. The teen and family denied the allegations. DCFS unfounded the investigation for substance misuse by abuse (#15) and substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). In May 2022, DCFS received a report that the teen's parents left the 15-year-old teen home alone, the teen held parties and used marijuana, and the teen did not attend school regularly. In addition, the family had been evicted from their home and the home was boarded up, but the mother moved back in. The CPI unsuccessfully attempted to see the family at home. The CPI also attempted to see the teen at school and learned she had not attended since the month before. The CPI continued efforts to contact the family. In July 2022, while the investigation remained pending, the teen died. DCFS later unfounded the investigation for inadequate supervision (#74).

Child No. 5	DOB: 10/2004	DOD: 08/2022	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Unrelated adult – street homicide		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was pronounced deceased at the scene after he was shot while at a bus station. He had been placed in a transitional living facility but had eloped two days earlier. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen came into care in 2019 through a no-fault dependency when his adoptive mother could no longer safely care for him due to his behavior. In the year prior to his death, he had been placed with a relative, but was detained in juvenile detention multiple times. In April 2022, upon his release, he was placed in a transitional living facility but refused to participate in mental health services or follow facility rules. He eloped from the facility on multiple occasions.

Child No. 6	DOB: 10/2006	DOD: 08/2022	Homicide
Age at death:	15 years		
Cause of death:	Gunshot wound to the torso		
Alleged perpetrator:	Unknown – street homicide		
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 taken to the emergency room for a gunshot wound to the chest. Medical staff attempted life saving measures, but the teen did not survive. DCFS did not investigate his death for abuse or neglect. The criminal investigation remains ongoing.

Reason for Review: In December 2021, DCFS received a report that the teen and a peer claimed a school resource officer hit them while trying to break up a fight. The teen stated he understood he was hit unintentionally, and the peer stated the security officer targeted him and hit him in the face. School personnel reviewed footage and stated the resource officer did not make intentional contact with any of the students other than attempting to separate them. The resource officer reported the school conducted an internal investigation and did not take disciplinary action against him. The teen's mother reported she knew of the fight; she did not pursue anything afterward because she was aware of her son's behavior and fights often broke out at the school. The CPI spoke with the teen and the peer at school, and both reported the resource officer only broke up the fight. In March 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 7	DOB: 08/2002	DOD: 08/2022	Homicide
Age at death:	20 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Deceased was a youth in care; unfounded child protection investigation within one year of deceased's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-year-old was in a liquor store when an unidentified man entered the store, approached the youth, and fired a weapon. The youth was transported to the hospital where he later died. A criminal investigation remains ongoing. DCFS did not investigate the death.

Reason for Review: In 2013, when he was 11 years old, the youth came into care after his parents left him and his four siblings, between the ages of 5 and 14 years, home alone in a condemned building. In the year prior to his death, he lived in a fictive kin foster placement and his permanency goal was

independence. He reported he wanted his case to remain open and to enter the Independent Living Program, which required consistent employment for 90 days. Between October 2021 and January 2022, he was arrested and detained twice, resulting in electronic monitoring. In May 2022, he survived being shot in the back while walking home from his girlfriend's house. In June 2022, DCFS received a report that the youth's 7-year-old foster sister disclosed physical abuse by her mother. The CPI observed the foster sister had no visible signs of injury and she reported she felt safe at home. The youth also reported he felt safe at home and had not observed any abuse or neglect. The youth's foster mother denied she abused her daughter. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The youth's caseworker last met with him approximately three weeks before his death.

Child No. 8	DOB: 05/2020	DOD: 09/2022	Homicide
Age at death:	2 years		
Cause of death:	Blunt force trauma due to physical abuse		
Alleged perpetrator:	Mother's paramour		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old died at the hospital where she had been admitted a month earlier in critical condition, after she was removed from life support. DCFS initially opened an investigation after she was found unresponsive at home by her mother's paramour. First responders noted the toddler was bruised and scarred, and hospital staff reported she had new and old fractures, injuries to her vagina and rectum, brain injuries, possible liver injuries, abrasions, and bruises. Medical staff found fluid in the toddler's lungs, and the paramour told them he placed the toddler in the bathtub to wake her up after he found her unresponsive. He stated the mother was at work at the time. The mother denied corporal punishment. DCFS took protective custody of the toddler and her 5-year-old, 6-year-old, and 7-year-old siblings. The siblings reported the mother's paramour did not like the toddler and they saw him punch her. The mother reported that she started working a night shift, and a few weeks earlier, she began to see bruises on the toddler. The mother stated the paramour told her the bruising was from the toddler playing at the park or playing with her siblings. During the investigation, the siblings participated in forensic interviews and disclosed physical and sexual abuse by the paramour and stated their mother knew of the abuse. DCFS indicated the toddler's mother and the paramour for death by abuse (#1); head injuries by abuse (#2); internal injuries by abuse (#4); bone fractures by abuse (#9); substantial risk of physical injury/environment injurious to health and welfare by abuse (#10); cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); sexual penetration (#19); and sexual molestation (#21). DCFS also indicated the mother for inadequate supervision (#74). The paramour is in jail awaiting trial for murder.

Reason for Review: In February 2022, DCFS received a report that the toddler's siblings had not attended school in six weeks, the mother had an alcohol use disorder, and the family's whereabouts were unknown. The CPI contacted the reporter, who stated the toddler's mother said she resided in a neighboring state and enrolled the children in school there. The CPI contacted school in that state and was informed the children were not enrolled. The CPI made attempts to locate the family, finding contact information from an arrest prior to the hotline report and contacted the mother who agreed to meet with the CPI and provided her address. The CPI met with the toddler's 6-year-old and 7-year-old sisters at school and then the CPI visited the home and met with the mother, the mother's paramour, the toddler's maternal aunt, the toddler's 5-year-old brother, and observed the toddler. The toddler and her siblings appeared free of injuries or bruises. The 7-year-old stated she witnessed an argument between her mother and her maternal aunt, her mother left the home, and her mother was later arrested. The mother stated the maternal aunt locked her out of the home, they argued, she kicked in the door, and she was arrested. The aunt corroborated her account. Both denied the argument turned physical. The 7-year-old reported she and her siblings lived with their grandmother while their mother was in jail, then they moved back in with the

aunt. The 7-year-old reported the mother consumed alcohol, but she did not know the last time she witnessed her mother drink. The aunt and the paramour denied concerns about the mother's alcohol use, and a collateral contact also denied concerns. The children's pediatrician denied concerns about the family but noted the toddler was a new patient and missed her initial appointment. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 9	DOB: 12/2013	DOD: 09/2022	Homicide
Age at death:	8 years		
Cause of death:	Gunshot wounds of the head		
Alleged perpetrator:	Stepfather		
Reason for review:	Closed intact family services case and indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old and his mother were shot and killed at home by the child's stepfather. Police immediately arrested the stepfather. DCFS placed the child's maternal half-sisters, 15-month-old twins, with their maternal uncle. The stepfather has been charged with six counts of first-degree murder. DCFS indicated the stepfather for death by abuse (#1) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In October 2021, DCFS received a report that the child's stepfather verbally abused the then 7-year-old child and his then 4-month-old twin sisters, the mother was afraid to leave, and the stepfather had a pending child abuse investigation in another state. The next day, DCFS received two related information reports that when the child's stepfather brought the twin sisters to the hospital for respiratory issues, the stepfather was abusive to the mother, so the hospital admitted the twins for safety reasons and escorted the stepfather from the premises. The mother filed a police report against the stepfather for domestic violence. The initial reporter stated the mother moved to Illinois to escape the stepfather, but he followed her. The child told the CPI that his stepfather tried to hurt his mother three times the day before, and he heard the altercations but did not witness them. He stated one altercation happened in the mother's bedroom while the child's twin sisters were in the room. He added the stepfather removed the knob from his bedroom door so he could not leave the room unless he was let out. The child reported that following the incident, his maternal uncle came to the home and picked up him, his mother, and his twin sisters, and he had been in the uncle's care since then. He reported his mother removed his electronics as punishment, but his stepfather spanked him with a belt and had once choked him. The child told the CPI he felt safe with his mother and uncle, but he did not want to be around his stepfather. Hospital staff reported the child's mother was appropriate at the hospital and told them of the domestic violence. A child abuse medical provider examined the twins and noted no signs of abuse or neglect. The hospital discharged the twins to the mother. The mother told the CPI the domestic violence began after the twins were born and she had tried to leave the relationship multiple times. The mother completed order of protection forms and reported she planned to divorce the stepfather. She denied he had ever harmed the twins, but he had used corporal punishment with the child. The mother agreed to intact family services. The CPI's attempts to contact the stepfather were unsuccessful and the stepfather had reportedly left the state. DCFS opened an intact family services case and indicated the stepfather for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the mother for the same allegation because the mother filed an order of protection and was going to divorce the father, and the child felt safe in her care. The intact worker met with the mother, who reported she no longer wished to participate in intact services. The intact worker discussed the decision with the mother and the intact team noted no new safety concerns with the family. In January 2022, the intact family services case was closed.

Child No. 10	DOB: 12/2008	DOD: 10/2022	Homicide
Age at death:	13 years		
Cause of death:	Gunshot wound to the head		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Split custody at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old was found by police in a park with a gunshot wound to his head. He was transported to the hospital in critical condition, where he was later pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In November 2021, DCFS received a report that the teen posted a picture of himself holding his adult brother's firearm. The CPI met with the teen, who denied his brother gave him the gun. The teen stated he found a BB gun in the alley. He confirmed he shared a picture of himself with the BB gun on social media. The teen reported he felt safe at home, and he was observed free of visible injuries. The teen's mother stated she did not believe the brother would put the teen in harm's way. The teen's brother denied he would allow a child to play with guns, and denied he saw the teen take a picture with a gun. DCFS unfounded the investigation against the teen's older brother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The teen's 19-year-old sister was a youth in care at the time of his death. The sister was substance-exposed at birth and initially came into care following her birth. A family friend later became her legal guardian until 2019, when the mother petitioned the court to have guardianship returned to her. As a result, the sister came back into DCFS care. In the year prior to the teen's death, the sister primarily resided with the mother in a self-selected unauthorized placement, though she was also on run for a period of time. The placement worker documented the mother completed all services, but the sister was inconsistent with services despite her caseworker's continuous efforts to engage her. The sister was referred for individual therapy, behavioral therapy, medication monitoring, and a GED program.

Child No. 11	DOB: 01/2005	DOD: 10/2022	Homicide
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-year-old was shot multiple times outside an apartment. He was brought by ambulance to the hospital, where he was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In April 2022, DCFS received a report that the teen, his 19-year-old brother, and his mother, bullied the teen's 14-year-old younger brother. The reporter stated the brothers called the 14-year-old homophobic slurs, the older brothers threatened the 14-year-old with guns, the 14-year-old engaged in self-harming behaviors, and he did not feel safe at home. The younger brother told the reporter that approximately one year earlier, one of the older brothers choked and tried to kill his sister. The CPI met with the younger brother at school. The younger brother stated his older brothers had threatened him with a gun, but his mother did not know about the incident because he did not feel safe to tell her. He disclosed self-harming behaviors to the CPI and added he wanted to live with a fictive kin aunt but had not asked his mother. Another younger brother stated their 20-year-old brother supervised when their mother went to work. He denied seeing a gun in the home and denied witnessing the older brothers physically attack the 14-year-old. During the investigation, DCFS received a related information report that Screening Assessment and Support Services (SASS) had been called because the 14-year-old was in crisis, but the mother refused to allow SASS to evaluate him. DCFS unfounded the investigation for

substantial risk of physical injury by abuse (#10) and by neglect (#60), mental injury by abuse (#17), and medical neglect (#79).

Child No. 12	DOB: 03/2021	DOD: 10/2022	Homicide
Age at death:	19 months		
Cause of death:	Nutritional neglect		
Alleged perpetrator:	Mother		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nineteen-month-old was found unresponsive in his crib by his maternal aunt. First responders were unable to resuscitate the toddler. The toddler's mother reported she saw him alive at 9:00am and his aunt arrived around 11:00am to care for him when his mother went to work. The aunt stated she checked on him around 2:00pm and found him unresponsive. The coroner initially suspected the toddler had been deceased for at least 12 hours. First responders also noted the home smelled of animal urine and feces and there were feces visible in the home, including in and underneath the toddler's crib. Four months earlier, the toddler was diagnosed with failure to thrive, and his mother was connected to the WIC program. He attended three follow-up appointments with his primary care doctor but missed a fourth appointment four days before his death. At autopsy, the toddler weighed only 9.5 lbs., his stomach was empty, and he only had a small, hard stool in his large intestine. The mother reported they only had two animals in the home, and it was the aunt's responsibility to clean up after them. DCFS indicated the toddler's mother for death by abuse (#1) and failure to thrive (#81). DCFS indicated both the toddler's mother and aunt for inadequate food (#76) and environmental neglect (#82). Police arrested the mother and she had been charged with first degree murder and felony child endangerment.

Reason for Review: In November 2021, DCFS received a report that law enforcement responded to a call that the toddler's 15-year-old maternal uncle was breaking into cars. Police found the uncle in dirty clothing and smelling of urine. The uncle stated he was breaking into cars to find money for food. He told police he had been kicked out of the home of his mother, so he had been living with his sister, the toddler's mother. However, he got in trouble for not doing chores, so he slept in a shed with a heater, and he preferred that arrangement. The toddler's mother told police she kicked the uncle out of the home and stated he slept in the shed for one night as a punishment. The CPI attempted to see the family but found no one at the home. Law enforcement told the CPI the uncle stated he chose to live with the toddler's mother, he chose to stay in the shed, and the toddler's mother provided him food and allowed him into the home to use the bathroom. The officer reported the uncle was dirty and malodorous, but he had no injuries and denied abuse. The CPI eventually met with the toddler's mother at home, who stated the uncle was only supposed to stay in the shed for one night, but he continued to stay there. While at the home, the CPI noted the then 10-month-old toddler appeared healthy, well cared for, and free of visible injuries. However, the CPI documented the home had a bad odor and was swarming with flies, the family had 10 cats and a dog living in the home, the litter box was full of feces, and there were also feces on the floor. The CPI instructed the toddler's mother to clean the home. The CPI met with the uncle at a behavioral health center, and he confirmed he preferred to stay in the shed. Staff at a behavioral health center reported the uncle had been accepted at a residential treatment center out of state. The toddler's pediatrician reported he had been seen recently, he was up to date on his immunizations, and he had not missed any appointments. The pediatrician noted the toddler had normal growth but was slightly delayed and had not started crawling. DCFS unfounded the toddler's mother and maternal grandmother for inadequate supervision (#74).

Child No. 13	DOB: 09/2019	DOD: 10/2022	Homicide
Age at death:	3 years		
Cause of death:	Blunt force injury to the head due to victim of child abuse		
Alleged perpetrator:	Stepmother		
Reason for review:	Pending child protection investigation at time of child's death; return home and intact family services case within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Three-year-old was found not breathing when his father arrived to pick him up from his stepmother. His father removed him from the car, attempted CPR, then went to the fire station for assistance. Hospital staff reported the toddler's body was cool to the touch upon arrival. The toddler's autopsy report noted he died of blunt force injuries. The stepmother stated the toddler's 4-year-old brother was jumping on the toddler, and she removed the toddler, the 4-year-old, and their 22-month-old brother from the couch to separate them. DCFS indicated the toddler's stepmother for death by abuse (#1) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the father and stepmother for death by neglect (#51) and unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The toddler's stepmother has been sentenced to 11 years in prison for involuntary manslaughter.

Reason for Review: In September 2021, DCFS opened an intact family services case after DCFS indicated the toddler's biological mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) after concerns about the mother's drug use. The then 2-year-old toddler was placed with his maternal uncle under a safety plan, and the mother was required to complete three negative drug tests and a substance use assessment to end the safety plan. In March 2022, the toddler's uncle expressed concern that the safety plan had not yet ended. In April 2022, the intact worker noted the mother was non-compliant with services, and the court granted DCFS custody of the toddler, and he remained in his uncle's care. The placement worker met with the toddler's father, who had recently established paternity, and the toddler began visits with his father. At the end of August 2022, DCFS placed the toddler with his father and stepmother. In September 2022, the toddler's mother expressed concern about bruises to the toddler. The toddler's father reported the bruises were from the toddler playing with the other children in the home. In October 2022, the court closed the placement case; DCFS continued to provide aftercare services. One week before the toddler's death, DCFS received a report that the toddler presented at school with a swollen lip; a lump on his forehead; a scratch by his ear; and bruising on his forehead, sternum, and left shin. The reporter stated the toddler, though limited in speech, provided the family dog's name when asked who bruised him but nodded his head yes when the reporter asked if his stepmother injured him. The CPI visited the home and met with the toddler, his four stepsiblings and paternal half-siblings, and the father and stepmother. The 9-year-old sibling stated the toddler may have been hurt from falling off a porch. The 11-year-old sibling stated the toddler may have been injured from the trampoline or slide, or because the 9-year-old hit people. Both denied their parents hurt them and stated they felt safe at home. The CPI observed the toddler's injuries and noted he did not have a swollen lip but did have a raised bump and bruise on his head, scratches, typical knee bruising, and a bruise to the chest. The toddler's stepmother reported the toddler's head was struck by a door between the kitchen and dining room when the toddler's 23-month-old brother pushed the door open while the toddler was standing behind it. She stated the toddler's other injuries were likely from normal play. The father stated he was not home at the time of the incident, but the stepmother informed him of the incident with the door. The father took the toddler to the hospital for evaluation, and the hospital discharged him. Six days later, while the investigation remained pending, the toddler died. DCFS later indicated the toddler's stepmother for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61).

Child No. 14	DOB: 11/2006	DOD: 10/2022	Homicide
Age at death:	15 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was shot at a street race along with four other victims. Three people, including the teen, died following the shooting. Police have not made any arrests. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In July 2022, DCFS received a report that the then 14-year-old teen was admitted to the hospital and intubated after a high-speed motor vehicle accident resulted in four passengers being hospitalized. The driver was reported to be a 16-year-old with a driver's permit who tested positive for several substances. The driver, a youth in care who was visiting her father for the weekend, reported she was driving her father's car and hit a police car, so they fled. She stated she was giving a friend a ride home when another friend, who had other people with him, also asked for a ride. The driver added no one was wearing their seat belts and the passengers were sitting on each other's laps. Police released her on bond. The CPI visited the teen at the hospital, but the teen refused to speak with the CPI. The teen lived with his grandmother, and the grandmother reported no knowledge of the teen using drugs or being involved in criminal activity. She stated the teen did not ask for permission to go out the night of the accident. In September 2022, the CPI visited the home and noted the teen appeared to be healing. The investigation remained pending at the time of the teen's death. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) because the driver was not an eligible perpetrator.

Child No. 15	DOB: 12/2006	DOD: 11/2022	Homicide
Age at death:	15 years		
Cause of death:	Gunshot of the head [sic]		
Alleged perpetrator:	Unrelated – street homicide		
Reason for review:	Split custody at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was shot in the head and law enforcement found his body after responding to reports of gunfire. He was transported to the hospital and died the next day. Police have arrested an unrelated adult for the teen's murder. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In 2016, at the age of 11, the teen's half-brother came into DCFS care on a delinquency petition. In the year prior to the teen's death, the then 17-year-old brother was incarcerated for residential burglary. The brother's caseworker met with the brother in-person at the juvenile detention center on a regular basis. In October 2022, the brother was released to the care of a relative. The teen did not receive services from DCFS during his brother's placement case.

Child No. 16	DOB: 12/2017	DOD: 11/2022	Homicide
Age at death:	4 years		
Cause of death:	Cocaine toxicity		
Alleged perpetrator:	Mother and mother's paramour		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation; report to Director on June 30, 2023		
	See Death and Serious Injury Investigation 2		

Narrative: Four-year-old medically complex child was found unresponsive by her mother and mother's paramour. They began CPR and called for an ambulance. The child was pronounced deceased at the hospital. The child was non-verbal and required a wheelchair and g-tube. The day of the child's death, the CPI visited the home and noted the home did not have items that would have been consistent with a child residing there, and the paramour refused to answer where the child's feeding bags were. The CPI also observed drug paraphernalia. The mother tested positive for cocaine and marijuana, and the paramour tested positive for cocaine, benzodiazepine, and marijuana. School staff reported that the day before the child's death, they contacted the mother because the child appeared sick, was lethargic, and her stomach appeared distended. At pickup, they informed the mother's paramour of these concerns and stated the child needed to be seen by her doctor that day. The mother told the CPI they gave the child an enema, provided Miralax and food through her g-tube, and put her to bed. The child's primary care physician reported they had not seen the child since September 2022, when she was seen for respiratory issues and sent to the emergency room. The doctor noted the child was supposed to be seen for monthly weight checks, and they attempted to contact the mother, but the mother did not bring the child in. At autopsy, the child was found to have died from cocaine toxicity. DCFS indicated the child's mother and mother's paramour for death by abuse (#1) and substance misuse by abuse (#15). The child's mother and paramour have been charged with first-degree murder and drug-induced homicide.

Reason for Review: The child was medically complex and had a diagnosis of epileptic encephalopathy resulting from an incident when the child was 9 months old, when she was found unresponsive and was hospitalized. Doctors noted her condition was due to ingesting medication, possibly a diabetes medication, and she sustained permanent and severe brain damage. Following the incident, DCFS indicated an unknown perpetrator for head injuries by neglect (#52). In November 2022, six days before the child's death, DCFS received a report that the child was having trouble with feedings, had lost significant weight, had a fever, was vomiting, had a rash on her face, and likely had pink eye, but she had not been seen by a doctor. The reporter added the child often went to school unbathed, in previously worn clothes that had vomit on them, and she sometimes smelled of marijuana. In addition, the child's mother did not respond to the reporter's attempts to contact her about these concerns. That day, the CPI documented a phone call with the mother after a good faith attempt at the family's home. The mother confirmed the child had been vomiting, so she contacted the child's dietician and planned to take the child to the emergency room the next day. She denied the child had a fever. The next day, hospital staff called the CPI to report they saw the child. Medical staff reported she had a rash, but it was not abnormal since she had been vomiting so much. Medical staff reported no concerns of abuse or neglect and noted the mother seemed informed about the child's medical condition. The hospital discharged the child that day. Five days later, while the investigation remained pending, the child died. DCFS later indicated the investigation for medical neglect (#79) and environmental neglect (#82).

Child No. 17	DOB: 11/2008	DOD: 11/2022	Homicide
Age at death:	13 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old and a peer were found deceased in the community with gunshot wounds. Police have not made any arrests. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In May 2022, DCFS received a report that the teen's father slammed the 15-year-old sister's head into a wall and put his foot on her neck while she was on the ground. The sister and her parents reported the sister stayed with her boyfriend the night before and the parents filed a missing person report. The parents found her at a bus stop the next day. The sister got in the car, but while the father was driving, she began kicking the father from the backseat. The father pulled the car over, the sister began hitting him, and the father had to physically restrain her. The sister stated she argued with her parents but denied they abused her. The other children in the home denied the father was abusive toward the sister. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In October 2022, DCFS received a report that the teen's father contacted the school looking for the teen because he had not been home in three days. The parents filed a missing person report. The reporter stated the father picked up the teen from school, and the teen ran away while they were enroute to the police station to close the missing person's report. The CPI spoke with school staff who stated they did not know what happened after the teen and his father left the school. The teen, his parents, and his siblings reported the teen had behavioral problems and ran from the home. The teen stated he stayed with a friend and his grandmother and continued to attend school. He denied anyone hit him and reported he felt safe at home. While the investigation was pending, the teen again ran away from home. The CPI confirmed the mother filed a missing person report. The teen's grandparents denied any concerns for abuse in the home. The mother told the CPI she had sought assistance, but the teen refused services. In October 2022, DCFS unfounded the investigation for inadequate supervision (#74). The CPI documented she referred the family for individual and family counseling.

Child No. 18	DOB: 09/2006	DOD: 11/2022	Homicide
Age at death:	16 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
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: Sixteen-year-old was found in a stolen vehicle with a gunshot wound to his chest. The teen was transported to the hospital, where he was later pronounced deceased. Police have not made any arrests. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the teen's then 16-year-old sister told school staff that she was kicked out of her home after an argument with her maternal grandmother. The reporter also stated the sister disclosed that the father of her sibling abused her, and she witnessed him murder her brother when she was younger. Three years earlier, DCFS had investigated the brother's death and indicated the father for death by abuse (#1). The father was also charged with homicide. The CPI met with the sister, who stated her mother was verbally abusive, had mental health issues, and kicked her out after an argument. She denied anyone physically hurt her. The teen's mother confirmed she locked the sister out of the home. She stated the sister was physically aggressive with the grandmother, so she made a care plan with the teen's maternal aunt. The CPI confirmed the plan with the aunt. The sister later recanted her allegations and stated she was safe. The mother declined intact family services. In December

2021, DCFS unfounded the investigation for lock-out (#84). Approximately one week later, DCFS received a report that the teen's sister flagged down a police officer and reported abdominal pain, so law enforcement transported the sister to the hospital, where the sister became uncooperative. Hospital staff attempted to contact a guardian for consent to treat her, but the sister provided multiple erroneous phone numbers. The hospital discharged the sister to her father before the CPI arrived. The CPI spoke with the mother, who reported the sister left the aunt's home and they did not know her whereabouts. She stated she had filed a missing person report. She added she had a 15-year-old child who was involved with delinquency as well. The mother declined intact family services. The teen's 9-year-old brother denied anyone in the home hurt the sister and stated he last saw her five days earlier. In the following weeks, the CPI attempted to locate the sister. In February 2022, the CPI met with the sister, who stated she was living with a cousin and felt safe, she denied she gave hospital staff a difficult time. The cousin confirmed the sister lived with her. The CPI referred the sister for community-based counseling services. In March 2022, DCFS indicated the teen's mother for inadequate supervision (#74).

Child No. 19	DOB: 08/2011	DOD: 11/2022	Homicide
Age at death:	11 years		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Brother		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; sibling of a former youth in care and two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eleven-year-old was shot at home. Emergency services responded to the home and transported the child to the hospital. Three days later, he was pronounced deceased. The mother provided inconsistent statements to law enforcement and the CPI regarding who was in the home at the time of the incident and how the shooting happened. DCFS took protective custody of the child's 10-month-old and 6-year-old siblings. The child's 19-year-old brother later told law enforcement that he and the child were play-fighting. He stated the child had a knife and the brother had a gun on his hip, but the gun fell on the ground while they were wrestling, and it fired when he picked it up. He stated he threw the gun over the balcony and woke his mother. Police arrested the child's older brother and charged him with involuntary manslaughter, aggravated unlawful use of a weapon, reckless conduct, and obstruction of justice. DCFS indicated the brother for death by abuse (#1) and wounds by abuse (#7). DCFS also indicated the child's mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the investigation for inadequate supervision (#74).

Reason for Review: In February 2022, DCFS received a report that the then 10-year-old child disclosed his mother, and her paramour smoked a white substance, the mother kicked the child in the stomach, and the mother left the children with a friend who sexually abused the child and his then 5-year-old sister. The child and his sister denied anyone struck the child and denied anyone touched either of them inappropriately. The child reported the mother smoked marijuana outside. The mother denied the allegations and stated she had given birth a few weeks earlier, and the hospital would have made a report if she used drugs. In March 2022, while the investigation remained pending, DCFS received a report that the mother and her paramour had an altercation when the children were present, the mother used drugs, the child stole from stores, and the mother sent the child to go to the store alone. During a home visit, the child told the CPI he observed fighting between family members and his mother called police. He stated he felt safe at home. He told the CPI he sometimes went to the store alone, which the CPI observed was directly behind the apartment building. The 5-year-old sister denied she saw her mother smoke a white substance, and she stated she felt safe at home. The mother denied she used any substances other than marijuana and agreed to drug testing. She confirmed there had been a fight in the home, she called police, and her landlord banned the other adults from the property. The CPI discussed safe sleep with the mother

and observed a bassinet for the 2-month-old sibling. The CPI noted the home appeared clean and did not observe drug paraphernalia. School staff denied concerns about abuse or neglect. The mother accepted intact family services. DCFS unfounded the first investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10) and by neglect (#60). DCFS unfounded the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74). The family's intact worker recommended a mental health assessment for the mother, parenting classes, and therapy. The intact worker conducted weekly home visits and noted the children consistently appeared well cared for. The mother attended parenting classes and therapy services through a community provider, and the provider noted they also addressed domestic violence issues. The child and 5-year-old sister attended school. The child's 19-year-old brother was a youth in care from 2019 through approximately three weeks before the child's death. The brother had documented intellectual, emotional, and developmental delays, and his therapist reported he would never be able to live independently. In the year prior to the child's death, the brother lived in residential care and his permanency goal was independence. In July 2022, the brother was placed with his grandmother, as residential facility staff reported the brother would benefit from a supervised placement with some independence and he required an adult guardian. In September 2022, the brother's grandmother reported his whereabouts were unknown. One week later, the mother reported the brother had come to live with her. The brother stayed with his mother in an unauthorized placement. Approximately three weeks before the shooting, the court closed the 19-year-old brother's placement case, and the brother remained in the mother's care. Two weeks later, DCFS received a report that the child's 6-year-old sister drank from a cup that contained alcohol. The CPI interviewed the family at home. The mother denied she or any of the children drank alcohol. The 6-year-old stated alcohol was only for adults and she denied she drank anything from her mother's cup that tasted bad or made her feel funny. The child also denied he or his siblings drank alcohol. The child's 10-month-old sibling appeared developmentally appropriate. The intact worker told the CPI the mother cooperated with her service plan but had issues with the fathers of the children. The investigation remained pending, and the intact case remained open at the time of the child's death. DCFS later unfounded the investigation for substance misuse by neglect (#65).

Child No. 20	DOB: 01/2005	DOD: 12/2022	Homicide
Age at death:	17 years		
Cause of death:	Massive head injury due to gunshot wound to the head		
Alleged perpetrator:	Unrelated adult – street homicide		
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: Seventeen-year-old was shot on the sidewalk in front of the family home by an unrelated adult. The teen was transported to the hospital, where he was pronounced deceased. The man reported he shot the teen in self-defense. DCFS did not investigate the teen's death for abuse or neglect. A criminal investigation remains pending.

Reason for Review: In April 2022, DCFS received a report that the teen's then 6-year-old sister disclosed that her mother and mother's paramour fought regularly, and she did not want to go home from school. The CPI met with the sister at school. She confirmed the report and added her mother had a wound on her head and the paramour owned a gun. The mother and her paramour reported a heated argument the night before, but denied it became physical, and the paramour denied he owned a gun. The mother agreed to intact family services. A LEADS background check showed an extensive history of domestic battery charges for the mother and paramour. DCFS indicated the mother and paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and opened an intact family services case. The teen, who had been living with relatives out of state, moved back in with his mother during the summer. The mother told the intact worker she had obtained an order of protection against the

paramour, who had moved out in June, and she had not had recent contact with him. The mother stated she no longer wanted services. The intact worker encouraged the mother to participate in services which could provide financial assistance. In November 2022, the intact worker attempted to meet with the teen at school and learned he had only attended eight days of classes that semester. The intact worker attempted to screen the case into court, but the state's attorney denied to file because the case was opened for domestic violence and the mother was no longer involved with the paramour. The intact case remained open at the time of the teen's death.

Child No. 21	DOB: 10/2022	DOD: 12/2022	Homicide
Age at death:	2 months		
Cause of death:	Closed head injuries due to inflicted head trauma		
Alleged perpetrator:	Mother and father		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old presented at the hospital one week prior to her death with significant head trauma. The infant died in the hospital. Neither parent could explain the injuries. The child abuse pediatrician at the hospital stated the injury was likely the result of abuse. Law enforcement interviewed the parents, who denied they hurt the infant. DCFS indicated both parents for death by abuse (#1) and head injuries by abuse (#2) because the medical examiner ruled the death a homicide and the parents were the only caretakers for the infant at the time. A criminal investigation remains pending.

Reason for Review: In November 2022, DCFS received a report that the then 4-week-old infant went to her pediatrician for a weight check, where they found she had a distended abdomen. Her pediatrician recommended the parents take her to the emergency room and arranged ride-share transportation for the parents, but they refused, so medical staff called 911 for an ambulance transport. The CPI spoke with staff at the emergency room, who reported they discharged the infant to her parents as there was nothing unusual in her test results. The CPI met with the family at home, observed a bassinet and formula for the infant, and noted the parents received WIC assistance. The infant's pediatrician noted she came for three prior weight checks and there were no concerns at the prior appointments. The infant's emergency room records showed no concerns for abuse or neglect. In December 2022, while the investigation remained pending, the then 8-week-old infant presented at the hospital with head trauma and died one week later. DCFS later unfounded the November 2022 investigation for medical neglect (#79).

Child No. 22	DOB: 06/2005	DOD: 01/2023	Homicide
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found deceased in the street. Police responded to a report of shots fired and found the teen with multiple gunshot wounds. Witnesses reported they heard six shots, then a car driving away, and saw another person running through the neighborhood. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In April 2022, DCFS received a report that the teen and a friend had driven and crashed a stolen vehicle. Police arrested the teen and his friend and released the teen to his friend's mother because the teen's mother did not have transportation. The friend's mother reported the teen told his friend the car belonged to his cousin and the friend did not know the vehicle was stolen. The teen's mother reported the teen did not come home the night before, had been skipping school, and was failing his classes. The mother stated she had trouble with his behavior and wanted to get him enrolled in a mentoring

program. She also reported he had an Individualized Education Plan (IEP) for emotional disability and had been on probation for stealing. The teen reported his mother did not know what he was doing the night of the incident and she had texted asking where he was. He added a friend picked him up and gave him the car keys, and he denied he knew the car was stolen. The teen reported he felt safe with his mother. In June 2022, DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 23	DOB: 11/2006	DOD: 01/2023	Homicide
Age at death:	16 years		
Cause of death:	Multiple gunshot wounds of the chest		
Alleged perpetrator:	Unknown – street homicide		
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 shot and killed when two unknown people fired their guns at a church. Two other people sustained injuries. DCFS did not investigate the teen's death for abuse or neglect. The criminal investigation remains pending.

Reason for Review: In October 2022, DCFS received a report that the teen and his twin brother were in a physical altercation with school security staff and the teen sustained injuries, but the school denied him medical treatment. The CPI spoke with the school principal, security officers, the teen, his twin brother, his mother, and his mother's paramour. The CPI also viewed school security footage of the incident. School staff and the teen reported the incident began when the twin was in the office, on a video call with his mother, but the connection failed. The mother called the teen to check on his twin, and the teen tried to enter the office but was blocked. The CPI noted school security footage showed the teen walking in an aggressive manner while speaking on the phone and confronting security officers. The teen became aggressive and security officers attempted to restrain him. School staff reported they sent for the school nurse to tend to the teen's injuries, but his mother wanted EMS to treat him, and she called EMS herself. In December 2022, DCFS unfounded the investigation against the school security staff for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 24	DOB: 09/2022	DOD: 02/2023	Homicide
Age at death:	4 months		
Cause of death:	Multiple injuries due to child abuse		
Alleged perpetrator:	Babysitter		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was transported by ambulance to the hospital. The next day, she was pronounced deceased. The infant's mother reported the babysitter called her and stated the infant stopped breathing, so the mother called 911. The 911 call lasted for 10 minutes due to a language barrier. A CT scan revealed the infant had a brain bleed, and she was diagnosed with hypothermia, cardiac arrest, and subdermal hematoma. The infant's mother told the CPI the babysitter had been caring for the infant for a few months, between 8:00am and 4:00pm, while the parents worked. The babysitter reported that on the day of the incident, the infant was sick and slept most of the day. When she got the infant ready for her mother to pick her up, the infant vomited and began coughing, and she called the mother. She stated she called the mother, and the mother arrived at the home, began CPR, and called 911. The CPI initiated a safety plan for paternal relatives to care for the babysitter's own two children. DCFS later returned them to their father. DCFS indicated the babysitter for death by abuse (#1), head injuries by abuse (#2), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Police arrested the babysitter, and she has been charged with murder.

Reason for Review: In January 2023, DCFS received reports that the infant's parents left her unattended in the front seat of a running vehicle, outside a bar. Police arrested the infant's parents, took protective custody of the infant, and took her to the hospital for an exam. That morning, the CPI placed the infant in a traditional foster home. The CPI met with the parents, who reported they went to get food, but the line appeared long, so the father went into the bar next door and left the mother and infant in the car, with the car running for heat. They stated the mother had to use the bathroom and left the infant in the front seat, and the father stated he kept the car in his sight while he was in the bar. They stated police arrived a few minutes later and arrested them. They denied either of them drank while in the bar. Two weeks before the infant's death, the state's attorney rejected custody and recommended intact family services with the reasoning that the parents had no prior involvement with DCFS, and it was unknown how long the infant was alone in the car. The infant returned to the parents' care. Two weeks later, while the investigation was pending, the infant died. DCFS later indicated the parents for inadequate supervision (#74).

Child No. 25	DOB: 10/2013	DOD: 03/2023	Homicide
Child No. 26	DOB: 02/2006	DOD: 03/2023	Homicide

Age at death:	9 years; 17 years
Cause of death:	Gunshot wound of head; Multiple gunshot wounds
Alleged perpetrator:	17-year-old's boyfriend
Reason for review:	Two unfounded child protection investigations and one closed child welfare services referral within one year of children's deaths
Action taken:	Investigatory review of records

Narrative: Nine-year-old and 17-year-old were shot and killed during a home invasion, along with the child's father, the teen's stepfather. The mother was also shot but underwent emergency surgery and survived. The teen's 3-year-old and 14-year-old siblings were uninjured. The teen's boyfriend was arrested and has been charged as an adult with first-degree murder, attempted first-degree murder, home invasion, aggravated battery with firearm, and aggravated unlawful use of a weapon. DCFS did not investigate the deaths for abuse or neglect.

Reason for Review: In March 2022, DCFS received a report that police responded to the family home when an unknown person cut the boyfriend of the then 16-year-old teen with a knife. At the time of the incident, the teen was left to supervise the then 8-year-old child and their 13-year-old brother. The reporter stated the teen's boyfriend came to the home and an unknown person was in the home, but no one knew how the unknown person got into the home. The children called their mother, who called police and returned home immediately. DCFS referred the report for child welfare services. The teen informed the caseworker she did not know the person directly but intended to buy marijuana from him, the man then forced his way into the home, and her boyfriend later arrived at the home and got into a physical altercation with the man. The caseworker referred the teen for counseling and closed the child welfare services referral. In April 2022, DCFS received a report that an argument between the teen and her mother turned physical, and the teen's stepfather restrained the teen while her mother hit her in the face with a closed fist. The teen's siblings were not home at the time of the incident. The CPI met with the teen at school, and the teen denied the incident occurred and denied any other abuse. The CPI documented the teen did not show any observable signs of abuse or neglect. The CPI met with all three children at home, who reported they felt safe and denied their parents used corporal punishment. The CPI observed no signs of abuse or neglect. The mother confirmed they had an argument because the teen missed the bus but denied it turned physical. The mother declined intact family services. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In August 2022, DCFS received a report that the mother called 911 and stated the teen was suicidal, and the teen was brought to the hospital. The teen denied she was suicidal and reported her mother physically abused her, but not her siblings. The CPI spoke with the reporter, who denied the teen had any visible marks or bruises.

The reporter stated the teen went to live with her maternal aunt. The aunt reported the teen was confrontational and there were issues between the teen and her mother, but she denied the mother was abusive. The school social worker denied the teen had reported any concerns about her home life or mental health. The CPI met with the teen at home, who stated she made up the reports of abuse because she was angry with her mother. The teen and her siblings denied physical abuse and reported they felt safe at home. The mother declined intact family services, and the CPI provided a list of community resources. In October 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 27	DOB: 06/2005	DOD: 03/2023	Homicide
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Child was a youth in care; pending child protection investigation at time of child's death; return home, unfounded child protection investigation, within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found on the ground, with multiple gunshot wounds, one block from his home. He was transported to the hospital, where he was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In January 2022, DCFS opened an intact family services case for the teen's family. Recommended services included individual and family therapy, and medication monitoring for the teen's then 14-year-old brother. During the intact case, the teen and his brother lived in multiple residences, including their mother's home and the homes of relatives and fictive kin. The intact worker documented the teen was on probation and the school had reported concerns about the teen and his brother having access to firearms. In April 2022, DCFS received a report that the teen's mother had concerns that the teen and his brother would be violent towards her and the younger children. She told the intact worker and CPI that she instructed the teen and his brother to leave after the teen flashed a gun, and she found stolen items which she returned to neighbors. The teen denied he stole from the neighbors, and stated his mother's paramour lost a gun in the backyard, and they blamed the teen for the missing gun. The teen added his mother drank frequently, and she and her paramour often fought in the home. The teen and his brother both stated they wanted to stay in the home and their mother frequently locked them out. The 7-year-old and 10-year-old siblings stated they felt safe with their mother, but they feared her paramour and had witnessed him hit their mother. The sister stated the teen kept a gun in the home. In May 2022, the court granted DCFS temporary custody of the teen and his brother. The teen's whereabouts remained unknown, the court issued a child protection warrant for the teen, and the placement worker filed a missing person's report. Two days later, the teen spoke with the CPI by phone but refused to provide his location. The teen declined services and transportation. Two weeks later, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74). The placement team recommended residential placement for the teen. Later that month, the teen was placed in his maternal grandmother's home, and the brother was placed with his godmother. In August 2022, the grandmother reported the teen left her home, so the placement worker filed a missing persons' report, contacted the Center for Missing and Exploited Children, and obtained a juvenile arrest warrant. The teen eventually returned to his mother's home, and in November 2022, the court officially returned the teen and his brother to their mother's care under an order of protection. The family received intensive placement stabilization services. However, in December 2022, the teen was shot in the leg by an unknown person, and in January 2023, the teen's mother reported she wanted them removed because of their criminal activity. DCFS placed the teen and his brother with their maternal grandmother. The younger siblings stayed with their mother, and they reported they felt safe in her home.

The placement worker spoke with the brother's probation officer, who reported the brother was on probation for three months after he had been arrested following a verbal altercation. During the investigation, law enforcement informed the CPI of a domestic disturbance call the day before the hotline report, and a child well-being check and lock-out of the teen the day of the report. While the investigation was pending, the teen died. Following the teen's death, DCFS indicated the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 28	DOB: 11/2004	DOD: 03/2023	Homicide
Age at death:	18 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Unfounded child protection investigation within one year of youth's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was shot multiple times from behind. Police responded to reports of gunfire and found the youth unresponsive. The youth was transported by ambulance to the hospital, where he was pronounced deceased. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: In October 2022, DCFS received a report that the youth's adult sister went to the school of her 11-year-old daughter, the youth's niece, to discuss her school performance, and she hit the niece on the back of the head with an open hand. The CPI spoke with the reporter, who clarified she did not directly witness the sister hit the niece, but she observed the niece duck down. School staff told the CPI they had issues with the niece's behavior, poor grades, and tardiness. The youth's sister and niece both denied the sister struck the niece. The sister denied that she used physical discipline with the children. The niece stated she felt safe at home. The youth and his 9-year-old niece also denied any issues in the home and reported they felt safe. The CPI noted no safety issues in the home. In December 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 29	DOB: 06/2005	DOD: 04/2023	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound of the abdomen		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Two indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was in a verbal altercation with two people at a store when a third person arrived and shot him. Emergency services transported the teen to the hospital, where he later died. A criminal investigation remains pending. DCFS did not investigate the death for abuse or neglect.

Reason for Review: In June 2021, DCFS received a report that the teen's mother sent photos of herself holding a gun in front of the children to the reporter, the mother's paramour intimidated the children with a gun, the mother and paramour attacked the teen, and the mother and paramour verbally abused the children. The reporter also cited concerns that the mother used substances and did not provide the teen his medication. DCFS received a related information report that the teen destroyed things in the home, law enforcement transported him to the hospital for a mental health assessment, he told hospital staff his mother hit him, and he did not feel safe at home, and his mother had a history of domestic violence. DCFS received two additional related information reports that the teen did not attend school, had previous arrests, and may have been involved in a gang. After multiple attempts over several months, the CPI contacted the family. The mother denied the allegations and stated the teen ran away from home, was involved in a shooting, and was arrested in a neighboring state. She stated the teen's father tried to break into her home,

her former paramour shot at the father, and police arrested the paramour. The mother denied the children were home at the time of the incident. During the visit, the mother and her new paramour got into an altercation and the CPI called police, who responded to the home and instructed the paramour to leave. The paramour reported he could not leave because his electronic monitor was assigned to that address, so police left without further action. The teen confirmed he had been arrested for criminal activities in another state but recently returned to his mother's home and re-enrolled in school. The teen and his siblings reported they felt safe at home, denied their mother had a gun, and denied their mother and her paramour physically fought but acknowledged they argued. DCFS indicated the first investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). In April 2022, DCFS received a report that law enforcement responded to the home and arrested the mother's paramour for domestic battery, and the children witnessed the incident. The mother told the CPI that the paramour no longer lived in the home, and she did not have contact information. She stated she and the paramour argued but she denied physical altercations. The CPI discussed domestic violence with the mother and provided contact information for the domestic violence hotline. The mother declined services. The teen and his siblings reported their mother ended her relationship with the paramour and they felt safe at home. The CPI completed the home safety checklist and noted no concerns. The children's maternal uncle reported he visited the home daily and had no concerns with the mother's parenting. DCFS indicated the paramour for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In September 2022, DCFS received a report that the teen's then 6-year-old brother had a 3-inch cut on his arm as well as bruises. The CPI spoke with the reporter, who stated the 6-year-old brother gave multiple explanations for the injuries. The CPI met with the family at home. The mother denied injuring the 6-year-old and stated the children often fought with each other. The mother agreed to have him seen by a doctor. The 6-year-old initially told the CPI his mother injured him, but when he could not demonstrate how it happened, he said he blamed his mother for the injury because he was mad at her. The CPI noted the injury appeared superficial. The teen and his siblings denied their mother used physical punishment and denied their mother hit the 6-year-old. The children reported they felt safe at home and the CPI documented no other injuries. The doctor who saw the 6-year-old stated the injury appeared consistent with his report that he was injured while playing with his siblings. DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 30	DOB: 02/2008	DOD: 04/2023	Homicide
Age at death:	15 years		
Cause of death:	Gunshot wound of head		
Alleged perpetrator:	Unknown – street homicide		
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 sleeping in the backseat of a vehicle when she was shot in the back of the head. She was taken to the hospital where she was pronounced deceased. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report that the mother's paramour fought with the mother and the teen's 17-year-old sister and threatened them with guns. The sister reported she did not feel safe at home and did not want to return, and the reporter noted she was wandering the community in a neighboring state. The CPI documented an attempt to see the sister at her mother's home, but her mother reported she was on run. The mother and her paramour denied the allegations. The mother stated the sister got "whoopings" because she refused to follow rules. The mother stated she believed the sister was living with her girlfriend in the neighboring state and was welcome to come home. The CPI observed the then

14-year-old teen and the paramour's 4-year-old and 9-year-old children. The CPI also requested police in the neighboring state conduct a welfare check on the sister, and police reported there was no response at the home. The primary care physician reported no concerns for the teen, but noted concerns for the sister, as she had weight loss with no explanation, reported marijuana use and symptoms of depression, and had not returned for follow-up treatment. The CPI later met with the sister in the community, and the sister stated she had no intentions of returning to her mother's home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 31	DOB: 03/2006	DOD: 04/2023	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wound to the abdomen		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old and a peer were shot on the sidewalk by a group of men. The peer was shot in the foot and received medical treatment. The teen was taken to the hospital and pronounced deceased. A criminal investigation is pending. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2022, DCFS received a report that the teen's mother was not helping him manage his diabetes. The mother told the CPI that the teen was diagnosed with diabetes three years earlier and took daily medication, but he recently told his doctors he no longer wanted to take medication. She reported the teen missed appointments due to her work schedule and they recently changed providers. She noted the teen had an appointment scheduled for later that month. The teen stated he understood diabetes was serious, but he was tired of sticking himself with needles every day. The teen told the CPI he told his mother he took his medication daily but sometimes did not. The CPI spoke with the teen's endocrinologist, who expressed concern that the teen had been to the emergency room twice in the prior six months. The CPI submitted a DCFS nursing referral. The DCFS nurse spoke with the mother. The mother told the nurse the teen refused to take medication regularly and did not allow anyone to assist him with monitoring his blood sugar. Later, the CPI met with the teen at school, and the teen reported he took daily insulin shots and checked his blood sugar twice per day. He stated he felt safe at home. DCFS unfounded the investigation for medical neglect (#79).

Child No. 32	DOB: 05/2021	DOD: 04/2023	Homicide
Age at death:	22 months		
Cause of death:	Blunt force trauma to the abdomen due to child abuse		
Alleged perpetrator:	Unsolved		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Twenty-two-month-old was found unresponsive, face down, on an adult bed. The toddler was a youth in care placed with his maternal grandmother. The day of his death, the toddler's family members reported his grandmother brought him to his mother's home for a visit before the mother left for work. The grandmother then left the toddler in the care of his 23-year-old maternal aunt. The aunt stated she left the toddler in the care of her paramour while she left the home for approximately 20 minutes to pick up the toddler's 8-year-old sister from school. The toddler was transported by ambulance to the hospital, where he was pronounced deceased. The court granted DCFS temporary custody of the toddler's sister. Both criminal and DCFS investigations of the toddler's death remain pending.

Reason for Review: In July 2022, DCFS received a report that the toddler's mother brought the then 13-month-old toddler to the hospital for seizures. The child had been born prematurely and experienced seizures, developmental delays, and a heart defect since birth. A scan done at the hospital found the toddler had a skull fracture and brain bleed. The reporter noted the toddler had been seen for multiple issues in recent weeks, including fever, lack of appetite, lack of urination or defecation, and seizures. The toddler's mother stated she did not know what happened, and the toddler's 20-year-old maternal aunt also cared for him. The maternal aunt told the reporter that three weeks earlier, the toddler fell out of her arms, on his back, on a hardwood floor, from a height of approximately two feet. She stated she informed the mother immediately. The reporter noted the injuries were not consistent with the explanation. The reporter stated the toddler's 7-year-old sister usually lived in the home but was elsewhere over the summer. She stated the day before coming to the hospital, the toddler slept more than normal and appeared to be having seizures that did not resemble prior seizures. The mother told the CPI the toddler did not show signs of injury after the fall the aunt reported. The CPI and medical staff noted the mother's interactions with the toddler appeared appropriate. Treating physicians reported the toddler had complex fractures on multiple parts of his skull and bilateral bleeding in the brain which appeared to be more recent than the reported timeframe. The aunt reported she lived with the mother and cared for the children when the mother worked. She denied she hurt the toddler. The aunt reported the toddler did not cry for long, did not show any visible injuries, and acted normal. She denied knowledge of how the toddler obtained his injuries. The court granted DCFS temporary custody of the toddler and DCFS placed the toddler with his maternal grandmother, who had been caring for the toddler's then 7-year-old sister since earlier that summer. The CPI observed the home was appropriate, provided a pack-and-play, and discussed safe sleep. The maternal grandmother denied any concerns that the mother would hurt or allow anyone else to hurt her children. DCFS indicated the toddler's mother and aunt for head injuries by neglect (#52). The mother successfully appealed the finding. During the placement case, the placement worker noted the toddler was non-verbal, required assistance to walk, and could not hold a bottle or feed himself. The toddler's sister appeared free from developmental delays. The mother reported she visited the children daily. In December 2022, the mother was granted unsupervised visits and the court returned the 7-year-old sister to the mother's care. The mother was enrolled in parenting classes, but her attendance was inconsistent due to her work schedule. The toddler was enrolled in occupational, speech, and developmental therapy services. The mother engaged in domestic violence services and individual therapy. Throughout the placement case, the family reported the mother visited the maternal grandmother's home daily and stayed until bedtime, and the grandmother reported no concerns about the mother's ability to care for the toddler.

Child No. 33	DOB: 09/2022	DOD: 04/2023	Homicide
Age at death:	7 months		
Cause of death:	Craniocerebral injuries due to blunt trauma of the head		
Alleged perpetrator:	Mother		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was found unresponsive by his mother. The infant was transported by ambulance to the hospital, where he was later pronounced deceased. First responders and medical staff noted the infant was cold to the touch and had bruises on his eyes, legs, and back. The mother reported she put the infant to bed around 1:00am and found him unresponsive around 1:45pm the next day. Law enforcement obtained a search warrant after the mother denied police access to the home and noted the mother's phone had been factory reset before they seized it. Collateral contacts reported the mother had a history of methamphetamine use. The CPI and police noted the mother drank and asked for alcohol during their interactions with her. DCFS indicated the infant's mother for death by abuse (#1) and the mother has been charged with first-degree murder, obstruction of justice, and child endangerment.

Reason for Review: In October 2022, DCFS received a report that the infant's father became angry and threw a baby bottle at the then 4-week-old infant, but the bottle did not hit the infant. The reporter noted the parents had a verbal altercation the previous night, and the mother and infant left the home but allowed the father to visit. The mother told the CPI there had been no prior physical altercations, but the father angered easily, and she encouraged him to seek counseling. During the visit, the father became upset when the mother told him she planned to come to his home with a police escort to retrieve her belongings. She confirmed he threw a baby bottle in the direction of the infant's carrier, but it did not hit the infant. She told the CPI she filed police reports and obtained an order of protection. The CPI observed no marks or bruises on the infant and noted he appeared clean and appropriately dressed. The CPI later met with the father, who denied any physical altercations. He stated he threw the bottle to the ground, but it was not near the infant. During the investigation, the parents reconciled and reported they attended weekly counseling. The infant's primary care physician noted no concerns. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 34	DOB: 07/2022	DOD: 04/2023	Homicide
Age at death:	9 months		
Cause of death:	Drowning due to neglect in bathtub		
Alleged perpetrator:	Mother		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-month-old was found unresponsive in a bathtub by his mother. The mother reported she put the infant and his 20-month-old sister in the bath, then did chores in another room for approximately 10 minutes. When she returned, she found the infant underwater, on his back. The mother called 911 and the infant was transported by ambulance to the hospital, where he was pronounced deceased. DCFS indicated the mother for death by neglect (#51), substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60), and inadequate supervision (#74).

Reason for Review: In January 2023, DCFS received a report about ongoing domestic violence between the infant's mother and father, in the presence of the infant and his 17-month-old sister. DCFS opened an investigation on each parent. The CPI made multiple attempts to locate the family and spoke with staff from a neighboring state's child protection agency, who shared the family had a history of unsubstantiated reports in that state, related to domestic violence. The CPI did meet with the mother at home. She confirmed there had been a domestic violence incident in December 2022, and the infant's sister witnessed the incident. She also disclosed she had a history with a neighboring state's child welfare agency due to domestic violence with the father. The mother added she and the infant's father were not in a relationship and she had not seen him in a few months. The CPI observed the infant and his sister and noted no marks or bruises on either child. During the investigation, the CPI also interviewed the mother's paramour, who denied any domestic violence. Law enforcement noted no domestic violence incidents in Illinois involving the infant's mother or father. The children's pediatrician reported no concerns. The CPI made multiple attempts to contact the infant's father without success. DCFS unfounded both investigations for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 35	DOB: 09/2019	DOD: 04/2023	Homicide
Age at death:	3 years		
Cause of death:	Gunshot wound to head		
Alleged perpetrator:	Unsolved		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was shot in the head while at the home of his mother's friend, and his mother brought him to the hospital. Six days later, the toddler was pronounced deceased. Police reported the mother stated two bullets came through a window, and one hit the toddler. Police observed there was no obvious damage to the windows, there was a gunshot hole in the ceiling, and there were obvious signs of attempts to clean the scene. The mother refused to speak to the CPI or police. DCFS indicated the toddler's mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In May 2022, DCFS received a report that the then 2-year-old toddler had a large burn on his arm, wrapped in a dirty paper towel. The CPI went to the home and observed the toddler walking home with his father and grandmother. The father refused to speak with the CPI and took the toddler into the home. The grandmother told the CPI the mother treated the burn at home, and the family took good care of the children. The mother spoke with the CPI outside and stated she left a hot hairstyling tool in the bathroom while she went to make the toddler a bottle, and the toddler walked into the kitchen crying and holding his arm, and she treated the toddler with first aid burn ointment. The CPI instructed the mother to take the toddler for medical treatment. The toddler's 13-year-old brother confirmed the toddler burned himself on his mother's hairstyling tool and denied any harm to himself or the toddler. The CPI observed the home was safe and adequate. The mother took the toddler to the emergency room and the treating provider told the CPI the burn was consistent with the mother's story. The toddler was scheduled for follow-up treatment with the burn unit, and medical providers in the unit informed the CPI the burn was healing appropriately, and the mother's story was consistent. The CPI observed the bathroom and completed a scene re-enactment with the mother. DCFS unfounded the investigation for burns by abuse (#5) and medical neglect (#79).

Child No. 36	DOB: 02/2006	DOD: 06/2023	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wounds of the head and chest		
Alleged perpetrator:	Unknown – street homicide		
Reason for review:	Child was a youth in care; pending child protection investigation at time of child's death		
Action taken:	Full investigation pending		

Narrative: Seventeen-year-old was found in a ditch with gunshot wounds. He was pronounced deceased at the scene. The teen's foster mother reported the teen went to the gas station for a snack, and she later received a call that his body had been found. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In 2019, the then 13-year-old teen and his then 3-month-old, 7-year-old, and 11-year-old siblings came into DCFS care after a failed intact family services case. They were placed with their maternal grandmother. In 2022, the mother gave birth, and the teen's newborn sibling tested positive for cocaine and amphetamines. The newborn also came into care and was also placed in the grandmother's home. The mother signed specific consents for the four older children to be adopted by their grandmother, and the court terminated their fathers' parental rights. The mother and the father of the newborn lived in a neighboring state. In December 2022, the grandmother was diagnosed with cancer and was hospitalized. One of the teen's maternal aunts cared for the children during the hospitalization. Following the grandmother's diagnosis, the teen began leaving the home at night and sometimes stayed with friends. In

January 2023, the mother met with the placement worker and reported she was in the area to help care for the grandmother. In February 2023, the placement worker informed the family that the mother could visit the children if she was sober and supervised by the grandmother, but if the grandmother was not awake or coherent, one of the aunts needed to supervise. The aunt reported she would move into the home if the grandmother was unable to care for the children. Later that month, DCFS received reports that the teen's mother and aunt physically fought in front of the children, and the mother was pregnant, used drugs and alcohol, drove the children while intoxicated, and threatened the children's grandmother. The CPI met with the children, who reported police brought their mother to the home late at night because she was intoxicated. The mother stated police brought her to the grandmother's home after she went out drinking because she only knew that address. The aunt later returned with the 10-year-old sister and became upset when she saw the mother was in the home, and a physical altercation ensued. Police arrested the mother. The children reported their mother had been living in the home four to five days per week for the prior few weeks, but this was the first time they saw their mother intoxicated. The grandmother denied the mother lived there or stayed overnight, but stated she was often in the home. In March 2023, the children were removed from their grandmother's care after continued reports that the mother frequented the home, had unsupervised contact with the children, and continued to use substances. The 14-month-old and 3-year-old siblings were placed with a paternal aunt. The teen and his 10-year-old and 15-year-old siblings were placed with fictive kin. That month, the mother again left the state, and she was not engaged in services. The fictive kin foster parent reported the children did not want her to adopt them, and she asked the placement worker to explore other placements. In May 2023, the older children moved to the home of their mother's paternal aunt after they expressed a desire to live with her. The teen completed 10th grade and the placement worker reported the children did well in their new placement.

SUICIDE

Child No. 37	DOB: 09/2002	DOD: 09/2022	Suicide
Age at death:	20 years		
Cause of death:	Asphyxia due to hanging		
Reason for review:	Deceased was a youth in care; unfounded child protection investigation within one year of deceased's death		
Action taken:	Investigatory review of records		

Child No. 38	DOB: 05/2006	DOD: 11/2022	Suicide
Age at death:	16 years		
Cause of death:	Toxicity of diphenhydramine, acetaminophen, and salicylate		
Reason for review:	Split custody at time of child's death		
Action taken:	Investigatory review of records		

Child No. 39	DOB: 02/2005	DOD: 01/2023	Suicide
Age at death:	17 years		
Cause of death:	Diphenhydramine toxicity		
Reason for review:	Pending child welfare services referral at time of child's death		
Action taken:	Investigatory review of records		

Child No. 40	DOB: 10/2007	DOD: 04/2023	Suicide
Age at death:	15 years		
Cause of death:	Hanging		
Reason for review:	Unfounded child protection investigation and closed child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 41	DOB: 09/2008	DOD: 05/2023	Suicide
Age at death:	14 years		
Cause of death:	Hanging		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

UNDETERMINED

Child No. 42	DOB: 02/2022	DOD: 07/2022	Undetermined
Age at death:	5 months		
Cause of death:	Sudden unexpected infant death syndrome		
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: Five-month-old was found unresponsive face down on a sofa by her mother, where the infant had been asleep with her 17-year-old brother. She was brought to the hospital by ambulance and pronounced deceased. The brother stated he fed the infant around 11:00pm and he went to sleep around 1:00am. DCFS unfounded the infant's mother and father for death by neglect (#51); cuts, bruises, welts, injuries, and oral abrasions by neglect (#61); and environmental neglect (#82); but indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In February 2022, DCFS received a report that the infant tested positive for cocaine and THC at birth. That day, the CPI observed the infant at the hospital. Hospital staff reported the mother tested positive for cocaine and THC in November 2021, and for THC in December 2021 and January 2022. The infant's mother denied she had used cocaine since December, and stated she used marijuana the day before the infant's birth. She reported she had enrolled in substance use treatment twice in recent months, but left the program first because of illness, and the second time because of a dispute with another resident. Hospital staff noted the infant did not show signs of withdrawal, and they discharged the infant two days later. The parents agreed to a safety plan for the infant and four of her siblings, who were between the ages of 1 year and 14 years, to stay with their maternal aunt. The parents agreed to stay sober, cooperate with drug screenings, and complete substance use assessments to end the safety plan. The CPI ended the safety plan after the mother began substance use treatment, and the parents agreed to intact family services. DCFS indicated the investigation for substance misuse by abuse (#15) and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The family's intact worker recommended substance use treatment for the mother, therapy for the parents, and protective daycare. The parents had a bassinet for the infant and a pack-and-play for the infant's 1-year-old sibling. The intact worker noted no concerns in the home and observed the parents were appropriate with the children. The intact worker visited the home weekly, the parents participated in services, and the infant received follow-up care with her pediatrician. In May 2022, the mother relapsed. The intact worker submitted referrals for the parents to begin individual therapy and the parents located a daycare program for the younger children. Approximately two weeks before the infant's death, the maternal grandmother moved into the home under hospice care. Three days before the infant's death, the intact worker conducted a home visit and noted no concerns for health or safety in the home. The next day, two days before the infant's death, the maternal grandmother died. The intact family services case remained open at the time of the infant's death.

Child No. 43	DOB: 08/2021	DOD: 07/2022	Undetermined
Age at death:	11 months		
Cause of death:	Unexplained sudden death (extrinsic factors identified)		
Reason for review:	One indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-month-old was found unresponsive in her crib and the family called 911. The infant was transported to the hospital by ambulance, where she was pronounced deceased. DCFS received

a report that the infant's mother and maternal grandmother used methamphetamine and fentanyl in the infant's presence. Law enforcement noted there was a full-size comforter, three pillows, a stuffed bear, and two bottles in the crib. Law enforcement also noted inconsistencies in the reported timeline and suspected the paramour was using drugs. The paramour refused a drug test and refused to allow the mother to complete a drug test or speak with the CPI alone. The autopsy noted the infant's toxicology report was negative for all substances. DCFS investigated the infant's death and unfounded the mother and paramour for death by neglect (#51).

Reason for Review: In October 2021, DCFS received a report about drug use in the home of the infant's maternal grandmother, where the then 2-month-old infant and her 17-year-old mother lived. The CPI made consistent good faith attempts to see the family, but they had been evicted and removed from the home shortly after the report. Law enforcement officers who had assisted with removing the family reported the infant appeared healthy. The CPI continued efforts to locate the family including checking with the local WIC office and the infant's pediatrician. WIC staff reported mother and infant had been there recently and they had no notable concerns and they provided information for the infant's pediatrician. The infant's pediatrician reported the infant was up to date on immunizations and there were no concerns at her last visit. DCFS unfounded the maternal grandmother for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). In April 2022, DCFS received a report that the infant's mother used methamphetamine with the infant present, and her paramour had been involved with law enforcement. Law enforcement confirmed the paramour had a history of domestic violence and theft. The CPI met with the mother, who reported she used marijuana; she denied any other drug use but refused to complete a drug test. She added she ended her relationship with the paramour due to his alcohol use. The CPI observed safe sleeping arrangements for the infant. The infant's great-aunt stated that the infant and her mother began living in her home four months earlier, she would not allow illegal substances in her home, and she had no concerns that the mother used drugs. She stated the infant's maternal grandmother used substances and the mother's paramour may have used drugs. The pediatrician's office reported no concerns of abuse or neglect. The CPI referred the mother for intact family services, but the mother did not participate in transitional visits despite the CPI's attempts to engage her. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In June 2022, DCFS received a report that law enforcement responded to the home on a different matter and learned the mother's paramour had burned the then 10-month-old infant while smoking marijuana. The reporter stated the paramour confirmed the incident occurred, but he did not intend to injure her, and he provided care immediately. Later that day, DCFS received an anonymous report that law enforcement responded to the home and found the mother under the influence of drugs, the mother sold drugs, the mother's paramour burned the infant, and the infant did not receive medical treatment, the mother left the infant in the care of known drug users, and the home lacked appropriate food. That day, the CPI met with the family at home and the paramour reported the burn was an accident. The CPI observed a healed burn mark on the infant but noted she otherwise appeared happy and healthy and had a crib in the mother's room. The CPI noted the maternal grandmother was agitated, began yelling while she attempted to interview the mother and paramour, and stated the infant was afraid of the paramour. That day, the CPI spoke with law enforcement, who reported the paramour called police because the infant's maternal uncle threatened him, and they found no indication of substance use in the home. In the following weeks, the mother and paramour moved into the home of a family friend, and both reported they were employed. The mother declined intact services. The CPI observed a crib and pack-and-play in the home. The infant appeared free of visible signs of abuse or neglect. DCFS indicated the paramour for burns by neglect (#55) but unfounded the mother for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60).

Child No. 44	DOB: 04/2022	DOD: 07/2022	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined causes		
Reason for review:	Pending child protection investigation at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive around 4:00am, in an adult bed, by her babysitter. The babysitter began CPR while the infant's grandmother called 911. The infant was transported to the hospital by ambulance, where she was pronounced deceased. DCFS opened an investigation. The evening before, the infant's mother left the infant with the grandmother and babysitter before she went to work. She reported the infant had been coughing and vomiting after bottle feedings that week, but she had not yet brought the infant to the doctor because her condition seemed to be improving. The grandmother reported that around 1:00am, she fed the infant then placed her to sleep next to the babysitter and the babysitter's 5-year-old child in an adult bed. The autopsy did not reveal a definitive cause of death, but the report noted asphyxiation could not be ruled out. DCFS unfounded the grandmother and babysitter for death by neglect (#51).

Reason for Review: In the year before the infant's death, the infant's babysitter was involved in multiple child protection investigations. In July 2021, DCFS received a report that the infant's babysitter left her 7-year-old child at an abandoned house, and the child's father found him alone on the porch around 3:00am. The father filed a police report and stated he wished to file for guardianship. The father stated the child's twin was still in the mother's care, however the twins' maternal aunt brought the twin to his home that day. He added both children reported their mother frequently made them get out of the car and walk home. The CPI interviewed the twin, who stated she was not with the child or her mother the night before. The child stated his mother brought him to his father's home, his father was outside with friends when they arrived, and he went to his uncle's home for some time before his father retrieved him. He denied his mother ever left him without care of an adult. The mother also reported she left the child with his father. The twins' maternal aunt and the mother's paramour confirmed the mother's report. The child's father reported the mother left the child outside by himself on a block where he usually spent time, and a friend called him to report the child was sitting on the porch of an abandoned building. He stated he called the mother to get the child, but she refused. The parents both reported they usually communicated through the twins' maternal aunt. DCFS unfounded the investigation for abandonment/desertion (#75). In January 2022, DCFS received a report that the children of the infant's babysitter had been overheard saying they did not have enough food, their mother's paramour hit them, the children were left home alone, their mother used drugs and alcohol, and the mother gave away items their father provided. The CPI met with the family at home. The babysitter's 5-year-old child and 8-year-old twins denied abuse, denied they were left alone, reported they had enough food, and stated they felt safe at home. The CPI noted they were free of visible marks or bruises. Their mother denied their father had recently provided anything for the children and stated he had not seen the children since the previous investigation. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and inadequate supervision (#74). Nine days before the infant's death, DCFS received a report that the infant's babysitter left her 8-year-old twins home alone for at least 45 minutes, and the twins asked a neighbor for food and stated their mother left them home alone often. The reporter believed the mother's paramour sold drugs and had guns in the home, and the mother used ecstasy. The reporter added the twins showed the reporter photos of themselves from three weeks earlier with bruises on their bodies caused by their mother and her paramour. The reporter stated they called police. That day, the CPI made attempts to contact the twins, their mother, their father, the reporter, and neighbors. The CPI was unable to reach the family in the nine days between the hotline report and the infant's death. DCFS later indicated the infant's babysitter for inadequate supervision (#74) to her children, but unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60).

Child No. 45	DOB: 05/2022	DOD: 07/2022	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Child of a youth in care; two indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found not breathing around 8:00am. Her father began CPR and paramedics responded to a 911 call. The infant's parents reported they co-slept with the infant in an adult bed despite being advised against the practice. The 15-year-old mother's relative foster parent reported she left for work around 5:00am, she knew the mother co-slept with the infant and she was not concerned with the arrangement. Law enforcement noted the mother asked permission to bring marijuana to the hospital and smoked marijuana while law enforcement remained in the home. The parents completed toxicology screenings; the mother tested negative for all substances and the father tested positive for marijuana. DCFS investigated the infant's death and indicated her parents for death by neglect (#51).

Reason for Review: In May 2021, DCFS received a report that the infant's maternal grandmother used cocaine and drank heavily, took the infant's then 14-year-old mother and then 12-year-old maternal aunt from a family member's home, owned a gun that she allowed the infant's mother to shoot, and there were drugs and drug paraphernalia in the home. The CPI made a good faith attempt at the home and spoke with law enforcement, who reported no knowledge of drug use in the home. The CPI located the children at the home of their paternal grandmother with whom they were living. The 14-year-old reported that her mother had come to the home intoxicated and began arguing but the teen could not recall what it was about. The mother refused to discuss the incident with the CPI but stated she wanted the teens to remain with their grandmother. DCFS unfounded the investigation against the infant's maternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In June 2021, while the investigation remained pending, DCFS received a report that during a sleepover, the infant's maternal grandfather provided alcohol and drugs to a 14-year-old friend of the infant's mother and raped the friend. The friend made credible statements of abuse in a victim sensitive interview. At the hospital, the friend was found to have marijuana, cocaine, and Xanax in her system, and tested positive for chlamydia. The CPI was unable to locate the infant's maternal grandfather during the investigation. DCFS indicated the maternal grandfather for substance misuse by abuse (#15), sexually transmitted diseases (#18), and sexual penetration (#19) to the mother's friend, and substantial risk of sexual abuse (#22) to the infant's mother and 17-year-old aunt. In July 2021, DCFS received a report that the infant's maternal grandmother punched the infant's mother while intoxicated, resulting in her arrest. DCFS took protective custody of the infant's mother and aunts and placed them with a relative. The infant's mother confirmed that the infant's maternal grandmother was intoxicated and hit her, resulting in her arrest. The maternal grandmother refused to cooperate with the investigation. DCFS indicated the infant's maternal grandmother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). During the placement case, the maternal grandmother remained incarcerated and the maternal grandfather's whereabouts remained unknown. The 17-year-old aunt reported she was pregnant and due in January 2022, so the worker made a referral to Teen Parenting Service Network. The infant's mother exhibited behavioral problems at school, and the worker referred her for mental health services. In October 2021, the foster mother reported the mother was pregnant with the infant and had prenatal care scheduled. The placement worker referred the mother to Teen Parenting Service Network. The older maternal aunt gave birth to her second child, and the placement worker observed safe sleeping arrangements for both of her children. After the grandmother was released from jail, the placement worker regularly met with her and noted she appeared ambivalent to reunification and tested positive for alcohol and cocaine. In May 2022, the 15-year-old mother gave birth to the infant. The mother completed parenting classes, and the placement worker also referred her to a DCFS educational adviser. The placement worker discussed safe sleep with the mother multiple times.

Child No. 46	DOB: 09/2013	DOD: 08/2022	Undetermined
Age at death:	8 years		
Cause of death:	Undetermined		
Reason for review:	Child welfare services referral within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Nine-year-old medically complex child was found, by her mother, unresponsive in a bathtub, with her face submerged in water. The mother reported she left the room to retrieve a towel for the child. The child was transported by ambulance to the hospital, where she was pronounced deceased. She had been diagnosed with cerebral palsy and seizures, was non-verbal, and used a g-tube and wheelchair. DCFS indicated the child's mother for death by neglect (#51) and inadequate supervision (#74).

Reason for Review: In June 2022, DCFS received a report regarding potential housing insecurity for the child's family. The child was non-verbal and required a wheelchair resulting from injuries she sustained at birth, and the hospital where the child was born had paid a settlement which went into an estate. The reporter stated the family did not pay rent for nine months, and the estate offered to pay back rent, as well as rent for the upcoming year. The landlord, though, declined the offer and stated there had been too many problems with the family and he wanted them removed from his property and filed for eviction. However, the sheriff who went to the home refused to evict the family when he saw the child's condition. The reporter stated the county authorized the bank to give the mother funds for an extended hotel stay, so the mother withdrew the funds in cash but went home to the apartment, not the hotel. The reporter cited concern for the child and her mother if they lost their housing, but reported the child had a full-time in-home nurse and there were no concerns about medical neglect. DCFS took the report for a child welfare services referral. The worker spoke with the reporter who stated the bank had not paid the rent because the mother had not provided them the address to send the payment. The reporter noted the family had moved into a hotel. The worker met with the mother, the child, the child's 4-year-old brother, and the child's nurse at the hotel. The nurse reported she cared for the child 60 hours per week and the mother was knowledgeable about and attentive to the child's needs. The mother reported the child's 12-year-old and 16-year-old siblings lived with other family members. The worker documented the child and her 4-year-old brother were safe in their mother's care. The mother stated she was open to intact family services. The worker referred the case for intact family services to assist the family with housing. In August 2022, the worker scheduled a handoff meeting for intact family services, but the child died the next day, before the handoff took place. The referral for intact family services was withdrawn following the child's death.

Child No. 47	DOB: 07/2022	DOD: 08/2022	Undetermined
Age at death:	4 weeks		
Cause of death:	Sudden unexplained infant death; significant contributing condition of unsafe sleeping environment		
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:	Investigatory review of records		

Narrative: Four-week-old was found not breathing; her family called 911 and began CPR. The newborn was transported to the hospital by ambulance, where she was pronounced deceased. The mother's paramour cared for the newborn that night while the mother worked. He stated he put the newborn to sleep in her bassinet. The reporter stated the newborn was found on her back, turned to the left, with a rolled-up towel under her neck, and the bassinet contained blankets, a pacifier, and a small bottle. The paramour stated he thought he was helping the newborn by propping up her head with a towel to prevent her from choking. The newborn was treated at the hospital a few days earlier after she choked while swallowing, coughed up blood, and had a lot of mucus. DCFS investigated and unfounded the newborn's mother and

her paramour for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In September 2021, DCFS received a report that police responded to a domestic disturbance between the mother and her former paramour, the father of the newborn's then 21-month-old sister. The mother reported a verbal altercation started in the car while the sister was in the backseat. The mother and her paramour went into the home and left the child in the car, and the altercation became physical. The reporter noted injuries on both the mother and the former paramour. Police arrested the mother for domestic battery. The sister's father told the CPI that the parents argued because he did not want the mother to use marijuana. He stated he could always see the sister in the car. Law enforcement reported they arrested the mother because she refused to leave the home. They reported it was difficult to tell who instigated the argument and no charges were filed. The mother told the CPI she had mental health issues but did not take medication. She stated she used marijuana but no other drugs, and she was engaged in virtual counseling. The CPI observed the sister who appeared well cared for with no observable injuries. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74). In March 2022, DCFS received a report that the mother and her new paramour had a domestic dispute while driving, during which the paramour struck the mother in the face, and the newborn's then 2-year-old sister was in the car. The reporter noted the mother was pregnant. The paramour fled the scene and was later charged with aggravated domestic battery. The mother told the CPI that she allowed the paramour to borrow her car, but he did not return it in time, and he slapped her in the face when she confronted him. She stated she called police, and the sister was in the backseat and unharmed. The mother added she ended the relationship with the paramour. The CPI observed a scratch on the mother's face and noted the sister appeared well cared for. The mother reported they lacked stable housing and lived in a shelter. She agreed to intact family services. DCFS unfounded the investigation against the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While that investigation was pending, DCFS received a report that the newborn's sister returned to her mother's care after a weeklong visit with her father, and she had a bruise to her buttock. The reporter added the sister's father previously hit his 7-year-old son with a paddle. The CPI met with the sister's father and his son at home. The son denied he received physical punishment and stated he felt safe at home. The CPI noted no signs of abuse or neglect. Both the father and his paramour stated the sister fell while she was playing at the park. The mother stated she observed bruising to the sister after a visit with her father, but the sister could not tell her what happened. The mother told the CPI she obtained an order of protection against the sister's father for herself, but the judge ordered visitation between the sister and her father every other week. The CPI observed the sister had faint marks on her right knee, outer right thigh, and right buttock. DCFS unfounded the investigation against the sister's father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). At the time the intact case opened, the mother stated she was approved to stay at the shelter for six weeks with possible extensions. The mother's intact worker recommended housing resources, mental health assessment, counseling, and 0-3 developmental screening. In June 2022, the mother moved into the home of the newborn's maternal great-grandmother and reported she was pregnant and due in July. The intact worker discussed safe sleep with the mother and provided a bassinet and a pack-and-play. The great-grandmother reported feeling overwhelmed with the family moving into her home and the intact worker and supervisor discussed housing options. In July 2022, the intact worker made an unannounced visit to the home and learned the mother was at the hospital to give birth. After the birth, the intact worked continued bi-weekly visits with the family. The mother and her paramour were exploring alternative housing arrangements but continued to live with the great-grandmother after the infant was born. The intact worker visited the home three days prior to the infant's death and noted no concerns.

Child No. 48	DOB: 09/2022	DOD: 10/2022	Undetermined
Age at death:	5 weeks		
Cause of death:	Undetermined causes		
Reason for review:	Closed intact family services case and three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found unresponsive by his grandmother. The grandmother reported the infant was in bed with her and the infant's three siblings. The grandmother called 911 and began CPR. The infant was transported by ambulance to the hospital, where he was pronounced deceased. The infant had a twin sibling who remained in the hospital following their birth for bradycardia. The grandmother reported she had the children overnight to give their mother a break. DCFS indicated the grandmother for death by neglect (#51).

Reason for Review: In July 2021, DCFS opened an intact family services case for the family following an unfounded child protection investigation. The intact worker documented regular visits to the home and noted the mother complied with her services. In October 2021, DCFS received a report that the infant's mother called police for assistance when the infant's then 13-year-old sister attempted to run away from home. The next day, DCFS received a related information report that the sister was hospitalized. The sister told reporters that her mother struck her with an extension cord, but neither reporter observed any injuries. The CPI met with the sister, who reported she got into an argument with her mother, her mother struck her with an extension cord, and the sister responded by throwing objects at the mother. She added police arrived and escorted her and the mother to the hospital. The CPI met with the mother at home, who reported the sister left the home, then returned and began throwing items, and she struck the sister after the sister hit her. The infant's then 6-year-old brother reported the older sister and mother argued often. The brother and the infant's then 3-month-old and 16-month-old siblings were observed and assessed safe at home, and the CPI noted they had safe sleep arrangements. Police informed the CPI that the mother had a red face and swollen eye when they responded to the home. Ten days later, the sister was discharged from the hospital; hospital staff noted she had refused to take prescribed medication and had follow up appointments scheduled. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10). In January 2022, the intact supervisor noted the mother had not yet initiated services. That month, DCFS received a report that the infant's 13-year-old sister walked home then returned to school and stated her mother threatened to hit her if she came inside the home. The reporter stated police brought the sister to school that morning. The CPI joined the intact worker for a home visit. The mother denied the allegations. The sister denied that her mother hit her. The infant's 6-year-old brother denied the sister and mother fought. The younger children were observed free of signs of abuse or neglect. The CPI spoke to school staff, who reported no other concerns. DCFS unfounded the investigation for inadequate supervision (#74). In April 2022, DCFS received reports that the 13-year-old sister threatened her mother and other family members. Police responded to the home and transported the sister to the hospital. The sister told the CPI she ran away from home two weeks earlier and went to live with a relative. She stated her mother forced her to return home and hit her. The emergency room physician reported the sister had no physical injuries and the sister did not need hospitalization. The sister disclosed to hospital staff that she did not feel safe to return home. The CPI met with the intact worker, who reported a family member agreed to accept guardianship of the sister, and the sister agreed to participate in services. In May 2022, the intact worker completed a referral to the extended family support program to help the family with transfer of guardianship for the sister. The great aunt reported the sister did well in her care. The 6-year-old brother and younger siblings were observed free of signs of abuse or neglect and the brother reported he felt safe at home. That month, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In July 2022, two months before the infant's birth, the intact case closed as a voluntary withdrawal.

Child No. 49	DOB: 04/2009	DOD: 10/2022	Undetermined
Age at death:	13 years		
Cause of death:	Undetermined		
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: Thirteen-year-old had multiple seizures and went into cardiac arrest. She was taken to the hospital, where she experienced acute respiratory failure, and her body went into shock. She died six days later. The day before her hospitalization, the teen returned home after being on run for approximately one week. Upon her return home, she vomited, but appeared better after eating soup and drinking water. The autopsy report noted her hospital treatment was complicated by progressive severe brain swelling with herniation, gastric hemorrhage, acute respiratory distress syndrome, acute kidney injury, cardiac function abnormalities, and hemorrhagic shock. Cultures and serology testing were negative for evidence of significant infection, and the pathologist found no evidence of significant trauma. The autopsy report also noted the exam was consistent with the teen's history of severe cerebral edema due to global hypoxic ischemic injury and acute respiratory distress syndrome. The pathologist wrote the teen's cause of death was undetermined because it was highly suspicious for ingestion of an unknown toxic substance that could not be identified with current tests, but they could not rule out spontaneous cardiac dysrhythmia. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In May 2022, DCFS received a report that the teen disclosed that when she was 6 years old, an employee of the in-home daycare she attended, had sexually assaulted her multiple times. The daycare had since closed. The teen's mother told the CPI they filed a police report when the teen disclosed the abuse to her. The mother stated the teen attended the daycare from her infancy until she was in fourth grade, and she confirmed the employee currently did not have access to or contact with the teen. The CPI spoke with the teen at school. The teen confirmed the report and stated she had not seen the employee since she was in fourth grade. The teen reported she felt safe at home. The CPI interviewed the employee, who stated he did not recall being alone with the teen. The employee reported he did not work at the daycare at the time of the alleged incidents, and provided employment records that showed he worked in a different county. DCFS unfounded the investigation involving the daycare employee after the child's death for sexual penetration (#19) and sexual molestation (#21). DCFS opened a second investigation in May 2022, after receiving a report that the teen was treated in the emergency room and while awaiting placement for hospitalization, she disclosed her mother's paramour molested her. She told the reporter she did not know where her mother was at that time, and her mother did not believe her when she disclosed the incident. She stated she did not have any unsupervised contact with the paramour since the incident. The CPI met with the teen at the hospital, and she confirmed the narrative in the hotline report. The mother told the CPI that she stopped allowing her paramour to come to the home after the teen disclosed the incident to her. The mother reported that the paramour was never in a caretaking role and did not know when the incident could have occurred. The CPI spoke with the paramour by phone, who denied the allegations. The teen participated in a forensic interview but provided inconsistent statements. DCFS unfounded the investigation against the paramour for sexual molestation (#21). The mother agreed to intact family services, including individual therapy for the teen. While the first May 2022 investigation was pending, but before the intact case opened, the teen died.

Child No. 50	DOB: 07/2022	DOD: 11/2022	Undetermined
Age at death:	4 months		
Cause of death:	Asphyxiation due to unsafe sleeping environment; significant contributing conditions of adenovirus and respiratory syncytial virus infections		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive on her side by her father, who reported he placed her to sleep on her back, on a mattress on the floor, with a lightweight blanket over her. The father called 911 and the mother began CPR. The infant was pronounced deceased at the hospital. The mother reported the infant, her twin brother, and her 23-month-old sister had been diagnosed with RSV three weeks earlier, but the doctor did not prescribe any medications. DCFS investigated the death and unfounded the infant's parents for death by neglect (#51) but indicated them for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In October 2022, DCFS received a report that the infant's father was heard saying he was going to harm the then 3-month-old infant and her twin brother, the twins missed medical appointments, the parents did not bathe the twins or their 22-month-old sister, and the family had been evicted from public housing because the parents grew marijuana. In addition, the reporter stated that two months earlier, the parents left the children with an out-of-state family member with less than one can of formula, and the parents did not answer any calls from the family that week. During the investigation, DCFS received additional reports that the parents fed the children by propping their bottles up. The CPI initially met with the family at the local DCFS office, as the mother reported they were living with the children's paternal uncle who did not want the CPI in his home. The CPI noted the children appeared clean and did not show signs of abuse or neglect. The mother reported that the infant's eye had been surgically removed because of cancer, and they attended follow-up appointments. The parents denied domestic violence, mental health issues, and substance use other than marijuana, and they denied they used marijuana in front of the children. They reported they were evicted because their landlord raised the rent before the mother could return to work following the twins' birth, and they were in the process of finding a new apartment. The parents denied the father made any statements about harming the children. They denied they fed the children by propping up their bottles, and stated they bathed the children regularly. The CPI discussed safe sleep with the parents, who reported the twins slept in bassinets. They declined offers of pack-and-plays. Law enforcement told the CPI the father had been arrested three times that year for incidents of telephone harassment and possession of cannabis in a motor vehicle without a valid driver's license. They reported an additional domestic incident, but there were no arrests. During the investigation, family members told the CPI of an incident where the father threw a rock at the mother, and the mother went to the emergency room for treatment. The children's pediatrician's office had no concerns about the infant's twin and noted the infant recently saw an optometrist for a retina blastoma. While the investigation was pending, the father reported the sister had RSV and the mother brought the twins to the doctor to have them checked for the virus. Later that month, while the investigation remained pending, the infant died. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and environmental neglect (#82).

Child No. 51	DOB: 08/2022	DOD: 11/2022	Undetermined
Age at death:	3 months		
Cause of death:	Unexplained sudden death (extrinsic factors identified)		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive, on his stomach, in an adult bed. The infant was transported by ambulance to the hospital where he was pronounced deceased. The mother reported the

family was staying in a friend's home. She stated the night before, she went out with the friend and left the infant and his 20-month-old, 4-year-old, and 15-year-old siblings in the care of their maternal grandmother. When she returned home, she stated the children and grandmother were asleep on the sofa. She stated she woke the 20-month-old and 4-year-old and brought them to share the bed with her, but she also found the infant in the bed when she awoke. The 15-year-old brother stated the mother asked him to bring the infant to the bedroom where she was sleeping, and she was awake when he placed the infant on the bed, but the mother stated she did not know the brother placed the infant in the bed. The mother reported she consumed three or four alcoholic drinks, denied she was intoxicated when she returned to the home. She reported she did not bring the pack-and-play to the friend's home. DCFS unfounded the mother for death by neglect (#51).

Reason for Review: In August 2022, the day after the infant's birth, DCFS received a report that the mother and her infant tested positive for marijuana at the birth. The reporter stated that while the mother had been pregnant, she had a mental health crisis and continued to struggle with mental health issues. The reporter noted the infant was born premature and required a g-tube and would remain hospitalized for several weeks. The CPI met with the infant and his mother at the hospital. The mother reported that she struggled with her mental health during pregnancy. She reported that she had stopped medication during pregnancy but planned to resume taking her prescribed medication after the birth and start counseling. The mother reported she lived with her children, her mother, and her adult brother who had developmental delays, and noted she and the children's father separated several months earlier. After the infant was discharged home, the CPI met with the mother, discussed safe sleep, and observed the infant slept in a pack-and-play in the mother's room. The mother reported the family planned to move later that month to be closer to family supports, but she wanted to participate in the intact program. The infant's 15-year-old brother reported his mother cared for everyone. The CPI noted the infant and his 19-month-old, 4-year-old, and 15-year-old siblings appeared free of signs of abuse or neglect. The infant's maternal grandmother reported no concerns about the mother's care for the children. She noted the mother cared for her in the home and took her to all medical appointments. The grandmother reported she helped with the children as much as possible, but she was not always able to assist due to her health. DCFS opened the intact family services case and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact worker recommended mental health assessment, counseling, and medication management for the mother. The infant died before the mother began services.

Child No. 52	DOB: 08/2022	DOD: 12/2022	Undetermined
Age at death:	4 months		
Cause of death:	Sudden unexplained infant death with co-sleeping		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old stopped breathing, so his mother called 911. Emergency services transported the infant to the hospital, where he was pronounced deceased. The mother reported she gave the infant a bottle then laid down with him, and she found him unresponsive when she awoke five or six hours later. DCFS opened an investigation into the infant's death and initiated an out-of-home safety plan for the infant's 5-year-old sister. After the infant's death, the mother completed a drug test that came back positive for cocaine. Subsequent drug tests were positive for THC. DCFS unfounded the infant's mother for death by neglect (#51) but indicated her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In July 2021, DCFS opened an intact family services case for the infant's family during an investigation in which his mother was indicated for death by neglect (#51). The infant's 8-week-old brother had died by asphyxiation after his mother propped a bottle in the brother's mouth and left him in a car seat. DCFS unfounded the infant's father for the same allegation because he was not caring for the brother at the time of his death. The intact worker conducted regular home visits and

recommended domestic violence services, parenting classes, housing advocacy, and grief counseling. The mother participated in counseling, and the infant's then 4-year-old sister participated in therapy. The intact worker noted the mother obtained a housing voucher and found appropriate housing for herself and the infant's sister. The infant's father was reportedly incarcerated and did not have any contact with the family or the intact worker. The intact worker noted the mother cooperated with intact services, participated in recommended services, obtained an order of protection against the infant's father, and maintained employment and housing. In February 2022, the court ordered the family's intact case closed.

Child No. 53	DOB: 10/2022	DOD: 01/2023	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined		
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: Three-month-old was found unresponsive after a nap. His father began CPR while his mother called 911. The infant was transported to the hospital by ambulance, where he was pronounced deceased. The parents reported they fed the infant, then placed him down for a nap on an adult bed, face up, with a pillow to prop him up and a blanket, and they checked on him a few times. Following the infant's death, the mother went to live with the maternal grandfather out of state. She did not cooperate with the DCFS investigation of the death. The infant's pediatrician reported that the infant had missed appointments with the pediatrician and three other specialists. The infant had not been seen by a doctor since being discharged from the hospital after birth. The infant's cause of death was undetermined at autopsy, and the medical examiner wrote in the autopsy report, "It is unknown if asphyxia due to unsafe sleep environment contributed to death. Also, molecular genetic testing for cardiac disease was not within the scope of the diagnostic workup and a spontaneous cardiac dysrhythmia cannot be ruled out." DCFS unfounded the mother for death by neglect (#51) but indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In July 2022, DCFS received a report that the infant's then 16-year-old mother was pregnant with the infant, the father was a 26-year-old man, and the mother's family was not concerned about the relationship. The reporter was also concerned about the potential for human trafficking of the mother and her 18-year-old sister. The mother and her parents confirmed that the mother was in a relationship with a 26-year-old man. The parents said they initially did not like it, but the mother continued to see him. In October 2022, while the investigation remained pending, the infant was born and remained in the NICU for one month. In November 2022, DCFS received related information that the infant was ready to be discharged but the mother had told the reporter that she did not have custody of her 2-year-old toddler. The mother reported that the infant's maternal grandfather was living out of state and was raising the 2-year-old toddler so the mother could focus on school. The mother planned to live with the infant's maternal great-grandmother for help caring for the infant while she continued school. In November 2022, DCFS unfounded the investigation against the maternal grandparents for inadequate supervision (#74). In December 2022, DCFS received a report that the 17-year-old mother left the then 2-month-old infant with people who had COVID-19 so she could attend a concert, the mother had not brought the infant to the doctor for a vision condition that could result in blindness if left untreated, and the infant had diaper rash because mother did not change his diaper overnight. The next day, DCFS received additional information that the infant he had missed two appointments and had not been seen since he was discharged from the hospital. The CPI spoke with the infant's treating physician at the hospital who stated the missed appointments constituted medical neglect. The CPI located the mother and the infant at the maternal grandmother's home. The mother reported she missed appointments because the doctor was too far away, and another provider canceled her appointment because they didn't take her insurance. She had been given the name of a clinic that was closer to her and had set up an appointment at that clinic. She reported she

took the infant to the emergency room and the infant was diagnosed with eczema and she was given cream to treat it. The mother reported she did leave the infant with relatives to attend a concert but denied that the relatives had COVID-19. The CPI spoke with the maternal grandfather, who reported that he had guardianship of the mother's older child and tried to assist the mother with the infant when he could. He lived in a neighboring state but planned to visit the mother and the infant. When the grandfather visited the mother, he, and the infant met with the CPI at the DCFS office. The mother and grandfather reported that the mother was going to give the grandfather short term guardianship of the infant. Later that night, the infant died. DCFS later indicated the investigation for medical neglect (#79).

Child No. 54	DOB: 11/2022	DOD: 01/2023	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive at home in the morning. His parents called 911 and he was transported to the hospital, where he was pronounced deceased. He slept in a bassinet in his parents' room, and they last checked on him around midnight. The infant was born with hydronephrosis inflammation and spent three days in the PICU. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report of domestic violence between the infant's mother and father, during which the father reportedly hit the mother with a belt and left with the infant's then 6-month-old sister. The father initially went to the home of the infant's paternal grandmother, who encouraged him to turn himself in. Police arrested the father and returned the sister to the mother. The mother stated there had been previous incidents, but none involved police. The father denied any previous incidents. The CPI provided the mother with domestic violence resources, but the family declined intact family services. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 55	DOB: 09/2020	DOD: 03/2023	Undetermined
Child No. 56	DOB: 07/2015	DOD: 03/2023	Undetermined
Child No. 57	DOB: 10/2014	DOD: 03/2023	Undetermined
Age at death:	2 years; 7 years; 8 years		
Cause of death:	Complications of carbon monoxide toxicity and inhalation injuries due to house fire; Inhalational injuries and probable carbon monoxide toxicity due to house fire; Complications of carbon monoxide toxicity and inhalation injuries due to house fire		
Reason for review:	Indicated and unfounded child protection investigations within one year of children's deaths		
Action taken:	Full investigation pending		

Narrative: Three children, a 2-year-old, 7-year-old, and 8-year-old, were home with their mother when a fire started. Firefighters responded to the scene. The children and their mother were transported to the hospital. The mother and children all died following the fire. DCFS did not investigate the children's death for abuse or neglect. An investigation of the cause of the fire remains pending.

Reason for Review: In May 2022, DCFS received a report that the then 6-year-old child was found approximately one block from home. The reporter noted he climbed the fence of his family home without his parents' knowledge, and added the child was non-verbal and diagnosed with autism spectrum disorder. The child was brought to the hospital and released to his father. The CPI met with the family at home and observed the child appeared safe and healthy. The father reported the child and then 7-year-old sister were playing in the back yard, then the older sister came inside and stated she did not know where the child had

gone. The father reported they immediately began to look for the child, and a neighbor told him a lost child had been taken to the hospital. The father reported the child climbed trees and short fences, they installed a fence around the home to prevent him from getting out, and the child had a tracking device, but the battery was not charged at that time. The mother reported she was at the grocery store during the incident, returned home to find that the father had gone to look for the child, and immediately called 911. She stated the father then returned home and they went to the hospital. Six days after the hotline report, while the investigation remained pending, DCFS received a report that the child was seen running around the neighborhood naked and opened another investigation. The reporter stated 911 was called, and first responders found the mother unresponsive and transported her to the hospital. First responders also noted the home was dirty. The reporter stated that first responders left the children in the care of their father, who had been in the coach house behind the home during the incident. The CPI met with the family and the mother reported that she took her weight loss medication, then consumed alcohol approximately 15 minutes later. The mother denied she knew of the side effects of mixing the medication and alcohol. She stated she passed out and later awoke in the hospital with an IV in her arm. The mother noted the 6-year-old child was not fully toilet trained and often removed his diaper and clothes, ran around the home naked, and defecated on the floor. The father reported he was sleeping in the coach house and did not know what happened inside the home until police knocked on the coach house door and informed him. He stated he saw the mother earlier in the day and noted she appeared coherent. The older sister told the CPI she observed the 6-year-old child was naked and left the home, and she went to retrieve him. When she did, a neighbor asked about their parents. The older sister stated she told the woman her mother was home, but she was unable to wake her, so the woman escorted them home and contacted police. The CPI observed no safety concerns and noted the home had working smoke detectors. DCFS unfounded the first investigation for inadequate supervision (#74) and indicated the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82).

Child No. 58	DOB: 12/2009	DOD: 03/2023	Undetermined
Age at death:	13 years		
Cause of death:	Undetermined		
Reason for review:	Child was a youth in care; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old medically complex teen was found unconscious after he and his 10-year-old foster brother had been playing. His foster father began CPR while his foster aunt called 911. He was transported by ambulance to the hospital, where he was pronounced deceased. The teen had surgery to place a pacemaker two weeks earlier, as he had a history of heart conditions, including Noonan syndrome, heart murmur, and renal artery stenosis. He was instructed not to do anything strenuous. The teen reportedly attempted to wrestle with his foster brother, who declined, so the teen pushed him, and his foster brother pushed back. His foster uncle and foster aunt were in the home at the time and told the teen to rest. The foster family later found him unconscious. The teen's autopsy noted no sign of injury. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen and his four siblings, who were between the ages of 4 years and 12 years old, came into DCFS custody in February 2022 after their mother stopped engaging in services during an intact family services case. The children were placed in separate licensed foster homes. They enrolled in school and attended medical appointments, including specialists for the teen and his twin sister's heart conditions. All five children received intensive placement stabilization services, and all were referred for counseling. The teen's mother completed parenting classes, psychological assessment, and a substance use assessment. She was recommended to complete outpatient treatment. She also began individual therapy and had a housing advocate. She was referred for other services, including domestic violence

counseling and random drug testing. In January 2023, the placement worker noted the mother was making progress toward return home. In March 2022, DCFS received a report that the then 15-year-old adoptive son of the teen's foster father molested his 10-year-old cousin. The teen was not involved in the investigation, and the teen's foster father was named a non-involved subject. The cousin did not live in the same home. The cousin completed a forensic interview and did not make any disclosures. Another cousin reported she had been slapped on the bottom while they were playing. That cousin's mother declined a forensic interview because she did not want the child to go through the process for a playful incident. The foster father also reported he believed the children had been playing, and he discussed the incident with them after he was informed of the allegations. In April 2022, DCFS unfounded the teen's 15-year-old foster brother for sexual molestation (#21) and substantial risk of sexual injury (#22). In November 2022, the teen's placement worker noted he was adjusting well to his foster home. His foster father took him to appointments with cardiac specialists. In February 2023, the teen's 10-year-old foster brother was placed in the foster home with the teen. In the month between this placement and the teen's death, the foster brother's placement worker noted he was adjusting well. In March 2023, the teen had surgery to place a pacemaker. His doctors reported the surgery went well and the foster father completed training at the hospital for the teen's care following discharge. One week after the surgery, and one week before the teen's death, he was discharged to his foster home.

Child No. 59	DOB: 10/2022	DOD: 05/2023	Undetermined
Age at death:	7 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was found face-down, unresponsive in his crib by his babysitter following a nap. The babysitter reported she placed the infant in his bassinette, on his back, and she checked on him every 15 to 20 minutes. The babysitter began CPR, and first responders transported the infant to the hospital, where he was pronounced deceased. A child protection investigation of the infant's death remains pending.

Reason for Review: In March 2022, DCFS received a report that the infant's siblings were not bathed regularly, their mother did not change their diapers regularly, the infant's then 3-year-old brother had a diaper rash for several months that resulted in hospitalization, and the mother only fed them milk. The reporter added the mother was pregnant, she had mental health challenges, and she was a habitual liar. That day, the CPI met with the parents at home, who denied the allegations. The mother stated she was 13 weeks pregnant with the infant, the infant's then 9-month-old sister was the only one who used a bottle, the infant's then 3-year-old brother had emergency surgery two months earlier to remove a boil from his diaper area. The mother added she took the infant's then 4-year-old sister to the emergency room the night before for cough and fever, and she was diagnosed with bronchitis. The mother also disclosed she had a history of a substance use disorder, but she was nine years sober. The infant's father reported they changed the children's diapers regularly and denied any recent concerns about the mother's mental health. The CPI discussed safe sleep with the parents and observed appropriate sleeping arrangements for the children. The CPI later interviewed the infant's then 8-year-old brother who reported he showered and brushed his teeth daily, and he always had clean clothes. The four children were again observed free of observable injuries and the verbal children reported they felt safe at home. The children's pediatrician reported the children were up to date on wellness checks and immunizations, and the 3-year-old brother had been seen in February 2022 for follow-up after the abscess removal. The 8-year-old's school noted past concerns with truancy that had improved and denied issues with the brother's hygiene. DCFS unfounded the investigation for environmental neglect (#82). In February 2023, DCFS received a report that the family's 17-year-old babysitter took the infant's then 20-month-old sister out of the home without the mother's permission, used drugs and alcohol while caring for the children, forgot to feed the children, left them in

soiled diapers, and left the children unsupervised. The reporter also stated the parents neglected the children's safety, hygiene, and school attendance, and the home smelled of urine. That day, the CPI went to the family home and met with the parents, the babysitter, the infant, and the 20-month-old sister. The parents denied the allegations and stated they had terminated a previous babysitter, who was a 17-year-old relative, for inadequate care. The father stated he'd observed the previous babysitter drink alcohol on one occasion, and they confronted her about it. They stated their current babysitter was hired through a professional agency that conducted thorough background checks. The parents stated the children were diagnosed with "ginger skin" and required special diapers, wipes, and creams. The CPI documented all five children were free of visible injuries, and the verbal children denied any concerns. The CPI later spoke with the current babysitter, who also denied any concerns. DCFS unfounded the investigation for inadequate supervision (#74).

PENDING

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

Child No. 60	DOB: 02/2012	DOD: 08/2022	Pending autopsy
Age at death:	10 years		
Cause of death:	Pending autopsy		
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: Ten-year-old medically complex child was found, disoriented, by her mother, who called 911. The child was transported by ambulance to the hospital, where she was pronounced deceased. The child's diagnoses included scoliosis, epilepsy, hypoxic/ischemic encephalopathy, cerebral palsy, and failure to thrive, and she required a g-tube. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In November 2021, DCFS received a report that the then 9-year-old child had missed medical appointments following a July 2021 orthopedic surgery, and she never attended school. The reporter told the CPI the child had missed appointments with her primary care physician, cardiologist, gastroenterologist, and physical and occupational therapists. The reporter added the child had remained in the hospital for six weeks following surgery and was discharged to her mother's care. The child's mother reported to the CPI that a lack of transportation posed difficulty in attending the child's appointments, and she stated she was working with the school district to enroll the child. The mother's paramour confirmed the mother's report, adding they made sure to seek care if something was wrong with the child. The CPI encouraged the mother to contact the hospital social worker to inquire about assistance with transportation. The CPI spoke to a hospital social worker, who provided a list of 17 appointments the child had missed since December 2020. The social worker stated the child's medical team believed the missed appointments constituted medical neglect because the child's health could deteriorate quickly if she did not attend regular visits with her medical specialists. Two weeks later, the child missed another appointment and the mother reported difficulty keeping up with all the appointments. DCFS indicated the investigation for medical neglect (#79). The mother agreed to intact family services. The intact worker completed weekly visits to the family home. In February 2022, a hospital social worker told the intact worker the child had been sent home with a Holter cardiac monitor two months earlier, but it did not appear the monitor had been used and the hospital was unable to reach the mother. The mother told the intact worker that she had attempted to contact the hospital multiple times for instruction. The hospital sent a new monitor to the mother and provided her information on usage. The intact worker documented visits and noted the home consistently appeared appropriate and the mother provided updates on the child's medical appointments. Hospital staff informed the intact worker the mother was compliant with the child's medical appointments, and they did not have recent difficulty reaching her. The intact worker also worked with the school district and hospital staff to ensure the child would be enrolled in school. The intact case remained open at the time of the child's death.

Child No. 61	DOB: 02/2023	DOD: 02/2023	Pending autopsy
Age at death:	0 days		
Cause of death:	Pending autopsy		
Reason for review:	Closed intact family services case and indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn was born at home. Her father cut the umbilical cord and called 911. She was brought to the hospital by emergency personnel and pronounced deceased shortly after arrival. The mother

reported the newborn did not cry following the birth. Hospital staff noted the mother received minimal prenatal care and tested positive for amphetamines at the time of admission. At autopsy, the newborn also tested positive for amphetamines. The maternal grandmother cared for the newborn's 16-month-old and 11-year-old siblings while the mother was in the hospital and the siblings remained in her care under a safety plan until intact family services began. The child protection investigation of the newborn's death remains pending.

Reason for Review: In December 2021, DCFS received a report that the newborn's mother called 911 for the newborn's then 2-month-old sister, who had labored breathing. The reporter noted the mother appeared intoxicated and could not answer basic questions about the sister, the parents did not go to the hospital to be with the sister, and the sister was in the hospital without a care plan. The CPI contacted the parents. The father reported he was not at the hospital due to lack of transportation, but a relative was on the way to take him. The CPI noted the mother was incoherent. She disclosed a history of drug use and stated she took medication for anxiety. The father agreed to a safety plan that the sister would be discharged to him, and he would supervise the mother's contact with the baby. The CPI went to the home the next day and observed the home to be in disarray with the pack-and-play full of items while the sister slept on the parents' bed and noted the mother slurred her speech. In addition, the CPI noted the father did not appear to be comfortable or experienced with caring for the sister. The family agreed to an out-of-home safety plan with a family friend and agreed to intact services. Two days later, DCFS received a related information report that the father found the mother intoxicated upon returning home and requested police remove her from the home. Police informed the father they were unable to do so. The father told the CPI he wanted an order of protection against the mother so he could have the sister returned to his care. The intact family services case opened while the investigation was still pending. The CPI and intact worker monitored the safety plan. The CPI noted the mother only sometimes appeared coherent and the mother tested positive for methamphetamine. The newborn's maternal grandmother, who had guardianship of the newborn's 10-year-old brother, reported the mother had past substance use issues but she had been doing well while she was pregnant with the newborn's sister. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact worker recommended parenting classes and substance use treatment. In April 2022, the father began services and he agreed to be responsible for the sister while the mother completed services. The intact worker noted the mother had two negative toxicology screenings but had not yet engaged in services. In June 2022, the mother began substance use treatment, In August 2022, the mother learned she was pregnant with the newborn. In the following months, the mother continued to test negative for all substances and the intact worker noted the home appeared appropriate at each visit. In November 2022, the mother completed substance use treatment. In January 2023, the intact family services case closed because the family completed all services and was doing well.

Child No. 62	DOB: 02/2006	DOD: 03/2023	Pending autopsy
Age at death:	17 years		
Cause of death:	Pending autopsy		
Reason for review:	Child was a youth in care; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found unresponsive by his relative foster mother. He had last been seen alive approximately two hours earlier. The aunt reported she did not know of the teen using any substances, but after his death, other family members informed her the teen bought pills from a classmate and took them with energy drinks. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In January 2022, DCFS received a report that the teen's sister had attempted to adopt the then 15-year-old teen after their parents died, but the sister no longer wanted to care for him due to his behavior, and he did not want to return to her home. The reporter noted the teen had been hospitalized

in 2021, but he did not take his prescribed medication. According to the reporter, the teen was staying with a cousin, and the reporter was concerned that the cousin used and sold marijuana. DCFS received a second report that the teen's sister called the school to say she would turn the teen over to DCFS. The teen went to live with his aunt, though she stated she could not care for him long-term, and noted he had issues with aggression. The teen told the CPI his sister became angry because he did not do chores and she thought he caused the toilet to overflow, but he was taking medication that caused him to vomit. He stated his sister tried to take his phone away and told him to leave, so he called his cousin to get him. He reported he felt safe with his aunt. The teen's sister stated she had struggled with the teen's behaviors for a while. She explained that he was in therapy and had been hospitalized, but refused medication and learned the teen was using and selling marijuana. During the investigation, the teen moved to the home of another aunt who agreed to care for him. DCFS unfounded the teen's sister for lock-out (#84). The CPI screened the case into court on a dependency petition. In February 2022, the court granted DCFS custody of the teen, and he remained in his aunt's care. His placement worker noted he was attending school, and participated in mentoring, life skills, and work training programs. The teen declined medication and therapy. In summer 2022, he worked a job and continued to move toward his permanency goal of independence. In fall 2022, he continued to attend school and participated in the mentoring program, and his aunt assured attendance to medical appointments. The teen's placement worker noted he was mourning the death of a cousin but felt he had support. In December 2022, the teen informed the placement worker he was considering returning to his sister's home. In January 2023, he began weekend visits in his sister's home but decided he would remain in his aunt's home so he would not have to change schools. The placement worker noted no significant issues in the aunt's home prior to the teen's death.

Child No. 63	DOB: 04/2023	DOD: 04/2023	Pending autopsy
Age at death:	10 hours		
Cause of death:	Pending autopsy		
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 approximately 10 hours after her birth. Medical staff noted she had a congenital heart defect. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: The newborn's mother lived with her sister, the newborn's maternal aunt. In October 2022, DCFS received a report that the aunt did not feed her 2-year-old, 4-year-old, and 5-year-old children; the 5-year-old was afraid to ask for food because the newborn's aunt hit her for asking; the children's clothes were damaged and unwearable, and the children did not bathe regularly. The CPI visited the family home and noted the newborn's 5-year-old cousin answered the door. The CPI spoke with the newborn's mother, who stated she was not comfortable allowing the CPI to enter the house while the aunt was not there. The CPI observed that the 5-year-old appeared clean and appropriately dressed. The CPI later met with the family at home and completed the home safety checklist. The CPI noted there was food in the home, diapers for the younger children, and the home had working utilities. The aunt reported the children regularly came home from their previous daycare hungry and in soiled diapers, and she stopped using that daycare provider. The infant's mother recently moved into the home to care for the children until the aunt located a new daycare. The CPI interviewed the newborn's 5-year-old, 11-year-old, and 13-year-old cousins at school. The children reported they ate and bathed regularly, and their mother stopped sending the younger children to daycare. The children's teachers, the older children's father, and the younger children's new daycare provider denied any concerns. Two weeks after the report, DCFS unfounded the investigation for inadequate food (#74).

Child No. 64	DOB: 09/2022	DOD: 04/2023	Pending autopsy
Age at death:	7 months		
Cause of death:	Pending autopsy		
Reason for review:	Open intact family services case at time of child's death; one unfounded and one indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Seven-month-old died at the hospital. She presented at a local hospital for labored breathing, had to be resuscitated, and was airlifted to a children's hospital for further treatment. She was pronounced deceased later that day. Hospital staff noted she had abrasions all over her body, her g-tube had not been cleaned properly, and she was malnourished. They added the mother's story was inconsistent and the family provided multiple addresses, including an address in a neighboring state. DCFS alerted the neighboring state's child protective services, who located the infant's siblings with a relative. The children were assessed safe with the relative. The court granted DCFS custody of the infant's siblings and placed them with a maternal family member. The DCFS investigation of the infant's death remains pending.

Reason for Review: In September 2022, DCFS received a report that the infant was born premature, at 28 weeks gestation, her mother disclosed that she used cocaine five days earlier, and the infant tested positive for cocaine at birth. The mother had a stroke during delivery and was in an induced coma. The CPI observed the infant at the hospital. Approximately two weeks later, the mother was discharged, but the medical staff reported the infant had a brain bleed and would remain in the NICU. The mother told the CPI that she had four other children, between the ages of 2 and 10 years old, but her oldest lived with a relative in a neighboring state. She stated she did not know she was pregnant; she would not have used drugs if she did, and she had never used cocaine before. The father denied he ever used drugs and denied any previous knowledge of the mother using drugs. The CPI met with the family at home, and the infant's verbal siblings denied they had ever witnessed their mother use drugs. The mother completed a drug screening and tested positive for cocaine. The mother completed two additional drug screenings over the following weeks and both tests were negative for all substances. Hospital staff reported the infant was nearing discharge and the parents had completed training for the infant's g-tube. DCFS indicated the mother in the September 2022 investigation for substance misuse by neglect (#65) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The family agreed to intact family services. The intact worker recommended substance use assessment and treatment, parenting classes, and mental health services for the mother, and a 0-3 assessment for the infant. During the visit, the father completed a negative drug test. The mother was unable to provide a sample, and an appointment was set for two days later. Within the week, the mother stopped complying with drug tests and visits with the intact worker. The family moved out of the home and did not inform the CPI or intact worker of their new address. DCFS opened a new investigation. The intact worker and CPI on the new investigation continued efforts to locate the family. A neighboring state reported the infant's 11-year-old sister was registered in school but had not attended that year. The investigation was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact family services case remained open, and the intact worker performed diligent searches for the family but never located the family prior to the infant's death.

Child No. 65	DOB: 12/2022	DOD: 06/2023	Pending autopsy
Age at death:	5 months		
Cause of death:	Pending autopsy		
Reason for review:	Child was a youth in care; three pending child protection investigations at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Five-month-old was found face-down, unresponsive by his 11-year-old foster sister. The foster sister called for her aunt, who began CPR, and the infant's adult foster sister called 911. The infant was transported by ambulance to the hospital, where he was later pronounced deceased. The aunt and the infant's adult foster sister were caring for the children while the foster mother was away. The family reported the infant had a bottle around midnight, then was put to sleep on an air mattress with his 2-year-old brother, and his 9-year-old and 11-year-old foster sisters who were watching movies. The placement team moved the infant's 2-year-old brother to a traditional foster home and temporarily placed the foster mother's birth children under an out-of-home safety plan. The child protection investigation of the infant's death remains pending.

Reason for Review: In March 2022, DCFS took protective custody of the infant's then 20-month-old brother and placed him in a fictive kin foster home after the parents failed to cooperate with intact family services. The court granted DCFS temporary custody. At that time, the family also had three pending child protection investigations. DCFS later indicated the infant's mother for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) in one of the investigations. The placement worker documented regular visits to the foster home and noted the foster mother cared for the brother appropriately. The infant's mother was not cooperative with visits or with services, including parenting classes, therapy, toxicology screenings, and medication monitoring. The placement worker also noted the mother refused to provide her address or employment information. During a visit, the mother disclosed she was pregnant with the infant. The placement worker discussed the pregnancy with the mother and informed her DCFS would likely take protective custody of the infant. In December 2022, DCFS received a report that the infant was born premature, at 33 weeks gestation, but was otherwise healthy and stable. The reporter noted that the mother became aggressive with hospital staff during the delivery. The CPI observed the infant at the hospital and directed staff not to discharge the infant without notifying DCFS. The CPI contacted the placement supervisor, who stated they would explore placement options. The CPI met with the infant's father, who had an outstanding warrant, had previously been arrested for domestic violence, and had a prior indicated finding for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's brother. In January 2023, while the investigation remained pending, DCFS took protective custody of the infant and placed him in the fictive kin foster home with his brother. The court granted DCFS temporary custody. The placement worker documented the mother was inconsistent with visitation and did not engage in services despite the placement worker's attempts. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In February 2023, DCFS received a report that the foster mother left the then 6-week-old infant and his 2-year-old brother with a relative and did not return to pick them up at the agreed time and did not respond to calls, so the relative left the children with their maternal aunt. The reporter stated there was an altercation between the relatives that became physical, the aunt grabbed the 2-year-old brother in an aggressive manner, and he hit his head on the wall and fell to the ground. The reporter stated police responded to the home and checked the brother for injuries but made no arrests. DCFS opened two investigations, one against the foster mother and one against the maternal aunt. The CPI visited the children at their aunt's home and noted they appeared free of signs of abuse or neglect and had safe sleeping arrangements. The aunt stated the placement worker knew she was caring for the children while the foster mother was in the hospital. In March 2023, DCFS received a report that the foster mother allowed her paramour, with whom she had a history of domestic violence, to live in the home. DCFS opened a new investigation against the foster mother. The foster mother's 5-year-old, 6-year-old, and

12-year-old children told the CPI they lived with their grandmother during the week so they could attend a better school. They denied violence in the home, denied any shooting incidents, and denied knowledge of the paramour named in the report. In June 2023, while the two February 2023 investigations and March 2023 investigation remained pending, and infant and his brother remained in care, the infant died. DCFS later unfounded the foster mother in the February 2023 investigation for inadequate supervision (#74). DCFS indicated the February 2023 investigation against the maternal aunt for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). DCFS unfounded the March 2023 investigation against the foster mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 66	DOB: 11/2006	DOD: 06/2023	Pending autopsy
Age at death:	16 years		
Cause of death:	Pending autopsy		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was at the beach with his family and went down a waterslide, then got stuck under the water for approximately five minutes before he was rescued. The teen was brought to the hospital and medical staff attempted resuscitation efforts before pronouncing him deceased. At the time of the incident, the teen's 20-year-old sister was reportedly supervising him, along with her 1-year-old and 3-year-old children. The teen's mother was also present, and the teen had spent the night at her home the evening before, despite a no-contact. The mother reported neither she nor the teen knew how to swim. The teen's foster father was out of state for the week and reported he gave permission for the teen's sister to care for him that weekend, but he did not know the teen's mother was present. Two child protection investigations relating to the teen's death are pending.

Reason for Review: The teen came into DCFS care in 2020, during an investigation in which his mother and her paramour were indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and by neglect (#61), and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In the year prior to his death, the teen resided in a relative foster placement with his paternal uncle. The placement worker noted she referred the teen to counseling, but the teen did not want to engage, and the placement worker did not pursue the referral further because the teen's behavior was improving. The teen's permanency goal was independence. The uncle reported he did not wish to adopt the teen because he did not want the teen's father, who was incarcerated, to lose his parental rights. The teen had regular phone calls with his father, but he had no contact with his mother. The teen was attending school and reported he wished to stay in his uncle's home long-term. The placement worker conducted the last home visit three weeks before the teen's death.

Child No. 67	DOB: 08/2022	DOD: 06/2023	Pending autopsy
Age at death:	9 months		
Cause of death:	Pending autopsy		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Nine-month-old, medically complex child, died in the hospital. He had been hospitalized since his birth. The infant was born substance-exposed, with a heart defect, had Russell-Silver syndrome, chronic lung disease, poor gastric motility, hyperinsulinism, and brachycephaly. In May 2023, he had heart surgery, and doctors reported his condition was showing improvements prior to his death. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: The infant's father had older children in DCFS care due to his substance use issues. The placement worker noted he did not complete drug screenings but self-reported he was engaged in a treatment program and was on parole and probation for drug-related charges. Two weeks after the infant's birth, DCFS received a report that the infant's cord blood tested positive for methamphetamines and marijuana. The reporter noted the infant had been born premature and hypoglycemic, and he remained in the hospital. The CPI spoke with the father's placement worker, who noted the infant's parents both had a history of methamphetamine use and did not have stable housing. The CPI spoke with the infant's paternal grandmother but was unable to reach either parent. DCFS took protective custody of the infant and the court granted DCFS temporary custody. The infant's mother attended the shelter care hearing, but the father did not. The court ordered the mother be allowed supervised visits with the infant. The infant remained in the hospital. DCFS indicated the infant's mother for substance misuse by neglect (#65). In February 2023, the court granted the mother unsupervised visits with the infant, who was still in the NICU. By March 2023, the mother was enrolled in substance use treatment and was testing negative for all substances. The father did not visit. After the mother completed substance use treatment services, the placement worker offered to assist the mother in moving towards the infant being released to her care by assessing the home, but the mother did not make her home available to the worker before the infant died.

ACCIDENT

Child No. 68	DOB: 01/2010	DOD: 07/2022	Accident
Age at death:	12 years		
Cause of death:	Acute asphyxiation due to drowning		
Reason for review:	Open intact family services case at time of child's death; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old and her 13-year-old brother snuck out of the family home to go fishing at a local dam while their father was asleep. The child jumped into the water to swim and was pulled under by a current. Her brother was unable to get her out. The brother ran to the parking lot to ask a bystander to call 911. DCFS investigated the child's death and unfounded the investigation for death by neglect (#51) and inadequate supervision (#74).

Reason for Review: In April 2022, DCFS received a report that the child and her brother met and went home with a "random person" after school and refused to go home because their father physically abused them and shot them with a BB gun. The children were at a police station at the time of the hotline report. After the report, the brother told police he had lied, and his father had never threatened to hurt him. The children reported going to a friend's home after school and lied about being abused because the brother stated they would get in trouble. The brother stated he did not like to follow rules and had left the home numerous times without permission. The father took the children home. The CPI met with the family at home, and the father reported he drove around for hours looking for the children when they did not return home from school, then received a call from police. The father reported the brother had been exhibiting escalating troubling behavior since the mother's death two years earlier, including the brother frequently leaving home without telling the father and being physically aggressive towards school personnel. The father tried to get the brother into a residential treatment program and stated both children were in counseling. In May 2022, DCFS opened an intact family services case and unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The intact worker visited the home weekly and completed referrals for parenting education, counseling with specialized trauma-focused providers. Three days before the child's death, the intact worker visited and learned the brother had snuck out of the home and not returned. The intact worker directed the father to report the brother missing, but as the police arrived at the home, the brother returned. The intact case remained open at the time of the child's death.

Child No. 69	DOB: 10/2020	DOD: 07/2022	Accident
Age at death:	21 months		
Cause of death:	Hypoxia due to ingestion of two toy Nerf balls		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-month-old was found choking in a church gymnasium where she and her foster siblings were playing. She was being supervised by her adult foster brother, and when she started choking, he removed a small ball from her mouth, noted she still could not breathe, and began CPR. Paramedics arrived, attempted life-saving measures, and transported her to the hospital, where she was pronounced deceased. Her foster father reported there had been one previous incident when the toddler placed a Lego in her mouth, but he did not recall any other similar incidents. DCFS investigated the toddler's death and unfounded the adult foster brother for death by neglect (#51).

Reason for Review: Three days after the toddler's birth in 2020, DCFS took protective custody of her during an investigation in which DCFS indicated her parents for substantial risk of physical injury/

environment injurious to health and welfare by neglect (#60) and inadequate shelter (#77). She was placed in a traditional foster home and remained in that home until her death. The toddler received in-home nursing and specialized medical care. The toddler's parents were initially cooperative with services, but during the case, they separated and became less engaged with services. In February 2022, one parent surrendered their parental rights. The other parent reported wanting to pursue custody but did not engage in services or visit the toddler. The toddler's placement team noted she was doing well in her foster home.

Child No. 70	DOB: 11/2007	DOD: 07/2022	Accident
Age at death:	14 years		
Cause of death:	Multiple blunt injuries due to motor vehicle collision		
Reason for review:	Four unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old died at the hospital after she, her 12-year-old sister, her 19-year-old paternal sister, and her father were in a car stuck by another vehicle. Law enforcement noted the father pulled over on the highway shoulder and another vehicle struck the family's car at approximately 90 miles per hour. The family's car lacked working seatbelts and all four were taken to the hospital. Medical staff reported they each had alcohol in their systems, and the teen and her father also tested positive for marijuana. Medical staff told the CPI the teen sustained a subdural hematoma and hip fracture, and she did not have any brain activity. The CPI spoke with the mother, who was separated from the father, and the mother said the teen and her sister began living primarily with the father in August 2021. The 12-year-old reported that before the accident, they attended an illegal street race, but left when police arrived. She stated she drank her 19-year-old sister's apple juice and did not know the drink contained alcohol. The mother denied knowledge of the father taking the children to the street race. The hospital treated the 12-year-old and discharged her to the mother's care. The father and adult sister remained hospitalized in stable condition. The father refused to cooperate with the DCFS investigation. Two days after the accident, the teen was removed from life support after she met criteria for brain death. DCFS indicated the father for head injuries by neglect (#52); substance misuse by abuse (#15); cuts, bruises, welts, abrasions, and oral injuries by neglect (#61); substantial risk of physical injury/environment injurious to health and welfare by neglect (#60); and inadequate supervision (#74). No one reported the teen's death to the hotline, and DCFS did not add allegations regarding the teen's death to the pending investigation. In June 2023, after DCFS received a report of the teen's death, DCFS added an indicated finding of death by neglect (#51) to the closed investigation.

Reason for Review: In May and June 2021, DCFS received multiple reports about the mother selling drugs; the mother, her paramour, and the children using drugs; domestic violence with the mother's paramour; children being left alone without food; and concerns about gang affiliation. CPIs visited the home, and the mother and children denied any issues. The CPI completed the home safety checklist and noted the home had adequate food and there was no drug paraphernalia or other concerns observed. CPIs spoke with the father, who voiced no concerns about the mother's parenting. The children reported they had not witnessed any violence between the mother and her paramour. During the investigation, the mother ended her relationship with the paramour but denied any domestic violence between them. DCFS unfounded the first investigation for substance misuse by abuse (#15) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60) due to insufficient evidence to support the allegations. DCFS unfounded the second investigation for inadequate supervision (#74) due to insufficient evidence. DCFS unfounded the third investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). In April 2022, DCFS received a report that the teen's father offered the teen's 13-year-old best friend a ride home, invited the friend to the family's home, then told her he was attracted to her. The CPI met with the friend, who confirmed the report and noted she considered the teen's father to be a father figure but was now uncomfortable and no longer wanted to go to the home. The teen's father denied the allegations and

reported he had never been alone with the friend because one of his children was always in the car when he drove her home. The father agreed to leave the home during the investigation and the teen's paternal grandmother agreed to care for the teen. The teen stated she did not like going to her mother's home and she preferred to live with her father. She denied her father ever made her feel uncomfortable, denied her friend told her about the incident, and denied her friend had ever been alone with her father. The CPI made multiple unsuccessful attempts to contact the friend's parents, who reported that they did not want the friend to complete a forensic interview or become involved with DCFS. Before closing the investigation, the teen stated she had not had recent contact with her friend. In June 2022, DCFS unfounded the investigation for sexual exploitation (#20) to the teen's friend and substantial risk of sexual abuse (#22) to the teen.

Child No. 71	DOB: 11/2014	DOD: 07/2022	Accident
Age at death:	7 years		
Cause of death:	Anoxic encephalopathy following resuscitated cardiopulmonary arrest due to drowning		
Reason for review:	Child was a youth in care; 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: Seven-year-old drowned in a hotel pool while on vacation with her paternal aunt. The child's 11-year-old cousin reported the child was unresponsive, and the aunt pulled her from the water, began CPR, and called 911. She was transported to the hospital. The next day she met the criteria for brain death and life support was discontinued. She died at the hospital that afternoon. DCFS unfounded the aunt for death by neglect (#51).

Reason for Review: In November 2021, DCFS received a report that the then 6-year-old child and her then 4-year-old brother witnessed an altercation between their mother and her paramour. The mother called police, and the paramour left the home before police arrived. Police issued a warrant for the paramour's arrest. The mother told the CPI she allowed the paramour to move into her home two weeks earlier because he lacked stable housing following his release from jail, and they got into an argument about his alcohol consumption. The mother declined to obtain an order of protection and reported she and the children moved into the maternal grandmother's home. The grandmother stated the paramour was not allowed at her home. The children reported they witnessed the incident, but they felt safe in their grandmother's home. Professional collaterals reported no concerns. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In March 2022, DCFS received a report that the mother gave birth and tested positive for cocaine, and the mother had a history of use of alcohol, cocaine, and opioids. The umbilical cord later tested positive for cocaine. The mother told the CPI she did not know she was pregnant until late in the pregnancy, and reported using marijuana in February 2022, but she denied using cocaine in the prior two months. She stated her former paramour was the father and they agreed to co-parent. The mother was discharged from the hospital, but the child's newborn sibling remained in the NICU for respiratory issues. The CPI observed the child and 4-year-old brother at their maternal grandmother's home, and they were assessed safe. The grandmother reported no concerns about drug use. The CPI opened an intact family services case for the family. Less than a week later, the mother again tested positive for cocaine and DCFS took protective custody of all three children placing them with the maternal grandmother. DCFS indicated the investigation for substance misuse by neglect (#65). The court ordered the mother and the paramour to complete random urine screenings as well as assessments and services for substance use, domestic violence, mental health, and parenting education. The child's father, who lived out of state, and the father of the child's 5-year-old brother, who was incarcerated, were recommended similar services. Two months later, in May 2022, DCFS received a report that the child and her brothers were at their mother's home

when the paramour assaulted the mother. The CPI interviewed the child at school, who reported the paramour hit her mother, and that she and her brothers sometimes stayed at their mother's home overnight while their grandmother was present. While the CPI was at the school, a family member arrived to bring the child to her mother's home, and the CPI instructed the family member to take her to the grandmother's home. The CPI and supervisor determined the children needed to be moved to a new placement because the grandmother violated the visitation agreement. The 5-year-old brother stated they were at their mother's home when the paramour hit her, and they heard yelling. The grandmother denied they stayed overnight at the mother's home and denied the children were present when the altercation happened, but reported the mother called her for a ride home from the hospital. The paramour denied the incident occurred. The mother stated she injured herself when she fell on the stairs while intoxicated; this mirrored the report the mother had provided to hospital staff. In June 2022, the court granted the child's father custody, but she remained in her maternal grandmother's home while the father's home was prepared and approved. In July 2022, the court deemed the paramour fit and gave the agency discretion to place the 4-month-old in his care. The mother was discharged from her parenting classes for lack of participation. The investigation remained pending at the time of the child's death. DCFS later indicated the May 2022 investigation against the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 72	DOB: 11/2009	DOD: 08/2022	Accident
Age at death:	12 years		
Cause of death:	Combined ethanol, fentanyl, and despropionyl fentanyl (4-ANPP) toxicity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old was found unresponsive by his mother. Emergency services responded to the home and found drug paraphernalia on his bed, including a pipe. His family reported he was watching television in the living room with his 17-year-old, 19-year-old, and 25-year-old siblings until approximately 3:30am, then he went to his bedroom. DCFS took protective custody of the child's 4-year-old, 6-year-old, and 10-year-old siblings. The mother's paramour denied knowledge of the child using drugs, but reported that earlier that year, he and the mother discovered the child's 19-year-old and 25-year-old siblings had been using Percocet (oxycodone-acetaminophen). The child's mother completed an oral toxicology screening that was positive for marijuana, benzodiazepines, and cocaine. DCFS indicated the child's mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In January 2022, DCFS received a report that the child's mother used cocaine and drank alcohol frequently, and the family home and the children were dirty. The CPI interviewed the child and his 4-year-old, 6-year-old, and 9-year-old siblings, noted they did not show signs of abuse or neglect, and reported they felt safe at home. The 9-year-old denied seeing drugs or drug paraphernalia in the home. The mother denied the allegations and reported she cleaned the home and cooked for the children. The CPI noted the child's mother did not appear under the influence of any substances during the investigation, and the mother reported she completed substance use treatment two years earlier. She completed a drug test that was negative for all substances. The CPI completed the home safety checklist and noted no concerns. School personnel reported the children attended school daily and appeared clean and the pediatrician's office reported the children were seen recently and there were no concerns noted. In April 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 73	DOB: 02/2005	DOD: 09/2022	Accident
Age at death:	17 years		
Cause of death:	Multiple injuries due to a motor vehicle collision with fence and brick building		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was a passenger in a car that hit a building after the 18-year-old driver lost control of the vehicle. The teen and the driver were both transported to the hospital where they were pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In December 2021, DCFS received a report that the teen's mother left the then 16-year-old teen and her 10-year-old and 11-year-old siblings with relatives. The reporter stated the relatives had trouble caring for the teen because she drank alcohol and used marijuana, and the teen stated her mother allowed the behavior. The reporter added the mother often left the children, they were not bathed, and she only fed them snacks. The teen told the CPI she had returned home intoxicated on two occasions but denied anyone in the home gave her permission to consume alcohol. She denied her mother abandoned her and stated her mother, stepfather, and siblings went on vacation to visit family and invited her, but she declined to go. The teen's siblings denied anyone in the home consumed alcohol regularly and denied their mother abandoned them. The mother reported the teen stayed with relatives when they went on vacation because she had to work. She noted the teen had come home intoxicated on two occasions, but she did not give the teen permission to drink, and she denied ever seeing the teen under the influence of marijuana. Family members denied the mother gave the teen permission to consume alcohol, and they denied the children had ever been left alone. The teen's grandmother reported she argued with the mother because she felt the mother's discipline was ineffective. The CPI provided the mother with referrals for parenting classes and therapy for the teen. In April 2022, DCFS unfounded the investigation for substance misuse by abuse (#15).

Child No. 74	DOB: 04/2005	DOD: 10/2022	Accident
Age at death:	17 years		
Cause of death:	Blunt cervical and thoacoabdimonnopelvic [sic] trauma		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was a passenger in a car that was struck by a semi-truck that did not stop at a stop sign. Both the teen and her grandmother, who was driving, died in the accident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Approximately two weeks before the teen's death, DCFS received a report that the teen sustained a cut on her hand and a contusion on her arm after an argument with her mother during which her mother shoved her out of the home in her pajamas because she missed the school bus. The teen told the CPI she had an altercation with her mother during which her mother pushed her and threw her backpack because she was not ready for school. She then went to her boyfriend's home and called her father. She denied she had any marks from the altercation and stated she did not know how she received a cut on her finger. She disclosed she asked her mother to sign emancipation papers the day before, but her mother refused. The CPI went to meet with the mother and teen's 13-year-old and 15-year-old sisters; the mother refused to allow the CPI into the home. The mother confirmed she threw the teens' backpack downstairs and she and the teen argued because the teen was not ready for school. She added the teen wanted to live with her father, but they would be attending court the following week because the father did not pay child support. The CPI also spoke with the teen's therapist, who reported the teen was disrespectful to her mother because privileges were taken away due to poor grades. The investigation remained pending at the time of the teen's death. DCFS later unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 75	DOB: 05/2022	DOD: 10/2022	Accident
Age at death:	5 months		
Cause of death:	Asphyxia due to prone and facedown position on a sectional couch next to an adult bed due to moving and falling off the adult bed while co-sleeping on the bed		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive, between a bed and large armchair. She was transported by ambulance to the hospital, where she was pronounced deceased. The infant had been in the care of her maternal grandfather while her mother worked. The grandfather reported he fed and burped her, then placed her on the bed, on her back, to play. He stated he unintentionally fell asleep and woke to find she had fallen between the bed and chair. The infant's mother reported the grandparents had cared for the children while she worked for the past two years, and she denied she ever had any concerns. Other family members also denied any concerns about the grandfather's care of the children. DCFS investigated the infant's death and unfounded her grandfather for death by neglect (#51).

Reason for Review: In January 2022, DCFS received a report that the infant's mother left the infant's 2-year-old sister and 6-year-old brother home alone overnight, and the mother had not replaced the brother's eyeglasses that were lost over a month earlier. After a prior unsuccessful attempt to meet with the family, the CPI spoke with the reporter, who stated they were no longer concerned with the 6-year-old's wellbeing, as he had new glasses and had been attending school clean and appropriately dressed. When the CPI met with the family, the brother was wearing glasses and told the CPI he felt safe at home. The mother reported that she had to save money to replace the brother's glasses, but he had since received two pairs. The mother and brother both denied she ever left the children unsupervised, and she sometimes had the children's maternal grandparents care for the children while she worked. The mother disclosed she was pregnant with the infant. The CPI completed the home safety checklist and noted the children had appropriate sleeping arrangements. The maternal grandparents confirmed the mother did not leave the children unsupervised. The children's pediatrician reported no concerns. In April 2022, DCFS unfounded the investigation for inadequate supervision (#74) and for medical neglect (#79).

Child No. 76	DOB: 04/2007	DOD: 10/2022	Accident
Age at death:	15 years		
Cause of death:	Combined drug (methadone, fluoxetine, and tadalafil) toxicity		
Reason for review:	Child was a youth in care; unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Fifteen-year-old was found unresponsive at their residential group home. The teen had reportedly gone on run for less than an hour the day before. Upon their return, residential staff reported they searched the teen and found no contraband, and the teen denied using any drugs while gone. The teen attempted to run again around 1:00am and residential staff prevented their departure. Residential staff reported that around 2:00am, a peer heard the teen vomiting in the bathroom, and the teen returned to their room approximately 20 minutes later. Staff performed routine bed checks throughout the night and confirmed the teen was in bed. The next morning, the teen was found unresponsive. Residential staff began CPR and called 911. Residential staff reported the teen had been sent to the hospital on two prior occasions for taking drugs that were not prescribed to them but refused substance use treatment. DCFS investigated the death and unfounded a staff member at the group home for death by neglect (#51).

Reason for Review: The teen came into DCFS care in June 2021, at the age of 14, after their father refused to take the teen home after a hospital did not admit the teen. DCFS indicated the father for lock-out (#84). In the year prior to their death, the teen had multiple placement disruptions. They were placed in two fictive kin foster homes, two traditional foster homes, a shelter, and a residential group home. Each

of their foster parents requested their removal due to difficulty managing the teen's behavior. There were ongoing concerns about the teen's mental health, medication non-compliance, and substance use. The teen's school also suspended them for fighting, and they had multiple interactions with law enforcement. In May 2022, during a hospitalization, DCFS received a report that the teen physically abused the foster parents' 6-year-old daughter, initiating a child protection investigation. The teen told the CPI they did not intentionally hurt the 6-year-old foster sister, and they reported they stopped using drugs. The foster parents stated the teen did not injure the 6-year-old, but the 6-year-old felt unsafe with the teen in the home. In August 2022, DCFS unfounded the teen for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). After discharge from the hospital, the placement worker sought placement options and eventually placed the teen in a residential group home. Residential staff reported concerns about the teen's behavior, including aggression, drug use, and elopement. The teen remained in this placement for approximately four months until their death in October 2022.

Child No. 77	DOB: 09/2022	DOD: 10/2022	Accident
Age at death:	7 weeks		
Cause of death:	Positional asphyxiation attributed to suffocation caused by rollover during-co-sleeping		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive in bed after co-sleeping with his mother and his 15-month-old sister. The mother called 911 and the infant was transported by ambulance to the hospital, where he was pronounced deceased. The mother told a first responder she placed the infant on a "boppy pillow," and she found the infant lying on his back, with his 15-month-old sister lying on top of him. The mother reported she consistently co-slept with her children. The detective observed a bassinet full of clothes and diapers. The mother initially agreed to intact family services but later declined, and the state's attorney declined to file a petition. DCFS unfounded the mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In March 2022, DCFS received a report that the infant's 3-year-old brother had a healing burn on his ankle. The reporter stated the brother was in pain, his mother did not take him for medical treatment, and he disclosed he received the burn when he and his brother jumped into a fire. The reporter added the brother also had a rash covering his entire body. The CPI spoke with the brother's teacher, who noted no prior concerns. The school nurse stated the brother had dermatitis that did not require immediate medical attention, and the burn appeared to scab after it bled. The CPI met with the brother at school, who reported he received a burn when he played with his mother's "fire stick." The CPI spoke with the mother by phone, who reported treating the rash with lotion, and the brother had an appointment scheduled in three days, but she agreed to take him to urgent care that day. The CPI interviewed the infant's then 15-year-old sister, who denied any knowledge of the brother being burned. The CPI noted the mother reported she co-slept with the infant's then 7-month-old sister and did not have a crib. The CPI provided a pack-and-play and discussed safe sleep with the mother. At urgent care, the brother was diagnosed with impetigo and prescribed an oral medication. One week later, DCFS received a report that the 3-year-old brother stated his mother punched him in the stomach because she was upset about the DCFS report. That day, the CPI went to the home and met with the brother, who reported his mother punched him in the stomach with a closed fist. The CPI noted the brother laughed when he told the CPI. He denied any pain and the CPI noted no visible marks. The mother denied she punched the brother. She stated she had used physical discipline in the past, but not recently. In September 2022, before closing the investigations, the CPI spoke with staff in the office of the children's pediatrician, who noted the brother was last seen in March for a wellness exam, he was up to date on his vaccinations, he was prescribed hydrocortisone for rosacea, and they provided a behavioral health referral. There were no abuse or neglect concerns documented. The CPI also met with all three children again and noted no signs of

abuse or neglect. The brother stated his mother disciplined him by turning off the TV and sending him to bed. The 16-year-old sister reported her mother disciplined her brother by smacking him on the bottom, with his pants up, and her mother disciplined her by restricting her phone access and outings with friends. The then 13-month-old sister appeared free of signs of abuse or neglect. During the investigation, the brother's rash appeared to improve. DCFS unfounded the first March 2022 investigation for burns by abuse (#5). DCFS unfounded the second March 2022 investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10).

Child No. 78	DOB: 12/2005	DOD: 10/2022	Accident
Age at death:	16 years		
Cause of death:	Multiple injuries due to a motor vehicle striking a fixed object		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old died in a single car accident, along with a 17-year-old. Two other people in the car survived the accident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In December 2021, DCFS received a report that the teen's stepfather held down and choked the teen in front of her mother. The next day, DCFS received a report that the teen's mother and stepfather punched the teen in the face and took her phone away so she could not call her father. Police conducted a wellbeing check and noted no concerns. DCFS took the report for a separate investigation. The CPI interviewed the family at home. The teen's stepfather stated he held the teen back while the teen's mother took her phone away for having inappropriate conversations. He denied physically abusing the teen. The mother stated a verbal altercation turned physical when the teen would not give the mother her phone. The mother denied the stepfather and the teen's 10-year-old brother were involved in the incident. The teen's 10-year-old brother confirmed his parents yelled at the teen, but denied he had ever witnessed his parents abuse her. The teen reported that while her mother was trying to take her phone, her stepfather held her down forcefully and choked her. The teen stated she still felt safe at home and had no marks or bruises from the incident. The CPI spoke with the teen's father, who stated he was concerned after the teen told him about the incident. The father later told the CPI he planned to pick the teen up from school and would seek an order of protection. DCFS received a related information report that the teen's mother contacted police to report the father kidnapped the teen. The mother stated she had primary custody of the teen but could not produce any custody paperwork. The mother eventually allowed the teen to stay with her father. In January 2022, the teen participated in a forensic interview and stated she did not feel safe in her mother's home because of physical abuse from her mother and stepfather. In February 2022, DCFS unfounded the first investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The second investigation remained pending because there was a criminal investigation. The teen remained in her father's home, and the CPI checked on the teen and her brother monthly. Approximately three weeks before the teen's death, DCFS unfounded the second investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 79	DOB: 11/2022	DOD: 11/2022	Accident
Age at death:	10 hours		
Cause of death:	Complications of placental abruption; significant contributing condition of maternal cocaine use		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: One-day-old was pronounced deceased at the hospital. He had been born by emergency c-section at 29 weeks gestation. The newborn required intubation and resuscitation immediately after birth

and was transferred to a different hospital. He had perinatal respiratory depression, severe encephalopathy, and severe metabolic acidosis. The newborn and his mother tested positive for opiates, cocaine, and marijuana. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: In February 2022, DCFS received a report that the newborn's then 3-year-old sister lived with her maternal grandmother in a truck, and the grandmother's paramour used drugs. The CPI had difficulty locating the family. The sister's paternal grandmother stated they may have been with the newborn's maternal uncle, who was not allowed around children due to an indicated sexual abuse investigation. After one month, the CPI found the family. The sister reported she felt safe with her maternal grandmother and stated they always lived in a house. The grandmother stated she moved in with her son, the maternal uncle, when she encountered financial difficulties, but she was working on obtaining a new home. She denied her paramour lived with her. The CPI observed that the grandmother and sister had their own space in the home. DCFS unfounded the investigation for inadequate shelter (#77). In August 2022, DCFS received a report that the maternal grandmother allowed the maternal uncle to live in the home with children, including the newborn's 4-year-old sister, and allowed him to be unsupervised with the sister. The CPI was unable to locate the family following a diligent search and sought assistance from law enforcement. Law enforcement reported they had a warrant for the uncle's arrest for a residential burglary charge, but they were also unable to locate the family. In September 2022, while the investigation remained pending, DCFS received a report that the newborn's mother, who was pregnant, arrived at the emergency room with cellulitis in her arm. The reporter stated the cellulitis was from a needle, the mother had a history of heroin use, she did not receive prenatal care, and she lacked stable housing. The hospital discharged the mother following treatment, and the hospital did not have the family's address. DCFS unfounded the investigation for substantial risk of sexual injury (#22).

Child No. 80	DOB: 03/2005	DOD: 11/2022	Accident
Age at death:	17 years		
Cause of death:	Multiple injuries due to motor vehicle collision(s)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old and a friend were speeding in a stolen car when they crashed into other cars. The car ignited and both the teen and his friend died. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the teen had been shot in the head while driving, which was the second time he was shot in the community in the previous 90 days, and the reporter was concerned about his supervision. The CPI visited the teen and his mother at the hospital, but the teen was unable to speak because he was intubated. The mother reported she had been in contact with the teen by text, and he responded he was on his way home. She later received a call from the hospital. The mother stated the shooting happened prior to the teen's curfew. The teen was discharged to his mother's care two days later with DCFS approval. Hospital staff reported the mother was at the teen's bedside daily. Following discharge, the mother reported the teen was doing well. The teen and his mother reported he stopped socializing with the friend group he had been with. The teen also reported he was in physical therapy. The teen's 22-month-old sister was observed to be safe and healthy. Police and collaterals reported no concerns. DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 81	DOB: 06/2007	DOD: 12/2022	Accident
Age at death:	15 years		
Cause of death:	Combined drug (fentanyl, despropionyl fentanyl [4-ANPP], heroin, and cocaine) toxicity		
Reason for review:	Child was a youth in care; indicated child protection investigation and closed child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old was found deceased at a hotel. She had been on run for almost two months prior to her death. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report that the teen's adoptive parents were getting older and were having a difficult time managing the teen's behavior. DCFS opened a child welfare services referral and provided the parents with a list of resources for behavior modification and possible residential options for the teen. In July 2022, DCFS received a report that the teen presented at a hospital but did not meet the criteria for hospitalization, and her parents refused to take her home. The CPI spoke with the mother, who reported the teen refused to take prescribed medications. She added the teen's boyfriend threatened her and the teen's father. The mother stated the teen told hospital staff she was being abused at home, and hospital staff escorted the mother from the hospital, but the teen later recanted her statement. The teen's father reported they had tried outpatient, partial hospitalization, and inpatient programs for the teen, but none had been successful. The teen reported she had a verbal altercation with her parents that turned physical. The teen stated she called police and was brought to the hospital for evaluation. The CPI noted the teen stated she did not know why she told hospital staff she was abused. DCFS took protective custody of the teen and placed her in a shelter. DCFS indicated the teen's parents for lock-out (#84). While the teen was placed in the shelter, she repeatedly went on run and refused to cooperate with DCFS. In November 2022, DCFS received a report that police arrested the teen for residential burglary and obstruction, but she did not have enough delinquency points for police to detain her. DCFS took both reports for information only and referred them to the teen's placement worker. Approximately one week before the teen's death, the court issued a warrant for the teen. At that time, the teen was reportedly three months pregnant and there were concerns she was being trafficked. She remained on run until her death.

Child No. 82	DOB: 05/2003	DOD: 12/2022	Accident
Age at death:	19 years		
Cause of death:	Drowning in bathtub at home due to a seizure		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old was found with her face underwater in a bathtub, and her body was outside the bathtub. The youth had a history of seizures. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: In 2018, at the age of 14, the youth came into care of DCFS during an investigation in which DCFS indicated the youth's maternal great-grandmother, her primary caregiver since birth, for sexual exploitation (#20). In the year prior to her death, the youth's permanency goal was independence. In 2022, she resided in several placements, including traditional foster homes, a fictive kin foster home, and an unauthorized relative placement. In July 2022, the youth was accepted by a transitional living program, but the placement did not occur because she was hospitalized. Following discharge, she moved into her maternal grandparents' home, which was an unauthorized placement because the grandparents refused to cooperate with DCFS to have the placement approved. In September 2022, the youth realized she was not yet ready to live alone and asked to be considered for a transitional living program again; she was put on the waitlist for the facility that previously accepted her. The youth expressed she wanted to stay in care until she was 21. The youth was compliant with services and maintained regular contact with her placement worker.

Child No. 83	DOB: 11/2020	DOD: 12/2022	Accident
Age at death:	2 years		
Cause of death:	Multiple injuries due to sport utility vehicle striking fixed object		
Reason for review:	Pending child protection investigation at time of child's death; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old died when the vehicle he was riding in struck a freeway on-ramp. The toddler's 4-year-old sister survived the accident, but the toddler and his mother were both pronounced deceased upon arrival at the hospital. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report that the toddler's father kicked the toddler's then 3-year-old maternal half-sister when she tried to intervene in an altercation between the toddler's mother and father. The reporter added there was a warrant out for the father's arrest. The mother denied prior domestic violence incidents. The mother told the CPI she and the father broke up in January 2022, and the father gained access to her home through a broken door, which she had since fixed. The mother stated the toddler's father intentionally kicked the sister, but it did not leave a mark and she did not take the sister to the doctor. Both children appeared free of marks or bruises. The CPI documented diligent search efforts to locate the toddler's father. That month, DCFS indicated the toddler's father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). In October 2022, DCFS received a report that the mother brought the toddler's sister to the emergency room an hour after her car was struck by another vehicle, the sister had been unsecured in the front seat, and the mother appeared intoxicated. The CPI met with the mother at the hospital, who reported she told hospital staff the sister was unsecured in the front seat in hopes they would treat her sooner. She stated the toddler was also in the car, but she did not bring him to the hospital because his side of the car was not hit. The CPI instructed her to take the toddler for a medical exam. The CPI observed both children and noted they appeared happy and healthy, and the sister only had a small mark on her nose. Police later confirmed the mother was not arrested and was not cited for a DUI following the incident. The children's maternal grandmother agreed to care for them under a safety plan. The mother agreed to intact family services. She completed a toxicology screening, which was negative. The mother denied drinking the day of the incident and reported the children were restrained in the car, but they sometimes left their seats and she sometimes had to direct them to stay in their seats while she was driving. In December 2022, while the investigation remained pending, the toddler and his mother died. DCFS later unfounded the October 2022 investigation for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61).

Child No. 84	DOB: 11/2003	DOD: 12/2022	Accident
Age at death:	19 years		
Cause of death:	Blunt trauma to the chest due to motor vehicle crash		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old died in a single-car accident when her car struck an interstate guardrail. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: In 2020, the then 16-year-old youth and her then 15-year-old sister came into DCFS care during an investigation in which DCFS indicated their legal guardian, who had raised them for over 10 years, for sexual exploitation (#20) and substantial risk of sexual injury by abuse (#22). Both children had several placement disruptions since their cases opened. In September 2022, they were placed with their maternal grandfather. At the time of her death, the youth's permanency goal was independence.

Child No. 85	DOB: 08/2022	DOD: 01/2023	Accident
Age at death:	4 months		
Cause of death:	Asphyxia due to co-sleeping on an adult bed with adults and a sibling in a prone facedown position; significant contributing condition of SARS-COV-2 (COVID-19) infection		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive and cold by his mother, and his parents called 911. The parents reported the father fed the infant then placed him to sleep in a prone position on a mattress with both parents and infant's 3-year-old brother. The parents reported they recently moved into the home of the infant's paternal uncle, and they were unable to bring a crib or bassinet with them. The father reported nothing unusual when he placed the infant in bed. The parents agreed to complete drug screenings, which came back negative for both parents. The infant tested positive for COVID-19 postmortem. DCFS investigated the infant's death and unfounded his parents for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In August 2022, DCFS received a report that while at the hospital following the infant's birth, the mother spanked the infant's then 2-year-old brother and dragged him by his arms to the couch because he spilled hot chocolate. The reporter also noted concerns the mother was instructed to feed the infant every three hours due to low blood sugar, but the mother went five hours between feedings. In addition, the mother tested positive for marijuana at the time of the infant's birth. The mother told the CPI she threatened the brother with a belt for touching things at the hospital she told him not to touch, and she stated she did sometimes spank him, but she denied she spanked him excessively or left marks. The mother reported she used marijuana and alcohol occasionally. The CPI noted the children appeared free of marks or bruises, the home was appropriate, and the family had safe sleeping arrangements for the children. In October 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 86	DOB: 08/2022	DOD: 01/2023	Accident
Age at death:	5 months		
Cause of death:	Suffocation with plastic bag over the face		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive by his mother, with a plastic bag across his face. The mother began CPR and one of the infant's siblings called 911. Medical staff reported the infant was deceased upon arrival at the hospital. The mother reported she had been co-sleeping with the infant who had been propped up on a pillow. First responders noted the home was cluttered and unkempt. The mother told the CPI she regularly co-slept with the infant, and sometimes placed pillows between herself and the infant. She stated she usually cleaned up items on the bed before going to sleep, but she was very tired that night and did not do so. During a home visit, the infant's four siblings, between the ages of 5 and 13 years old, reported they felt safe at home and appeared free of signs of abuse or neglect. The CPI noted the home appeared clean but cluttered, and there were many people living in a small space. DCFS indicated the infant's mother for death by neglect (#51).

Reason for Review: In December 2022, DCFS received a report that the infant's 13-year-old sister and two non-related 13-year-old females disclosed a doctor inappropriately touched each of them during medical exams they completed upon inpatient admission to a hospital. Hospital staff reported they alerted the patients' parents, conducted an internal investigation, and placed the doctor's contract on hold. A nurse who was present for the exam of the infant's sister stated she did not witness any inappropriate actions by the doctor. The CPI attempted to see the sister and another patient at the hospital but learned they had been discharged. In January 2023, the CPI met with the sister at school and noted no signs of abuse or neglect.

The mother told the CPI the sister disclosed she felt uncomfortable after the exam, and the mother attempted to speak with the doctor but was not allowed to. The mother agreed to a forensic interview for the sister. Three days later, while the investigation remained pending, the infant died. Following the infant's death, the sister did not attend the forensic interview and the CPI was unable to locate the family. The doctor told the CPI that he believed the allegations stemmed from a portion of the exam when he checked the pelvic pulse below the naval. He denied any wrongdoing or sexual intent in the exams. The doctor also provided the CPI a written explanation of his medical exam process and reasoning for the need to touch the lower abdomen on each patient. He also noted he had been practicing medicine for over 30 years without prior complaints. One of the other patients completed a forensic interview and did not make any disclosures of sexual molestation by the doctor. Police closed the criminal investigation with no charges. In July 2023, DCFS unfounded the investigation for sexual molestation (#21).

Child No. 87	DOB: 05/2015	DOD: 01/2023	Accident
Age at death:	7 years		
Cause of death:	Multiple injuries due to school bus striking pedestrian		
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 bus while walking home. The child's parents witnessed the accident from their home and called 911. The child was transported to the hospital, where he was pronounced deceased. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In July 2022, DCFS received a report that the child's 13-year-old brother sexually assaulted a 13-year-old girl he was in a relationship with. Both sets of parents knew of the relationship. The child's mother stated the girl's mother informed her of the incident, and both families went to the police station to make a report. Police investigators determined the incident began consensually, and the girl asked the teen to stop. The teen stated he stopped when the girl asked him to and waited with her in the park for her mother to pick her up. DCFS unfounded the investigation against the child's brother at the initial stage for substantial risk of sexual abuse – sibling of sex abuse victim (#22b) to the child.

Child No. 88	DOB: 01/2023	DOD: 02/2023	Accident
Age at death:	4 weeks		
Cause of death:	Asphyxia due to prone facedown sleeping position on an adult bed on soft bedding while co-sleeping with an adult		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-week-old was found unresponsive in an adult bed by her mother, who reported she had friends in her home that night and went to bed around midnight or 1:00am. The mother stated the newborn was fussy and fell asleep in her arms, and when she woke around 9:00am, she found the newborn not breathing, so she alerted her friends, who called police. A friend confirmed the timeline of events. The mother denied she used marijuana that night and she tested negative for illegal substances. The mother stated the newborn usually slept with her, but she had a portable co-sleeper bassinet that sat on top of the bed. At the time of the newborn's death, the newborn's 16-month-old sister was not in the home because she lived with the maternal grandmother under temporary guardianship to help the mother adjust to having a newborn. Before the DCFS investigation closed, the mother agreed to give full guardianship of the sister to the grandmother and the court granted the grandmother guardianship. DCFS unfounded the investigation for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In June 2022, DCFS received a report that the newborn's mother and the father of the newborn's then 8-month-old maternal half-sibling had an argument during which the father threw

objects while the sister was in the room. The CPI met with the mother and sister at home. The mother reported the father was in jail due to the incident and he did not live in the home. The newborn's 15-year-old maternal aunt told the CPI she was also present for the incident and witnessed the sister's father throw a coffee table and push the mother against a wall. The aunt stated she took the sister to a different room. The maternal grandmother confirmed the mother's and aunt's reports. Both the mother and grandmother stated the father was no longer allowed in the home. The CPI discussed safe sleep with the mother, observed the home, and assessed the sister safe with the mother. The CPI later spoke with the sister's father, who confirmed he did not live in the home, he had been arrested following the incident, and he knew he was not allowed to return to the mother's home. The sister's father reported he flipped the coffee table, which struck the mother. In July 2022, DCFS indicated the sister's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 89	DOB: 11/2018	DOD: 02/2023	Accident
Age at death:	4 years		
Cause of death:	Acute hypoxemic respiratory failure due to tracheostomy became dislodged		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-year-old was pronounced deceased at the hospital after his tracheostomy became dislodged. His mother called 911 because she could not replace it. Emergency medical responders attempted to resuscitate him for 30 minutes. The toddler was medically complex. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In March 2022, DCFS received reports that the toddler's mother was seen on social media intoxicated and making statements about self-harm while being the sole caretaker for the then 3-year-old toddler and his then 4-year-old brother. The CPI spoke with the reporters, who stated they also called police for a wellness check. The CPI spoke with local police who confirmed they checked on the mother and noted she appeared coherent, and they observed a child sitting on the couch, attached to machines. The CPI met with the toddler's grandmother and 4-year-old brother at the grandmother's home and noted the brother was a double amputee and recently had surgery. The next day, the CPI met with the mother, her husband, and the toddler. The mother and her husband denied the allegations. The CPI observed the toddler on the couch, attached to machines. The children were assessed safe. Three days later, DCFS received a related information report that the mother contacted police regarding issues with the toddler's g-tube, but she did not take the toddler to the hospital immediately. The reporter stated that when the mother did bring him to the hospital, he was having respiratory issues and his g-tube had come out. The CPI obtained the toddler's medical records and spoke with his pediatrician, who reported no concerns. The mother denied any recent substance use or domestic violence. She reported the toddler had recent surgeries, and the CPI observed the toddler. The CPI interviewed the brother at school, who reported he felt safe at home. The brother's teachers reported no concerns. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74).

Child No. 90	DOB: 12/2022	DOD: 02/2023	Accident
Age at death:	2 months		
Cause of death:	Positional asphyxiation		
Reason for review:	Open intact family services case at time of child's death; 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: Two-month-old was found unresponsive, wedged between couch cushions, around 5:30am. His mother called 911 and began CPR. The infant was transported by ambulance to the hospital, where he was pronounced deceased. The mother reported that the night before, she fed the infant, then placed him to sleep on his stomach, with his head on the armrest of the couch and his torso and legs on the seat of the couch. The mother disclosed she was overwhelmed and tired, and recently began taking a new medication. She added that the night of the infant's death, the children's father was supposed to care for them, but he was not present when she attempted to drop the children off at his home. DCFS investigated the death and indicated the mother for death by neglect (#51), but unfounded her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In December 2021, DCFS received a report that the infant's then 2-month-old brother had not gained weight, and his mother and maternal grandmother did not adhere to his feeding schedule. The reporter noted the mother had been hospitalized, and the maternal grandmother had custody of the children and appeared overwhelmed. In the days following the report, the CPI conducted multiple attempts to see the family, submitted a nursing referral, and spoke with the family's pediatrician who advised the family to use larger nipples and to increase the number of feedings. Later that month, the pediatrician reported the brother gained weight and appeared stronger. The CPI met with the children and grandmother, who stated she helped care for the children while the mother was hospitalized. The grandmother denied she felt overwhelmed as she rarely cared for all the children at once. She reported the brother's weight had improved with adjustments to his formula and bottles. The CPI spoke with the mother, who confirmed she had been hospitalized and received treatment. The parents agreed to intact family services including respite care for the infant's three siblings, then 3 months, 2 years, and 3 years old. In March 2022, the children returned to their mother's care and the intact worker visited weekly. DCFS unfounded the investigation for failure to thrive (#81). The family's intact worker noted the mother was engaged in individual counseling and medication management, the brother attended medical appointments and continued to gain weight, and the children were enrolled in protective daycare and completed developmental assessments that noted no concerns. The children's father was minimally involved during the intact case. In July 2022, DCFS closed the family's intact services case as successful. In November 2022, DCFS received a report that the infant's 4-year-old sister disclosed the father touched her and she was in pain. The CPI met with all the children and noted no visible injuries. The then 13-month-old brother's daycare provider reported no concerns, the 3-year-old reported she felt safe at home, and the teacher reported no concerns. The CPI spoke with the mother, who reported the sister saw her father recently, but he was not alone with the children. She agreed to cease contact with the father during the investigation. The 4-year-old sister completed a forensic interview and medical exam. She made no disclosures of sexual abuse or inappropriate touch, and the medical exam was normal. Detectives interviewed the father, who denied the allegations, and law enforcement closed their investigation. The CPI spoke with the father, who again denied the allegations. While the investigation was pending, the mother gave birth to the infant eight weeks prematurely, and the infant remained hospitalized. The mother also requested a referral for intact family services. In January 2023, the infant was discharged from the hospital. The CPI discussed safe sleep with the mother who reported the infant slept in a pack-and-play, and she had appropriate sleeping arrangements for him. DCFS unfounded the investigation for sexual penetration (#19) and substantial risk of sexual abuse (#22). The family's intact worker recommended childcare assistance, Norman funds, mental health services for the mother, and counseling for the

4-year-old sister. The family was also involved in an in-home parenting program. The mother was cooperating with intact family services when the infant died.

Child No. 91	DOB: 01/2023	DOD: 03/2023	Accident
Age at death:	6 weeks		
Cause of death:	Unexplained infant death (extrinsic and intrinsic factors identified)		
Reason for review:	Split custody; one indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found not breathing by her maternal grandmother. The grandmother reported she fed the infant early that morning, then placed her on her back, on an infant mattress, on top of the grandmother's bed. The infant's maternal uncle called 911 while the uncle's paramour began CPR. Paramedics transported the infant to the hospital by ambulance, where she was pronounced deceased upon arrival. First responders noted a strong smell of marijuana in the grandmother's bedroom but did not observe any drug paraphernalia. Police obtained a warrant for a drug test and the grandmother tested positive for amphetamine and methamphetamine. The autopsy report noted the infant was placed in an unsafe sleep environment, but she also had renal disease of uncertain significance, both of which may have contributed to her death. DCFS indicated the grandmother for death by neglect (#51) because she placed the infant in an unsafe sleep environment and because she was under the influence of substances that impaired her ability to care for the infant.

Reason for Review: In March 2022, DCFS received a report of a physical altercation at the home of the maternal grandfather. Reportedly, the grandparents did not want the mother to take the infant's then 15-month-old and 4-year-old maternal siblings' home because the mother had a history of using methamphetamine. Police responded to the home and the mother left with the children. The 4-year-old denied he saw fights between his mother and grandparents. The children's grandfather and step-grandmother stated they did not feel safe allowing the children to return to their mother's care because they suspected she was using methamphetamine. The children's maternal uncle and his paramour stated they watched the children while the mother worked and shared the mother had a history of drug use, but they had no recent concerns. The mother stated that the day of the incident, she locked her keys in her car and left her phone at her mother's home, so her paramour had to drive her to pick up the children. She initially denied drug use, then admitted she used the day after the incident, and she tested positive for methamphetamine and THC. The siblings' father reported he used drugs in the past but stated he no longer used. The CPI initiated a safety plan for the children to stay with their maternal uncle until the mother completed three negative toxicology screenings. In April 2022, DCFS took protective custody of the infant's siblings and placed them with their maternal uncle because the mother continued to test positive for methamphetamine. The mother and the siblings' father both entered substance use treatment programs. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In August 2022, the mother completed substance use treatment. The service plan also included recommendations to complete parenting and domestic violence classes. In September 2022, the infant's siblings were moved to the home of their maternal grandfather and step-grandmother, and the parents began unsupervised visitation. In December 2022, DCFS reinstated supervised visits for the mother after she tested positive for methamphetamine. The siblings' father continued to have unsupervised visits. In January 2023, the mother gave birth to the infant and DCFS opened an investigation. The placement worker informed the CPI the mother had relapsed in her substance use a few months earlier, but she had completed three negative toxicology screenings and had returned to unsupervised visits. The placement worker reported no concerns about the mother caring for the infant but reported she had not yet met the infant's father. The mother denied any plans to live with the infant's father, and stated he was required to complete random drug screenings as part of probation. DCFS allowed the hospital to discharge the infant to the mother's care because there were no immediate safety concerns. Before closing the

investigation, the CPI completed the home safety checklist, discussed safe sleep with the mother, and observed the infant's bassinette. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) and the siblings' placement case remained open. The day the investigation closed, the mother tested positive for methamphetamine, but her placement worker did not receive the results until the day after the infant's death.

Child No. 92	DOB: 06/2006	DOD: 03/2023	Accident
Age at death:	16 years		
Cause of death:	Fentanyl, dextromethorphan, hydroxyzine, buprenorphine, doxylamine, MDMA, and cocaine intoxication		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old died of a drug overdose. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In September 2022, DCFS initiated an investigation against the teen after a report that the 16-year-old teen and his 16-year-old girlfriend had a sexual relationship, the teen became violent when the reporter asked the girlfriend to leave the home, and the teen and his girlfriend used drugs. The reporter stated the teen also had a history with law enforcement, who had found live ammunition but no weapon in his bedroom. The teen refused to speak with the CPI, so the CPI provided the teen's father with the notification of investigation. Two days later, law enforcement arrested the teen for domestic violence to his girlfriend. The CPI later interviewed the teen's girlfriend, who reported the teen's mother allowed her to stay in the home on the condition that she went to school or obtained employment. She stated she felt safe in the home, was sexually active with the teen, and their relationship was consensual. The teen's mother confirmed the temporary guardianship arrangement. Two weeks after the hotline report, DCFS unfounded the investigation against the teen for sexual penetration (#19) because the teen was not in a caregiving role for his girlfriend. DCFS also unfounded a companion investigation against the girlfriend's father for inadequate supervision (#74). One month later, in October 2022, DCFS received a report that the teen had been arrested, and the teen reported a history of his father striking him. The CPI spoke with the teen's probation officer; the teen pleaded guilty to domestic battery to his father. He noted the teen had been released from probation six months earlier but committed new offenses. The CPI met with the teen at the juvenile detention center. He denied his father ever hit him. He reported he used marijuana and alcohol. The teen's mother reported the teen was violent with her and the teen's father, and he previously attended drug treatment, but he did not complete the programs. She denied the teen's father ever physically harmed him. The father denied he was ever physically aggressive toward the teen. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Three weeks later, DCFS received a report that the teen ran away from an alternative sentencing facility for youth with substance use issues. The teen told police he ran away after facility staff grabbed him and shoved him to the floor because he refused to close his door. He also stated a peer struck him in the head with a pillow, resulting in head pain, blurred vision, and hearing loss in one ear. The teen told the CPI he ran from the facility several times. He reported ear pain after a peer struck him, but staff did nothing, so he ran away, but reported staff later took him to urgent care for treatment. The teen also reported a separate incident where a staff member shoved him into his room after residents were told to go into their room because of an altercation on the floor. He told the CPI he did not feel safe at the facility. The staff member denied the allegations, and stated she slightly pushed the teen and his roommate so she could close the door after she asked them several times to do so. The CPI reviewed video footage of the incident and noted no evidence of a physical altercation. The teen's probation officer reported the teen entered the facility for a 90-day program and the probation officer had no concerns about him remaining there. In January 2023, DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10).

Child No. 93	DOB: 12/2022	DOD: 03/2023	Accident
Age at death:	3 months		
Cause of death:	Asphyxia due to co-sleeping on a couch with an adult while breastfeeding		
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 by her mother, who called 911. First responders reported the mother stated she put the infant on the couch with a blanket, and the mother also fell asleep on the couch. The infant's father reported he was not at the home at the time of the infant's death. The parents agreed to intact family services and grief counseling. DCFS unfounded the mother for death by neglect (#51). DCFS indicated her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) due to on-going domestic violence, but unfounded the father for the same allegation because he no longer lived in the home.

Reason for Review: In August 2022, DCFS received a report that police responded to the family home for a domestic violence incident during which the infant's then 10-month-old and almost 3-year-old siblings were present. The CPI met with the mother who reported the father grabbed her by the neck and forcibly moved her so he could leave the home, and he had not returned since the altercation. She confirmed the children were in the home but stated they were in a different room during the incident. The CPI observed the children and completed the home safety checklist. The almost 3-year-old sibling stated police came to the home, but he did not know why. Two days later, DCFS received a report that police had again responded to the home for domestic violence. The report was taken for related information. Law enforcement confirmed the reports, noted the father was the aggressor, and they suspected gang affiliations. Two weeks later, the CPI again met with the mother, who reported she had not allowed the father to return to the home since the incident. The children's pediatrician reported no concerns but noted the children were due for well child exams. The mother told the CPI they had appointments scheduled. The CPI was unable to locate the father during the investigation. In September 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 94	DOB: 01/2008	DOD: 03/2023	Accident
Age at death:	15 years		
Cause of death:	Fentanyl and alprazolam intoxication		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old had gone to her boyfriend's home, used illicit drugs, and fell asleep. The following morning, her boyfriend found her deceased and called 911. The teen's parents reported she left the home the afternoon before and when she did not return by her 10:00pm curfew, they filed a missing person report. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In January 2023, DCFS received a report that the teen and her mother had an altercation after the mother confronted the teen about vaping and skipping school. After the fight, the teen left the home with a friend, the mother called police to report the teen missing, police located the teen, and the teen agreed to go home. The next day, DCFS received a report that the teen was afraid her mother was going to physically assault her when she returned home from school. The CPI spoke with the teen at school, who reported she left the home after a fight with her mother and called a friend to meet her at a nearby gas station, where police found her. She stated she returned home, but she had not spoken to her mother or stepfather since the incident. The teen reported she was trying to quit using drugs but was having trouble doing so, and stated she used marijuana and nicotine. The teen's parents confirmed an altercation occurred. They reported difficulty with the teen's behavior, and stated the teen skipped school, frequently used drugs, and was in a drug treatment program. The teen's 5-year-old and 13-year-old siblings denied corporal punishment or physical abuse and denied they witnessed the altercation. The investigation

remained pending at the time of the teen's death. The CPI noted police had received seven missing person reports on the teen between the beginning of the child protection investigation and the teen's death. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 95	DOB: 08/2006	DOD: 04/2023	Accident
Age at death:	16 years		
Cause of death:	Fentanyl toxicity		
Reason for review:	One indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was found unresponsive by his mother, who attempted to wake him before she left for work. The teen's mother called 911, and the teen was transported to the hospital, where he was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In September 2022, DCFS received a report that two months earlier, the teen had overdosed while supervising his then 3-year-old and 6-year-old siblings. The CPI met with the parents, who stated the teen watched his siblings during the summer, while they went to work, and they did not know the teen used drugs until the incident occurred. They stated the father worked from home following the incident so he could supervise the children. The teen reported his mother found him unresponsive the day of the incident and called the police. The teen entered a residential treatment facility after the overdose, then began receiving counseling at school. In December 2022, while the first investigation remained pending, DCFS received a report that the teen and his 7-year-old brother were wrestling when a dresser fell on the 3-year-old sister's toe. The reporter stated the father became angry and started going through the teen's belongings, the teen went into the father's room and began throwing things, and the father threw an object at the teen. Police responded to the home. The CPI met with the teen at school, and the teen reported his father became angry and the father began throwing his belongings, so the teen went into his father's room and threw the father's belongings. The teen stated he did not have a good relationship with his father, but he felt safe at home. The CPI met with the mother at home, who stated she was not home at the time of the incident, but reported she called police when she learned what happened. The parents informed the CPI they were in the process of divorcing. The father stated the boys were playing rough, so he told them to calm down, and he made a mess of the teen's room because he was looking for the teen's laptop, but the teen would not tell him where it was. The teen's younger siblings reported they felt safe at home. That month, DCFS unfounded the investigation at the initial stage for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). DCFS later indicated the teen in the first investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 96	DOB: 07/2022	DOD: 04/2023	Accident
Age at death:	9 months		
Cause of death:	Drowning		
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:	Investigatory review of records		

Narrative: Nine-month-old was found submerged in the bath. The mother had asked the children to clean the house, and the 9-year-old brother stated he thought the infant needed a bath, so he placed her in the bathtub, left the room to take out the garbage, and asked his 4-year-old and 6-year-old siblings to watch the infant. When the 9-year-old brother returned, he found the infant under the water. The mother removed the infant from the bath and called 911, and paramedics transported the infant to the hospital by ambulance.

DCFS took protective custody of the infant's three siblings. A child protection investigation of the child's death remains pending.

Reason for Review: In May 2022, DCFS received a report that the mother punched the infant's then 5-year-old brother in the head because he did not want to ride the school bus. The brother denied anyone hit him at the bus stop. School staff denied he had disclosed an incident and denied any prior concerns with the family. The maternal relatives he lived with also denied any physical abuse. In August 2022, while the investigation remained pending, DCFS received a report that the mother's home had cockroach and rat infestations; the mother was a sex worker; and the mother left the children, who were then 4 weeks, 3 years, 5 years, and 9 years old, unsupervised at home while she worked. The reporter also noted concerns about domestic violence, drug sales, a firearm, and lack of food, and hot water in the home. During a home visit, the CPI noted the home lacked hot water but had working electricity. The mother denied the allegations and stated the rats and roaches "came with the apartment." The landlord reported the infestations were due to the home being dirty, but he was unaware of the lack of hot water and stated he would have that fixed. The mother agreed to intact family services. Later that month, DCFS unfounded the May 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). In October 2022, DCFS opened an intact family services case. The CPI on the second investigation noted there was a gun in the home that was locked, and the home had food, hot water, and gas. That month, DCFS unfounded the August 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), inadequate supervision (#74), and environmental neglect (#82). The intact worker visited the home regularly. The mother agreed to participate in parenting classes and individual therapy but did not engage in services. In January 2023, while the intact case remained open, DCFS received a report that the mother had a history of not picking up the children from school on time, so the school had to deny the 9-year-old brother from participation in afterschool programs, and the mother had physically threatened school personnel. The mother denied the allegations. She stated the school did not inform her the brother was removed from his afterschool program, and school personnel had called her names. The infant's father also reported the school had not informed them the brother was removed from the afterschool program. Before the investigation closed, the school informed the CPI there had been no additional concerns since the initial incident. DCFS unfounded the investigation for inadequate supervision (#74). The intact case remained open at the time of the infant's death, and the intact worker noted the mother had not engaged in parenting classes and counseling services.

Child No. 97	DOB: 09/2004	DOD: 05/2023	Accident
Age at death:	18 years		
Cause of death:	Combined drug (cocaine, fentanyl, and despropionyl fentanyl [4-anpp]) toxicity		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old's body was found on the sidewalk in the late afternoon. The medical examiner ruled she died of combined drug toxicity. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: In 2020, the then 15-year-old youth came into DCFS care on a dependency petition. At the time she came into care, the youth was on run and her whereabouts were unknown. She was frequently on run in the following years and her placement worker documented continued efforts to locate her. In the year before her death, the youth's permanency goal was independence. She was placed in a fictive kin foster home and engaged in some, but not all, of the services her placement worker recommended. In June 2022, she moved to the home of her grandmother with the plan to stay in that placement until she could move into a transitional living program. In October 2022, the youth again went on run. A few weeks later, the youth called her placement worker from a school phone and reported she was safe and staying with a friend, but she would not provide any further information. Her placement

worker made continuous efforts to locate the youth, but her whereabouts remained unknown until her death in May 2023.

Child No. 98	DOB: 07/2003	DOD: 06/2023	Accident
Age at death:	19 years		
Cause of death:	Multiple blunt force injuries due to motor vehicle vs motor vehicle collision (driver)		
Reason for review:	Deceased was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old was the driver of a car that crossed the centerline and collided with another car head-on. The youth was pronounced dead at the scene. The driver of the other car was taken to the hospital by ambulance and later died of his injuries. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: In 2018, when the youth was 15 years old, he came into DCFS care through a no-fault dependency in juvenile court. His family had been cooperative with intact family services and child protection investigations, but the youth needed residential treatment. In the year prior to his death, his permanency goal was independence. The youth resided in a transitional living program, began working, and attended therapy to work on his social skills. In the fall of 2022, he lost his job, and his placement worker noted a setback in his behaviors. In December 2022, he was hired into a new position. In January 2023, he moved into an apartment after he was accepted into the independent living program. In the spring of 2023, he obtained his driver's license and purchased a car. At the time of his death, the youth's placement worker noted he had been doing well and living independently.

Child No. 99	DOB: 07/2007	DOD: 06/2023	Accident
Age at death:	15 years		
Cause of death:	Carbon monoxide toxicity due to inhalation of motor vehicle exhaust		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old and a 32-year-old man were pronounced deceased of carbon monoxide poisoning in a car. The man was identified immediately, but the teen's body was not identified for almost two months following her death. The teen had been on run, but her mother did not report her missing initially. The mother reported to police that the teen had a history of being around older men and she was often found at train stations and abandoned homes. Approximately one month after the mother reported her missing, the mother was contacted to identify the teen's body. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In December 2022, DCFS received a report that the teen's mother used heroin in front of her children, the family had been staying with relatives for several months, the children slept on the floor, and the children were always hungry because the mother sold their Link benefits for money to purchase drugs. The CPI interviewed the mother, the teen, and the 13-year-old and 16-year-old sisters. The children denied they saw their mother use drugs and reported they always had food. The mother denied she used heroin and agreed to complete a drug test. The CPI noted the mother did not appear under the influence of any substances during the interview. The mother reported there was a fire in their home, so the family was staying with relatives while looking for new housing, and she had a Section 8 housing voucher. The CPI documented the home had plenty of food, working utilities, was fully furnished, and was free of hazards. The CPI later spoke with the teen's 18-year-old brother, who reported he was staying with a different relative but had no concerns about his mother or sisters. The teen's aunt, who they were staying with, denied anyone in the home used drugs and stated they could stay in her home as long as

necessary. In March 2023, DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) and inadequate food (#76).

Child No. 100	DOB: 01/2018	DOD: 06/2023	Accident
Age at death:	5 years		
Cause of death:	Drowning		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old and her family were standing near a pool at a waterpark when the mother realized she had not seen the child in about two minutes. Lifeguards cleared the pool and found the child in a four-foot-deep adjoining pool. They began CPR and the child was transported by ambulance to the hospital, where she was pronounced deceased. The child did not know how to swim, and she was not wearing any flotation devices at the time. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In September 2022, DCFS received a report that the child's then 11-year-old sister disclosed her mother dragged her by her hair and called her names because she did not take the dog out, and she was responsible for watching her younger siblings while her mother went out to party. The reporter denied the sister had any visible marks or bruises. That day, the CPI went to the school and interviewed the child's then 6-year-old, 8-year-old, and 11-year-old siblings at school. The 11-year-old reported her mother was frustrated with her for getting out of bed late and told her to take the dogs out, then grabbed her arm and hit her on the shoulder, but not hard. The 8-year-old sibling stated she heard her mother hit someone but did not witness it, then heard her mother apologize and say it would not happen again. She denied their mother dragged the 11-year-old by the hair. The 6-year-old reported he felt safe at home. The 6-year-old's teacher stated the 11-year-old took on a parenting role and the teacher had difficulty communicating with the mother. The mother told the CPI that she did not pull the 11-year-old's hair, denied calling her names, and denied corporal or excessive punishment. She stated the family recently moved and the 11-year-old had a difficult time adjusting because they previously resided with the children's grandmother. The mother declined intact family services. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#11).

NATURAL

Child No. 101	DOB: 05/2008	DOD: 07/2022	Natural
Age at death:	14 years		
Cause of death:	Anoxic brain injury due to cardiorespiratory arrest; significant contributing condition of congenital hypoventilation syndrome		
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 medically complex teen was found unresponsive by her mother. The mother performed CPR until paramedics arrived and transported the teen to the hospital, where she was removed from life support and pronounced deceased. The teen had diagnoses of cerebral palsy, respiratory abnormalities, and epilepsy. She was non-verbal, received in-home nursing care, and required a tracheotomy and ventilator. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In June 2021, DCFS received a report that the family lacked stable housing and lived in a hotel, the teen's mother had sex in front of the children with gang affiliated men who used drugs, and the teen's then 16-year-old sister was pregnant but would not disclose the father's name. The mother, 8-year-old sister, and 16-year-old sister denied the allegations. The mother reported they moved into a hotel because the teen's father, who had recently been released from prison, repeatedly came to their home, and she suspected he made the report. The CPI noted the father had a history of substance use, and the family's prior DCFS involvement was tied to the father. The teen's medical caseworker reported the then 13-year-old teen attended her medical appointments. During the investigation, the family moved into a townhome. The 16-year-old sister also gave birth, and the CPI confirmed the sister had a bassinet for her newborn. DCFS unfounded the investigation for sexual penetration (#19), sexual exploitation (#20), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and medical neglect (#79). In September 2021, DCFS received a report that the teen's 9-year-old sister reported men came to the family's home to use drugs and the mother used methamphetamine. The reporter added they recently heard the mother slurring her words during a conversation and saw the teen lying in feces and urine for at least three hours. The CPI met with the teen's 4-year-old and 9-year-old siblings at school and noted both appeared well. The 9-year-old denied the allegations. The CPI observed the teen appeared clean and free of visible marks or injuries and the home was clean. The mother denied substance use and completed a toxicology screening which was negative for all substances. The mother again stated she suspected the father made the report because she did not allow him to see the children due to his continued drug use, and she showed the CPI a text conversation during which the father threatened to retaliate against her. Police denied any contact with the mother related to drug use. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82).

Child No. 102	DOB: 04/2009	DOD: 07/2022	Natural
Age at death:	13 years		
Cause of death:	Complications of clear cell carcinoma of the neck		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old died at the hospital from complications of cancer. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the teen's mother was drinking and said she watched the then 12-year-old teen shower, slept in the same bed as the teen, and used the bathroom in front of him. The reporter added the mother drank often so the teen frequently stayed with his

grandfather. The CPI met with the teen at his maternal grandparents' home, and he reported he stayed with them during cancer treatments. The teen resided with his grandparents through the duration of the investigation. The teen's mother denied the allegations and the teen participated in a forensic interview where he made no disclosures that anyone hurt him or touched him inappropriately. DCFS unfounded the investigation for sexual exploitation (#20).

Child No. 103	DOB: 05/2017	DOD: 07/2022	Natural
Age at death:	5 years		
Cause of death:	Sudden cardiac arrest due to hypsarrhythmia; significant contributing conditions of microcephaly, epilepsy, and OSA		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old medically complex child went into cardiac arrest at home. Her mother began CPR and called 911. An ambulance transported her to the hospital, and she was pronounced deceased. The child had diagnoses including dysphagia, ventricular septal defect, right frontal periventricular white matter, seizure disorder with persistent tremors, obstructive sleep apnea, blindness, and cataracts. She was non-mobile and non-verbal, and had a g-tube, feeding bag, BiPAP machine, and cochlear implant. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In May 2022, DCFS received reports that the mother gave the child expired medication, neglected to provide her prescribed laxative, failed to change her feeding bag as required, failed to regularly clean her medical equipment, and the child had bed sores and rashes. In addition, the reporter stated the mother only fed the child's then 15-month-old brother once daily and left him alone in a crib most of the day. The reporters also noted concerns about domestic violence, police involvement, and the parents' ability to care for the children. The CPI met with the mother, who denied the allegations. The CPI observed the child's medications and noted none were expired, and noted the home was appropriate and had ample food. The mother reported there had been domestic violence incidents with her and the father, resulting in the father's arrest, but there were no recent issues, the father did not reside in the home, and he was not active in the children's lives. She declined intact family services. The father reported no concerns with the mother's care and the child's primary care physician and specialists reported no concerns. The CPI completed a nursing referral. The CPI also obtained police records of two domestic violence incidents in March 2022 and April 2022, but no charges were filed for either incident. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), inadequate supervision (#74), inadequate food (#76), and medical neglect (#79).

Child No. 104	DOB: 07/2022	DOD: 07/2022	Natural
Age at death:	13 hours		
Cause of death:	Multiple congenital anomalies and complications of premature birth; significant contributing condition of in utero exposure to methamphetamine and phenobarbital		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn began to experience respiratory problems shortly after her birth. She was air-lifted to a different hospital and treated in the NICU, where she was pronounced deceased. She had been born premature, at 28 weeks gestation, and the mother had not received prenatal care. Upon admission to the hospital, the mother tested positive for methamphetamines and the baby tested positive for methamphetamines and phenobarbital. The mother initially reported she did not know she was pregnant, but police reported body cam footage from one month earlier that recorded her telling a police officer they could not place her in handcuffs because she was pregnant. She reported she used methamphetamine one

week before the birth because she was in pain. DCFS indicated the newborn's mother for death by neglect (#51) and substance misuse by neglect (#65), but unfounded her for substance misuse by abuse (#15).

Reason for Review: In June 2021, DCFS received a report that the newborn's mother gave birth to the newborn's sister, the mother received very little prenatal care, the mother tested positive for amphetamines and communicable diseases at a previous prenatal visit, and the maternal great grandmother had guardianship of the then 2-year-old sibling. The CPI met with the mother at the hospital, who reported she had a mental health diagnosis and had been unable to take medication during the pregnancy. The mother agreed to a short-term guardianship and the newborn's sister was placed with her maternal great aunt. The mother's medical providers reported that approximately one month earlier, at her last prenatal visit, she tested positive for marijuana and amphetamines, and she had not picked up prescribed medication. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The newborn's siblings remained in the care of relatives.

Child No. 105	DOB: 07/2022	DOD: 07/2022	Natural
Age at death:	8 days		
Cause of death:	Acute hypoxic encephalopathy due to persistent pulmonary hypertension due to patient ductus arteriosus due to maternal abruptio placenta due to maternal methamphetamine abuse		
Reason for review:	Open placement case and pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-day-old died at the hospital where he had been born and received treatment in the NICU. He had been born with multiple medical issues, his mother had a history of drug use, and his cord blood tested positive for methamphetamine. DCFS indicated the newborn's mother for substance misuse by neglect (#65) but unfounded her for death by abuse (#1) and death by neglect (#51), and unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: The newborn had four paternal siblings who came into DCFS care in 2019. The father and the siblings' mother surrendered custody of the newborn's three paternal brothers. In April 2021, the newborn's paternal sister was returned to her mother's care. In November 2021, DCFS closed the paternal sister's placement case. The newborn's father and the siblings' mother have had no further documented contact with the brothers, who remain in a fictive kin foster home, and the brothers' placement cases remain open. In 2019, DCFS indicated the newborn's mother for death by neglect (#51) to the newborn's 6-month-old maternal sister and indicated the sister's father for death by abuse (#1). In July 2022, DCFS received a report that the newborn's mother gave birth to him, she had a past indicated finding for a child's death, and she tested positive for methamphetamine and marijuana. DCFS planned to take protective custody when the newborn was discharged. The investigation remained pending at the time of his death.

Child No. 106	DOB: 08/2022	DOD: 08/2022	Natural
Age at death:	1 hour		
Cause of death:	Pulmonary hypoplasia due to absent abdominal wall; significant contributing condition of intrauterine growth restriction		
Reason for review:	Two unfounded child protection investigations within one year of child's death, pending child welfare services referral at time of child's death;		
Action taken:	Investigatory review of records		

Narrative: Newborn was pronounced deceased at the hospital shortly after her birth. The pregnancy had been high risk due to an abdominal wall defect and spinal defect. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: In September 2021, DCFS received reports that the newborn's maternal grandmother allowed sex work, trafficking, substance use, and domestic violence in the home, in view of the newborn's then 14-year-old mother, and the mother's then 5-year-old and 9-year-old siblings. The reporter also shared that the mother and her 9-year-old sister used marijuana, the 14-year-old mother was dating a 30-year-old man, the adult brother's paramour was being trafficked out of the home, and the home was dirty. The CPI interviewed the grandmother who denied the allegations. She stated the newborn's mother was on probation and her behavior had improved. The newborn's mother denied she was involved with an older man and denied anyone used physical violence or drugs in the home. The mother's siblings denied the allegations. The CPI also met with the paramour of the mother's adult brother, who denied she was trafficked. Five days later, DCFS received a related information report about drug manufacturing in the home. Law enforcement accompanied the CPI to the home and police observed no indications of drugs in the home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60), sexual penetration (#19), sexual exploitation (#20), and substance misuse by neglect (#65). In January 2022, DCFS received a report that the adult brother was violent with his paramour and their 2-year-old son, and he trafficked the paramour. The CPI met with the family and brother's paramour. The paramour denied the allegations. The minors in the home presented without injuries and denied they observed physical altercations. The paramour declined intact family services. DCFS unfounded the newborn's maternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Nine days before the newborn's birth, DCFS initiated a child welfare services referral after medical providers reported that the 15-year-old mother used marijuana during her pregnancy. The assigned child welfare specialist made three unsuccessful attempts to locate the family. DCFS closed the intake after the newborn's death.

Child No. 107	DOB: 10/2018	DOD: 08/2022	Natural
Age at death:	3 years		
Cause of death:	Complications of extreme prematurity		
Reason for review:	One indicated and two unfounded and one indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old medically complex toddler went into distress. His in-home nurse performed CPR and 911 was contacted, but the toddler was pronounced deceased at the scene. The toddler had been born at 23 weeks gestation and was diagnosed with spinal stenosis and chronic respiratory issues. He required a g-tube and tracheotomy. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In December 2021, DCFS received a report that the toddler's nurses, who came to the home every two weeks, were concerned that the mother would not allow the nursing agency into the home to complete a wellness check on the toddler, and the family was at risk of losing their DSCC waiver. The CPI visited the home, and a nurse stated the mother had since allowed the nurse in, the toddler was observed, and there were no concerns. The CPI observed the toddler to be free of injuries or signs of neglect. The parents denied they refused entry to the nurse, and stated the nursing agency was understaffed, unable to come during the hours the family had requested, and inconsistent with providing services. The family reported they secured a new agency and were pleased with their services. The DSCC worker reported no concerns and denied the family was at risk of losing their waiver. The pediatrician reported the toddler had been seen a few months earlier for a wellness visit and there were no concerns. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In February 2022, DCFS received a report that the mother had previously been trained on how to connect the toddler's g-tube properly, but in the prior week, she had twice contacted the nursing facility for help. Nursing facility staff instructed the mother to seek emergency care, but the mother declined to do so. The reporter added that the toddler missed two appointments with specialists that month. The CPI interviewed the mother at home, who reported she felt overwhelmed while the father was in the

hospital for cancer treatment, but both she and the father stated she could care for the toddler alone. The CPI observed the toddler to be free of signs of abuse or neglect. The CPI completed a nursing referral and requested the toddler's medical records. In March 2022, DCFS received a related information report that the mother was overwhelmed, so doctors offered to hospitalize the toddler to provide respite, but the mother refused and stated she had a friend care for the toddler, though the reporter thought the friend was not trained on the toddler's care. The CPI visited the home, observed the toddler, and noted no concerns. The pediatrician expressed concern that the toddler had missed several appointments and told the CPI they were trying to help the mother enroll the toddler in part-time school to provide respite. In April 2022, DCFS opened a new investigation after receiving a report that the mother was hospitalized after she was assaulted by a friend in her home. The reporter stated the mother and her friend had been drinking alcohol, and the toddler was home at the time of the assault but was not harmed. The CPI met with the mother at home that day, as she had already been discharged. The CPI noted the toddler appeared happy and healthy, but the home was in disarray. The mother stated she declined the sexual advances of the friend, she asked him to leave, and he became angry. She added the toddler was sleeping in a different room and did not hear the altercation. She stated she sought medical treatment in the morning and planned to file a police report. The CPI screened the case with the state's attorney, but the case was declined. The court instructed the CPI to return to court if the mother failed to protect the toddler. In May 2022, the toddler's primary care physician informed the CPI the mother failed to follow up with their efforts to enroll the toddler in school, continued to miss appointments, and did not address the toddler's medical needs. DSCC noted concerns about the mother's behavior. In June 2022, the CPI offered intact family services, but the family declined. DCFS indicated the February 2022 report for medical neglect (#79). DCFS unfounded the April 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 108	DOB: 02/2022	DOD: 09/2022	Natural
Age at death:	7 months		
Cause of death:	Aspiration of vomitus due to abnormalities of birth defects		
Reason for review:	One indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old aspirated on formula and went into sudden cardiac arrest. The mother called 911 and began CPR. Paramedics transported the infant to the hospital and medical professionals attempted to revive him for more than two hours. He had last been seen for a well child visit less than two weeks earlier. The infant had a cleft palate and lip, birth defects that can cause complications with feeding. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In November 2021, DCFS received a report about inappropriate touching between the infant's then 4-year-old brother, 5-year-old paternal half-sister, and 9-year-old maternal half-brother, in the home of the infant's father. The 5-year-old's mother stated she asked the father about the incident and took the sister for a medical exam. The father stated he found the children unclothed, so he and the infant's mother spoke with the children about appropriate behavior. The CPI met with the 5-year-old sister and her mother, but the sister did not want to speak to the CPI. The CPI then met with the infant's mother and father, who reported the incident happened a few months earlier and they spoke with the children. The father stated both the 9-year-old and 7-year-old siblings went to get the father when the incident happened. Both children confirmed the father's report. The children's schools and pediatricians reported no concerns. The local children's advocacy center provided resources to the mother of the 5-year-old. DCFS unfounded the investigation for inadequate supervision (#74). In April 2022, DCFS received a report that the father of the infant's 4-year-old and 7-year-old maternal half-siblings was in possession of child sex abuse images. The CPI met with the infant and his mother, 4-year-old, 7-year-old, and 1-year-old maternal half-siblings at home. The CPI also met with the paramour of the

maternal half-siblings' father, and the paramour's daughter. The mothers agreed the father would not have access to the children during the investigation. The verbal children participated in individual forensic interviews, and all denied incidents of inappropriate touch. The CPI met with the father, who admitted he viewed child sex abuse images. He reported he had been charged with 10 felonies and could only see his children while supervised. DCFS indicated the father of the maternal half-siblings for substantial risk of sexual abuse (#22).

Child No. 109	DOB: 02/2019	DOD: 10/2022	Natural
Age at death:	3 years		
Cause of death:	Viral myocarditis; significant contributing conditions of sickle cell disease and viral nephritis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was brought to the hospital by her mother because she was vomiting and had a fever. Her mother reported her symptoms began the day before. Medical staff provided fluids and a pain reliever/fever reducer and discharged the toddler to her mother's care. Less than two hours later, the toddler's mother brought her to back to the hospital because she was lethargic, unresponsive, and had labored breathing. Medical staff attempted lifesaving measures, but she was pronounced deceased a few hours later. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In October 2021, DCFS received a report that the family's home was dirty and had an ongoing roach infestation; the mother did not bathe the then 2-year-old toddler, wash her clothes, or comb her hair; the mother was emotionally and verbally abusive to the toddler; the mother and her paramour fought in the toddler's presence; and the mother allowed her dog to starve to death. The CPI visited the home and did not observe any roaches or pets, and noted the home did not appear unkempt. The mother reported her dog died after it ate poisoned food outside the home. The toddler presented without any bruises or injuries. One week later, the CPI visited the home again and did not observe any roaches, unclean areas, or observable hazards. The toddler's pediatrician noted she had missed her 18-month wellness visit but she had been seen at 15 months, and there were no documented concerns. DCFS unfounded the investigation for environmental neglect (#82).

Child No. 110	DOB: 07/2019	DOD: 10/2022	Natural
Age at death:	3 years		
Cause of death:	Bronchopneumonia of the lungs due to complications of prematurity and recent COVID 19 and RSV infections		
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: Three-year-old medically complex toddler was found unresponsive at 4:00am by his mother and was brought to the hospital, where he was pronounced deceased. He had a history of cardiopulmonary arrest, pulmonary hypertension, seizures, bronchopulmonary dysplasia, and respiratory failure. He required a tracheotomy and g-tube. The toddler's mother reported she checked on the toddler and left the home around 3:00am to pick someone up and another adult was in the home. Law enforcement obtained video surveillance that showed the mother left the home at 9:00pm the evening before, and phone records that showed the other adult was not in the home. The medical supply company for the toddler's concentrator machine confirmed the machine was working correctly and would have sounded alarms. The mother stated she did not ensure the machine was plugged in before she left the home. DCFS indicated the mother for death by neglect (#51), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and inadequate supervision (#74).

Reason for Review: In June 2022, DCFS received a report that EMS and police responded to the family home because the toddler's tracheotomy dislodged, but the mother was not home and had left the toddler in the care of his 9-year-old maternal aunt. The mother told the reporter she was home the entire time, but the 9-year-old stated the mother went to pick up the toddler's 17-month-old sister from a location 25 minutes away. The reporter stated the toddler had special medical needs, the mother was trained in his care, she successfully fixed the toddler's tracheotomy, and the toddler's breathing returned to normal. The reporter added the mother was hostile to the first responders. The toddler's maternal grandfather told the CPI he was not present for the incident, but he had been told the mother was a few doors away while the toddler's 9-year-old aunts watched him. Both of the toddler's 9-year-old aunts told the CPI no adults were in the home at the time of the incident and the mother had gone to another town to retrieve the toddler's younger sister. One of the aunts stated she watched the toddler alone for a few hours the week before, but the mother was only a few doors away and she could walk to get her if she needed anything. She stated she sought help from the neighbors to call the toddler's maternal grandfather and the neighbors called 911. The mother confirmed she left the home to pick up the toddler's younger sister, but she denied she would ever leave the toddler without adult supervision. She stated the toddler's 18-year-old maternal uncle was home at the time of the incident and she did not know why the aunts did not wake him up. The mother initially declined intact family services but later accepted services. The neighbor stated the mother's car was gone for at least 30 minutes and no adults were in the home at the time of the incident. In July 2022, DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), inadequate supervision (#74), and medical neglect (#79). DCFS opened a high-risk intact family services case and the intact worker recommended parenting classes, mental health assessments, and substance use assessments. The mother cooperated with the assessments and no further services were recommended. At the time of the toddler's death, the intact case remained open, and the mother was engaged in parenting classes.

Child No. 111	DOB: 01/2009	DOD: 10/2022	Natural
Age at death:	13 years		
Cause of death:	Restictive [sic] lung disease chronic respiratory failure due to dilated cardiomyopathy nodal reentrant tachycardia due to pansclerotic morphea; significant contributing condition of chronic open wounds due to skin disease malnutrition		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old medically complex child died of complications of pansclerotic morphea, a rare terminal condition that causes significant skin problems. The teen received treatment from specialists but had ongoing issues with pain and sores that required bandaging at home. She also required a wheelchair and needed assistance for daily tasks. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In May 2022, DCFS received a report that the teen and her 9-year-old brother were left home alone, and their mother hit the teen when she returned home because the teen had wet her pants. The reporter believed the 9-year-old brother was left in a caregiver role because of the teen's medical issues and limited mobility. The CPI spoke with both children at school, and they reported an older sibling would be home with them if their parents had to run errands. The teen reported she could use the bathroom with assistance. They both reported their mother had yelled at the teen for wetting her pants when they were home with their father, but they denied physical discipline. The teen's 16-year-old sister confirmed she stayed home with the younger children when needed. DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 112	DOB: 10/2022	DOD: 10/2022	Natural
Age at death:	2 weeks		
Cause of death:	Neonatal septicemia due to extreme prematurity		
Reason for review:	Open placement case and pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old died at the hospital. He had been born premature, at 28 weeks gestation, had respiratory distress syndrome, was in critical condition, and remained in the NICU. The day of his death, the newborn had a blood transfusion but went into crisis. He did not respond to medical intervention. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: The newborn had two maternal siblings in DCFS care. In 2018, one sibling came into care at the age of 7 months, during an investigation in which DCFS indicated his parents for medical neglect (#79), and he was placed in a specialized foster home. In 2021, the newborn's second sibling came into DCFS care following her birth, and she was placed in a traditional foster home. In June 2022, the court terminated the mother's parental rights to the newborn's 4-year-old brother. The brother's father consented to voluntary termination of his parental rights. The brother's permanency goal was changed to adoption. In the year prior to the newborn's death, the permanency goal of the newborn's 19-month-old sister remained return home, but the mother was not cooperative with services. The sister's father was not involved in her placement case. In October 2022, DCFS received a report of the newborn's birth and opened an investigation. The reporter stated the newborn was born premature and would remain in the NICU for several weeks. The CPI observed the newborn at the hospital, and medical staff stated the main concern was the newborn's prematurity, but there were no other medical issues. The CPI interviewed the mother, who stated she learned she was pregnant at five months gestation, and she immediately stopped smoking marijuana. She denied any other drug or alcohol use. The CPI planned to take protective custody when the newborn was discharged. The investigation remained pending at the time of the newborn's death. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 113	DOB: 03/2020	DOD: 10/2022	Natural
Age at death:	2 years		
Cause of death:	Metastatic atypical teratoid rhabdoid tumor		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old had a seizure in the home of his foster parents, who administered CPR. The toddler was transported to the hospital, where he died 12 days later. A year prior, he had been diagnosed with a tumor, underwent treatment, and was declared cancer-free. However, the cancer returned, and medical staff reported his prognosis was poor. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In September 2021, DCFS received a report that the then 17-month-old toddler had been hospitalized for three months with a brain tumor and cancer, but his parents were not participating in his care and rarely visited him in the hospital. The CPI met with the mother at the hospital, who stated she participated in the required classes and was willing to learn about the child's care. Hospital staff stated they informed the parents they needed to provide a 48-hour care rotation, the parents questioned why they needed to be present, and they noted concerns that the mother had trouble grasping the care the toddler needed. Four days later, DCFS took protective custody of the toddler and his four siblings, ages 4 years to 11 years. DCFS temporarily placed the children with their grandmother, then moved them into a traditional foster home. DCFS indicated the toddler's parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS also indicated the parents for substantial risk of

sexual abuse (#22) because the father was an indicated sex offender in a previous investigation regarding the toddler's 6-year-old maternal half-brother, and the family previously had an intact case that closed with the understanding the father could not live in the home, but the children reported he did live in the home. In December 2021, the hospital discharged the toddler and DCFS placed him in a licensed specialized foster home. In March 2022, the toddler was declared cancer-free. In April 2022, the mother completed parenting classes and was scheduled for a psychological evaluation. In July 2022, the toddler's cancer returned. In August 2022, the court granted DCFS discretion to return the children to their mother's care. In September 2022, DCFS placed the siblings with their maternal grandmother during the transition toward return home. The placement case remained open at the time of the toddler's death.

Child No. 114	DOB: 10/2022	DOD: 11/2022	Natural
Age at death:	4 days		
Cause of death:	Sepsis shock due to necrotizing enterocolitis due to extreme prematurity; significant contributing condition of pericardial effusion		
Reason for review:	Open intact family services case at time 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		

Narrative: Four-day-old was born at 22 weeks gestation by emergency c-section after her mother had an abruption. She remained in the NICU until she died. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: In January 2022, DCFS received a report that police responded to the family home due to an altercation in which the newborn's father struck her mother in the face in the presence of the newborn's siblings. The father fled the home before police arrived. The reporter observed redness and swelling underneath the mother's eye. The next day, the CPI interviewed the newborn's 6-year-old sister at school, who stated she was afraid of her younger siblings' father and confirmed the incident. The sister reported this was the second incident between them, but her mother also had prior incidents with different people. The mother informed the CPI she took the children to stay with a family member following the incident. The CPI observed the 2-month-old and 2-year-old siblings, who were free of observable signs of abuse or neglect. The mother stated the father hit her in the head while she was holding the 2-year-old, she called police, and the father left. The CPI observed injuries on the mother's face. The mother stated there had been prior incidents of the father breaking things, but this was the first incident where he struck her. DCFS indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The mother agreed to intact family services and the case opened in February 2022. The mother reported she and the father were again living together and the father also agreed to services, including parenting classes, domestic violence assessment and services, and counseling. From April 2022 to June 2022, the parents received in-home parenting classes. In May 2022, while the intact case remained open, DCFS received a report that the father hit the mother, resulting in an injury to the mother's eye. The CPI met with the mother at home, the mother denied any domestic violence in the last five months, and she denied the father lived in the home. The father later corroborated the mother's report. The CPI did not observe any injuries to the mother or observe any signs of an altercation in the home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In July 2022, the mother informed the intact worker she was pregnant with the newborn. In August 2022, their intact case was assigned to a new intact worker who had difficulty contacting the family. Approximately three weeks before the newborn's birth, the family met with the intact worker and reported they had been out of town because the mother required hospital treatment for pregnancy complications. The family also reported there had been no further domestic disputes. The mother was put on bedrest and the family reported they could not participate in services at that time but wanted help with housing resources. The intact supervisor recommended keeping the case open and

referred them for wraparound services, housing services, and 0-3 services. In October 2022, while the intact case remained open, the newborn was born and subsequently died.

Child No. 115	DOB: 07/2007	DOD: 11/2022	Natural
Age at death:	15 years		
Cause of death:	Pneumonia non traumatic due to tracheotomy dependence due to microcephaly capillary malformation syndrome		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		
Narrative:	Fifteen-year-old medically complex teen was brought to the hospital with respiratory issues and was admitted to the PICU. She was diagnosed with pneumonia and a blood infection. Five days after hospital admission, the teen was pronounced deceased. The teen had a DNR order in place. DCFS did not investigate the teen's death for abuse or neglect.		
Reason for Review:	The teen came into DCFS care at the age of 2 years after DCFS indicated her parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and medical neglect (#79). At the time of her death, her permanency goal was substitute care, home environment not appropriate. In the year prior to her death, the teen was placed in a residential medical facility. She had frequent hospitalizations for respiratory distress, rhinovirus, and pneumonia. In 2022, she was hospitalized nine times. Her placement team held regular child and family team meetings, and her placement worker documented regular visits.		

Child No. 116	DOB: 11/2022	DOD: 11/2022	Natural
Age at death:	8 days		
Cause of death:	Necrotizing enterocolitis		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		
Narrative:	Eight-day-old died in the NICU. He had been born three months premature and never left the hospital. The treating physicians did not suspect abuse or neglect, noted the newborn died of complications of premature birth, and an autopsy was not conducted. DCFS did not investigate the newborn's death for abuse or neglect.		
Reason for Review:	In November 2022, DCFS received a report that the newborn's mother gave birth, lacked stable housing, had a history with DCFS due to battery charges against the newborn's older siblings, and her parental rights had been terminated. The CPI spoke with the mother's case manager through a housing program who stated it would not be appropriate for the newborn to go home with the mother. The case manager reported the mother planned to have housing before the newborn's birth, but she did not have housing arranged because he arrived three months early. DCFS later received a related information report that the mother used marijuana and methamphetamine during her pregnancy, and she was on probation for criminal child abuse. Medical staff reported they did not complete drug testing at the newborn's birth because the mother did not report recent drug use. DCFS later unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).		

Child No. 117	DOB: 10/2022	DOD: 11/2022	Natural
Age at death:	5 weeks		
Cause of death:	Pneumonia of the lungs; significant contributing condition of pyloric stenosis		
Reason for review:	Child was a youth in care; three indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old died at the hospital. He had been vomiting and losing weight and saw his primary care physician five days before his death. The doctor observed the infant's tongue was tied and clipped his tongue and scheduled an ultrasound. The infant was scheduled to have surgery for pyloric stenosis. Medical providers started the infant on intravenous fluids; he did not have the surgery before his death. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In November 2021, DCFS received a report that the infant's mother tested positive for amphetamine and marijuana after giving birth to the infant's sister. The mother told the CPI she used marijuana during the pregnancy and that she used a non-prescribed Adderall a few days before the birth. The sister's cord blood was positive for marijuana. The mother reported she had supplies for the sister and she lived with the infant's maternal grandmother. The grandmother confirmed the mother and the infant's then 2-year-old sister moved into her home four months earlier, and there had been no issues. She denied knowledge of the mother using substances during her pregnancy. The mother declined intact family services. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In March 2022, DCFS received a report that the infant's mother called 911 and reported the father of the infant's then 3-month-old sister assaulted her. Police arrested the father. The mother reportedly told police she did not want the father arrested and just wanted him out of the home for the night. She added she wanted to sign guardianship of her children over to their maternal grandmother and she did not plan to carry her current pregnancy to term. The CPI attempted to see the family at home and the landlord reported the family was moving out of state. The CPI then spoke with the mother, who denied the father physically assaulted her and the children were with a neighbor during the argument. She disclosed prior domestic violence but stated the children were never present for the incidents. The CPI spoke with the neighbor, who confirmed a verbal argument, but denied witnessing anything physical between the parents. The CPI spoke with the father while he was in jail; he reported the children were at the neighbor's home during the argument. The mother declined intact family services. DCFS indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In June 2022, DCFS received a report that a grand jury indicted the infant's parents for selling methamphetamine and heroin, and a child was present during a drug deal. The parents were both arrested. The CPI attempted to locate the children. The mother reported the children were with their maternal grandparents. The mother stated she was seven months pregnant. The CPI located the children, took protective custody, and obtained placement clearance for the children to remain in the care of their maternal grandparents. DCFS indicated the June 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The mother was released from jail and the placement worker noted she cooperated with services, completed toxicology screenings, and was allowed 12 hours of visitation with her children per week. The father remained incarcerated for a previous domestic violence incident. In October 2022, DCFS received a report that the mother gave birth to the infant and had two children who were in DCFS care. The CPI met with the mother at the hospital, took protective custody of the infant, and placed him with his siblings. The placement agency approved the mother for visits. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 118	DOB: 08/2022	DOD: 11/2022	Natural
Age at death:	3 months		
Cause of death:	Cardiorespiratory failure due to prematurity		
Reason for review:	Child was a youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old died at the hospital. He was born premature, at approximately 28 weeks gestation, the mother tested positive for drugs and the baby remained in the NICU since birth. Hospital staff reported he gained weight but had a g-tube inserted because he had trouble taking a bottle. Shortly before his death, the infant went into cardiorespiratory failure and medical staff attempted to revive him, but he did not respond to life-saving measures. DCFS investigated the infant's death and indicated his mother for death by neglect (#51) and substance misuse by neglect (#65).

Reason for Review: In February 2022, DCFS received a report that the infant's mother was hospitalized for methamphetamine use and mental health concerns, and the reporter was concerned about her ability to care for the infant's 2-year-old sister. The CPI determined the court had terminated the mother's parental rights and the sister's foster parents, whose care she had been in since she was 6 months old, planned to adopt her. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). In August 2022, DCFS received reports that the infant was born prematurely; the mother tested positive for methamphetamine, cocaine, and marijuana; and the mother left the infant at the hospital without leaving contact information The mother told the CPI she was still actively using drugs. DCFS took protective custody of the infant, and the infant remained hospitalized in the NICU. DCFS indicated the infant's mother for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60) and abandonment/desertion (#75).

Child No. 119	DOB: 11/2005	DOD: 12/2022	Natural
Age at death:	17 years		
Cause of death:	Cardiopulmonary arrest due to aspiration pneumonia no trauma; significant contributing conditions of Noonan syndrome and refractory Lennox-Gastaut		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old medically complex teen was found unresponsive, on his bedroom floor, by his mother. He was transported to the hospital by ambulance, where he was pronounced deceased. The teen had diagnoses including Noonan syndrome, intractable seizures, and hydrocephalus. He received in-home nursing care, feedings through a g-tube, and multiple daily medications. DCFS investigated the teen's death and unfounded his mother for death by neglect (#51).

Reason for Review: In November 2021, DCFS received a report that the teen's then 13-year-old adoptive sister died. She had sustained a traumatic brain injury when she was 7 months old that resulted in seizures and special health needs. The CPI met with the teen's mother in the hospital, who reported the sister sustained her injuries as an infant, and she adopted the teen and his sister in 2009. She reported the sister was non-verbal and non-mobile, required a g-tube, and received in-home nursing care 16 hours per day. She stated the nurse was with the sister when she began choking, so she began CPR, drove the sister to the hospital, and contacted the mother. The mother went to the hospital and her adult daughter cared for the teen at that time. The nurse had worked for the family for 12 years and the mother reported she took good care of the sister. The CPI noted the teen appeared safe and free of signs of abuse or neglect, but he was unable to provide information regarding his sister's death due to developmental delays. The mother was recovering from eye surgery at the time of the death. The children's primary care physician reported no concerns about the mother's care. The medical examiner ruled her death was caused by the head trauma she sustained as an infant, before she came into her adoptive mother's care. DCFS unfounded the mother for death by neglect (#51).

Child No. 120	DOB: 04/2017	DOD: 12/2022	Natural
Age at death:	5 years		
Cause of death:	Cardiopulmonary arrest due to status epilepticus due to possible aspiration; significant contributing conditions of cerebral palsy Lennox-Gastaut seizure disorder [sic]		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Five-year-old medically complex child was found unresponsive in the early morning by his foster mother. The child was transported by ambulance to the hospital, where he was pronounced deceased. The child was born with severe hypoxic ischemic encephalopathy, and was later diagnosed with spastic seizure disorder, bilateral hearing and vision loss, and horizontal nystagmus (uncontrolled eye movements). The child was non-verbal and required a wheelchair for mobility. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In 2018, the child came into DCFS care during an investigation in which DCFS indicated his mother for medical neglect (#79). He was placed with his paternal great aunt, who was a licensed, specialized foster parent. His birth parents signed specific consents for the child's foster parent to adopt him. In the year prior to the child's death, the foster mother kept current with the child's medical needs. The child's placement worker was in the process of completing an adoption subsidy. The subsidy required medical staff input because the child required medical equipment, and the home needed a lift to accommodate the child's wheelchair as he grew and other modifications. In July 2022, the child's medications changed, he started overnight feedings, and the hours he received nursing care increased. In August 2022, the child began to attend in-person kindergarten. His placement worker continued regular visits as his case moved toward adoption and contractors began to provide bids for the home modifications. The child's adoption court date was set for March 2023, but the child died before the adoption was finalized.

Child No. 121	DOB: 10/2010	DOD: 12/2022	Natural
Age at death:	12 years		
Cause of death:	Intestinal failure due to small bowel obstruction		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old died at the hospital with brain cancer. She had been in the hospital for six months, was receiving hospice care, and had a DNR order. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In the year prior to her death, the child was often in the hospital for treatment. In December 2021, DCFS received a report that the child's then 12-year-old sister, who was also receiving treatment for brain cancer, was sick at school because their mother did not refill her nausea medication and the school had a difficult time reaching her to pick up the sister. The reporter added that earlier in the year, they also had difficulty reaching the parents when the child's 8-year-old sister was experiencing a sickle cell crisis. The mother reported she missed the school's call because she slept while they were in school, and she called the school immediately upon waking. She reported the 12-year-old sister did not receive her nausea medication due to an insurance issue which she, the doctor and the pharmacy were working on. Doctors denied any concerns for abuse or neglect. The family declined intact family services, and the CPI submitted a nursing referral for the family. DCFS unfounded the investigation for medical neglect (#79). In March 2022, DCFS received a report that neighbors found the child's 3-year-old sister wandering the neighborhood alone, wearing only a t-shirt, in cold weather. The parents reported the father went to the store and the 3-year-old attempted to follow him. The mother said police brought the child to the home approximately six minutes after the father left. The siblings reported their parents normally knew where they were and would know if they left the home. At a later home visit, the CPI observed a chain

lock and knob cover had been installed on the door. The family declined intact family services. DCFS unfounded the investigation for inadequate supervision (#74). In September 2022, DCFS received another report that the child's 3-year-old sister again got out of the home. The mother reported that at the time of the incident, she was doing homework upstairs, and the father was downstairs cleaning the home. The other children said they did not hear the 3-year-old leave. The CPI observed the safety latch the family installed after the previous incident and noted it was at the child's level. The CPI discussed adding an additional safety mechanism, and the family later reported they installed an alarm. DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 122	DOB: 08/2020	DOD: 12/2022	Natural
Age at death:	2 years		
Cause of death:	Staphylococcus aureus and respiratory syncytial virus (RSV) bronchopneumonia due to multiple complications of POLRA3A genetic mutation		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old medically complex toddler was found unresponsive in the morning by her mother, who called 911. The toddler was pronounced deceased at the scene. The toddler had been diagnosed with RSV two days earlier at the emergency room. The toddler had diagnoses of POLR3A genetic mutation, low tone, swallowing dysfunction, and aspiration. The toddler and mother lived in the home of toddler's maternal great-grandparents. The toddler received in-home nursing care and was also under the care of multiple medical specialists. DCFS unfounded the toddler's mother for death by neglect (#51).

Reason for Review: In June 2021, DCFS opened an intact family services case for the mother after DCFS indicated the toddler's father for cuts, bruises, welts abrasions, and oral injuries by abuse (#11) and indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61). The intact worker visited the home weekly and recommended parenting education and victims counseling. The toddler received early intervention services, physical therapy, and occupational therapy. She consistently gained weight and showed motor skill improvements. The toddler was hospitalized multiple times during the case for congestion and viral infections. The mother completed parenting education and participated in counseling. The mother attended school remotely and maintained employment. The intact worker attempted to engage the toddler's father, but he was unresponsive. In March 2022, DCFS closed the intact case successfully because the mother completed services and there were no safety issues identified.

Child No. 123	DOB: 11/2010	DOD: 12/2022	Natural
Age at death:	12 years		
Cause of death:	Bacterial pneumonia; significant contributing conditions of undiagnosed severe congenital disease with severe dehydration		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Twelve-year-old medically complex child was found unresponsive and not breathing at home. The mother reported her health had declined in recent weeks, and her g-tube had been leaking. The mother said she had planned to take the child to the doctor but had not yet. The parents told EMS they put purees into the child's g-tube because they could not afford her supplement after the mother's paramour began dialysis treatment. Law enforcement and DCFS investigated the child's death, and the parents did not cooperate with either agency. During forensic interviews, the other children in the home reported they were responsible for most of the child's care. The father reported he had been cut off from the children. The autopsy report noted the child died of bacterial pneumonia. DCFS obtained a second opinion from a forensic pathologist who reported the child's death was "a case of clear death by neglect." DCFS took

protective custody of the child's siblings, but the court returned them to the mother's care. DCFS indicated the child's mother for death by neglect (#51) and environmental neglect (#82). The state's attorney is pursuing criminal charges.

Reason for Review: In January 2022, DCFS received a report that the child's mother pushed the 11-year-old daughter of her paramour into a wall, causing a bruise on the hip. The CPI interviewed the children in the home, and each described the incident differently. However, both the paramour's daughter and the child's mother reported the paramour's daughter was angry, she bumped into the child's 13-year-old brother, so the child's mother bumped her in the same manner. Both denied the mother intended to hurt the paramour's daughter. The mother stated it was not the most mature way for her to handle the situation. The mother denied physical domestic incidents. The CPI also observed the child and noted it appeared her physical needs were met appropriately. The child's medical team reported no concerns. Approximately one week after the initial report, the CPI received a call that the child's 9-year-old sister disclosed a domestic violence incident between the mother and her paramour. The paramour denied any incidents of physical violence. He reported he and the mother sometimes disagreed about parenting styles, but he denied any concerns about the children's safety in her care. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 124	DOB: 04/2011	DOD: 12/2022	Natural
Age at death:	11 years		
Cause of death:	Batten's disease; significant contributing condition of epilepsy		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-year-old medically complex child died from a genetic condition associated with a short life expectancy. He received hospice care prior to his death. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In November 2022, while the child was in the hospital for RSV and pneumonia, DCFS received a report that his parents stated they sometimes left the child home alone for multiple hours. The reporter stated the child was blind, non-verbal, non-mobile, and he did not have a wheelchair. The parents reported his medical condition made it difficult for him to leave the home, and they monitored him with cameras placed throughout the home. The CPI met with the father, who reported the family recently moved to the United States and did not know they could not leave the child home alone. He stated they left the child alone for about two hours and monitored him with cameras in the home. He reported they had previously lost a child to Batten's disease, the same genetic condition the child was diagnosed with, and they were seeking additional services to get nursing care and a wheelchair for the child. The hospital later discharged the child with the proper medical equipment. The CPI visited the home and found it appropriate, clean, with ample food. The child's younger siblings reported they felt safe at home. The mother reported they were still learning local laws and had left the child home alone while taking the other children to the doctor. The mother reported they sought assistance for nursing services. The investigation was pending at the time of the child's death. DCFS later unfounded the investigation for inadequate supervision (#74).

Child No. 125	DOB: 09/2006	DOD: 01/2023	Natural
Age at death:	16 years		
Cause of death:	Hepatosplenic T cell lymphoma		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old died of cancer. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In February 2022, DCFS received a report that the teen's mother and stepfather had a physical altercation at the hospital during the teen's chemotherapy treatment, and the teen's mother had a history of being intoxicated at the hospital. The reporter told the CPI that hospital staff called police on the mother, and she was no longer allowed in the facility. The teen's stepfather reported he was separated from the teen's mother and was primary caregiver for the teen, though the mother lacked housing and sometimes stayed in their home. The teen, his stepfather, and hospital staff all reported the mother was the aggressor during the incident. The stepfather obtained an emergency order of protection against the mother for both himself and the teen. In April 2022, the stepfather reported the mother had a warrant out for her arrest for unlawful entry and burglary of his home. The CPI recommended the stepfather obtain guardianship of the teen through probate court and offered intact family services, which the stepfather declined. The teen was hospitalized multiple times during the investigation. The CPI obtained the teen's medical records and submitted a nursing referral. The DCFS nurse recommended the teen attend all medical appointments and cancer treatments. In July 2022, DCFS indicated the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and unfounded the teen's stepfather for the same allegation.

Child No. 126	DOB: 12/2022	DOD: 01/2023	Natural
Age at death:	5 weeks		
Cause of death:	Viral pneumonia		
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: Five-week-old was found unresponsive by her mother, and family called 911. EMS transported the infant to the hospital, where she was pronounced deceased. The mother reported she co-slept with the infant and her 4-year-old and 6-year-old children. DCFS opened an investigation. The infant's siblings received medical exams, and the CPI initiated a safety plan for the siblings to stay with their maternal grandmother. The mother completed a drug test that was negative for all substances. The safety plan ended after the preliminary autopsy report noted no signs of trauma or abuse to the infant. The mother continued to participate in intact family services. DCFS unfounded the infant's mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In March 2022, DCFS received a report of domestic violence between the infant's parents, and the infant's then 3-month-old, 3-year-old, and 6-year-old siblings were present during the altercation. The reporter added the home was messy with trash throughout. The 6-year-old brother reported the mother and infant's father fought; he was holding his 3-month-old sibling during the argument, but he denied the fight was physical. The mother and the infant's father told the CPI that they argued but denied a physical altercation. The CPI observed all three children to be free of marks or injuries. The CPI noted the home appeared messy but did not appear to pose a risk to the children. Local police had no records of domestic violence. The children's teachers, daycare providers, and doctors denied concerns about the family. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82). In September 2022, DCFS received a report that police responded to a domestic violence call and observed the mother had injuries. The mother

told the CPI this was the first time the infant's father physically harmed her, and she called the children's grandmother, who called police. The CPI observed the reported injuries to the mother's face. The mother reported the children were home during the incident, but remained in another room, and she and the children went to the grandmother's home following the incident. She added she was seven months pregnant with the infant. The CPI documented the children had no observable injuries. The CPI initiated a safety plan for the children to stay with the grandmother, and the mother agreed to obtain an order of protection against the infant's father. Police reported they arrested the infant's father, but the mother was not cooperative with their investigation. DCFS took protective custody of the children, but the court declined to grant DCFS temporary custody. DCFS indicated the mother and infant's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The CPI submitted a referral for intact family services. The intact worker recommended parenting classes, domestic violence services, individual counseling, and anger management counseling. The intact worker observed the home met minimum standards and had safe sleeping accommodations for the infant's then 9-month-old sibling. During the first month of the intact case, the intact worker made weekly visits to the home and noted no concerns; the mother started parenting, domestic violence, and counseling services; and she went to court and obtained a two-year order of protection. The intact worker referred the fathers for parenting and domestic violence services and visited each of their homes. In December 2022, the infant was born, and the intact worker observed a safe sleep environment for the infant. The mother continued to comply with services. The intact worker's last visit to the home occurred three days before the infant's death.

Child No. 127	DOB: 12/2021	DOD: 01/2023	Natural
Age at death:	13 months		
Cause of death:	Withdrawal of life sustaining activities due to hemorrhaging stroke with herniation due to staph bacteremia		
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:	Investigatory review of records		

Narrative: Thirteen-month-old with congenital heart issues, was removed from life support after he had been hospitalized for 12 days. He had a blood infection, became septic, and underwent emergency bedside surgery to mechanically support his heart. He was stabilized after surgery, but medical staff determined he had a massive intracranial hemorrhage. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report that the toddler's mother got into an altercation with neighbors while smoking marijuana. The toddler's then 18-month-old brother reportedly got knocked over during the fight and the reporter stated the mother smoked marijuana in front of the children. The reporter added that the toddler used a breathing tube, and the mother had left the toddler home alone multiple times. The mother confirmed an incident but denied the children were involved. She also denied smoking marijuana in front of the children and denied ever leaving them unattended. The mother reported the toddler was in the hospital for open heart surgery and she visited regularly. Neither hospital staff nor the children's pediatrician reported concerns of abuse or neglect. At the time the investigation closed, the family was living with the toddler's maternal grandmother, who provided support. DCFS unfounded the investigation for inadequate supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). In August 2022 DCFS received a report that the then 8-month-old toddler had been in the hospital and his mother removed him against medical advice. She brought him back to the hospital when the doctor contacted her but was not present or responsive to phone calls. The hospital learned through the toddler's maternal grandmother that the mother was incarcerated. Later that day, hospital staff told the CPI the mother was no longer incarcerated and was available to sign consents, and the hospital was also in close communication with the maternal grandmother. The mother informed the CPI she was on house arrest and

was not able to leave but was working with other social service agencies for assistance. The CPI submitted a nursing referral and hospital staff stated they would refer the toddler to DSCC. The mother initially agreed to intact family services, but after receiving assistance from the hospital she felt she no longer needed them. DCFS unfounded the investigation for inadequate supervision (#74). In September 2022, DCFS received a report that the then 9-month-old toddler was brought to the hospital because his g-tube had been dislodged for over 12 hours and he needed to be transferred to another medical facility for reinsertion. The mother wanted to take a rideshare to the other facility, though medical staff wanted the child transported by ambulance. Doctors took protective custody of the toddler transported him to the second hospital. The mother told the CPI she could not go with the toddler because of her ankle monitor and curfew. The next day, DCFS took protective custody of the toddler but allowed it to lapse when mother agreed to intact services. In October 2022, DCFS unfounded the investigation for medical neglect (#79). The intact worker made twice-monthly visits and established protective daycare services and individual counseling for the mother. The family was also working with a care coordinator for transportation to medical appointments. In the two weeks before the toddler's death, the mother informed the intact worker of multiple hospital visits as the toddler's health declined and his organs began to fail. The intact worker visited the hospital and medical staff reported the mother was providing appropriate care. The intact worker also met with the toddler's 12-month-old brother at daycare and observed him free of visible signs of abuse or neglect. The intact case remained open at the time of the toddler's death.

Child No. 128	DOB: 05/2022	DOD: 01/2023	Natural
Age at death:	8 months		
Cause of death:	Bronchopneumonia and COVID 19 infections due to congenital heart disease		
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: Eight-month-old medically complex infant was found having seizures. His parents transported him to the hospital, where medical staff attempted resuscitation before they pronounced him deceased. The infant spent five months in the hospital after birth and required multiple hospitalizations following the initial discharge. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In November 2022, DCFS received a report that the then 6-month-old infant had been transported to the hospital after his mother accidentally dislodged his g-tube. The reporter stated hospital staff heard the mother yell at the infant, witnessed her hitting him on the chest with an open hand, and they were concerned that the mother was overwhelmed and could not properly care for him. The reporter stated the doctor took protective custody of the infant and planned to have the infant transported to a different hospital. At the hospital the CPI observed the mother yell at the infant when he cried and strike him on the chest when he had a coughing spell. The mother reported the infant's physiotherapist directed her to strike the baby's chest to help with coughing. She told the CPI she was overwhelmed but was receiving services. The CPI placed the infant in a safety plan with his paternal grandparents who also supervised the mother's visits with the baby. The infant's pediatrician reported no concerns, and the mother participated in counseling weekly. The CPI terminated the safety plan and the mother agreed to intact services. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). One week before the infant's death, the intact worker conducted the first home visit, asked the mother to consider what services she may need, and noted no concerns. The infant died the day the intact worker was scheduled to hold a second home visit.

Child No. 129	DOB: 07/2016	DOD: 01/2023	Natural
Age at death:	6 years		
Cause of death:	Recurrent aspiration pneumonia due to dysplasia secondary to neurological causes due to profound intellectual disability; substantial contributing factor of hypoxic ischemic encephalopathy		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Six-year-old medically complex child was found unresponsive by nursing facility staff, who called 911 and began CPR. EMTs were unable to revive the child and she was pronounced deceased. The child had a history of seizures and diagnoses of encephalopathy, cerebral palsy, and global developmental delay. She used a ventilator and g-tube. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In 2019, when the child was 3 years old, she came into DCFS care after DCFS indicated her parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and medical neglect (#79). In the year prior to her death, the child lived in a nursing facility. The child's father was incarcerated, and the mother regularly visited the child's 4-year-old and 5-year-old siblings, but she did not visit the child. The child's caseworker visited consistently and noted the child appeared well cared for. In February 2022, the mother completed substance use treatment. In April 2022, medical staff reported a bacterial infection, diagnosed two months earlier, had colonized, meaning the infection would likely never resolve and the child was kept on a low dose of antibiotics. Medical staff reported her condition was stable. In May 2022, the court changed the children's permanency goal to substitute care pending termination of parental rights because neither parent had engaged in services. In September 2022, the child was hospitalized for difficulty breathing. In October 2022, she was hospitalized for pneumonia. In December 2022, she was discharged from the hospital and returned to the nursing facility where she remained until her death.

Child No. 130	DOB: 10/2017	DOD: 01/2023	Natural
Age at death:	5 years		
Cause of death:	Acute respiratory failure due to presumed respiratory infarction; significant contributing conditions of hypoxic brain, jury dishagia shout gut syndrome [sic], obstructive sleep apnea, seizing disorder, and aorta dilation		
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: Five-year-old medically complex child was transported to the hospital after her home health nurse noted the child had low oxygen levels. The nurse administered supplemental oxygen, instructed the mother to take the child to the hospital, and called the hospital to inform them of her impending arrival. Upon arrival the child was pronounced deceased. The child had been born at 33 weeks gestation; her diagnoses included respiratory insufficiency, anemia, cardiac arrest episodes, anoxic brain injury, sepsis, gangrene, amputation below the left know due to gangrene, necrosis, and a seizure disorder. DCFS opened an investigation into the child's death. The child's parents reported they initially wanted to wait to have the child seen until her scheduled appointment the following day but took her to the hospital when her breathing became more labored. The child's pediatrician and medical specialists denied concerns about the parents' care for the child and noted the child had not been expected to survive infancy. DCFS unfounded her parents for death by neglect (#51).

Reason for Review: In September 2022, DCFS received a report that law enforcement responded to the family's home because the child's father was striking the mother's car with a baseball bat while the then 4-year-old child and her then 5-year-old brother were in the car. Police arrested both parents and called the child's maternal grandmother to pick up the children. The CPI met with the children at the

grandmother's home. The brother reported he was in the car while his parents fought. The brother denied anyone hurt him. The CPI noted the children appeared free of signs of abuse or neglect. The child's father told the CPI that he and the child's mother were no longer romantically involved, but they lived together and co-parented. The father stated the child required care 24 hours per day and he or the mother was always home with her because they lacked outside support and had not been able to obtain nursing care. He confirmed he hit the car with a baseball bat, but denied issues with substance use, mental health, or domestic violence. The CPI met with the mother who acknowledged the domestic violence concerns. The mother reported they previously had a home health nurse, but the nurse made an error that resulted in the child being hospitalized, and they did not want a nurse in their home. The child's medical providers informed the CPI the child had recently missed several appointments, and the child previously received in-home nursing care, but her parents canceled the services. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The mother agreed to intact family services but appealed her indicated finding and it was overturned. The indicated finding against the father remained. The family's intact worker met with the family weekly, noted no concerns in the home, and documented the parents appeared knowledgeable about the child's needs. The intact worker referred the parents for domestic violence services and parenting classes. At the time of her death, the child was receiving in-home nursing services.

Child No. 131	DOB: 02/2017	DOD: 01/2023	Natural
Age at death:	5 years		
Cause of death:	Chronic respiratory failure causing cardiopulmonary arrest due to Lennox-Gastaut epilepsy due to hypoxic ischemic encephalopathy; significant contributing conditions of tracheostomy and ventricular dependent, and gastrostomy dependent		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Five-year-old medically complex child was found unresponsive early in the morning, by her foster mother. The foster mother called 911 and she and the foster mother's adult daughter performed CPR until paramedics arrived. In the two days before her death, the foster mother called the pediatrician twice to report problems with her breathing machine. Both times, technicians responded to the home to fix the machine. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In 2018, the then 13-month-old infant and her then 3-year-old brother came into care for allegations of failure to thrive (#81) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In the year prior to her death, her placement worker conducted monthly home visits and twice-monthly video visits. The child received in-home nursing 16 hours per day, and she was followed by multiple medical specialists. The child's foster mother planned to adopt her.

Child No. 132	DOB: 07/2007	DOD: 02/2023	Natural
Age at death:	15 years		
Cause of death:	Septic and hypovolemic shock due to C/B abdominal compartment syndrome leading to multi-organ system failure		
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: Fifteen-year-old medically complex teen was brought to the hospital by her mother because of an elevated heart rate and died the next day. The teen's diagnoses included sleep apnea, seizures, cerebral palsy, and delayed milestones in childhood. She received in-home nursing care. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In June 2022, DCFS received a report that the teen's mother was then 30 weeks pregnant, the mother's paramour drank to intoxication daily, and while he was intoxicated, he broke things in the home in the presence of the children. The reporter stated the teen's then 11-year-old sister was often left in a caregiving role for the then 14-year-old teen, who was non-verbal, used a wheelchair, and was diagnosed with epilepsy, quadriplegia, and hydrocephalus. The teen's 7-year-old and 11-year-old siblings and their mother told the CPI the paramour drank, and he had thrown things and broken doors in the home. The 11-year-old stated the paramour had once hit her when he was angry but denied he ever hit any other family members. The mother stated the paramour drank to excess every day but denied the paramour ever hit her or the children. The paramour denied he drank alcohol daily or that he had a drinking issue. He told the CPI he had once punched a wall because he was upset. The children and mother denied the mother ever left the home overnight, but the mother stated she sometimes left the children in the care of the teen's in-home nurse. The mother and paramour agreed to intact family services. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), but unfounded the investigation for inadequate supervision (#74). In July 2022, the family's intact case opened. The family's intact worker recommended the mother participate in family counseling and domestic violence services. The intact worker recommended the paramour participate in substance use assessment and treatment, individual and family counseling, and domestic violence perpetrator assessment and treatment. The intact worker met with the family weekly and noted they were cooperative with services and ensured the children were adequately supervised. In October 2022, while the intact case remained open, DCFS received a report that the teen's then 11-year-old sister was experiencing a mental health crisis, and the mother had been contacted three times to request she take the sister to the hospital, and the mother failed to do so. The reporter added the sister disclosed recent domestic violence in the home. The CPI spoke with the reporter, who shared that an ambulance was called to the school for the sister, and she was admitted to the hospital. The CPI met with the sister at the hospital, who reported she felt safe at home, and denied the altercations between her mother and mother's paramour were physical. The CPI observed the sister was free of visible marks or bruises. The hospital discharged the sister six days after the hotline call and enrolled her in an outpatient program, which she completed six weeks later. The family's intact worker informed the CPI, the mother and paramour followed through with services and there were no concerns with the family. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60), and medical neglect (#79). The day the teen died, the paramour contacted the intact worker to report the teen was in the hospital and had undergone emergency surgery, but her prognosis was poor.

Child No. 133	DOB: 11/2009	DOD: 02/2023	Natural
Age at death:	13 years		
Cause of death:	Bronchial asthma; significant contributing condition of viral myocarditis		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old, who had a history of asthma, was having breathing issues. His mother gave him his nebulizer, but he went into respiratory arrest. The mother called 911 and an ambulance transported the teen to the hospital, where he was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In November 2022, DCFS received a report that the teen's 11-year-old cousin disclosed the teen's father, her maternal uncle, sexually abused her a few years earlier. The CPI went to the cousin's home where the cousin's mother denied the cousin previously disclosed any sexual abuse to her. She stated she did not have concerns about the teen's father, but she believed her daughter and they had not seen him in several months. The cousin and her 6-year-old brother participated in victim sensitive interviews. The cousin stated she had been watching a movie with her uncle on the opposite end of the couch, and when she stretched her foot, it touched her uncle's penis. She reported she immediately got off

the couch and did not say anything to her uncle. She denied he ever asked her to touch him, denied he touched her, and she had no knowledge of him touching anyone else. The cousin's brother did not disclose any sexual abuse or knowledge of any sexual abuse. During the investigation, DCFS opened a second investigation against the teen's father for substantial risk of sexual abuse to the teen due to the initial allegations against the teen's father. The teen's father denied he ever touched or said anything inappropriate to the teen's cousin, and stated he had no contact with the cousin or her brother since the report. The teen denied any issues in the home, and the teen's mother denied any concerns. DCFS unfounded the first investigation for sexual molestation (#21) and substantial risk of sexual abuse (#22) to the teen's cousins DCFS unfounded the second investigation for substantial risk of sexual abuse (#22) to the teen.

Child No. 134	DOB: 07/2005	DOD: 02/2023	Natural
Age at death:	17 years		
Cause of death:	Seizure disorder; significant contributing condition of viral myocarditis		
Reason for review:	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 in her bedroom in the morning by her parents, who called 911. Emergency services brought her to the hospital, where she was pronounced deceased. Her parents reported they last saw her alive around 9:00pm the previous evening. She had been diagnosed with autism, epilepsy, and had cognitive delays. Hospital staff reported she had recently changed her seizure medication. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In September 2022, DCFS received a report that the teen's then 10-year-old brother disclosed that the parents recently fought, and the mother hit the brother with a closed fist in the back and on the arms. The reporter did not observe any marks or bruises on the brother. The teen's mother and brother both denied the argument between the parents was physical and denied anyone in the home hurt the brother. The teen's siblings, then 13, 13, and 15 years old, all stated they felt safe at home and denied they had ever been hurt by their parents. The siblings reported the brother often exaggerated, and the mother reported he was working with a counselor. The teen did not want to speak with the CPI; the mother reported the teen was diagnosed with autism and had mental delays due to a brain tumor. In October 2022, while the investigation was pending, DCFS received a report that the teen's brother, who had turned 11, had an altercation with his grandfather after his grandmother hit his sister. The mother, 15-year-old sister, and grandfather all reported there had been an incident where the grandfather yelled at the sister, then the sister ran outside. All denied the brother was involved. The brother denied his grandfather hit him and stated he exaggerated the incident when he relayed it to the reporter. DCFS unfounded the September 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and unfounded the October 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 135	DOB: 05/2016	DOD: 02/2023	Natural
Age at death:	6 years		
Cause of death:	Chronic respiratory failure due to cerebral palsy due to hypoxic-ischemic encephalopathy; underlying cause of holoprosencephaly		
Reason for review:	Child was a youth in care; pending child protection investigation at time of child's death; closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old medically complex child died at the hospital where she had been inpatient for several months. She had been born premature, experienced a stroke at birth, had seizures, limited mobility, and was blind and non-verbal. She required a g-tube, supplemental oxygen, breathing treatments,

and a CPAP machine. In the months prior to her death, she experienced increasingly frequent neurostorms or periods of intense agitation. She had been intubated for a hospital transfer. Two weeks before her death, the child came into DCFS care because her parents' inabilities to care for her or make medical decisions. Five days before her death, the DCFS Guardian signed a DNR for the child and the hospital scheduled an extubating procedure. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In August 2021, DCFS opened an intact family services case for the child's family during an investigation in which her parents were later indicated for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). The intact worker met with the family weekly while the child was home, kept contact with the family during the child's frequent hospitalizations, conducted regular safety assessments, and noted the child had in-home nursing care. The parents' recommended services included counseling, domestic violence services, parenting services, and substance use disorder assessments. In January 2022, while the intact case remained open, DCFS received a report that the child's parents failed to take her to neurology, ENT, and primary care appointments though the child received in-home nursing care and her medications were filled on time. The child was hospitalized during the investigation and medical staff reported she was experiencing more frequent neurostorms. She saw her primary care physician following discharge and had an appointment scheduled with her neurologist. The child's primary care physician declined to comment on whether the child was medically neglected because she was a new patient but reported no concerns. DCFS unfounded the investigation for medical neglect (#79). In May 2022, while the intact case remained open, DCFS received a report that the child's parents were not providing her breathing treatments in the evening and on weekends, when she did not have in-home nursing care, and she had soaked diapers and rash on her bottom. In June 2022, suspicions that the child's parents were using drugs began to arise. The child's father never completed a drug test, and the mother initially refused to complete drug tests, but later tested positive for methamphetamine. In July 2022, the child was admitted to the hospital for respiratory distress, projectile vomiting, active seizures, high heart rate, and fever. The child's mother struggled with understanding the seriousness of the child's medical issues. The child remained hospitalized for the remainder of her life and medical staff reported concerns with the mother's behavior. The assistant state's attorney filed for court-ordered intact services. The child continued to experience more frequent neurostorms and ongoing infections. The hospital offered the option of a risky surgery or palliative care, and the parents declined surgery. The hospital began pursuing discharge options and asked the mother to complete a 48-hour trial to demonstrate she could care for the child by herself. The mother failed three attempts, and the hospital offered other discharge options, including a transfer to another hospital or a step-down facility, but the family refused the transfers. In February 2023, two weeks before the child died, the court ordered the child into DCFS care due to the parents' refusal to make end of life decisions. Following the child's death, DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and unfounded the investigation for medical neglect (#79).

Child No. 136	DOB: 02/2022	DOD: 02/2023	Natural
Age at death:	12 months		
Cause of death:	Severe peritonitis; significant contributing conditions of atrophied cerebrum with hydrocephalus		
Reason for review:	Closed intact family services case and indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-month-old medically complex toddler was found unresponsive by his mother. The mother called 911 and EMS transported him to the hospital, where he was pronounced deceased. The toddler had been born premature, at 27 weeks gestation, was diagnosed with hydrocephalus and diabetes, and was fed through a g-tube and required a shunt. The mother reported that the toddler's g-tube became dislodged the night before, but she replaced it without problem. The mother stated that in the morning he

appeared fine, and she had tube fed the toddler in bed as usual. She went to clean up the equipment and came back to find the toddler unresponsive. The family had recently moved back to Illinois after briefly living in a neighboring stated when the toddler was hospitalized. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In February 2022, when the toddler was born, DCFS received a report that his mother tested positive for opioids, cocaine, and cannabinoids. In addition, the toddler's mother reported she did not know she was pregnant. The mother told the CPI she sought medical treatment because she was in significant pain and thought she had a urinary tract or kidney infection. She stated she took Tylenol for the pain, but the pain did not decrease so the toddler's father gave her Tylenol with codeine that he had been prescribed when he had kidney stones. She reported she used marijuana occasionally and recently used ecstasy, but she denied regular use and stated she would not have taken ecstasy or Tylenol with codeine if she knew she was pregnant. She denied the toddler's father had substance use problems. The mother agreed to drug testing and a home safety check. Hospital staff reported the mother had been cooperative and open with them. The hospital discharged the mother, but the toddler remained in the NICU with complications. The toddler's cord blood tested positive for cocaine, opiates, and THC. The CPI observed the mother's home to be appropriate, and the CPI provided a pack-and-play for safe sleep. The mother tested positive for cocaine and marijuana multiple times. She engaged in substance use treatment and her counselor noted she was compliant with drug tests through the program. The state's attorney declined to file a petition. Before the investigation closed, the toddler was discharged to his mother's care with in-home nursing services. The mother agreed to intact family services. DCFS indicated the toddler's mother for substance misuse by neglect (#65) but unfounded her for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). The intact worker met with the family weekly, except for times when the toddler was hospitalized. The intact worker consistently reported the toddler's mother appeared well-informed and capable of caring for the toddler. She brought the toddler to appointments with his medical specialists and had reliable transportation. The mother completed weekly drug screenings. In September 2022, she was successfully discharged from substance use treatment services. The intact worker discussed parenting classes with the mother. The intact worker noted she never appeared intoxicated during visits, and medical staff reported the same. The final supervisory note before the intact case closed noted the mother acknowledged her past use of cocaine, which she previously struggled to acknowledge. In September 2022, the toddler had surgery to place a shunt, and doctors reported the surgery went well and he was discharged home. Two weeks later, the toddler was hospitalized with an infection. He had surgery to have the shunt removed and was treated with antibiotics. He was later transferred to a hospital in a neighboring state for a higher level of care. The family moved out of state to be closer to the hospital. Hospital social workers reported they were connecting the family with local resources. In November 2022, DCFS closed the intact family services case successfully because the family moved out of state, the mother ensured the toddler's medical needs were met, she never appeared intoxicated, and she completed substance use treatment services.

Child No. 137	DOB: 12/2005	DOD: 02/2023	Natural
Age at death:	17 years		
Cause of death:	Sudden unexpected death in epilepsy (SUDEP)		
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: Seventeen-year-old reportedly was found unresponsive by her mother after having a seizure. The mother called 911 because she could not wake her. She was transported by ambulance to the hospital, where she later died. The medical examiner noted the teen had an abrasion on the left side of her face and swelling to her left eye, and the injuries did not appear to be the result of the seizure. The mother

stated the teen had been having seizures for two months, and she took medication. She stated the teen's last seizure occurred in November 2022. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In November 2022, DCFS received a report that the then 16-year-old teen was hospitalized for a seizure and the hospital was unable to contact her mother to coordinate the teen's discharge. The teen's aunt agreed to care for the teen, but the hospital needed the mother's consent. The reported noted the aunt shared concerns that the mother left the children alone when she went out of the country, exposed the children to drug use, and used physical violence with the children. The CPI was unable to locate the mother. A relative stated the family had been living with her, but the mother left two days earlier, did not return calls, and may have left the country with the teen's 8-year-old and 11-year-old siblings. The CPI met with the teen at the hospital, who stated she did not know the last time she saw her mother. The CPI noted the teen stated she attended school online but could not provide more information. Hospital staff reported the mother knew of the teen's discharge date, but she did not come to the hospital or return calls. The next day, the CPI met with the family at the hospital. The mother denied she knew the teen was ready for discharge. She stated she visited relatives out of town to ask for help with the children. She added she had phone difficulties and never would have left the teen at the hospital. The teen's 8-year-old sister reported she felt safe at home and appeared free of observable injuries. The CPI noted the teen and her 11-year-old brother were diagnosed with autism spectrum disorder. DCFS unfounded the November 2022 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74). In January 2023, while the investigation remained pending, DCFS received a report about concerns with the family's unstable housing. The reporter stated law enforcement connected the mother to housing assistance. The reporter also did not know if the children had eaten and did not know if the children attended school. That day, the CPI contacted the shelter and met with the family at the motel the shelter funded. The mother denied she had any family members to provide support and stated the children were enrolled in school out of town. The children appeared safe. In February 2023, the CPI spoke with the family's housing advocate and noted difficulty contacting the mother. The housing advocate stated they continued to fund the motel and provided the CPI with an updated phone number. The CPI made multiple attempts to contact the mother. Approximately three weeks later, while the investigation remained pending, the teen died. Following the teen's death, the mother stated they had lived in several states over the prior two years, and previously stayed with a local relative, but the relative no longer assisted them. DCFS took protective custody of the teen's 8-year-old and 11-year-old siblings, and the CPI took them to the hospital for medical exams. The children's father stated he provided child support and he wanted to care for his children, but the mother did not allow him to contact them. DCFS placed the children with their father. DCFS later indicated the investigation for inadequate food (#76) and inadequate shelter (#77).

Child No. 138	DOB: 05/2005	DOD: 03/2023	Natural
Age at death:	17 years		
Cause of death:	Hepatic necrosis due to multi system organ failure due to complications of scoliosis and cerebral palsy		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old medically complex teen died at the hospital. She had undergone back surgery earlier in the year, but had infections and seizures related to the procedure. The teen had been diagnosed with Pura syndrome, XQ 23 deletion with seizures, cerebral palsy, and developmental delay. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In August 2022, DCFS received a report about concerns with the teen's health and home environment. The next day, DCFS received a related information report that the mother did not clean the teen's g-tube and left her in a dirty diaper, and the mother grabbed the teen's 19-year-old stepsister by the shoulder and left a bruise. The CPI visited the family and completed the home safety

checklist. The home had stacks of boxes which the mother reported were merchandise for her home-based businesses, but the home did not present a danger to the children. The teen's father told the CPI that the mother kept the teen's g-tube clean, and they took the teen to the hospital when needed. He stated the teen was overweight a few years earlier, but she lost weight after she contracted pneumonia; she required a g-tube and her weight stabilized. The father reported the teen slept in the parents' bedroom due to aspiration and because her g-tube needed to be suctioned. The father added the teen had seizures. The CPI noted the teen was non-verbal but appeared free of observable signs of abuse or neglect. The teen's 7-year-old sister reported she felt safe at home and denied corporal punishment. The paramour of the teen's 19-year-old stepsister told the CPI the stepsister no longer lived in the home, but he had witnessed the mother leave bruises on her and threaten to knock her teeth out. A nurse with the teen's primary care doctor's office reported the mother met with a nutritionist regarding the teen's weight, the teen was scheduled to have scoliosis surgery, and both children were up to date on immunizations. The nurse stated the mother took good care of the children and they had no concerns of abuse or neglect. In November 2022, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82).

Child No. 139	DOB: 10/2022	DOD: 03/2023	Natural
Age at death:	4 months		
Cause of death:	Multiple genetic abnormalities		
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: Four-month-old medically complex infant was found unresponsive. Her father began CPR and her mother called 911. The infant was transported by ambulance to the hospital, where she was pronounced deceased after unsuccessful resuscitation efforts. Her parents reported they put her in the crib on her back and later found her rolled over on her chest. The infant had been born with multiple health issues, including a missing kidney and fluid on the brain. DCFS did not investigate her death for abuse or neglect.

Reason for Review: In September 2022, DCFS received two reports that the infant's 4-year-old sister had bruises on her legs that looked like handprints, marks on her back, her teeth were rotting, and she came to school daily with hygiene issues. The CPI met with the sister at school and observed bruises on her legs but noted no hygiene concerns. The CPI met with the infant's parents, 17-month-old sister, and 7-year-old sister at home. The 4-year-old and 7-year-old sisters were both non-verbal and had been diagnosed with autism spectrum disorder, and the parents reported they had not been to the dentist because they needed a pediatric dentist who saw patients with autism. The parents stated they bathed the 4-year-old regularly and changed her diaper every morning, but she might soil herself on the long bus ride to school. They denied causing harm to the children, and reported they observed bruising on the children the year before, discussed it with the school, and stated they believed the bruising was from their car seat straps. The parents agreed to have the 4-year-old examined by a doctor. The pediatrician reported no concerns. The mother disclosed she was pregnant with the infant and knew the infant was missing limbs due to a chromosomal abnormality. In October 2022, DCFS received a report that the infant was born, and the mother disclosed she had a pending child protection investigation. DCFS took the report for related information to the pending investigation. In November 2022, DCFS received a report that the infant's father was experiencing a mental health crisis and he was the sole caretaker for the three sisters while the infant and her mother were at the hospital. Police conducted a well-being check and noted the infant's grandmother had gone to the home to help watch the sisters. The CPI met with the family at home and the parents reported the mother called police for a welfare check after the father sent her concerning text messages. The parents noted they had four special needs children, and the father was overwhelmed caring for them alone. The father reported he was following up with mental health services. The CPI noted the

children were observed free of marks or bruises but were all non-verbal. The parents declined intact family services and stated they had necessary services in place. The infant's paternal grandmother confirmed she often went to the home to help with the children, and denied the children were at risk of harm at any time. Later that month, DCFS unfounded the first investigation for cuts, welts, bruises, abrasions, and oral injuries by abuse (#11); medical neglect (#79); and environmental neglect (#82). In March 2023, while the investigation remained pending, the infant died. DCFS later indicated the father in the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 140	DOB: 04/2010	DOD: 03/2023	Natural
Age at death:	12 years		
Cause of death:	Diabetic ketoacidosis; significant contributing condition of obesity		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twelve-year-old child died of diabetic ketoacidosis. He had been diagnosed with autism spectrum disorder and was non-verbal. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In November 2022, DCFS received a report that the child's mother frequently left the child and his 4-year-old, 7-year-old, and 9-year-old siblings in the care of their 11-year-old brother for long periods of time, including overnight. The 11-year-old brother burned himself while cooking for the children and the home was unsanitary. The CPI went to the home and observed it met minimal standards. The CPI did not observe any rodents, but the mother stated the home did have rodents, and she reported the problem to the landlord, but the landlord had not addressed it. The verbal children denied their mother left them alone for multiple days, but stated she left them home in the evenings, and the 11-year-old was responsible for cooking. The 11-year-old stated he knew how to contact her if needed. He reported he burned his chin while cooking, but the CPI did not observe any marks. The mother stated the burn was minimal and treated with over-the-counter antibiotic ointment. The mother reported the 12-year-old child was non-verbal and diagnosed with autism. The CPI explained that the mother needed to arrange alternative care when she was not home, because leaving the children in the care of their 11-year-old brother was inappropriate, especially because one of the children had special needs. The mother disclosed two of the children's fathers had been murdered due to gang involvement, and the CPI completed a referral for grief counseling. DCFS indicated the investigation for inadequate supervision (#74) and unfounded the investigation for burns by neglect (#55) and environmental neglect (#82).

Child No. 141	DOB: 01/2023	DOD: 03/2023	Natural
Age at death:	8 weeks		
Cause of death:	Viral pneumonia; significant contributing condition of premature birth		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-week-old was found unresponsive by her mother. The infant was transported to the hospital by ambulance, where she was pronounced deceased. The mother reported the infant was born premature, at 33 weeks gestation, and remained in the NICU for two weeks after her birth. The mother reported the infant switched formula the day before her death and ate normally. She stated she swaddled the infant, placed her on her back in her bassinet, and found her unresponsive when she awoke the next morning, so she began CPR. The infant's primary care physician saw the infant for her 2-month well child check the day before the death and noted there were no concerns at the appointment. DCFS unfounded the investigation for death by neglect (#51).

Reason for Review: In February 2023, DCFS received a report that the maternal grandmother's paramour, who lived in the grandmother's home, was a registered sex offender and sold drugs from the

home. The reporter stated a few children also lived in the home. In addition, the paramour initially lived with his own children after his release from prison, but DCFS informed him he could not live in the home until he completed a sex offender evaluation, and he refused the evaluation. The CPI spoke with the paramour, who denied he lived in the maternal grandmother's home. He provided his home address but refused to cooperate with the CPI. The CPI met with the family at home. The infant's maternal grandmother, mother, and 12-year-old and 16-year-old maternal uncles all denied the paramour lived in the home. The CPI documented the infant had a bassinet, and she discussed safe sleep with the mother. Two weeks later, while the investigation remained pending, the infant died. DCFS later unfounded the investigation for substantial risk of sexual abuse (#22) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 142	DOB: 08/2005	DOD: 03/2023	Natural
Age at death:	17 years		
Cause of death:	Acute respiratory failure due to aspiration pneumonia		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old medically complex teen was found unresponsive at home by his adoptive mother. He was diagnosed with cerebral palsy, microencephaly, congenital cytomegalovirus infection, developmental disorder of motor function, quadriplegia, acquired absence of left hip joint, and required a g-tube. He received in-home hospice care. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen's adoptive mother had also been a foster and adoptive parent to other children. In September 2021, DCFS received a report that the teen's then 9-year-old foster sister did not feel safe at home because her then 10-year-old brother was violent. The teen's adoptive mother reported she was working with the foster brother's case worker due to a decline in his behavior. During the investigation, the foster sister was returned to the care of her mother. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In November 2021, DCFS received a report that the teen's foster sister disclosed she was afraid of her brother, who hurt her when she went to the home of the teen's adoptive mother. The adoptive mother reported the foster sister only visited the home for a few hours each day for sibling visits since she had been returned home. The adoptive mother reported she supervised the foster siblings during their visits and denied the foster brother harmed his sister. DCFS unfounded the investigation for inadequate supervision (#74). The teen was not involved in either investigation.

Child No. 143	DOB: 08/2013	DOD: 03/2023	Natural
Age at death:	9 years		
Cause of death:	Cardiorespiratory arrest secondary to viral respiratory illness due to hypoplastic left heart syndrome SP Glenn palliation due to right ventricular dysfunction; significant contributing condition of WPW SVT tricuspid regurgitation aortopulmonary collateral vessels		
Reason for review:	Former youth in care		
Action taken:	Investigatory review of records		

Narrative: Nine-year-old medically complex child experienced a heart attack due to complications of Wolff-Parkinson-White (WPW) syndrome, a congenital heart defect that causes tachycardia, which can lead to sudden cardiac death. His foster mother performed CPR while his in-home nurse called 911. He was transported to the hospital by ambulance, where he was pronounced deceased. Medical providers noted the child lived a longer life than was expected with his diagnosis. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In 2014, when the child was 11 months old, he came into care during an investigation in which DCFS indicated his mother for medical neglect (#79). In 2015, he was placed in the specialized foster home where he resided at the time of his death. In the year prior to his death, the child was hospitalized for a cardiac catheterization procedure. His placement worker made regular visits. In June 2022, the court granted his foster mother guardianship and closed his placement case.

Child No. 144	DOB: 09/2020	DOD: 03/2023	Natural
Age at death:	2 years		
Cause of death:	Bronchopneumonia		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was having seizures and stopped breathing. The toddler was transported by ambulance to the hospital, where she was later pronounced deceased. The reporter stated that when first responders arrived, the home was dirty and smelled of vomit. The toddler's mother reported the toddler had been sick with a cold, so she gave the toddler Robitussin with the dosing based on guidance she received for the toddler's older siblings. The mother stated the toddler had been vomiting in the days prior, but not that day. She added the toddler had been born premature but was generally healthy. The CPI noted the toddler had been born at 26 weeks gestation and was treated in the NICU for 23 months. DCFS did not investigate the toddler's death for abuse or neglect but did initiate an investigation related to the condition of the family's home at the time of the incident. The DCFS investigation for environmental neglect (#82) remains pending.

Reason for Review: In August 2022, DCFS received a report that the toddler's then 15-year-old sister disclosed she was inappropriately touched by someone in the home, and law enforcement had been called for a recent incident in which she had been attacked in the home. The CPI met with the toddler's mother and the toddler's four siblings, who were between the ages of 3 years and 18 years, at the home. The 15-year-old sister denied she was touched in a sexualized manner and denied she told anyone about inappropriate touching. The siblings appeared well-groomed and showed no signs of abuse or neglect. The toddler's mother and father denied the allegations. The 15-year-old completed a forensic interview and again denied she had been touched in a sexualized manner. In October 2022, DCFS unfounded the investigation for sexual molestation (#21) and substantial risk of sexual abuse (#22).

Child No. 145	DOB: 08/2022	DOD: 03/2023	Natural
Age at death:	7 months		
Cause of death:	Viral pneumonia; contributing condition of Kabuki syndrome		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old vomited, aspirated, and went into cardiac arrest. His mother called 911 and the infant was transported by ambulance to the hospital, where he was later pronounced deceased. Hospital staff reported the mother stated she fed the infant a bottle of milk and tried to give him cereal, but he vomited. DCFS unfounded the infant's mother for death by abuse (#1), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and environmental neglect (#82).

Reason for Review: In October 2022, DCFS received a report that the then 2-month-old infant saw his pediatrician for a check-up and only weighed 6.1 lbs., which was lower than his birth weight. He was transported to the hospital by ambulance, and his mother stated she would follow the ambulance in her car but never arrived at the hospital. The reporter stated hospital staff called the mother, and she stated she had young children at home, and she was not able to go to the hospital. The CPI observed the infant at the hospital and spoke with hospital staff, who stated his low weight was a result of non-organic failure to

thrive. During the investigation, the infant's three other siblings were also hospitalized for malnourishment. The CPI met with the siblings at the hospital and noted all appeared free of injuries. The mother stated she fed the children regularly and kept food in the home. She added the infant was not given his prescription formula at birth and she spoke with the pediatrician about the prescribed formula, but still did not receive it. The children's treating physician noted the children were all underweight and expressed concerns about the mother's care of the children. The children's maternal aunt told the CPI she visited the home weekly, the mother took excellent care of the children and kept ample food in the home. Multiple collateral contacts reported the children were picky eaters but denied that the children were ever restricted food. The physician diagnosed all four children with failure to thrive. DCFS took protective custody of the children, but the state's attorney declined to screen the case. The treating physician stated the mother did not bring the infant to the pediatrician until he was 2 months old, and the infant had feeding challenges. The physician also noted all the children gained weight in the hospital. Five days after they were admitted, the infant's siblings were discharged from the hospital. The 7-year-old was also diagnosed with rhinovirus, the 4-year-old was also diagnosed with previous history of asthma and adenovirus, and the 2-year-old was also diagnosed with microcytic anemia. In November 2022, hospital staff told the CPI the infant gained weight, his feeding challenges improved, and he received physical therapy. In addition, the mother needed training to learn how to care for him. The next day, the CPI met with the mother at home, provided a pack-and-play for the infant, observed food in the home, observed the siblings free of injuries, and noted no safety concerns. One week later, the intact family services case opened, and a nursing referral was submitted for the family. The intact worker recommended individual counseling, in-home parenting program, protective daycare services, medical monitoring, 0-3 assessment, developmental services for the infant, and Norman fund services. In December 2022, the hospital discharged the infant to his mother's care. The mother participated in medical training for the infant's feeding technique. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and neglect (#60); inadequate food (#76); and failure to thrive (#81). In January 2023, the intact worker received an email from a doctor that noted the infant's weight loss could have been due to Kabuki syndrome. The infant's primary care physician reported the mother brought the infant for all medical appointments since his discharge. The mother was also enrolled in parenting classes and individual counseling. In February 2023, the infant's early intervention services began. The nursing diagnosis and recommendations noted the infant had imbalanced nutrition related to disease process secondary to Kabuki syndrome and he was at risk of developmental delay. The intact worker obtained the list of all scheduled medical appointments for the children. Later that month, the intact family services case closed after the family successfully achieved the recommended goals. At the final visit, the intact worker noted the children all presented without injuries, and the home was observed free of hazards.

Child No. 146	DOB: 05/2008	DOD: 03/2023	Natural
Age at death:	14 years		
Cause of death:	Sudden unexpected death in epilepsy		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was found unresponsive and was brought to the hospital, where she was pronounced deceased upon arrival. The teen's mother reported the teen stated she did not feel well and went to take a nap, but she found the teen unresponsive on the floor when she went to check on her. The teen had a seizure disorder and had been seen in the emergency room a month earlier for a seizure. Her mother reported the teen was compliant with medication. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2022, DCFS received a report that the teen's mother brought her to the hospital after the teen's father hit her on the hand and leg with a stick when he learned a sexual video of the teen was circulating in her school. The reporter noted the teen had a mark on her hand. The next

day, the CPI met with the teen at school, who stated the rumor was false and denied there was a video. She reported she felt safe at home, she was living with her grandmother at that time. The CPI reviewed the teen's hospital records. In November 2022, the CPI met with the teen at home, and the teen disclosed that the rumors about the video were true. The teen's mother reported the father did not live in the home. She accepted a referral for mentoring and counseling services for the teen. The CPI spoke with the father, who reported he became upset because he heard the rumors about the teen, and the day of the incident, the teen turned off her phone and her parents could not locate her for three hours. DCFS unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 147	DOB: 12/2022	DOD: 03/2023	Natural
Age at death:	3 months		
Cause of death:	Respiratory failure in newborn due to triploidy due to trisomy 17; significant contributing condition of multiple congenital anomolies		
Reason for review:	Pending child protection investigation and open return home case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old medically complex infant died at the hospital. He remained inpatient following his birth due to multiple genetic and congenital abnormalities, and he was not expected to live. The infant had been born premature, at 34 weeks gestation, and his cord blood tested positive for cocaine. Hospital staff stated his health conditions were not due to drug exposure in utero. DCFS did not investigate his death for abuse or neglect.

Reason for Review: The infant's 16-month-old brother was a youth in care. The brother came into care shortly after his birth during an investigation in which the mother was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The brother had been born premature, at 28 weeks gestation, and his mother tested positive for cocaine during prenatal visits. In addition, DCFS previously removed eight children from her care and these children were adopted after the court terminated her parental rights. In March 2022, the brother returned home by court order under the conditions that the parents participate in services. The caseworker noted the infant's parents were cooperative with services, the mother tested negative for all substances, and the parents engaged in parenting classes. The infant's father completed parenting classes, but the mother did not. They did not complete domestic violence classes due to scheduling conflicts. Two days after the infant's birth, the court closed the brother's case, but re-opened when two weeks later, DCFS received a report that the infant's cord blood tested positive for cocaine. The brother remained in the parents' care and the same workers, who had not closed the case at the agency, continued to service the case. The worker, who consistently visited the home, noted the mother engaged in substance use services, regularly completed negative toxicology screenings. In March 2023, while the investigation remained pending, the infant died. DCFS later indicated the investigation for substance misuse by neglect (#65) but unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 148	DOB: 04/2009	DOD: 04/2023	Natural
Age at death:	13 years		
Cause of death:	Cardiac arrest due to Duchenne muscular dystrophy		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-year-old medically complex child died of cardiac arrest due to muscular dystrophy. He was diagnosed with muscular dystrophy as an infant and received regular medical care. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2022, DCFS received a report that the teen was unsanitary, there were bugs on his wheelchair, and the reporter believed the problem was getting worse. The reporter noted the teen was paralyzed from the neck down. At the time of the report, the family was living with the father of the teen's 5-year-old and 6-year-old maternal half-siblings while the mother's home was being repaired after it flooded. The CPI noted the home met minimal standards, the teen's siblings denied there were insects in the home, and the teen appeared clean and appropriately dressed. The mother and siblings reported the home did not have a ramp, so they kept the wheelchair outside. The teen's teacher denied they had recently seen any insects on the teen. DCFS unfounded the investigation for environmental neglect (#82).

Child No. 149	DOB: 12/2005	DOD: 04/2023	Natural
Age at death:	17 years		
Cause of death:	Dehydration due to viral illness; significant contributing conditions of fatty liver and psychiatric disorder		
Reason for review:	Child was a youth in care		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found unresponsive on the bathroom floor. His mother reported he had been sick with flu-like symptoms for several days but had not seen a doctor. Law enforcement reported the motel room where the family resided smelled of vomit, had drug residue, and there were items for a baby, but no crib or playpen. Motel staff reported the mother had lived there for over a year, and they had seen the teen there for the prior two weeks. The mother did not cooperate with law enforcement or the child protection investigation. The court issued a juvenile warrant for the teen's 5-year-old sister, whose whereabouts remained unknown. DCFS indicated the mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: The teen came into care in 2013, when he was 7 years old. In the year prior to his death, the teen's whereabouts were unknown. His placement worker reported him missing in February 2022 and the court issued a juvenile warrant. The placement worker maintained contact with the detective assigned to his missing persons case, the Center for Missing and Exploited Children, and relatives. The placement worker also conducted regular diligent searches. He remained missing until his death in April 2023.

Child No. 150	DOB: 11/2006	DOD: 04/2023	Natural
Age at death:	16 years		
Cause of death:	Pulmonary infarctions due to pulmonary thromboemboli due to deep vein thrombosis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old medically complex teen was found unconscious by his 7-year-old sister. Paramedics responded to a 911 call, and he was transported to the hospital by ambulance, but medical staff were unable to revive him. The teen's diagnoses included dysphasia, arterial septal defect, gastroesophageal reflux disease, and tracheoesophageal and esophageal strictures. The autopsy noted the teen may have had an undiagnosed blood clotting disorder based on a family history of blood clotting disorders. DCFS did not investigate his death for abuse or neglect.

Reason for Review: In February 2022, DCFS received a report that the then15-year-old teen disclosed he did not have food or heat at home, he asked to see the school nurse daily, and his mom did not provide his prescribed acid reflux medication or eyeglasses because she could not afford them. The reporter added the teen's mother worked third shift. When the CPI met with the teen the next day, he reported the home had water, heat, and plenty of food, but they had issues with the landlord. He stated he received an over-

the-counter acid reflux medication that was more affordable than the prescription, and he confirmed he did not wear glasses because the family could not afford them. The teen stated he cared for his then 6-year-old sister when his mother worked, he had a phone, and he could contact his neighbors if needed. The sister reported she felt safe at home and confirmed the home had food, heat, and water. During the investigation the teen reported he had obtained the prescribed acid reflux medication. The children's' pediatrician reported no concerns. The CPI interviewed the children at school multiple times but was unable to reach the mother during the investigation. DCFS unfounded the investigation for inadequate food (#76), inadequate shelter (#77), and medical neglect (#79).

Child No. 151	DOB: 11/2022	DOD: 05/2023	Natural
Age at death:	5 months		
Cause of death:	Pulmonary hypertension due to atypical teratoid rhabdoid tumor		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old died of complications from cancer in May 2023. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In December 2022, DCFS received a report that the infant's father argued with the mother, became upset that the infant was crying and then left the home with the infant in only a onesie and a light blanket. An ambulance was called to examine the infant and she was returned to her mother, and police made no arrests. The mother told the CPI she attempted to block the door, but she allowed the father to exit because he was holding the infant and she did not want the infant to be injured. She stated she called police as soon as the father left. The mother denied domestic violence and reported the father did not live in the home. The CPI observed the infant and spoke with the infant's 9-year-old cousin, who was in the home at the time of the incident. He stated he felt safe with the infant's mother and reported he was in the bedroom during the incident and did not witness it. The father told the CPI that he walked outside with the infant in a onesie and blanket, and he was outside no more than five minutes. The CPI spoke with hospital staff who reported the infant had been hospitalized for cancer treatment. DCFS unfounded the investigation for inadequate clothing (#78) and substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60).

Child No. 152	DOB: 07/2013	DOD: 05/2023	Natural
Age at death:	9 years		
Cause of death:	Respiratory failure		
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: Nine-year-old medically complex child went into cardiac arrest at home. Her in-home nurse called 911 and began CPR. The child was transported by ambulance to the hospital, where she was pronounced deceased. The child had been diagnosed with DiGeorge syndrome, had chronic heart and lung conditions, and required a ventilator and in-home nursing care. Her in-home nurse noted her heart and lung conditions had been worsening and she had been approved as a transplant candidate. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In December 2022, DCFS received a report that the child's 12-year-old paternal half-brother disclosed that during a recent visit with his father, his father required him to do manual labor from 8am to 6pm for three days in a row and allowed him to take only a lunch break. The reporter added the brother experienced panic attacks prior to court-ordered visits with his father. The CPI spoke with the reporter, who stated the child's mother could not afford to return to court to modify the visitation agreement. The brother told the CPI he had been ordered to clean out his grandmother's home with his

cousins while his father sat around and yelled at him. He denied his father physically hurt him. The father reported the brother helped clean the paternal grandparents' home because the paternal uncle and grandfather recently died, and they planned to sell the home so the paternal grandmother could move into more appropriate housing. The father denied he made the brother carry anything too heavy. The father stated the brother did not like to visit because he did not like to do his chores or follow the rules. The child's 8-year-old brother confirmed they helped clean the home, but stated they had plenty of time to play. He also denied corporal punishment. The CPI observed the child and noted she was non-verbal. The brother's therapist reported the brother attended therapy due to panic attacks related to visits with the father. The brother's primary care physician reported the brother had worsening symptoms despite working with a therapist. The father declined intact family services. DCFS indicated the child's father for mental injury by neglect (#67). The father appealed the finding, and it was overturned. In February 2023, DCFS received a report that the child had bruises on her forehead and forearm. The child's in-home nurse told the CPI the bruise to the child's arm occurred during a hospital stay. She stated she had not noticed the forehead bruise, and she denied any concerns about the parents' care for the child. Both parents reported the arm bruise was from an IV. The child's 8-year-old brother reported he felt safe at home and denied his parents ever hit him or his siblings. The CPI observed no visible signs of abuse or neglect. Hospital staff confirmed the child received medication through an IV during a hospitalization, and it was possible for her to have a bruise from the IV for several days afterward. The child's treating physician reported they witnessed the child hit her forehead to get someone's attention, and she used enough force to result in a bruise. In March 2023, the child had heart surgery. The child's cardiologist noted no concerns with the child's parents. In May 2023, while the investigation remained pending, the child died. DCFS later unfounded the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 153	DOB: 08/2014	DOD: 05/2023	Natural
Age at death:	8 years		
Cause of death:	Presume septic shock due to unknown organism		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Eight-year-old medically complex child died in the hospital. She had a central line and developed a fever and septic infection that led to her death. The child was and had been diagnosed with cerebral palsy, hypoxic ischemic injury, global developmental delay, and scoliosis. She required a tracheotomy and ventilator and had a g-tube. The child also had recurring pneumonia and had previously been hospitalized for COVID-19 infection. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In January 2023, DCFS received a report that the child had a broken tibia, and her home health nurse reported hearing a pop while she changed the child's clothes. The CPI observed the child at the hospital and noted she responded to stimulation but was unable to walk, move, or communicate. Hospital staff reported she was on a ventilator. In February 2023, the child was discharged from the hospital. The nurse told the CPI she was using normal pressure when he heard the pop and denied she intentionally hurt the child. She stated she cared for the child 60 hours per week. Hospital staff noted the child was more vulnerable to bone fractures due to low bone density because she was not ambulatory. DCFS unfounded the investigation for bone fractures by neglect (#59).

Child No. 154	DOB: 10/2007	DOD: 05/2023	Natural
Age at death:	15 years		
Cause of death:	Heart failure due to congenital heart disease due to genetic disorder		
Reason for review:	Closed child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old died in the hospital where she had been admitted four days earlier due to worsening health. She had dysplastic tricuspid mitral valve, a congenital heart condition. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In October 2022, DCFS received a report that the teen's mother left the then 12-year-old teen and her then 5-year-old brother home alone. DCFS opened the report for a child welfare services referral. The mother informed the CPI the children were in school during the day, the teen was capable of caring for herself, and the mother refused services. In November 2022, DCFS closed the referral.

Child No. 155	DOB: 01/2008	DOD: 05/2023	Natural
Age at death:	15 years		
Cause of death:	Acute respiratory distress syndrome due to acute graft vs host disease due to acute myeloid leukemia		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old died in the hospital from leukemia. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In February 2022, DCFS received a report that the teen, then 14 years old, disclosed her father pulled her hair, hit her with a paddle, slapped her across the face, could only sit on a lawn chair when she had her menstrual cycle, and was verbally abusive. The father reportedly had mental health issues. The father confirmed he had the teen sit on a lawn chair when she was on her menstrual cycle but had since stopped. He denied the physical abuse allegations. The mother had an order of protection against the father. The mother reported the teen appeared sick and weak after she returned to her mother's home from her father's care, and she was subsequently diagnosed with leukemia. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 156	DOB: 09/2008	DOD: 06/2023	Natural
Age at death:	14 years		
Cause of death:	Cardiorespiratory arrest non trauma due to seizure disorder		
Reason for review:	Closed intact family services case, one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old teen died at the hospital. The teen had been diagnosed with autism spectrum disorder, had developmental delays, was nonverbal and had a history of seizures. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: In August 2022, DCFS opened an intact family services case after an unfounded investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The intact worker applied for Norman funds to assist the family with utilities. The mother struggled with the demands of care for the teen, so the intact worker made referrals for respite care and explored possible placement at a residential facility. The worker also supported the family in getting therapy for the teen's 12-year-old sister, and recommended family therapy for the sister and mother. The mother declined parenting classes and therapy. In October 2022, while the intact case remained open, DCFS received a

report that the teen's mother told the teen's 12-year-old sister to leave the home after she purchased something with the mother's credit card. The CPI met with the mother, who denied that she kicked the sister out and stated the sister ran away, but later returned home. The sister confirmed that she used her mother's credit card without permission and ran away. The other children denied any abuse. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and inadequate supervision (#74). The family's intact worker documented the mother continued to struggle with the sister's behavior. The intact worker and mother attended a meeting at the sister's school to discuss a behavior plan and evaluation for one-to-one monitoring. In January 2023, DCFS received a report that the teen's 12-year-old sister opened a package addressed to the teen's mother and took items from it, leading to a physical altercation between the sister and mother. The reporter noted the sister had three scratches on her face that appeared swollen. The CPI visited the home, and the mother reported the sister hit her, so she fought back. During the investigation, the sister was hospitalized. The CPI met with the sister at the hospital, and the sister reported her mother attacked her first and she fought back. She stated she felt safe at home and wanted to return to her mother's care. Following discharge, the sister completed an outpatient treatment program. During the investigation, the mother requested the closure of the intact case. DCFS indicated the investigation for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). Following the investigation, the intact family services case was closed.

Child No. 157	DOB: 05/2017	DOD: 06/2023	Natural
Age at death:	6 years		
Cause of death:	Hypernatremia due to respiratory infection due to type 1 spinal atrophy		
Reason for review:	Open intact family services case at time 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		

Narrative: Six-year-old medically complex child died in the hospital 11 days after he was found unresponsive in the care of his stepfather. After an MRI revealed minimal brain activity, his mother and stepfather agreed to withdraw care. Child had been diagnosed with spinal muscular atrophy, a chronic kidney issue, and hypotonia. He required a wheelchair for mobility, a g-tube for feeding and a breathing machine. Upon admission, the child had two different viruses, subdural hematomas, and very high sodium levels which doctors reported indicated dehydration. The child's mother, stepfather, and home health nurse reported his formula was changed two weeks earlier and he had been sick with a cold for approximately one week. All three denied concerns that he missed feedings. The mother stated the child appeared to be doing well on the new formula, but the nurse noted the child had been asking for water in the week prior to his hospitalization. She stated the mother called the child's pediatrician to discuss his increased thirst, but the pediatrician's office had no notes in the child's file about the child's cold or thirst. The state's attorney declined to file criminal charges. DCFS indicated the child's mother and stepfather for death by neglect (#51). DCFS unfounded the investigation for head injuries by abuse (#2), and for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: In August 2022, DCFS received a report that the family's pediatrician sent the child's then 6-month-old sister to the hospital for low weight, and medical staff determined her weight was due to improper feeding. The mother had also missed 2-month and 4-month checkups for the baby. The CPI met with the mother at the hospital, who reported she fed the sister, but the baby had been spitting up a lot, so she thought she was feeding her too much. The mother explained she missed some appointments because of lack of transportation. She reported she had five children at home, including the then 5-year-old child, who had special needs. The CPI learned the family agreed to in-home nursing care. The hospital released the sister to the care of the mother after the family agreed to in-home nursing care. The mother later reported the sister's doctor placed her on a new formula and feeding schedule. The mother agreed to intact family services and noted they would need to find new housing soon because their landlord planned to sell their home. Throughout the investigation, the sister continued to gain weight and her

pediatrician reported she was growing and developing well. DCFS indicated the child's mother and stepfather for failure to thrive (#81). DCFS opened a high-risk intact family services case. The intact worker met weekly with the family at their home. In March 2023, the mother reported they were given a five-day eviction notice and she was looking for new housing and employment. She stated the family would stay at a hotel if they did not locate a new apartment in time and the intact worker made a referral for Norman funds. One week later, DCFS received a report that the then 5-year-old child did not receive appropriate follow-up medical care, including missed appointments with pulmonology and missed treatment injections. The CPI saw the family at home and noted the child was seen sleeping on the couch, hooked up to his g-tube, and he showed no outward signs of abuse or neglect. The mother and the DSCC worker reported the child received his injection one week earlier and had additional appointments scheduled. The parents reported they were still looking for a new home. In May 2023, the CPI observed the family in their new home and noted the home was appropriate. The reporter informed the CPI the family had attended all appointments since the hotline call. The CPI also spoke with the DCFS nurse, who noted the child had a terminal condition and his mother had a right to refuse the injections. The child's pediatrician stated she did not believe the child was medically neglected. Before the investigation closed, the mother reported she was getting back on track with finances, they had a new home and new car, and they received in-home nursing services five or more days per week. DCFS unfounded the investigation for medical neglect (#79). The intact case remained open at the time of the child's death.

Child No. 158	DOB: 01/2023	DOD: 06/2023	Natural
Age at death:	4 months		
Cause of death:	Multiple congenital abnormalities		
Reason for review:	Two unfounded child protection investigations and child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old medically complex infant died of natural causes. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: In September 2022, DCFS received a report that the infant's maternal grandmother allowed the then 17-year-old mother to be in a sexual relationship with a man in his 40s. The mother told the CPI she was two months pregnant and began dating her 42-year-old neighbor four months earlier. The grandmother stated she tried to keep the mother away from the neighbor and believed the neighbor was the infant's father, but she had not contacted police about the situation. The mother reported the infant's father was 19 or 20 years old, but he did not have a phone and she had not seen him since the month prior. The grandmother declined a forensic interview and stated the mother told her the relationship was consensual, and she declined intact family services. The mother's medical providers reported the mother received prenatal care, was up to date on immunizations, and there were no concerns for abuse or neglect. The CPI, noting the legal age of consent in Illinois is 17 years, unfounded the investigation for sexual penetration (#19). In January 2023, the infant was born at 28 weeks gestation. He remained in the NICU for two months. In April 2023, DCFS received a report that the infant had been discharged home, but he was re-admitted to the hospital several days later. The reporter stated the mother needed assistance with housing, parenting, and supportive services. DCFS took the report for a child welfare services referral. The infant's 18-year-old mother told the case worker the infant had COVID-19 and required a breathing tube. She stated she participated in a transitional housing program, had housing at a motel until June 2023, and she participated in therapy. The DCFS worker completed a screening tool for depression and arranged for the mother to get a mental health evaluation. DCFS then received a report that the infant's mother required hospitalization. The infant remained in a different hospital for treatment of COVID-19. The infant's medical team told the CPI the infant went into cardiac arrest and was resuscitated, and he would need extensive care upon discharge. DCFS took protective custody of the infant and placed him in a foster home and submitted a referral to the DCFS nurse. After the mother was discharged from the

hospital DCFS allowed protective custody to lapse. That month, the mother reported she moved back into the maternal grandmother's home. The mother initially agreed to intact family services but canceled the handoff meeting due to her work schedule. The CPI attempted to reschedule the meeting, but the mother later refused services. She told the CPI she continued to receive services from community agencies. DCFS unfounded the April 2023 investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 159	DOB: 03/2022	DOD: 06/2023	Natural
Age at death:	15 months		
Cause of death:	Myocardial ischemia due to congenital heart disease with significant contributing conditions of anoxic brain injury, subdural hemorrhage, status epilepticus, acute kidney injury, and respiratory failure		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Fifteen-month-old died at the hospital approximately three months after he was admitted for symptoms of heart failure. The toddler had been born with congenital heart defects and underwent multiple elective procedures, but his condition continued to decline. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: In March 2023, DCFS received a report that the mother and toddler's father slapped the toddler's 7-year-old maternal half-sister in the face, used a bug swatter on her face and bottom, and the mother had previously hit and kicked the sister. The reporter noted the sister never appeared with marks or bruises. The CPI interviewed the sister who reported she and her 4-year-old brother were spanked on the bottom when they got in trouble. She denied she was spanked with any objects. The CPI noted that the sister, the 4-year-old brother, and the toddler did not show signs of abuse or neglect, and the siblings reported feeling safe at home. The CPI met with the mother at home, who denied she or the toddler's father spanked either child, and reported she disciplined the children by sending them to their rooms. The mother reported she and the sister's father were in the process of getting divorced. The toddler's father also denied the allegations. The 4-year-old's teacher noted the mother requested the 4-year-old half-brother start seeing the school counselor and required the school remove the half-brother's father from the list of people approved to pick him up from school. During the pending investigation, DCFS received a related information report that the half-siblings' father was suspected of sexual abuse, after the sister disclosed her father's paramour and friends touched her. The sister completed a forensic interview and did not disclose any sexual abuse. Two weeks later, DCFS received a related information report that the sister was taken to the doctor to be evaluated for bedwetting due to possible sexual abuse, and she disclosed her father, his paramour, and his friends touched her bottom, but did not provide specifics. During the investigation, law enforcement closed their case and the state's attorney declined the case because the sister did not make any disclosures. The sister's pediatrician stated she saw the sister for bedwetting, but there were no concerns of sexual abuse, and the sister did not disclose anything concerning when she was asked about inappropriate touch. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10).

Child No. 160	DOB: 06/2023	DOD: 06/2023	Natural
Age at death:	2 weeks		
Cause of death:	Adenovirus pneumonia due to extreme prematurity 29 weeks		
Reason for review:	Pending child protection investigation at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old died of pneumonia. He had been born premature and never left the hospital following his birth. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: In November 2022, DCFS received a report that police responded to the parents' home because the father threw water bottles and baby bottles at the mother during an argument. The reporter stated the newborn's then 2-month-old and 12-month-old siblings were in the home but sleeping at the time of the altercation. The parents confirmed they argued but denied they threw any objects. A witness corroborated the parents' reports and denied any past physical violence. The mother and children moved out of the home. DCFS unfounded the investigation for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). In January 2023, DCFS received a report with concerns about the mother's drug use, mother's mental health and the baby living with the maternal grandmother and step-grandfather who also used drugs and had prior DCFS involvement. The CPI visited the home and observed that it was appropriate, and the children appeared free of signs of abuse or neglect. The mother disclosed past drug use but reported she received treatment, denied recent use, and completed a drug screening that was negative for all substances. She stated she and the children moved into the grandparents' home after she and the father separated. The father stated he and the mother had a visitation schedule and he had no concerns about the children's care. Police denied any record of contact with the mother. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). In June 2023, DCFS received a report that police responded to a domestic disturbance between the newborn's mother, father, and paternal aunt. The reporter stated the father was drunk and threw the newborn's 9-month-old sister around and hit her head. When police officers arrived on the scene, they noted that the father did not appear intoxicated, the sister was smiling and did not have any visible injuries, and the mother and father were living with the newborn's paternal grandparents until the mother could obtain her own home. When the CPI spoke with the mother, she reported she was in the hospital with the newborn, who had pneumonia, and she planned to stay overnight. Two days later, while the investigation remained pending, the newborn died. The CPI later interviewed the parents and paternal aunt, who confirmed an argument occurred but denied the newborn's sister was hurt. The mother denied domestic violence, mental health issues, and substance use. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

TWENTY-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2004-17		2018		2019		2020		2021		2022		2023		2004-2023		
															TOTAL	AVERAGES	
CASE STATUS	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**#**	**%**
Youth in Care	307	21.0%	16	16.3%	22	17.9%	21	20.6%	11	9.0%	26	15.2%	30	18.8%	**433**	**22**	**19.4%**
Unfounded DCP	360	24.6%	37	37.8%	47	38.2%	29	28.4%	45	36.9%	53	31.0%	55	34.4%	**626**	**30**	**28.0%**
Pending DCP	210	14.4%	12	12.2%	19	15.4%	11	10.8%	20	16.4%	34	19.9%	23	14.4%	**329**	**16**	**14.7%**
Indicated DCP	94	6.4%	15	15.3%	9	7.3%	14	13.7%	14	11.5%	11	6.4%	14	8.8%	**171**	**8**	**7.6%**
Child of Youth in Care	30	2.1%	1	1.0%	2	1.6%	1	1.0%	0	0.0%	1	0.6%	1	0.6%	**36**	**2**	**1.6%**
Open Intact	197	13.5%	8	8.2%	8	6.5%	13	12.7%	14	11.5%	23	13.5%	19	11.9%	**282**	**14**	**12.6%**
Closed Intact	63	4.3%	3	3.1%	7	5.7%	5	4.9%	6	4.9%	8	4.7%	8	5.0%	**100**	**5**	**4.5%**
Open Placement/ Split Custody	82	5.6%	3	3.1%	4	3.3%	2	2.0%	9	7.4%	6	3.5%	6	3.8%	**112**	**5**	**5.0%**
Closed Placement/ Return Home	24	1.6%	0	0.0%	2	1.6%	1	1.0%	3	2.5%	3	1.8%	0	0.0%	**33**	**2**	**1.5%**
Others	94	6.4%	3	3.1%	3	2.4%	5	4.9%	0	0.0%	6	3.5%	4	2.5%	**115**	**6**	**5.1%**
TOTAL	**1461**	**100%**	**98**	**100%**	**123**	**100%**	**102**	**100%**	**122**	**100%**	**171**	**100%**	**160**	**100%**	**2237**	**110**	**100%**

FISCAL YEAR	04-17	18	19	20	21	22	23	Totals 04-23
Total Deaths	**1461**	**98**	**123**	**102**	**122**	**171**	**160**	**2237**
Youth in Care	**307**	**16**	**22**	**21**	**11**	**26**	**30**	**433**
Natural	156	5	9	7	5	9	9	**200**
Accident	41	4	5	4	2	3	8	**67**
Homicide	73	4	6	4	2	10	7	**106**
Suicide	20	0	0	3	1	1	1	**26**
Undetermined	17	3	2	3	1	3	5	**34**
Unfounded Investigation	**360**	**37**	**47**	**29**	**45**	**53**	**55**	**626**
Natural	111	12	8	11	21	23	22	**207**
Accident	127	12	16	13	8	11	15	**202**
Homicide	57	4	11	1	6	11	15	**105**
Suicide	15	0	3	1	3	3	1	**26**
Undetermined	50	9	9	3	7	5	2	**86**
Pending Investigation	**210**	**12**	**19**	**11**	**20**	**34**	**23**	**329**
Natural	63	2	4	7	7	12	8	**103**
Accident	55	4	7	3	7	9	4	**89**
Homicide	36	4	2	1	3	7	6	**59**
Suicide	5	0	2	0	0	1	1	**9**
Undetermined	51	2	4	0	3	5	4	**69**
Indicated Investigation	**94**	**15**	**9**	**14**	**14**	**11**	**14**	**171**
Natural	28	4	3	6	4	4	5	**54**
Accident	33	2	3	3	4	2	2	**49**
Homicide	15	4	1	2	2	4	2	**30**
Suicide	3	0	1	1	2	0	0	**7**
Undetermined	15	5	1	2	2	1	5	**31**
Child of a Youth in Care	**30**	**1**	**2**	**1**	**0**	**1**	**1**	**36**
Natural	13	0	2	0	0	0	0	**15**
Accident	5	0	0	1	0	1	0	**7**
Homicide	4	0	0	0	0	0	0	**4**
Suicide	0	0	0	0	0	0	0	**0**
Undetermined	8	1	0	0	0	0	1	**10**
Open Intact	**197**	**8**	**8**	**13**	**14**	**23**	**19**	**282**
Natural	92	0	2	4	5	11	8	**122**
Accident	44	5	0	5	3	5	3	**65**
Homicide	27	1	2	2	3	4	3	**42**
Suicide	3	0	1	0	0	0	0	**4**
Undetermined	31	2	3	2	3	3	5	**49**

FISCAL YEAR	04-17	18	19	20	21	22	23	Totals 04-23
Closed Intact	**63**	**3**	**7**	**5**	**6**	**8**	**8**	**100**
Natural	18	1	5	4	2	2	4	**36**
Accident	19	1	2	0	2	3	0	**27**
Homicide	14	0	0	0	0	1	1	**16**
Suicide	0	0	0	0	0	1	0	**1**
Undetermined	12	1	0	1	2	1	3	**20**
Open Placement/ Split Custody	**82**	**3**	**4**	**2**	**9**	**6**	**6**	**112**
Natural	49	2	2	1	4	2	2	**62**
Accident	16	0	1	0	0	3	1	**21**
Homicide	9	1	1	0	1	1	2	**15**
Suicide	0	0	0	0	1	0	1	**2**
Undetermined	8	0	0	1	3	0	0	**12**
Adopted	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Former Youth in Care	**16**	**0**	**0**	**0**	**0**	**4**	**1**	**21**
Closed Placement/ Return Home	**24**	**0**	**2**	**1**	**3**	**3**	**0**	**33**
Interstate Compact	**2**	**0**	**0**	**0**	**0**	**0**	**0**	**2**
Preventive Services	**32**	**1**	**0**	**0**	**0**	**0**	**0**	**33**
Subsidized Guardianship	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Child of Former Youth in Care	**4**	**0**	**1**	**2**	**0**	**0**	**0**	**7**
Extended Family Support	**14**	**0**	**0**	**0**	**0**	**0**	**0**	**14**
Child Welfare Referral	**25**	**2**	**2**	**3**	**0**	**2**	**3**	**37**

** Autopsies that remain pending at time of publication are included in "Undetermined" manner. These tables have been updated to reflect the final manner of death for autopsy reports that were released after the OIG Annual Report in which the death was reviewed.*

PART III: GENERAL INVESTIGATIONS

GENERAL INVESTIGATION 1

COMPLAINT

A private agency caseworker placed a newborn infant with the caseworker's daughter after the infant entered the Department's care. The complainant alleged that the caseworker did not disclose to the private agency that she placed the infant with her daughter. The complainant additionally reported the caseworker previously placed a 6-month-old infant with the caseworker's friend after the child entered the Department's care. The caseworker identified the friend, a previously licensed foster parent with a different agency, as the 6-month-old infant's fictive kin. The private agency learned of the inappropriate placements after the caseworker resigned from the agency and began employment with the Department as a child protection investigator. The daughter refused to release the infant to the private agency, and the agency called law enforcement to the daughter's home. The former caseworker, while a Department employee, interfered with the infant's removal by portraying herself as a representative of the Department with assignment to the case and asserted the private agency had no right to remove the infant.

INVESTIGATION

The newborn infant came to the Department's attention after the mother gave birth to the infant during an open placement case. The mother and infant subsequently tested positive for cocaine and the Department took protective custody of the infant. According to SACWIS notes contained in the child protection investigation and the placement case, the private agency had responsibility for placing the infant. The assigned caseworker did not document her personal relationship to the placement caregiver. The caseworker told IG investigators that she had no input regarding the infant's placement, and that the assigned child protection investigator placed the baby with the caseworker's daughter. The caseworker stated that she did not learn about the infant's placement with her daughter until the daughter called the caseworker on the day the hospital discharged the infant. In a separate interview with IG investigators, the assigned child protection investigator denied participating in the placement decision and reported the private agency found the placement and transported the infant from the hospital to the placement. IG investigators also obtained a recording of the call made to the placement clearance desk by the caseworker on the day of the infant's discharge and the caseworker reported to placement clearance desk staff that the placement was with the infant's relative.

The caseworker told IG investigators that after she learned about the infant's placement with her daughter, she notified the private agency's director. The caseworker stated the director responded that the private agency would remove the caseworker from the case upon completion of the placement. In separate interviews, the former director and the caseworker's former supervisor told IG investigators that they had no recollection that the caseworker disclosed a relationship with the infant's caregiver. The caseworker told IG investigators that five months after the placement, she requested that her new supervisor remove her from the case. However, the caseworker remained on the case until she left the private agency five months later. IG investigators interviewed the supervisor, who stated she did not know about any relationship between the caseworker and the infant's caregiver.

The private agency assigned the caseworker to a separate placement case of a then 6-month-old infant. The 6-month-old infant had been placed in a traditional foster home, and the caseworker subsequently removed the then 6-month-old due to domestic violence in the foster home. The caseworker told IG investigators that she attempted to place the infant with relatives, and after exhausting all options, she asked the private agency's licensing department for the foster parent recruitment list. The caseworker stated she identified a placement for

the infant from the list who was her former acquaintance. The caseworker stated that she recalled meeting the acquaintance at a previous foster parent recruitment event. The caseworker stated that on a separate occasion, the acquaintance mentioned she was a foster parent for her brother's children, with case management through a different agency. The caseworker told IG investigators that she assumed the acquaintance had a foster home license with the case management agency of her brother's foster children, but never confirmed licensing status.

The acquaintance informed IG investigators that she never previously fostered any children and never attended a foster parent recruiting event. The acquaintance stated the caseworker contacted her inquiring if she knew anyone who could take the 6-month-old. The acquaintance and her spouse subsequently agreed to be the infant's foster parents.

The caseworker told IG investigators that she spoke with her supervisor prior to placing the child, and the supervisor offered to obtain information from the acquaintance while the caseworker contacted the placement clearance desk. However, the supervisor told IG investigators in a separate interview that she did not approve the acquaintance as the child's foster parent. The supervisor stated she was new to the private agency at that time, and the caseworker told her that she staffed the placement with the private agency director, who the supervisor believed approved the placement. The IG investigators interviewed the former private agency director, who did not recall staffing the placement with the caseworker.

The supervisor informed IG investigators that the caseworker reported the placement as the infant's fictive kin who had a foster home license with another agency. However, the acquaintance told IG investigators that she did not have a relationship with the infant or know the family. The acquaintance stated the caseworker called her after placing the infant, stating that she told the private agency licensing representative that the acquaintance had previously been licensed but the license had expired. The acquaintance told IG investigators that the caseworker instructed her to lie when the licensing representative contacted her and to provide the same story.

The supervisor told IG investigators that she did not learn until the following month that the acquaintance was not fictive kin to the infant after a newly assigned caseworker attended the family's administrative case review two months after placement. During the administrative case review, the mother replied that she did not know the foster mother. The supervisor stated that at that time, she informed the private agency's interim director of her concerns that the previous caseworker inappropriately placed the infant. The supervisor stated she never discussed the issue with the previous caseworker because the previous caseworker had become combative towards her due to other work issues, and that the interim director handled everything with the previous caseworker from that point forward; however, by that point, the previous caseworker had given her notice to leave the private agency because she had accepted a position with the Department.

The private agency administrator told IG investigators that after learning of the child's inappropriate placement, the private agency reviewed the former caseworker's previous cases and found that the previous caseworker shared the same address as the placement she identified for the newborn infant in the separate case. The private agency administrator reported a series of phone conversations with the former caseworker's daughter, who denied any relation to the former caseworker. The private agency administrator also informed the daughter that they found inconsistencies in her foster parent application for the infant and asked about her relationship to the infant. The daughter subsequently reported she was the infant's fictive kin, as the infant's maternal grandmother babysat the caseworker's daughter in her youth. The private agency contacted the maternal grandmother, who denied she knew the infant's foster mother, which led the private agency to remove the infant from the placement. However, the daughter did not cooperate with returning the infant and the private agency called law enforcement to the daughter's home for assistance in removing the infant.

IG investigators obtained the body camera footage from law enforcement who responded to the daughter's home. The footage showed the former caseworker at the daughter's residence, where she identified herself as a child protection investigator to law enforcement and provided her DCFS identification. The time stamped

footage also showed that the former caseworker repeatedly told law enforcement that the private agency did not have the right to remove the infant.

IG investigators found that the former caseworker falsified her Department attendance reports and documented that she worked at the time when she was actually at her daughter's residence and interfering with the infant's removal. IG investigators additionally found that the former caseworker falsified six overtime forms, in which she reported writing case notes and assessments for specific child protection investigations. IG investigators reviewed the specific investigations and found no case notes or assessments written during the claimed overtime periods.

RECOMMENDATIONS

1. The Department should pursue discharge of the former caseworker.

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

GENERAL INVESTIGATION 2

COMPLAINT

A DCFS employee sent harassing emails to a former coworker at a different state agency. The complainant alleged that some of the emails referenced harm to the former coworker's children as well as threats of sexual assault and murder to the former coworker. The complainant also alleged that the employee misused the state telephone system when she called a different former coworker of another state agency, of whom she had a history of harassment against. During the OIG investigation the employee transferred to the f initiated a joint investigation of the DCFS employee's alleged misconduct while working at both DCFS and HFS.

INVESTIGATION

Since September 2001, the DCFS employee had worked at seven different state agencies. The OIG reviewed the DCFS employee's personnel files from the various state agencies, interviewed the former coworkers, and found that the DCFS employee had a substantial documented history of harassment and disruptive conduct. The DCFS employee made racial slurs and leveled unfounded accusations of misconduct or illegal behavior of other employees. Multiple former coworkers had reported that the DCFS employee's behavior caused them to fear for their safety and interfered with their ability to do their job. The state agencies that employed the DCFS employee consistently imposed progressive discipline.

The OIG found that the DCFS employee used her personal cell phone to call the state phone of her former coworker at a different state agency, and therefore, the DCFS employee did not misuse a DCFS issued phone. However, DCFS IG and the HFS BIA investigators found that the DCFS employee had a significant history of harassing the former coworker, leading the coworker to file a police report that stated the coworker received harassing emails and phone calls from the DCFS employee.

DCFS OIG and HFS BIA investigators interviewed a second former coworker at another state agency, who stated from 2014 to 2021, the DCFS employee sent her emails that threatened physical harm to the coworker, her family, and her children. DCFS OIG and HFS BIA investigators obtained almost 2,000 emails that the DCFS employee sent between March 2019 and January 2022 which contained repetitive themes of a sexual nature, degrading and defaming insults, physical threats, and other forms of harassment. The joint investigators found that the DCFS employee sent 95.8% of those emails from the DCFS employee's confirmed personal email addresses. The remaining emails were sent from various email addresses that appeared similar to the style and format of the harassment emails from the DCFS employee's confirmed personal email addresses. The joint

investigators found that the DCFS employee sent almost 500 of the emails during the DCFS employee's work hours at both DCFS and HFS.

The OIG and the HFS BIA found that the DCFS employee violated the State of Illinois Code of Personal Conduct, which requires state employees to conduct themselves with "integrity and in a manner that reflects favorably upon the state." The OIG also found that the DCFS employee violated the DCFS Employee Handbook, Section 3.1, *DCFS Professional Conduct*, which instructs DCFS employees to act in a "responsible professional manner in all work situations, whether dealing with clients, co-workers or the general public," because DCFS employees "are in positions of public trust and are expected to refrain from conduct which could affect adversely the confidences of the public in the integrity of the Department of Children and Family Services." Section 3.1of the DCFS Employee Handbook also provides that DCFS employees can be disciplined up to and including discharge if the employee's off-duty conduct "raises reasonable doubt concerning the employee's suitability for continued state employment in the present assignment or position, or which adversely affects the confidence of the public in the integrity of the Department of Children and Family Services."

The OIG referred the allegations to the Illinois State Police, Division of Internal Investigations for a criminal investigation of the emails allegedly sent from the DCFS employee to the second former coworker. The state's attorney charged the DCFS employee with two counts of Harassment Through Electronic Communications to which the DCFS employee pled guilty.

RECOMMENDATIONS

1. The Department of Children and Family Services should discipline the employee up to and including discharge.

The Department agrees. The employee was discharged from the Department.

GENERAL INVESTIGATION 3

COMPLAINT

An out-of-state sheriff's department detained an Illinois child protection supervisor and confiscated her Department issued cell phone. After returning to Illinois, the Department employee filed a false police report, which documented that she left her Department issued cell phone in a restroom, and the phone was no longer there when she returned to retrieve it. The employee's filing of a false police report was referred to the Illinois State Police, Division of Internal Investigations. In addition to the false police report, the child protection supervisor also submitted her Department timesheet, which recorded she worked in a DCFS office on the day and time she was known to be detained outside of Illinois. The OIG investigation addressed the allegations of failure to perform work duties and submission of a fraudulent timesheet.

INVESTIGATION

The out-of-state sheriff's department informed the Department that they detained the Illinois child protection supervisor after law enforcement arrested the vehicle's driver, related to suspicion of distributing narcotics. The out-of-state sheriff's department detained the child protection supervisor for approximately two hours and seized the supervisor's Department issued and personal cell phones.

The child protection supervisor submitted a signed Department timesheet documenting in-person work in the DCFS Field Office for the entire workday for the date and time of detainment out of state. The area administrator, who oversaw the child protection supervisor, had previously scheduled benefit time that day and did not know of the supervisor's absence. The area administrator told IG investigators that the child protection

supervisor reported losing her Department issued cell phone. In the process of requesting a replacement cell phone, the child protection supervisor filed a police report which falsely reported that, on the same date the supervisor was detained, she left her Department issued phone in a restroom at the DCFS field office, and it was gone when she returned.

An OIG review of Department emails revealed that the child protection supervisor had responsibility for assigning intake investigations on the day law enforcement detained her out-of-state. That day, the child protection supervisor sent numerous emails related to case assignments until approximately one hour prior to her detainment, then sent no other emails until the following morning. During the period of inactivity, the child protection supervisor did not respond to emailed questions involving a child's safety plan and did not assign at least two intake investigations. When questioned about her unresponsiveness by a temporarily assigned administrator, the child protection supervisor lied and said her phone did not notify her of the intakes.

The Illinois State Police, Division of Internal Investigations investigation resulted in the child protection supervisor's arrest and charge with misdemeanor Fraud Against a Government Entity/<$300. The criminal case remains pending.

RECOMMENDATIONS

1. The child protection supervisor should be disciplined up to and including discharge.

The Department agrees. The child protection supervisor was discharged from the Department.

GENERAL INVESTIGATION 4

COMPLAINT

A private agency intact worker allegedly threatened to take custody of a mother's child if the mother did not stop messaging the worker. During the investigation, IG investigators identified issues related to the Department's implementation of specialty services for a parent with disabilities and compliance with the Americans with Disabilities Act of 1990.

INVESTIGATION

The mother first came to the attention of the Department when she was indicated for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to a 6-year-old relative. Years later, the Department was notified of the birth of the mother's first child and concerns about the mother's ability to care for the infant given her cognitive delays and impulsive behaviors. The Department conducted four child protection investigations related to these concerns within the first two years of the child's life; one investigation resulted in an indicated finding of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

The Department received a report that the mother's 3-year-old child walked to the neighbor's home alone. The call floor worker noted the mother and her paramour were deaf and communicated using American Sign Language (ASL). To meet the mandate, the child protection investigator attempted to see the family without an ASL interpreter, as the Department-contracted vendor for interpreter services required pre-scheduling. The investigator's subsequent visits with the family were scheduled to ensure the presence of an ASL interpreter. The child protection investigator provided door locks for the family to keep the child from leaving the home unsupervised. A relative reported overseeing the mother's disability benefits and finances. The Department indicated the mother for an allegation of inadequate supervision (#74) and opened an intact family services case

to assist the mother with childcare, protective daycare, parent education, and to connect the mother to community services.

The intact case was assigned to a private agency and an agency supervisor provided services to the family due to temporary staffing issues. The supervisor visited the home weekly, accompanied by an ASL interpreter. The supervisor noted that the child appeared delayed and struggled with verbal communication. The supervisor documented the mother struggled to communicate and appeared to have difficulty understanding questions and providing answers during the integrated assessment interview. The mother also did not appear to provide consistent supervision for the child. The supervisor planned to have the child assessed and enrolled in preschool.

During the intact case, the Department conducted seven additional child protection investigations involving the family. Child protection investigators used relatives to care for the child under safety plans while the investigations were pending. The Department indicated the mother and her paramour for allegations of inadequate supervision (#74) in four of the investigations, which included additional indicated allegations of inadequate clothing (#78) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The Department also unfounded the mother and paramour for allegations of cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and by neglect (#61); and environmental neglect (#82). Throughout the child protection investigations, staff noted concerns about the mother and paramour's cognitive abilities, and the mother's difficulty with managing her anger. Intact family staff also noted the mother appeared uncooperative at times.

After the initiation of the third child protection investigation during the intact case, the private agency supervisor, on the suggestion of the child protection investigator, sent a request to a DCFS intact supervisor tasked with case assignments to ask that the family's case be transferred to DCFS for continued intact services. The private agency supervisor stated that the mother's disability and lower functioning required a higher level of intervention, and the private agency had a vacant intact worker position, which left the supervisor to serve as the caseworker. The intact supervisor reported that despite providing the family with supplies, the child continued to get out of the home, and daycare programs would not accept the child because of the child's behavioral needs. In addition, the supervisor reported barriers to establishing services because of the need to coordinate with interpreters. The DCFS intact supervisor stated to IG investigators that DCFS Intact Family Services would not accept the return of cases from private agencies unless there was an extreme situation, such as low staffing, or significant performance issues. The case remained with the private agency. Initiation of services took months, in part because of the need for ASL interpreter services for the parenting classes and for the school assessment for the child. A school assessment found the child had significant cognitive, social emotional, and communication delays, which made the child eligible for the school district's early childhood special education program.

Both DCFS child protection and the private agency appeared to struggle with providing the family with services. Child protection investigators could not secure on-demand ASL interpreters for visits and at times relied on writing notes back and forth with the mother. The intact supervisor experienced delays with service referrals because of the case complexities and the need for an ASL interpreter. The DCFS Statewide Deaf and Blind Service Coordinator reported to IG investigators that they become involved in a case after being contacted by the field, as occurred in this case. The coordinator reported staff are reminded of this specialty service through annual or biannual email and intranet announcements. The coordinator stated that DCFS did not have automatic notification to the coordinator of a new deaf or hard of hearing client. The coordinator reported that they did not maintain notes or files on any case consultations and did not have a database of DCFS deaf or hard of hearing clients.

The Department Procedures 302, Appendix L, Section V, *Working with Deaf or Hard of Hearing Children or Families* provides guidance on serving families with hearing impairments. According to the procedure, written material explaining their rights should be given to clients who are deaf and hard of hearing. The procedure also

includes a list of interpretation services, and auxiliary aids, such as Telecommunications Device for the Deaf (TDD), assistive listening devices, specialized smoke detectors, and telephone handset amplifiers, that can be provided to the client. The State of Illinois maintains a master contract with a Chicago-based company for interpretation services; the Department has two smaller contracts with specific providers for short term ASL interpretation.

According to DCFS Procedures 302, Appendix L, Section V, *Working with Deaf or Hard of Hearing Children or Families*, all DCFS regional offices are required to have a list of resources and instructions on accessing resources for deaf and hard of hearing clients. Procedure instructs DCFS and CWCA supervisors to assign deaf or hard of hearing clients to 1) staff who specialize in services for this population and can communicate using ASL or 2) staff who have no less than five years of experience with DCFS or their agency and have completed all training pertaining to deaf clients and deaf needs. If neither of these options are available, the procedure directs that cases involving deaf or hard of hearing clients should be assigned to the most senior staff member, who should reach out to the statewide coordinator to obtain training on deaf clients and their needs.

Four months after the case opened, an intact worker was assigned to the case who was new to the field of child welfare. During this same period, after the fifth child protection investigation during the intact case, DCFS convened a clinical staffing. The clinician recommended tasks for the agency which included reviewing general safety planning with the mother, written in simple terms; referring the mother for a psychological and/or a parenting capacity assessment; conducting multiple unannounced visits; referring the mother to community providers for housing, securing a social security disability insurance payee; identifying a guardian for the mother and the child; and obtaining the police report from a disturbance at the address. The intact supervisor also spoke to the county's assistant state's attorney, who agreed to file a petition for court supervision.

Shortly thereafter, the DCFS deaf and blind coordinator and the DCFS developmental and intellectual disabilities coordinator met with the intact worker and supervisor. Intact staff repeated concerns about the mother's psychological functioning and parenting capacity, and the child's behavioral needs. The supervisor reported that multiple providers were contacted to conduct the mother's psychological evaluation, with no success. The coordinators recommended the intact supervisor find a Certified Deaf Interpreter, a specialized interpreter, to use in conjunction with an ASL interpreter for the mother's evaluation. The coordinator also advised the intact team to contact the Illinois Service Resource Center, funded by the Illinois State Board of Education, for parent coaching. The deaf and blind coordinator noted Illinois had only a few psychologists fluent in ASL and provided the intact supervisor with three out-of-state ASL providers. After the staffing, the intact supervisor attempted to schedule a meeting with the mother, an ASL interpreter, and a Certified Deaf Interpreter who was not available for two months. The supervisor secured a psychological evaluation for the mother with an ASL-certified psychologist, but there was a four-month wait for the appointment.

An ASL-fluent parenting coach began working with the mother while awaiting the evaluation. After an initial session, the coach reported concerns with the mother's functioning level and opined that the mother functioned at a first or second grade level and her impairments impeded her ability to parent. The parent coach identified that the mother needed more assistive technology in the home, such as flashing light door alarms. In preparation for the psychological evaluation, a prior evaluation was reviewed that had been conducted when the mother was 17 years old. The prior evaluation noted the mother had mental health diagnoses, had threatened family members, and she had an IQ of 50.

The state's attorney requested an emergency shelter care hearing seven months after the intact family case opened. The child had marks, and the mother continued to be uncooperative with services. The court awarded the Department custody and placed the child with maternal relatives. The mother participated in services but made minimal progress.

The OIG reviewed cell phone screen shots in which the intact worker told the mother to stop texting after work hours and get her anger under control, and she the mother that the intact worker had the authority to have the

courts remove her child. The intact worker told IG investigators that the mother's messages contained expletives and continued over a three-to-four-day period. The intact worker said she blocked the mother's number, but the mother obtained different numbers to send the messages from. Phone records available to the OIG documented that the mother sent the intact worker 73 texts over three days, and the worker sent 10 reply messages before sending the message about the child coming into care.

RECOMMENDATIONS

1. The Department must secure a mobile application for child protection and other DCFS and private agency staff to use for on-demand video for American Sign Language interpretation services.

The Department agrees. DCFS Operations will work with the Department's Office of Information Technology Service and Office of Legal Services to select a mobile application.

2. The Department should review and evaluate its compliance with Procedures 302, Appendix L, Services for Deaf and Hard of Hearing Clients.

The Department agrees. The Department's Clinical Division is in the final stages of revising Procedures 302, Appendix L. Mandatory training requirements for all caseworkers and supervisors will be incorporated in the revisions.

3. The Department should create a tab on the D-Net for the Specialty Services Unit to highlight information on all DCFS specialty services programs and program specialists for DCFS and private agency workers.

The Department agrees. There is currently information listed on the D-Net under the Resources tab that describes specialty services, including Deaf and Blind Services. A new Clinical Division's Behavioral Health tab is in the development stages. In addition, DCFS Behavioral Health Administration is working with the Office of Information Technology to create a Behavioral Health Specialty Services tab that will include contact information that directly links to each Behavioral Health Specialist, as well as resources and educational materials tailored to each behavioral health specialty area.

4. The Department should develop and implement a means to identify and track child victims, youth in care, parents, guardians, and other individuals involved with the Department who are deaf or hard of hearing and blind.

The Department agrees. The Deaf and Blind Services Coordinator is working with IllinoisConnect to develop a means of identifying and tracking case members who are deaf, hard of hearing or blind. In addition, the Department's Behavioral Health Administration and the Deaf and Blind Services Coordinator are using the new Augintel System to track and identify DCFS cases that have case members who are deaf, hard of hearing or blind in order to provide outreach and assistance.

5. The DCFS Statewide Deaf and Blind Services Coordinator should meet with the DCFS Child Welfare Advisory Committee (CWAC) to present information on services available for clients who are deaf or hard of hearing and blind.

The Department agrees. The DCFS Statewide Deaf and Blind Services Coordinator will meet with the DCFS Child Welfare Advisory Committee to present information available for clients who are deaf, hard of hearing, and blind.

6. The Department must establish a process addressing requests by private agencies for cases to be returned to the Department when specialized services are required.

The Department agrees. The Department's Specialty Clinical Services Unit within the Clinical Division provides support to all agencies and DCFS around the following specialties: Domestic Violence, LGBTQ, Deaf/Blind, HIV, Sexually Problematic Behavior, Developmental Disabilities or Substance Abuse. Per contract, the Child Welfare Contributing Agencies (formerly known as private agencies) are required to identify and provide appropriate services to families, including specialty services. All Department specialty services and consultations are available. If an agency is having challenges or not able to provide the level of service necessary to adequately address the family's needs, they shall request a Clinical Staffing to determine if a transfer would be in the best interest of the family/child. The respective Specialist from the Clinical Unit and Division of Agency Performance Monitoring and Execution (APME) shall participate in the staffing. If a transfer is recommended from the Clinical Staffing, the case transfer process will be initiated with final approval from the APME Deputy. Administrative Procedures 9, *Transfers of Placement Cases by Purchasing of Services Agencies*, will be amended to reflect the transfer process as a result of a clinical staffing or a recommendation by the APME Administrator.

7. This report should be shared with the assigned private agency for educational purposes.

The Inspector General's Office shared the report with the private agency.

GENERAL INVESTIGATION 5

COMPLAINT A private agency placement worker failed to complete essential case management tasks in the provision of permanency services to youth in care, including obtaining consents for mental health services, derailing the youths' permanency plans.

INVESTIGATION The Department initiated three child protection investigations in the span of seven months on the mother and stepfather. The mother and stepfather were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and the then 15-year-old and 16-year-old teens were taken into care and placed with a relative. Four months after entering foster care, the parents surrendered their parental rights and both the teens and the relative foster parent wanted to pursue adoption by the relative.

While in foster care, both teens had behavioral health needs that required treatment. Within the first three months of the case opening, both required psychiatric hospitalization and received referrals for medication management, outpatient counseling, and a school-based mental health program for services. As youth in care, consents for treatment must be obtained from the DCFS Office of the Guardian, through the consent unit which accepts requests through fax or email. When youth in care are over the age of 12, the youth must also sign consents for their treatment.

The child protection investigator initiated the consent process after obtaining information from the foster parent and provided the consents to the placement worker for submission to the DCFS Guardian's Consent Unit. The placement worker told IG investigators they could not recall what happened with those consents. Records from the private agency case record contained consents signed by the youth but not the DCFS Guardian.

Throughout the case, the worker had difficulty obtaining proper consents for treatment and providers cancelled appointments because of the lack of proper consent documentation. Emails obtained by the OIG revealed communications between the placement worker and the Consent Unit regarding obtaining consent with a lack of follow through by both the placement worker and Consent Unit staff. The worker sent consents to the wrong

unit and was directed by Consent Unit staff to send to another mailbox. DCFS Guardian Consent Unit staff reported sending signed consents to the worker, but the documentation was not in the private agency's case record. The foster parent told IG investigators that the placement worker did not know the process for obtaining consents or what information to include in requests. The 16-year-old had initial appointments for mental health services cancelled because of lack of consent, and later chose not to participate in services.

Five months after entering foster care, the 15-year-old began individual counseling with the school-based program. The program's director told IG investigators that they did not have consent from the DCFS Guardian but provided services to the teen citing the Illinois Mental Health and Developmental Disabilities Code, which allows for youth ages 12 and older to access limited counseling services and psychotherapy without consent from their parent or guardian, until consent has been obtained. The program's director told IG investigators they felt not providing services would be more detrimental.

Eleven months after coming into care, during a permanency hearing, the judge ordered the placement worker to obtain consents, signed by both the youth and the Guardian. Following that hearing, the placement worker emailed consents signed by the youth and requested consent from the DCFS Guardian for mental health services. The worker told IG investigators that the worker had signed the youths' names after becoming frustrated with the process of obtaining consents from the DCFS Guardian.

The placement worker also did not create a service plan that included integrated assessment recommendations and did not document regular visits to the foster home. Case notes contained in the record lacked specificity and did not reflect critical events or services. When the 16-year-old reported his girlfriend's pregnancy, the placement worker did not refer the youth to the Teen Parent Services Network (TPSN) until two months after the infant's birth. Teen Parenting Service Network provides financial support and services, such as parent training and equipment and services begin during pregnancy.

The supervisor never documented supervision meetings, intervened to address the problems in the case, or ensured the completion of basic case management tasks required to move the case towards adoption. After over two years as youth in care, both youth turned 18 years old before plans for adoption by their relative could be finalized.

RECOMMENDATIONS

1. This report should be shared with the placement supervisor for training purposes.

The placement supervisor is no longer employed by the agency.

2. This report should be shared with the private agency to address deficiencies identified in the report.

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

3. The Department should develop and implement a means to maintain electronic records of all consents approved by the DCFS Guardian in a youth in care's person management file in the Department's new data system, IllinoisConnect (formerly known as CCWIS) or SACWIS.

The Department agrees. Staff from the Office of the Guardian has met with the IllinoisConnect development team and requested that the new data system allow for all consents to be transported to the youth in care's casefile.

4. The Department should conduct a clinical staffing to review this case, identify needs and services for the teens, and meet with both youth in care to share this information to ensure the teens are able to make an informed decision about continued DCFS involvement.

The Department agrees. Two clinical staffings were held, and a comprehensive staffing report and clinical summary action plan were developed as a result of the meetings.

5. This report should be shared with the Agency Performance Monitoring and Execution (APME) team assigned to the agency to address issues identified in this report.

The Department agrees. The report was shared with APME to address issues identified in the report.

GENERAL INVESTIGATION 6

COMPLAINT A 12-year-old youth in care was removed from his relative foster home in response to allegations of child abuse and neglect in the foster home. The complainant reported concerns for the youth's safety and alleged that the youth's private agency caseworker returned the youth to the relative foster home two weeks into the pending child protection investigation without contacting the placement clearance desk (PCD) for approval prior to returning him to the home.

INVESTIGATION In August 2019, the then 9-year-old youth came to the attention of the Department after law enforcement arrested the youth's adoptive father for aggravated criminal sexual abuse to the youth's then 13-year-old sibling. The Department subsequently indicated the adoptive father for sexual molestation (#21) to the sibling and substantial risk of sexual abuse - sibling of sex abuse victim (#22) to the youth. The adoptive mother signed over temporary guardianship of the sibling to the youth's maternal relative. In October 2019, the Department referred the family for intact services and the youth continued to live with his adoptive mother until his adoptive father was released from jail in December 2019. The youth then moved in with fictive kin. In February 2020, the court found the adoptive parents unfit and granted the Department guardianship of the youth. The court also granted guardianship of the sibling to the maternal relative. The placement case was opened to a private agency. In May 2020, the private agency placed the youth with his maternal aunt and uncle after the fictive kin reported they were no longer able to care for him.

In December 2021, the Department initiated a child protection investigation after the 12-year-old youth disclosed his maternal uncle punched him when he misbehaved and left bruises. The youth reported the last incident occurred approximately one month prior. During the child protection investigation, the youth recanted his statement, the uncle denied the allegations, and the youth's caseworker reported no concerns for the youth's safety. In January 2022, the Department unfounded the uncle and closed the investigation.

In May 2022, four months after the Department closed its investigation into the uncle, the Department initiated an investigation for an allegation of cuts, bruises, welts, abrasions, and oral injuries to the youth by an unknown perpetrator after the youth came to school with bruises on his arms. When asked about the bruises, the youth stated his dog bit him, but the reporter informed the hotline that the bruises looked like handprints. The Department listed the aunt and uncle as non-involved subjects.

The next day, the child protection investigator met with the youth at school and photographed his bruises. The youth reported the bruises came from playing with his dog and running into a trash can. The youth denied corporal punishment and stated he felt safe with his aunt, uncle, and two cousins. That afternoon, the child protection supervisor told the investigator that the aunt needed to take the youth to a doctor to examine his

bruises. The child protection investigator told IG investigators that she contacted the aunt that same day, but neither the aunt nor the uncle could take the youth to the doctor.

The following day, the child protection investigator contacted the private agency to request they take the youth to the doctor. The private agency sent an on-call caseworker to take the youth to the doctor, as the assigned caseworker had scheduled benefit time. The on-call caseworker went to the youth's foster home, but the aunt and uncle refused to allow the youth to leave. The on-call caseworker told IG investigators that the aunt and uncle threatened her and told her to leave the property. The on-call caseworker called law enforcement, who assisted the on-call caseworker in removing the youth from the home. While at the hospital, the on-call caseworker told hospital staff about her experience at the foster home and her concerns about the foster parent's aggression. The medical staff provided the on-call caseworker with the discharge paperwork that documented that medical staff could not determine if the bruises were due to abuse but had concerns about the aunt and uncle's aggression towards the on-call caseworker, which they believed may have warranted further investigation from the Department. The on-call caseworker called the child protection investigator, read the discharge statement, and inquired if she needed to place the youth in respite care. The investigator responded that the agency had discretion on the use of respite care. The on-call caseworker called her supervisor, the youth's caseworker, and private agency administrators, but no one answered their phone. The on-call caseworker told IG investigators that she felt uncomfortable returning the youth to his foster home given the earlier aggression, so she placed the youth in a respite home.

One week after the hotline call, the youth's caseworker emailed the child protection investigator about the status of the investigation. The investigator replied she would likely indicate the investigation because the bruises did not appear to be from a dog and the aunt and uncle demonstrated inappropriate behavior to the on-call worker. The youth's caseworker responded that the aunt and uncle reported that the on-call caseworker did not provide identification and that the aunt and uncle responded negatively because they were guarded about unfamiliar people coming to the home. The child protection investigator told IG investigators that she initially believed the investigation would be indicated, and while she had concerns about the bruising, the caseworker's explanation for the aunt and uncle's behavior provided a different perspective.

Two weeks after the hotline call, the youth's caseworker returned the youth to the aunt and uncle's home during the pending child protection investigation. The youth's caseworker told IG investigators that earlier that day, the private agency administrator instructed him via email to return the youth. The youth's caseworker stated he had no concerns regarding the youth's safety at the aunt and uncle's home, but the caseworker knew the youth was not supposed to be returned, as PCD would not approve the placement during a pending child protection investigation. When the caseworker questioned the private agency administrator, he said he felt the administrator dismissed his concerns, and he was directed to return the youth without seeking PCD approval.

The OIG obtained the email exchange between the private agency administrator and the youth's caseworker in which the administrator wrote that the child protection investigator reported the investigation would be unfounded and instructed the caseworker to return the youth that same day. The youth's caseworker responded via email and inquired if he could move the youth during a pending investigation. Less than an hour later, the private agency administrator responded via email that she believed they could return the youth, as the child protection investigator had given no previous directions about the youth's placement. Three hours later, the youth's caseworker responded that he returned the youth and would contact PCD.

Six hours later, the youth's caseworker called PCD. IG investigators obtained a recording of the call, in which the youth's caseworker asked the PCD worker when he could return a child to a home during a pending child protection investigation. The PCD worker confirmed that the youth could not be returned until the investigation was closed. That same evening, the youth's caseworker sent an email to the private agency administrator and wrote that PCD stated the investigation had to be closed before PCD can approve the placement. The next day, the youth's caseworker went on vacation.

Appendix E in Procedures 301(b)(6)(A), *Pending CA/N Investigation*, provides that in a pending child protection investigation, household members that are named as a non-involved subject can only be cleared through PCD with a waiver from the regional or area administrator. In the youth's investigation, the Department listed the perpetrator as unknown and the aunt and uncle as non-involved subjects in the investigation. During the phone call between the caseworker and PCD, the caseworker never provided the PCD worker with the aunt and uncle's specific information that included that they were non-involved subjects, and the PCD worker never informed the caseworker that a waiver could be obtained. PCD staff told IG investigators that it is standard practice to inform the person calling PCD of the waiver process when non-involved subjects are listed.

The private agency administrator told IG investigators that she decided to return the youth after the caseworker reported the child protection investigator planned to unfound the allegations. The private agency administrator told IG investigators that she gave the caseworker general instructions to return the youth, expecting that the caseworker would contact PCD. The private agency administrator did not know about the PCD waiver for non-involved subjects in pending child abuse and neglect investigations.

The private agency administrator told IG investigators that she had no recollection of the caseworker's email that indicated the placement could not clear PCD during the pending investigation. She told IG investigators that she assumed the PCD approved the youth's return to the home.

However, according to emails, on the day after the private agency returned the youth to the home, the private agency administrator emailed the child protection investigator, requested the investigation be expedited, and wrote that the child could not return to the home until the investigation closed. The OIG review of SACWIS revealed that the youth's return to his aunt and uncle's home was not documented in the case notes until the following month. The child protection investigator and supervisor told IG investigators that the private agency staff never informed them of the youth's return until three months later, which was approximately three weeks before the investigation closed.

Three weeks after the initial email, the private agency administrator sent another email to the child protection investigator and again noted that the pending investigation prevented the youth's return to the home and requested the investigation be expedited, though the youth had been in the home for the prior three weeks.

Approximately one month after the youth's return, the child protection investigator resigned without documenting her completed tasks for the investigation. The newly assigned child protection investigator told IG investigators that she reviewed the previous investigator's emails to identify the completed and pending tasks. The second child protection investigator also stated that she inherited approximately 30 investigations after the previous investigator left the Department, so she had roughly 45 total cases, which she began to triage.

Four months after the hotline call, the Department closed the child protection investigation and unfounded the unknown perpetrator. IG investigators reviewed the child protection investigation and identified numerous deficiencies. Neither child protection investigator documented interviews with the hotline reporter nor additional household members of the foster home. Neither child protection investigator obtained the medical records from the evaluating physician of the youth's bruises and only learned of the inconclusive results of the hospital visit third hand, from the agency supervisor. After learning of the inconclusive results, neither child protection investigator referred the child medical records for a second opinion as dictated in Department Procedures Section 300.100(c)(6)(A), *Obtaining Second Medical Opinions*, which notes that a child protection investigator should seek a second opinion when the treating physician is unable to offer an opinion.

RECOMMENDATIONS

1. This report should be shared with the private agency. The private agency should pursue disciplinary action of the private agency administrator, in accordance with the agency's personnel policy, for leaving a child in a foster home

without the required Placement Clearance Process approval, for failing to disclose that the youth had been returned to the foster home, and for providing misleading information to DCP staff.

The Inspector General's Office shared the report with the private agency. The Inspector General met with the agency's administrators and a member of the Board of Directors to discuss the findings and recommendations made in the report. The agency disciplined the Regional Director and is developing agency wide training on the Department's placement clearance process.

2. The child protection supervisor should be counseled for failing to ensure the May 2022 child protection investigation was adequately investigated.

The Department agrees. The Inspector General's report was discussed with the child protection supervisor and the supervisor was issued a counseling memo.

3. The second child protection investigator should be counseled for deficiencies in the May 2022 child protection investigation.

The Department agrees. The Inspector General's report was discussed with the child protection investigator and the investigator was issued a counseling memo.

4. This report should be shared with the Child Protection Regional Administrator of this region to review this case with the appropriate involved leadership at the involved field office.

The Department agrees. The Child Protection Regional Administrator reviewed the report with the involved leadership staff.

5. This report should be shared with the Department's Agency Performance Monitoring and Execution (APME) monitor assigned to the involved private agency.

The Department agrees. The report was shared with the APME monitor.

GENERAL INVESTIGATION 7

COMPLAINT A private agency's intensive placement stabilization program allegedly inappropriately provided a sensory sock to a foster family for use as a therapeutic device with a 6-year-old youth in care. A sensory sock is a loose-fitting garment that encloses the child's body, including hands and feet, and leaves the head exposed. In 2021, the Department indicated the foster parents for tying/close confinement (#14) and torture (#16) to the youth in care after the foster parents placed the child in the body sock and tied the child to a balcony railing at their out-of-state vacation condominium.

INVESTIGATION The Department previously indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) after receiving a report that the child's parents engaged in domestic violence in the presence of the then 6-month-old child and the child's then 2-year-old sibling. The family declined intact services.

Three years later, the Department initiated two separate investigations involving the family. The first investigation, later indicated to the father, involved an allegation of inadequate supervision (#74) after the neighbors found the child's then 2-year-old sibling walking alone on a road. During the pending child protection investigation, the Department initiated a separate investigation after a report of domestic violence between the parents. The parents denied physical aggression and reported the children did not witness the argument. The

Department unfounded the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the then almost 4-year-old child and her 5-year-old, 3-year-old, and 1-year-old siblings. The family agreed to participate in intact family services, and the Department opened an intact family services case at the end of May 2019. Initial services for the family included housing assistance and protective daycare so the parents could gain employment.

Approximately five months after opening the intact services case, the Department initiated a child protection investigation after a report that the youngest sibling came to daycare with significant bruising and cuts on his tail bone and between his buttocks. The then 4-year-old child reported the father whipped the child and her sibling. The Department took protective custody of the four children, and the court granted temporary custody to the Department. The Department indicated the parents for cuts, welts, bruises, abrasions, and oral injuries by abuse (#11) to the sibling and substantial risk of physical harm/environment injurious by neglect (#60) to the other three children.

The Department placed the four children with their maternal grandmother. A 21-year-old maternal uncle also lived in the home. The family's case transferred to a private agency for placement services. The placement worker completed the integrated assessment as outlined in DCFS Procedures 315.95b) *Worker Assessment of the Child and Family*, as the case did not meet criteria for a clinical screener through the Integrated Assessment Program. Disrupted intact cases only qualify for the program if the disruption occurs during the first 14 days of the intact family case. The placement worker and supervisor interviewed the parents but did not interview any of the children, citing their young age and the oldest sibling's refusal. The placement worker and supervisor also did not interview the maternal grandmother who cared for the children. Information about the children's birth history and development was briefly included in the mother's section of the assessment, but the integrated assessment did not contain any additional information about the children. The private agency did not include information received from HealthWorks regarding the child's prior medical care that included multiple assessments related to developmental delays, neurological evaluations, and aggressive behaviors.

While placed with the maternal grandmother, the child began attending an early learning center, and the staff determined that the child met the criteria for special education services because of delays in her social and emotional development. The center arranged for the child to spend the first half of the school day in a smaller classroom while sharing an aid with another student before spending the rest of the day in a normal-size classroom.

The child and her three siblings remained with their maternal grandmother for just over one month until the grandmother issued a 14-day notice for removal of the children and stated she could not care for them while working full time. The next day, the Department initiated a child protection investigation after law enforcement responded to the grandmother's home when the maternal grandmother and uncle engaged in an altercation, and the uncle admitted he struck the grandmother. The same day as the hotline report, the Department removed all four children and placed them into a temporary foster home while the agency attempted to find a new placement. The Department subsequently unfounded the maternal grandmother for substantial risk of physical injury/ environment injurious by neglect (#60) to the four children and closed the investigation.

Over the next 19 months, the private agency moved the child eight more times after receiving 14-day notices from the subsequent traditional and fictive kin foster homes. Each request for removal was related to the child's behavior issues including aggression and tantrums.

Approximately four months after the child entered foster care, while in her fourth foster home, the private agency case manager referred the child for counseling. Two months later, the case manager completed a second referral for the child to have individual therapy after the first therapy agency placed the child on a waitlist for services. The child's goals for therapy included learning coping skills and regulating her emotions.

The child was moved to her fifth foster home, a traditional placement, in the six months after she entered foster care. While in this home, the child began therapy sessions with a licensed clinical social worker through the private agency, which ended after one month when the child began therapy through a community provider. However, just two weeks later her behaviors escalated, and this traditional placement disrupted.

While in her sixth foster home, another traditional foster home, the private agency referred the child to intensive placement stabilization (IPS) services because of her frequent placement disruptions and her significant behavior issues. Department Procedures 301.66 outlines that IPS provides short-term services, interventions, and support to address issues that place youth at risk for placement disruptions. A different private agency accepted the IPS case less than three weeks later. IPS workers do not have the ability to enter notes into SACWIS, so the child's IPS worker created notes and sent them to the child's placement case manager monthly, who included the notes in the hard file. During the initial visit, the foster parents reported to the IPS worker that the child had disruptive behaviors and did not respond well to redirection. The IPS private agency completed an Individual Plan of Care, and the placement private agency provided the family's client service plan and integrated assessment for historical information. This information did not include the child's medical history, which included developmental delays and specialty care for her aggressive behaviors and sleep difficulties, even though the placement case record included medical records outlining her history since birth. The IPS worker completed a mental health assessment and noted the child had difficulty with identifying and expressing her emotions which led to verbal and physical aggression. The child's therapist through the placement agency also opined that the child suffered complex trauma and recommended a trauma therapist, but one was not available in the area, so the therapist planned to continue to work with the child on anger, self-regulation, and impulse control.

After the initiation of IPS services, the foster parents continued to report issues with the child exhibiting aggression towards peers and adults in the home and daycare. The IPS worker began to hold sessions with the child at daycare to assist with her behaviors. The next week, after consulting with the IPS worker, the foster parents called the Crisis and Referral Entry Service (CARES) line after the child head-butted daycare staff. The Screening Assessment and Support Services (SASS) worker screened and deflected the then 5-year-old child from psychiatric hospitalization. Two days later, the foster parent contacted the IPS worker again due to the child's extreme aggression that included biting the foster father and drawing blood. Both IPS and SASS staff planned to work with the foster family on ways to deescalate the child and pursue tools to assist the child in creating a safe space.

After two months in the sixth foster home, the foster parents took the child for an initial psychiatric evaluation for increased outbursts, defiance, and hour-long tantrums. The clinician completing the assessment did not have access to the child's medical and developmental history. The clinician diagnosed the child with multiple diagnoses, prescribed psychotropic medication, and recommended individual and group therapy. The following week, the IPS worker provided the foster parents with instructions and ways to utilize calming tools, including a weighted vest. Less than one week later, the foster parents reported to the IPS worker that the tools no longer alleviated the child's behaviors. The following week, the foster parents requested the child's removal and cited increased aggressive and disruptive behaviors.

The next day, DCFS Clinical convened a Clinical Intervention for Placement Preservation meeting to discuss the child's services and multiple placements. The recommendations included consideration of specialized foster care, including a statewide broadcast for an appropriate foster home, a psychological evaluation and assessment, consult with occupational therapy, refer for extracurricular physical activities, consult the Department's education advisor, and purchase a weighted blanket. The child would continue with SASS services at home and in the community and the child's current play therapist would include attachment work during sessions, until an attachment therapist could be located. IPS services would continue in the foster home and community, and the agency would consult with the child's therapist about transitioning to a new foster home and reconvene in 45 days. The private agency placement supervisor told IG investigators that they experienced several barriers

to referring the child for appropriate services. The supervisor stated that the agency's licensing staff worked to locate a specialized foster home throughout the life of the case with little to no success. The staff utilized statewide broadcasts, but often the only placements the agency could locate were through fictive kin. The supervisor also told IG investigators that the agency had difficulty locating service providers for specialized therapy in the region and clients experienced long wait times. The supervisor stated she voiced her concern about delaying pursuing a residential placement for the child because she did not believe the child could be cared for in a foster home setting because of her behaviors. The supervisor stated that clinical team members wanted to continue to try foster care due to the child's young age.

Almost one year after entering foster care, the agency placed the child in a fictive kin placement, the then 5-year-old child's seventh foster home. Two weeks later, a clinician denied the request for psychological testing, noting the child received appropriate services, and that a psychological evaluation of a child this young would be difficult and unnecessary, given the current services in place. While in the seventh foster home the child's special education teacher completed a report, documenting the child's behaviors, such as flipping furniture and aggression towards others, impeded her learning and put her own safety at risk. A hospital evaluated the child and recommended occupational therapy to assist with balance and fine motor skills, and the child received expressive language disorder services that same day. After three months, the child's seventh foster parents notified the private agency that they could no longer keep the child because of her aggressive and disruptive behaviors. About two weeks later, the agency placed the child in her eighth foster home with fictive kin. The agency rationale included that the foster parent had experience with special needs, the child knew the foster parent, and the child would continue attending the same school. Less than three weeks later, the foster parent reported the child's aggressive behaviors had escalated and asked the child's case manager how to keep the child safe and not allow her to injure herself or others. Less than a month into the placement, the foster parent requested the child's removal due to increased tantrums and aggression.

The agency then moved the child to her ninth foster home with fictive kin where she had to move to a new school and transition to a new therapist. The following month, the foster mother reported several concerns to the private agency about the child's aggressive behaviors towards the foster parents and the family pets. The foster mother also contacted the IPS worker for guidance on regulating the child's behaviors as she began pulling her hair and pinching herself. The IPS worker instructed the foster mother to utilize muscle relaxation and the child's weighted blanket. During a follow up Clinical Intervention for Placement Preservation meeting, the placement supervisor requested an alternative plan for the child if her placement disrupted. The team planned to evaluate the possibility of residential in 30 days. The supervisor told IG investigators that she continued to advocate for the private agency to place the child in a residential placement because of the child's continued externalizing behaviors despite supportive services being in place.

Two months after moving to the new foster home, the IPS worker documented discussing items in the child's coping basket with the fictive kin foster parents, including a sensory sock. During the visit to the home, the child demonstrated using the sensory sock and reported that she liked to place her head in the bag which eliminated outside stimulation. The IPS worker instructed the foster parent to remain in proximity of the child and be able to see her whenever she used the coping tools including the sensory sock.

During the fourth month of placement with the fictive kin, the family obtained permission to travel out of state for vacation. Less than two weeks later, the Department initiated an investigation after receiving a report that the foster parents placed the child in the sensory sock and secured the child's ankles with rope to the condo's railing while on the out-of-state vacation. Law enforcement responded to the condo, and the out-of-state child services took custody of the child and transported her back to Illinois. The private agency placed the child in an emergency traditional placement where the child protection investigator assessed her as safe. The child participated in a forensic interview and reported that she had been in the sensory sock on multiple occasions

where the foster parents used zip ties to close the sock over her head. The child stated she felt upset in the sock, but it did not hurt, and she could still breathe.

The foster parents told the child protection investigator that the IPS worker ordered the sensory sock for the child but denied receiving instructions on use of the item. The foster parents reported they initially kept the child's head outside the sensory sock, but after it no longer worked, they began securing the opening with zip ties over the child's head. The foster mother stated the child was never in danger and did not sustain any marks or bruising. The foster mother also reported the child's placement case manager previously observed the child in the sensory sock with the zip ties to close the head's opening. The placement case manager told the child protection investigator that the IPS agency purchased the sensory sock for the child. The case manager reported to the child protection investigator that after she observed the foster mother use zip ties to close the sock over the child's head, she planned to discuss the situation with her supervisor. However, the family planned to leave on vacation, and she did not believe the situation was immediate as she did not think the family would take the sensory sock on vacation.

During the investigation, the child protection investigator interviewed the IPS worker, who reported learning about the use of the sensory sock while speaking with a professional about another client. The IPS worker reported discussing the sensory sock with her supervisor, and the IPS management approved the purchase. The IPS worker stated she discussed the use of the sensory sock with the foster mother both over the phone and in person. When the child reported to the IPS worker that she placed her own head in the sensory sock, the IPS worker told the child protection investigator that she specifically instructed the child and foster parents not to put her head in the sensory sock. The IPS worker told the child protection investigator that she attempted to speak with the child's therapist about use of the sensory sock, but the placement agency never followed through with providing consent for her to speak to the therapist. The IPS worker also stated that she attempted to contact the placement case manager about the issue four times but never received a response. The placement supervisor told IG investigators that she did not know of any communication issues between the case manager and IPS staff; however, the IPS staff did not always discuss interventions with the case manager prior to implementing them in the foster home.

The Department subsequently indicated the foster parents for tying/close confinement (#14) and torture (#16) to the child. The private agency case manager resigned from the agency and later voluntarily relinquished her CWEL. The private agency who supervised the placement case removed a sensory sock from the foster home of the child's youngest sibling, and the placement staff confirmed with the IPS staff that no other foster homes had been provided with sensory socks. While in the temporary foster home, the 6-year-old child required psychiatric hospitalization for approximately one month and then moved into a residential facility.

RECOMMENDATIONS

1. The Department should include disrupted intact family service cases in the Integrated Assessment Program regardless of the length of time from case opening to disruption.

In May 2023, Northern Illinois University (NIU) conducted an Integrated Assessment training with DCFS and Child Welfare Contributing Agency (CWCA) staff on how to interview and conceptualize the Integrated Assessment process. The Intact Family Services Area Administrators will ensure that this training will be conducted on an annual basis by NIU at their quarterly statewide intact training and informational meetings. A tip sheet will also be developed and will be provided to the field to help staff navigate the Integrated Assessment process. Permanency staff will be providing this same training to DCFS and CWCA staff in January 2024.

OIG Comment: This investigation involved an intact family services case that disrupted and resulted in the children coming into care. Once in care, the integrated assessment completed by the placement worker lacked salient historical information including developmental assessments, neurological findings, and

recommendations for needed follow up and services to address difficult behaviors. Disrupted intact cases suggest that a family has more issues than were initially identified and the need for assessment from a clinical professional is warranted. While training related to Integrated Assessments is valuable and a critical step, the OIG maintains that the Department should include disrupted intact family service cases in the Integrated Assessment Program. Additionally, the Department should ensure that the Integrated Assessment training is provided Statewide.

2. The Department should ensure that Intensive Placement Stabilization Service agencies have the ability to enter notes and review documents in the new Illinois Connect system.

The Department agrees. Intensive Placement Stabilization Service providers now have the ability to enter contact notes and review documents in SACWIS.

3. The Department's Medical Director should review the child's complete case history, including preplacement medical history and consult with the child's current placement to ensure that the child receives the appropriate medical treatment and services.

The Department agrees. The Medical Director will review the medical records and provide guidance. In addition, the Medical Director has recommended that the DCFS Child Psychiatry consultant also provide recommendations regarding the child's diagnoses and treatment recommendations.

4. This report should be shared with the child's current residential placement.

The Inspector General's Office shared the report with the child's current residential placement.

5. This report should be shared with DCFS Clinical, clinical support specialists and their supervisors who are part of the Consolidation of Clinical Intervention for Preservation of Placement, priority clinical staffing and regional clinical staffings initiative. Clinical staff should facilitate a discussion that includes the topic, accessing information when deciding placement of young children with complicated histories.

The Department agrees. The report will be shared with DCFS clinical staff and the discussion will be facilitated during an all-staff clinical meeting which will also include the DCFS psychologists.

6. This report should be shared with the private agency that provided intensive placement stabilization services.

The Inspector General's Office shared the report with the private agency.

7. This report should be shared with the private agency that provided case management services to the child.

The Inspector General's Office shared the report with the private agency.

GENERAL INVESTIGATION 8

COMPLAINT

A child protection investigator, who had previous employment as a correctional officer, reportedly harassed an inmate, filmed the incident, and posted it on social media while employed as a correctional officer.

INVESTIGATION

The OIG obtained surveillance video from the correctional facility that previously employed the child protection investigator. The OIG reviewed the video which showed the employee walking towards an inmate in the holding cell and taking out his phone, appearing to film while laughing and pointing to the inmate. On video footage, the child protection investigator engaged in inappropriate sexualized gesturing. The employee then appeared to move closer to the inmate in the cell and, using his cellphone, filmed himself and the inmate in the same frame. The surveillance video footage of the incident showed that the interaction between the employee and the inmate lasted approximately 4½ minutes, during which time the employee appeared jovial and was laughing. The OIG also obtained the cellphone video recorded on the employee's phone, which had reportedly been posted to the employee's social media account. The OIG reviewed the video footage posted to social media which showed the employee appearing to antagonize the inmate from the correctional facility.

IG investigators interviewed correctional facility management, who reported initiating a disciplinary investigation of the employee for violating policies involving the harassment of inmates as well as filming and posting work related material to social media. Following the correctional facility's investigation, the employee resigned his position as a correctional officer.

Approximately 17 months following his resignation as a correctional officer, the employee was hired by the Department as a child protection investigator. The child protection investigator confirmed to DCFS IG investigators that when employed as a correctional officer, he recorded the inmate but denied posting the video to social media. The child protection investigator stated he was attempting to calm the inmate by mirroring the inmate's behavior and joking with the inmate. The child protection investigator reported he then opened the cell to retrieve an item from the inmate; however, neither video showed these actions. The child protection investigator denied malicious intent but stated that he felt ashamed of his behavior toward the inmate.

The OIG also reviewed and identified discrepancies in the child protection investigator's DCFS employment application and resume, including omitting his previous employment at the correctional facility. IG investigators contacted the child protection investigators' former employers and learned the child protection investigator falsified dates of his previous employment when he applied to the Department. The child protection investigator told IG investigators that he extended the dates of his former employment to cover the time gap in his work history caused by the omission of his employment at the correctional facility. The child protection investigator stated he intentionally omitted this on his application and resume because he felt nervous about what information his previous employer would provide.

RECOMMENDATIONS

1. The child protection investigator is currently in probationary status with DCFS. The Department should not certify the employee in the position of child protection investigator.

The Department agrees. The child protection investigator was discharged from the Department.

GENERAL INVESTIGATION 9

COMPLAINT

The Child Welfare Employee Licensure (CWEL) Emergency Licensing Review Team received a complaint alleging a child protection investigator falsified records for an investigation when she documented in the Statewide Automated Child Welfare Information System (SACWIS) that she conducted an in-person visit with a mother and her child for a closing assessment. The OIG investigated the CWEL complaint pursuant to DCFS Part 412, *Licensure of Direct Child Service Employees and Supervisors*, Rules 412.60, *Investigations, Notice and Proceedings Involving Formal Complaints*.

INVESTIGATION

The Department assigned the child protection investigator an investigation of environmental neglect. During the initial home visit on the same day as the hotline call, the child protection investigator met with the 12-year-old child and her mother. The child protection investigator noted multiple concerns including damage to walls, dog feces, trash, and a urine smell throughout the home. The child protection investigator told the mother that she would return the following day to check on the conditions of the home. The investigator did not document in SACWIS that she returned to the home on the next day, but the mother later confirmed to the child protection investigator's supervisor that the child protection investigator returned to the home the day after the first visit.

The child protection investigator told IG investigators that she did not feel well on the day the investigation was due and stated she could not remember much about that day, noting that she had a medical condition that impacted her memory. The child protection investigator reported she set out to conduct an unannounced visit at the family's residence, but she had to return to her home, where she fainted. Hours later, the child protection investigator came to and informed her supervisor that she was too sick to work the rest of the day but had traveled to the family's home that morning.

In an OIG interview, the supervisor reported making multiple attempts to speak with the child protection investigator that day but could not reach her for several hours. The child protection supervisor alerted the area administrator regarding the difficulty in contacting the child protection investigator. The child protection supervisor updated the area administrator that the child protection investigator reported feeling ill but went to the home that morning. The area administrator instructed the supervisor to contact the mother that same day to discuss the family's service needs, and the mother told the supervisor that the family had not had any contact with the investigator for two months.

The supervisor told IG investigators that the child protection investigator submitted a timesheet documenting she worked for 1 ½ hours on the day she was sick, to which the supervisor told the child protection investigator that she did not have any case notes in SACWIS documenting she worked on that day. In a separate interview, the child protection investigator informed IG investigators that prior to speaking with her supervisor, she had no intention of entering a SACWIS note on the day she was sick. The child protection investigator reported to IG investigators that she told her supervisor that she did not recall the visit to the family's home, but the supervisor told her that she needed to enter a note if she wanted to get paid. The child protection investigator reported that she had handwritten notes with no dates in the working file, but no details as to when the visit occurred. The child protection investigator entered these notes into SACWIS, marking the visit occurred on the day she was sick. According to SACWIS, the child protection investigator entered two contact notes documenting a visit at the family's home at which the investigator interviewed the mother, observed the 12-year-old minor, and completed a walkthrough of the home, noting the conditions of the home improved.

The supervisor told IG investigators that after the child protection investigator entered the contact notes, the supervisor discussed the issue with the area administrator and regional administrator. The supervisor stated the area administrator instructed her to not send the investigator back to the family's home and not to inform the investigator that the supervisor knew no visit took place on the date she documented.

In the following month, the Department held a pre-disciplinary meeting with the child protection investigator and subsequently suspended the child protection investigator pending discharge. After receiving the suspension, the investigator submitted a letter of resignation.

During these two months, the child protection investigation remained open, and the supervisor made two attempts to see the family with no avail. Three days after the child protection investigator resigned, the Department assigned a new investigator, who went to the family's home and assessed the child as safe that same day, closing the investigation; however, no one from the Department had seen the child for almost four months.

Almost three weeks after the child protection investigator's resignation, the CWEL Emergency Licensing Review Team received a complaint alleging the investigator falsified her July contact notes for the investigation. Upon completion of the OIG investigation, no charges were issued against child protection investigator's CWEL.

RECOMMENDATIONS

1. This report should be shared with the Department's Ethics Officer to lead a discussion regarding ethical responsibilities with the regional administrator, area administrator and supervisor.

The Department agrees. The Department's Ethics staff led a discussion with the involved administrators.

2. A redacted copy of the report should be shared with the Department and incorporated in outreach and education regarding ethical decision making for supervisors and managers.

The Department agrees. The Department's Ethics Office will utilize the redacted report in outreach and education regarding ethical decision making for supervisors and managers.

GENERAL INVESTIGATION 10

COMPLAINT

A private agency caseworker had an inappropriate relationship with a father on the worker's caseload and sent the father inappropriate text messages. The complaint alleged that the caseworker showed favoritism to the father during the family's placement case and recommended the court grant the father custody of the then 8-year-old child instead of the mother. The mother and father later refused to work with the private agency due to the alleged relationship with the caseworker, and the court removed the private agency from the case. During the OIG investigation, IG investigators found that private agency staff conducted deficient casework on the family's case.

INVESTIGATION

Between 2013 and 2019 the Department conducted ten child protection investigations involving the family. The Department unfounded seven of the investigations. In 2017, the Department indicated the mother for substance misuse by neglect (#65) to the infant after both the mother and infant tested positive for amphetamines at the time of the birth. Two weeks after the infant's birth, the Department initiated and subsequently indicated the father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to his children ages 3, 14 and 16 at the time. In December 2019, the Department received a report that the mother used meth, did not appropriately supervise the children, and the home appeared filthy. The Department later indicated the mother for inadequate supervision (#74) and environmental neglect (#84) to the then 6-year-old and 2-year-old children.

In March 2020, the Department received a report that the then 2-year-old was found outside of the mother's home unsupervised. The reporter stated the mother was passed out in the home and could not be woken. That same day, the Department took protective custody of the then 6-year-old and 2-year-old children. The next day, the court granted the Department temporary custody of the children, and the Department placed them with their maternal relatives. The Department indicated the mother for inadequate supervision (#74), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to both children. The Department opened a placement case, and a private agency provided the family with services.

The father of the then 2-year-old child, who was not part of the household, cooperated with the placement agency and completed his services. The child was placed with the father and the court closed the juvenile court case and the private agency closed the child's case. The father of the then 6-year-old, also not a household member began services with the private agency and participated in the interview for the integrated assessment. The clinical screener documented concerns about the father's statements during the interview, including that the father likely under reported his drug usage, anger issues, and domestic violence. The clinical screener recommended the father participate in a substance use disorder evaluation that included drug tests and follow any treatment recommendations. The clinical screener also recommended the father engage in mental health counseling to correct his behavior, as he denied any history of domestic violence despite the mother having an order of protection against him at the time of the integrated assessment. The mother did not participate in an interview for the integrated assessment, and the clinical screener based the recommendations from the previous child protection investigation, which included a substance use disorder assessment and any recommended treatment, random drug tests, mental health assessment and services, in-home parenting, and domestic violence services to address the mother's reported history of domestic violence with the father.

The mother and father of the 6-year-old made minimal progress in the first year of their placement case, as the father failed to appear to all four of his drug tests, but he completed his substance use disorder and mental health assessments. In the spring of 2021, the Department received a report that the mother's 17-year-old child moved into the mother's residence during the open placement case. The Department indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the 17-year-old.

In August 2021, the private agency assigned a new caseworker to the family's case. The caseworker told IG investigators that she began working at the private agency one-month prior to receiving the family's case and had no prior experience in child welfare. The caseworker told IG investigators that she relied heavily on her supervisor's guidance on her cases and did not know she needed to review the family's prior history. The caseworker told IG investigators that she thought the father of the then 7-year-old had completed all his services before receiving the case and did not know that she needed to continue referring the father for drug tests. A week into the caseworker's assignment to the placement case, the caseworker's supervisor documented the critical decision to increase the father's visits to overnight visits. The caseworker told IG investigators that she had no part of the critical decision, asserting her supervisor and the previous caseworker made the decision. The supervisor told IG investigators that she could not recall who recommended an increase in visits for the father. The IG investigators found no documentation in the placement file regarding the rationale to grant the father overnight visits.

During a permanency hearing held after the father began overnight visits with the 7-year-old, the caseworker reported the mother had not completed her mental health, substance use disorder, or parenting services. The caseworker testified that the father completed his services and had unsupervised visits with the then 8-year-old child. The caseworker reported the father tested negative on the drug test one month earlier; however, the caseworker did not report the father failed to complete four previous drug tests. Based on the caseworker's recommendation, the judge ordered custody of the child to the father and guardianship would remain with the

Department. In the OIG interview, the caseworker stated the father began to supervise the mother's visits with the child in the community after the court hearing.

In the two months after the permanency hearing, the father failed to appear to each of his drug tests, and the private agency staff did not document in the casefile any follow-up response to the missed tests. The caseworker told IG investigators that she had not observed any evidence of drugs in the father's home and had no concerns about the missed drug tests. During this time, the placement supervisor documented the child struggled in school. Also, the mother had tested negative for all substances, and over the next few months, the mother continued with counseling and completed substance use disorder, mental health, and parenting services.

In the spring of 2022, the caseworker attempted to contact the father via phone and at his home with no response. The caseworker called law enforcement to the father's home, and they found an extension cord coming from a window, the electrical meter was removed, and the home had no electricity. The father returned the caseworker's call, initially stating he stayed with a friend but then reported he lived with the mother. The caseworker went to the mother's residence that same day, and the father stated he got behind on the electric bill and was embarrassed to ask for help. The caseworker discussed applying for Norman Funds to pay his overdue utilities bill and restore his electricity. The caseworker documented that the mother stated she would allow the father and child to stay as long as they needed, and the caseworker discussed with the parents that they could live together until the father had the utilities restored. Later that month, the caseworker contacted the power company and learned that the father's electricity had been off for almost two years. The caseworker told IG investigators that during her home visits to the father's residence, she observed working lights and a refrigerator and she never noticed the father stole electricity. The caseworker also reported that she initially did not know what to do about the parents living together, but her supervisor stated the parents could live together as long as they both agreed to the arrangement and the father did not leave the child unsupervised with the mother. The caseworker told IG investigators that she did not know about the mother and father's history of domestic violence, but that neither the mother, father, nor child expressed a concern with them all living together. The caseworker stated that her supervisor instructed her to recommend to the court to close the placement case, as the father and child lived with the mother. In a separate OIG interview, the caseworker's supervisor reported she did not have concerns about the parents living together, and that her supervisor advised the living situation should not last for a long period of time. The caseworker's supervisor told IG investigators that the parents completed their services, and the mother tested negative for substances. However, the OIG review of the placement record found that the father failed to attend 10 of his 12 drug tests. In a separate interview with IG investigators, the mother stated she felt pressured to allow the father and child to live with her and she told the caseworker it was not right to put her in that situation due to past domestic violence, stalking and harassment. The mother told IG investigators that she felt excited to have her child at the home and attempted to go along with the plan.

Three weeks after the caseworker learned the father and child lived with the mother, the Department initiated an investigation after receiving a report of domestic violence between the parents and a related information report that the father took the child, and the mother's wallet, car and house keys, and cell phone. The mother did not know where the father took the child. The next day, the parallel child protection investigator located the father and took protective custody of the child, who returned to the previous foster home with maternal relatives. The father told the parallel investigator the domestic incident occurred after the mother took his cell phone, and then struck him twice in his face. The father also stated that while living with the mother, he suspected she used methamphetamine. The father reported he did not disclose this information to the caseworker because the father and mother had been getting along and he did not want their child to view the mother poorly. During the child protection investigation, the child's maternal aunt reported to the investigator that after the court returned the child to the father's custody, the father often told the mother he did not have food for the child. The mother confirmed this statement to the child protection investigator, reporting the father refused to allow the mother to

see the child if she did not give him food and cigarettes. The caseworker documented in SACWIS and told IG investigators that she observed food in the father's residence when she conducted home visits.

Prior to closing the investigation, the child protection investigator spoke to the child's guardian ad litem (GAL), who reported the father had a prior arrest for possession of methamphetamine during the pending child protection investigation. The child protection investigator also interviewed the child's teacher, who reported concerns about the child's academic performance and behaviors after the child began living with the father. The Department indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate shelter (#77). The placement supervisor documented that the father needed to engage in substance use disorder services with random drug testing, as well as domestic violence services, and obtain appropriate housing and employment. The placement supervisor also noted the mother needed to engage in substance use disorder services with random drug testing and engage in the domestic violence class again, as the father reported the mother continued to use drugs and was the aggressor in the domestic altercation.

In an interview with IG investigators, the father reported the caseworker appeared to pursue an inappropriate relationship with him as she called or texted him daily and about five to six of her communications regarded sexual experiences. The father told IG investigators that he could not provide these messages from the caseworker, as he had deleted the text messages and the rest of the conversations about sex occurred verbally over the phone. The father stated he never reciprocated her perceived advances but said he went along with the conversations, believing if he did not, there would be repercussions regarding custody of his child. The father told IG investigators that he believed the caseworker was jealous of the mother, and that the March 2022 domestic incident was due to the caseworker asking the mother to delete text messages between the father and caseworker, and the mother took his phone while he was asleep and refused to give it back to him. The father stated he asked his attorney to remove the caseworker from the permanency case because the father felt that he fell out of favor with the caseworker and was being punished.

The mother told IG investigators that she did not observe any inappropriate text messages between the caseworker and the father. The mother stated that after the father and child began staying at her residence, the mother saw the father sent text messages to the caseworker, stating that the mother used drugs and that the caseworker needed to get the father and child out of her home. The mother told IG investigators that she was upset because she allowed the father to stay with her, but he lied about her using drugs. The mother stated she could not take a screenshot of the conversation, and the father attempted to leave the residence with the child when the mother confronted the father about the messages.

The caseworker told IG investigators that she did not engage in sexual communication nor have an inappropriate relationship with the father. The caseworker stated she confronted the father regarding the allegations, and he replied that he did it to make the caseworker mad. The caseworker also told IG investigators that the mother threatened to make it appear that the caseworker had a relationship with the father. The caseworker stated she informed her supervisor about the allegations. According to SACWIS, the agency removed the caseworker from the placement case in May 2022. The following week, the private agency administrator met with the caseworker. The private agency administrator told IG investigators that the caseworker showed her a text message she sent to the father that may have been misinterpreted, but the private agency administrator stated the text message simply offered assistance to the father. The private agency administrator said she did not remember how many text messages she reviewed, but she did not read anything that appeared inappropriate. Four days after the caseworker's removal from the placement case, the father's attorney motioned the court to remove the private agency from the family's case, and the court reassigned the case to the Department.

IG investigators subpoenaed the caseworker's phone records and found that during her assignment to the family's placement case, there were over one thousand contacts or attempted contacts between the caseworker and father via phone calls or text messages, and the caseworker initiated 50.8% of the contacts. IG investigators

also found that 68% of the contacts occurred during working hours but over 100 contacts occurred after 9 p.m. The case worker told IG investigators that she did not recall making that many phone calls and text messages, stating she never called more than once a week. The caseworker stated she attempted to build a rapport with the father but that she maintained a professional relationship with the father, and she regretted being friendly with him. The caseworker also stated in the first three to six months of working at the private agency, she often called clients after hours to reach them but has since changed that practice. IG investigators did not substantiate the complaint of an inappropriate personal relationship with the father but identified issues with the caseworker's boundaries.

RECOMMENDATIONS

1. This report should be shared with the private agency to review and address the casework and supervision deficiencies in the family's placement case.

The Inspector General's Office has shared the report with the agency and will meet with the agency's administrators and a member of the Board of Directors to discuss the findings and recommendations made in the report.

GENERAL INVESTIGATION 11

COMPLAINT

A private agency assigned a caseworker to two placement cases where she was related to the foster parent. According to the complainant, the private agency disregarded multiple requests to reassign the caseworker because of a conflict of interest. The complainant also alleged that the caseworker communicated confidential information about the biological parents to the foster parent.

INVESTIGATION

In January 2022, the Department initiated a child protection investigation after two youth in care, a then 7-year-old and a then 5-year-old, disclosed that their foster parent beat them with a belt when they misbehaved. The children also reported their foster parent had hit the hands of their 1-year-old foster brother. The caseworker removed the three children from their foster home and placed them with fictive kin.

The next day, the assigned child protection investigator observed all three children, noting they appeared to be healthy with no marks or bruises. The child protection investigator separately interviewed the 7-year-old and 5-year-old youths in care, who repeated the allegations that their foster parent beat them. The child protection investigator scheduled an in-home interview with the foster parent, which the foster parent's mother and the caseworker's supervisor also attended. The foster parent stated she had been fostering the older children for approximately three years, who had multiple caseworkers during that time. The foster parent reported no issues until the private agency assigned the current caseworker in April 2021, because the foster parent reported being related to the caseworker, which made the foster parent uncomfortable. The foster parent told the child protection investigator that she reported her concerns about the caseworker on multiple occasions to the caseworker's previous supervisor and the private agency's management, but the private agency did not address her concerns. The foster parent also stated the caseworker did not address the foster parent's concerns about the children and the foster parent believed the caseworker inappropriately discussed issues about the biological parents. The foster parent told the child protection investigator that she had been afraid to upset the caseworker in fear of retaliation.

In March 2022, the child protection investigator retired, and the Department re-assigned the investigation. In April 2022, the Department closed the investigation and unfounded the foster parent, citing insufficient evidence to support the allegations.

IG investigators interviewed the foster parent, who reported being related to the caseworker, and stated they did not get along. The foster parent told IG investigators that she immediately reported the conflict of interest to the caseworker's former supervisor who took no action. The foster parent also stated the caseworker acted unprofessionally and did not address foster parent's concerns about the children. The foster parent told IG investigators that she feared retaliation if she attempted to set boundaries with the caseworker.

During the OIG investigation, the caseworker left employment with the private agency and the Illinois child welfare system. IG investigators separately interviewed the caseworker's previous supervisor and the private agency's management, who independently reported not recalling the foster parent reporting a conflict of interest with the caseworker. The caseworker's previous supervisor and the private agency's management stated the caseworker informed them that she did not believe working with the relative foster parent would be an issue. The former supervisor also stated the foster parent complained about the caseworker inappropriately discussing the biological parents' social media pages with the foster parent rather than discussing case related matters. The supervisor reported that private agency management discussed the issue with the caseworker, who reportedly believed there was no issue because the foster parent also had access to the biological parents' social media pages. The private agency's management told IG investigators that after observing the caseworker and foster parent work well together during multiple child and family team meetings, there did not appear to be any concerning interactions.

During the OIG investigation, a separate complainant alleged that the retired child protection investigator demonstrated favoritism towards the foster parent because of a personal relationship with the foster parent's mother that impacted the January 2022 investigation. The complainant reported the child protection investigator's biased actions and the conflict of interest to the investigator's supervisor, but according to the complainant, the supervisor dismissed the concerns. A review of the January 2022 child protection investigation in SACWIS by IG investigators showed that the DCFS supervisor documented weekly supervision with the retired child protection investigator and provided instruction to complete needed tasks. However, the notes were not entered prior to the child protection investigator's retirement. The lack of documentation made it difficult to assess if the retired child protection investigator completed investigative responsibilities or if her conflict of interest influenced the investigation prior to re-assignment after the children protection investigator retired.

RECOMMENDATIONS

1. A copy of this report should be shared with the private agency for training purposes.

The Inspector General's Office shared the report with the private agency. In response to the OIG report, the private agency created a new position within the agency to assist with matters of compliance, policy and ethics.

2. The Area Administrator of this region should conduct a review of the January 2022 child protection investigation to determine if the retired child protection investigator's conduct affected the investigation's findings.

The Department agrees. The redacted report has been shared with administrators in the region to conduct a review.

GENERAL INVESTIGATION 12

COMPLAINT

A child protection supervisor allegedly misused state resources by using her Department-issued cellphone to advertise and sell tickets to a non-DCFS event. The complainant also alleged that the supervisor instructed her team of child protection investigators to submit their work early to allow the supervisor time to prepare for non-DCFS business matters.

INVESTIGATION

A child protection supervisor sent a text message using her Department-issued cellphone containing a website link promoting the supervisor's upcoming event to the team of child protection investigators she supervised. The following week, the supervisor allegedly reminded her team about the event, suggesting they make it a team event. The complainant reported that the next day, the supervisor stated during a team meeting, that she would work from home on the day of the event and instructed her team of investigators that any work due on the day of the event, a Friday, or over the weekend needed to be submitted on the prior Thursday.

IG investigators interviewed the team of child protection investigators and observed on their Department-issued cellphones that their supervisor sent a link for purchasing event tickets to her team during state work hours. In an OIG interview, the child protection supervisor confirmed to IG investigators that she used her Department-issued phone to invite her team to her event. The supervisor stated she sent the invitation through a text message thread with her investigative team because the supervisor did not have their personal contact information and believed the event could offer an opportunity for team building. The supervisor told IG investigators that she assisted with the event every month and did not report her activities as secondary employment because she did not receive payment; however, the supervisor stated she understood that this was a misuse of state resources and reported the text message invitation as a one-time occurrence that she had not repeated.

RECOMMENDATIONS

1. The child protection supervisor should be disciplined for misuse of state resources, using her state issued cell phone to send an invitation to buy tickets to a social event, she produced, to her supervisees on their state cell phones, during work time.

The Department agrees. The employee was issued an oral reprimand.

2. The child protection supervisor should be counseled for issuing an invitation to her supervisees for a social event in which she has a financial interest, creating the appearance of a conflict.

The Department agrees. The report was discussed with the employee and the employee was issued an oral reprimand.

GENERAL INVESTIGATION 13

COMPLAINT

A child protection supervisor was appointed as a city council member for a city that overlapped with the jurisdiction of her assigned DCFS field office. The complaint alleged that the child protection supervisor regularly and wrongfully requested the reassignment of child protection investigations to other supervisors, citing a conflict of interest with her city council position.

INVESTIGATION

The child protection supervisor initially sought guidance from the Department's Conflict of Interest Committee regarding her secondary employment. The Conflict of Interest Committee determined that the child protection supervisor could continue in her city council position providing: her secondary employment duties took place outside of her DCFS working hours, the supervisor refrained from the use of State time and resources in furtherance of any secondary employment, the supervisor did not share confidential information gained in her State employment with anyone in her secondary employment, and the supervisor utilized approved time off to conduct any city council work or duties during her DCFS work hours.

Child protection supervisors in the same field office told IG investigators, in separate interviews, that DCFS management never held a meeting at the field office to discuss the supervisor's secondary employment or how to manage possible conflict of interest issues. One child protection supervisor interviewed by the OIG reported one instance of reassignment of a child protection investigation to her team after the supervisor with secondary employment cited a conflict of interest.

The OIG interviewed the supervisor's investigators, who all reported no issues with their supervisor and that her city council duties never interfered with the investigative work. The OIG additionally spoke separately with the area administrators (AA) who oversaw the field office. The AAs stated, in separate OIG interviews, that they had a protocol for re-assigning cases based on any conflict of interest with the supervisor's city council position. The AA who oversaw the supervisor told IG investigators that she discussed the Conflict of Interest Committee's guidance with the supervisor and reassigned two investigations due to a conflict of interest. Another AA reported to the IG investigators that the field office experienced several vacancies, and that at one point, the child protection supervisor had one investigator on her team. Because of the vacancies, the AAs redistributed numerous pending investigations from that supervisor's team, and the AA told IG investigators that the other supervisors knew about the distribution of investigations. The reassignments were not due to conflicts with the supervisor's secondary employment. Both AAs told IG investigators that they had not received any complaints from the field office regarding investigation reassignments or the supervisor's secondary employment.

RECOMMENDATIONS

1. The Regional Administrator should issue a memo to the involved field office to notify the other child protection supervisors of the supervisor's city council position. The memo should note the boundaries for investigations that would create a conflict for the supervisor, requiring reassignment to another team. The memo should also outline how the Area Administrators will adjust assignments in the event of a conflict with the supervisor's secondary employment.

The Department agrees. A memo was sent to staff of the involved field office.

GENERAL INVESTIGATION 14

COMPLAINT

A Department employee's public facing social media account reportedly included two different comments involving threats of murder to the President of the United States and Hillary Clinton. The Department subsequently placed the employee on desk duty pending an OIG investigation.

INVESTIGATION

The OIG reviewed the Facebook profile allegedly associated with the Department employee. The author of the social media profile posted a solicitation for a hitman to kill the United States President, and in a separate post the author threatened to kill Hillary Clinton.

The OIG interviewed the Department employee, who denied authoring the social media profile in question. During the OIG interview, the Department employee identified inconsistencies, including that the profile picture did not resemble the employee, the employee never lived at the address listed in the profile, and never attended the college specified in the profile. An OIG review of the Department employee's personnel file and a public record database corroborated the employee's statements regarding the address and college inconsistencies.

The OIG completed a search using Google.com with the employee's name and "DCFS" and found a link to a website containing an Illinois University sample social work resume that used the same name as the Department employee. The resume had multiple similarities to the Facebook profile, including the mailing address and college.

The OIG found no credible evidence to support that the Department employee created the Facebook profile that contained posts of threatening statements.

RECOMMENDATIONS

1. The Department employee should be removed from desk duty and returned to normal job functions.

The Department agrees. The employee was provided notice of her return to full work status.

2. A copy of this report should be included in the Department employee's personnel file and attached to any notification related to desk duty.

The Department agrees. A copy of the report was placed in the employee's personnel file.

PART IV: ERROR REDUCTION TRAINING

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

As a result of this legislation, over the past decade the OIG has developed Error Reduction Training curricula and provided statewide trainings to DCFS and private agency child welfare workers and administrators, including clinical and legal staff, permanency, intact and child protection workers.

The basis for the error reduction legislation was a recognition that flawed organizational practices can contribute to potentially tragic outcomes for children, including death or serious injury. The Inspector General's training curricula that grew from this legislation introduced the concept of error management – i.e., what can be done to prevent the occurrence of tragic error by applying error reduction methods to child protection investigations involving cuts, welts and bruises, mental health, domestic violence and egregious acts of physical abuse of children. By using a systems perspective and root cause analysis, the Inspector General has developed and presented field trainings designed to identify and reduce such errors.

Error Reduction Trainings have addressed:

- 2009: The correlation between death and serious harms to child with prior unfounded investigations of cuts, welts, and bruises allegations. This included the development of the CANTS 65-A Referral Form for Medical Evaluation of a Physical Injury to a Child to capture the written medial opinion of an evaluating medical provider.

- 2010-2011: Patterns of problematic practices prompted the development of error reduction trainings focusing on intact families with parental mental illness. The training included discussion of worker obtaining relevant records, sharing relevant facts with treating clinicians and framing questions to providers to close information gaps. The OIG developed form CFS 968-90 *Questions for Mental Health Professionals* to assist the field. To support the training the Department issued policy guidelines directing child protection investigators to ask parents/caregivers abut mental health issues, requiring investigators to obtain relevant mental health records (see Policy Guide 2011.07 *Obtaining Records of Patients with Mental Illness*).

- 2013: Continued issues identified in intact family services cases led to the development of Specialized training for High-Risk Intact Specialist. The training provided an overview of the mental health training, obtaining relevant documents, facilitated discussions and communication with mental health professionals, and working with families with parental mental illness, substance use and domestic violence.

- 2014: Multi-System Error Reduction Trainings targeting a select audience of DCFS and Private Sector staff, content included: Young Parent Training; Cuts, Welts, Bruising training; and Child, Family Grief and Loss.

- 2015-2016: Introduction of Egregious Acts Training-Lessons Learned from Physical Abuse Fatalities and Systematic Errors in the Legal System and High-Risk Specialized Assessment. To

assist the field in conceptualizing case direction for egregious acts of maltreatment the OIG created the Maltreatment Continuum, a visual tool illustrating the spectrum and characteristics of child abuse: Minor Abuse, Severe Abuse, Egregious Acts

- 2017, 2018, 2019: Continued refinement, implementation, and delivering of Error Reduction curricula targeting: specified region/areas of the state, direct service providers, clinicians, legal personnel, community partners, and multi-disciplinary teams.

- 2020-2022: In recognition of the COVID-19 pandemic, continued restrictions, and numerous mandatory training agenda for frontline and administrative staff advanced by the Office of Learning and Professional Development, the OIG suspended its planned delivery of Return Home Toolbox trainings. This training focuses on reunification planning as an ongoing process in advance of the anticipated return home date. Planning that included: identifying issues to consider when assessing/reassessing interventions being used by the family; mapping out local resources, reinforcing an understanding of the progress of the case; conducting clinical staffings with family and providers as the case progresses toward potential closure. OIG staff continued to work with the Office of Learning and Professional Development to inform the mandatory trainings for the field.

In FY 2023, the OIG submitted a new ERT training plan to the Director (see summary below). The Director accepted the plan and OIG staff developed the curriculum and initiated statewide trainings. The training is being conducted regionally using cases, identified in OIG investigations, specific to the region. Regional trainings allow for addressing differences in local practices and with community partners which can impact decision making as well as continuing to address the larger child welfare systemic issues.

ERROR REDUCTION MEMO

SUBJECT

The OIG is mandated by statute to remedy patterns of errors or problematic practices that compromise or threaten the safety of children as identified in OIG death and serious injuries investigations and by Child Death Review Teams (20 ILCS 505/35.7). The ERT plan submitted to the Director for 2023 utilized OIG investigative findings as a basis for training material addressing the use of a family's prior involvement with the Department in critical decision-making for assessing risk to children. The goal for ERT deliveries is to encourage and support the use of critical thinking, resulting in drawing logical conclusions based upon available information. Enhancing critical thinking in staff allows for readjusting conclusions as new information becomes available.

Recent OIG investigative findings and recommendations have addressed the decision-making process for cases in which critical and well-documented family histories directly related to risk factors were not reviewed, sufficiently considered, or shared across disciplines concurrently working with the family.

The following summaries are a small sampling of the cases identified to be used as training content for this delivery and stem from both OIG recommendations and Child Death Review Team reviews and recommendations:

- A 7-month-old infant was found unresponsive, with his face covered by a weighted blanket. The family's home had environmental concerns including animal feces and dead mice, garbage, and dirty dishes with rotten food. The family also used the neighbor's electricity to power space heaters. Between March 2015 and October of 2019, the family came to the attention of the Department on four separate occasions regarding two other children residing in the home. Each report to the SCR pertained to ongoing concerns of substance

use, domestic violence, and environmental neglect. [from January 2022 OIG Annual Report, Death and Serious Injury Investigation 6]

- A 6-year-old was found unresponsive by her mother and stepfather who later told police that they gave the child the mother's prescription medication to make her sleep. Five years previously, in 2015, DCFS indicated the child's stepfather for inadequate supervision to the then 22-month-old child. Between 2017 and 2019, DCFS unfounded four additional child protection investigations regarding the family and received two additional hotline calls that were not opened for investigation. The family had an open intact case at the time of the child's death and the intact worker was in the process of completing the integrated assessment. [from January 2022 OIG Annual Report, Death and Serious Injury Investigation 1]

- A family dog attacked and killed a 12-month-old. At the time of her death, the infant lived with her mother, maternal grandmother, grandmother's paramour, and two maternal uncles all of whom had extensive involvement with the department. Between 2006 and 2016, the Department conducted 29 investigation involving the infant's maternal grandmother. The Department indicated five of the investigations for allegations including cuts, bruises, welts, abrasions, and oral injuries; substantial risk of physical injury/environment injurious to health and welfare by abuse; and substantial risk of physical injury/environment injurious to health and welfare by neglect. [from January 2023 OIG Annual Report, Death and Serious Injury Investigation 3]

- A 4-month-old was found unresponsive, wedged between an adult-sized mattress and the wall which led the infant's death Three months prior to the death, DCFS received a report that the infant's mother had an open child welfare case in another state, where the infant's two older siblings lived in foster care. According to the reporter, the mother had a history of mental health and substance use issues, did not cooperate with services and fled to Illinois with the infant. The Department opened an Intact Family Services case with the mother and infant in June 2021 and over the next three months the mother did not comply with services, experienced housing instability. The mother also had two separate incidents of domestic violence where she was the aggressor and two subsequent hotline reports. [from January 2023 OIG Annual Report, Death and Serious Injury Investigation 12]

- Law enforcement and fire department contacted the Department after finding the deceased body of a 4-year-old child, later ruled as a homicide, at the site of an arson in an abandoned residence. The deceased child, and three siblings, had been returned to their mother's care in June of 2015 and the family's service case remained open until November of 2015. Prior to the children's return to their mother's care, child welfare staff documented concerns regarding physical abuse during unsupervised visitation. In November and December of 2014, the children had bruises and subsequently told their foster parents that their mother had slapped and hit them. The Department subsequently unfounded a child abuse investigation. Ultimately the children returned to their mother's care despite her sporadic compliance with services. The concerns continued after the children returned home when the oldest child, age 8, contacted former foster parents asking to be removed from their mother because of her volatile behavior. [from January 2019 OIG Annual Report, Death and Serious Injury Investigation 2]

In addition to the importance of a full review of the family's prior history with the Department as a part of critical decision-making, recent OIG investigative findings demonstrate the need for a reprise of training addressing the following: evaluation of indicators of physical abuse and neglect, accepting self-report of alleged

perpetrators without corroboration and the use of medical professionals. Identified OIG cases addressing these issues include the following:

- [from January 2022 OIG Annual Report, Death and Serious Injury Investigations 1, 3 and 8]
- [from January 2023 OIG Annual Report, Death and Serious Injury Investigation 11]
- [from the current OIG Annual Report, Death and Serious Injury Investigation 5]

Error reduction trainings will be delivered regionally in small venues to Area Administrators and Supervisors and include case examples specific to each region to reflect practice at the local level. The participants will be from Child Protection, Intact and Permanency Placement within their region creating a setting for an exploration of the factors influencing local decision-making. This approach will also encourage identifying and addressing systemic issues and regionally specific practices that impact children's safety.

The full day trainings will be delivered in-person by IG training staff. Multiple sessions will be scheduled for each region to ensure ample opportunities for attendance without unduly burdening operational needs of Department staff. To lend ongoing support to the field, the OIG will provide, as necessary, post training consultation and support. The OIG will explore collaborating with Quality Assurance for data collection, training efficacy, and information feedback loops between the field and the OIG, such as virtual post training check-ins with ERT/OIG staff to assess the efficacy of the training.

RECOMMENDATION **Pursuant to statute, the Office of the Inspector General submits the above detailed Error Reduction Implementation plan to the Director of DCFS for review and approval (20 ILCS 505/35.7(a)).**

The Department agrees. The OIG developed the training curriculum and has begun delivering Error Reduction Trainings statewide.

DEPARTMENT UPDATE ON PRIOR SYSTEMIC RECOMMENDATIONS

The Office of the Inspector General's systemic recommendations are designed to strengthen the child welfare system to better serve children and families. The OIG tracks and monitors the implementation of recommendations accepted by the Department until the recommendation has been fully implemented. The following systemic recommendations were made in prior fiscal years and were pending when last year's OIG Annual Report was issued. The Department's current implementation status is detailed below in the following categories:

- **CHILD PROTECTION**
- **INTACT FAMILY SERVICES**
- **PERSONNEL**
- **SERVICES**
- **TECHNOLOGY**

CHILD PROTECTION

FY 2022

Procedures should require that when a child protection investigator learns that a child 1 month old to 12 months old has never been seen by a doctor, the child protection investigator should ensure the child is seen for a medical evaluation (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 5).

FY 2023 Department Update: The recommendation will be incorporated into the current revisions of Procedures 300. The procedural revisions will include that child protection specialists ensure that children who are between the ages of 1 month and 12 months who have never had a medical exam are seen by medical professionals. This rewrite will encompass the Department's new safety decision tool, Safe Assessment and Family Evaluation (SAFE), which will include revisions to child protection protocols. This rewrite will take place in conjunction with the Department's conversion to the new comprehensive child welfare information system, IllinoisConnect. The system's implementation date is scheduled for Spring 2025. The Department will incorporate the OIG recommendation into the rewrite as the SAFE model and the IllinoisConnect systems near completion during the fourth quarter of 2024.

FY 2023 OIG Comment: This recommendation has been pending since FY 2022. The OIG agrees that a procedural change should be made. In the interim, the Department should issue communication to the field to ensure that this requirement is put into practice in a timely manner.

FY 2022

The Department should collaborate with hospitals/medical systems for which obtaining records and/or information has been identified as problematic, to allow for a more efficient and timely exchange of information (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 7).

FY 2023 Department Update: In 2023, DCFS joined with the Illinois Hospital Association (IHA) to explore issues around timely access to medical records, particularly during a child abuse or neglect investigation. As a result, in November 2023, the IHA sent a letter to its member hospitals underscoring the importance of timely information sharing with DCFS and explaining the Department's relevant legal authority to investigate cases of abuse and neglect, including the use of administrative subpoenas to obtain medical records. Additionally, staff from the Office of Legal Services met with representatives from the Illinois Attorney General's Office, Child Law Bureau, to confirm the Attorney General's willingness to discuss seeking enforcement of administrative subpoenas.

FY 2022

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

FY 2023 Department Update: The recommendation will be incorporated into revisions to Procedures 300.50, Procedures 300.130 and Procedures 302.389. The revisions will include instruction on how to use short-term guardianship, including, when it might occur during an investigation where there is not present danger, due to abuse or neglect.

FY 2022

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

FY 2023 Department Update: The recommendation will be incorporated into revisions to Procedures 300.50, Procedures 300.130 and Procedures 302.389. The revisions will include instruction on how to use short-term guardianship, including, when it might occur during an investigation where there is not present danger, due to abuse or neglect.

FY 2022

The Department should develop procedures for notifying the local Illinois Department of Human Services (IDHS) Child Care Assistance Program when a protection plan is implemented, and a daycare is temporarily voluntarily closed. The Department should also immediately notify IDHS Childcare Assistance Program of a change in the status of the protection plan for the daycare facility (from January 2023 OIG Annual Report, General Investigation 6).

FY 2023 Department Update: The recommendation has been incorporated into revised Procedures 383.45. Revised Procedures 383 is expected to be approved by the end of the first quarter of 2024. In addition, the field has already implemented the recommendation in practice.

FY 2022

The Department should provide the field with guidance on use of DCFS Nurses during pending investigations of child abuse and neglect. The Department should review, and change as needed, the CFS 531 Regional Nurse Referral Form to include the role of DCFS Nurses in child protection investigations (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 11).

FY 2023 Department Update: In the Fall of 2022, Child Protection staff worked with the Department's Clinical and Nursing staff to streamline the CFS-351, *Nurse Referral Form*. The CFS-351 is in the process of being revised. The revised form has been shortened and reframed. The CFS-351 will provide specific and separate directions for Child Protection, Intact Family Services and Permanency workers. The form remains pending with the Office of Child and Family Policy. In addition, the Nursing division was granted access to SACWIS and DCFS Nurses can now document completed consultations in SACWIS to ensure the record is complete.

FY 2022

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

FY 2023 Department Update: The recommendation has been incorporated into revisions to CFS-2040. The revisions will be posted for Proposed Policy Review by the Office of Child and Family Policy. In addition, the IllinoisConnect project (formerly known as CCWIS) began July 1, 2022. The workflow capabilities of IllinoisConnect will support automated notifications to the referring person.

FY 2022 and FY 2021

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

FY 2023 Department Update: The Department is in the process of revising Procedures 300, including Allegation #79-Medical Neglect. The recommendation will be incorporated into the revised procedures. This rewrite will encompass the Department's new child welfare system entitled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the Allegation system. The revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The system's implementation date is scheduled for Spring 2025. On October 19, 2023, the Department issued a Practice Memo titled, *Procedures 302.388 Services to Medically Complex Youth*, to all DCFS and Contributing Agency caseworkers to ensure nursing referrals are completed for youth coming into care or already in care and specifically for youth with special health needs. The recommendation will be incorporated into the revisions as the IllinoisConnect system nears completion during the fourth quarter of 2024.

FY 2021

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

FY 2023 Department Update: The Department agrees and is in the process of implementing a new Safety Decision Tool called Safe Assessment and Family Evaluation (SAFE), that will address the OIG

recommendation by including a mechanism to ensure the safety of children when absent a determination of "UNSAFE" but there is an agreement by the family to make 'care plans' formally.

FY 2023 OIG Comment: This recommendation has been pending since FY 2021. The OIG agrees that the recommendation should be incorporated in the Department's new safety decision tool. In the interim, the Department should issue communication to the field to ensure that this requirement is put into practice in a timely manner.

FY 2021

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

FY 2023 Department Update: The Department is in the process of replacing the CERAP with a new safety decision tool called Safe Assessment and Family Evaluation (SAFE). The recommendation will be incorporated in the Department's new safety decision tool.

FY 2021

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

FY 2023 Department Update: The Department agrees that in the absence of the Public Service Administrator, only a Child Protection Advanced Specialist or Area Administrator should approve a Child Endangerment Risk Assessment Protocol, approve a critical decision regarding protective custody and provide a Final Supervisory Decision. The recommendation will be incorporated into revisions to Procedures 300.

FY 2023 OIG Comment: This recommendation has been pending since FY 2021. The OIG agrees that a procedural change should be made. In the interim, the Department should issue a practice guide to ensure that this requirement is put into practice in a timely manner.

FY 2020

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

FY 2023 Department Update: The recommendation was addressed in a Practice Memo dated November 16, 2022, that was shared with Child Protection staff, the Office of Learning and Professional Development staff, Regional Administrators and Area Administrators with the direction to share at the team and worker level. Additionally, the Department is in the process of revising Procedures 300 which will address the consistent application of the definition of "blatant disregard." The revisions will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the Allegation system. The procedural revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, Illinois Connect. The system's implementation date is scheduled for Spring 2025. The Department will incorporate the provisions outlined in the November 2022, Practice Memo, into revisions to Procedures 300.

FY 2019

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

FY 2023 Department Update: The Department is conducting an overall revision of Procedures 300, including Section 300.80, *Child Protection Supervisor/Area Administrator Waivers* which will address the steps investigators must take when an alleged child victim is inaccessible or otherwise unable to be seen in the proper time period. This rewrite will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the child protection protocols. The revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system (IllinoisConnect). The system's implementation date is scheduled for Spring 2025. The Department will incorporate the OIG recommendation into the revisions as SAFE and the IllinoisConnect system comes near completion during the fourth quarter of 2024.

FY 2023 OIG Comment: This recommendation has been pending since FY 2019. The OIG agrees that a procedural change should be made. In the interim, the Department should issue a practice guide to ensure that this requirement is put into practice in a timely manner.

FY 2005

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

FY 2023 Department Update: The Department is in the process of replacing the CERAP with a new safety decision tool called Safe Assessment and Family Evaluation (SAFE). The recommendation will be incorporated in the Department's new safety decision tool.

OIG Comment: This recommendation has been pending since FY 2005. The OIG agrees that the recommendation should be incorporated in the Department's new safety decision tool. In the interim, the Department should issue communication to the field to ensure that this requirement is put into practice in a timely manner.

INTACT FAMILY SERVICES

FY 2021

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

FY 2023 Department Update: The recommendation has been incorporated in revisions to Procedures 302.388, *Intact Family Services* which is pending divisional approval and will then be posted for public

comment. In the interim, a Practice Memo was issued to all DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors on October 20, 2023, with an effective date of November 1, 2023.

FY 2021 and FY 2019

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

FY 2023 Department Update: The recommendation has been incorporated in revisions to Procedures 302.388, *Intact Family Services* which is pending divisional approval and will then be posted for public comment. In the interim, a Practice Memo was issued to all DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors on October 20, 2023, with an effective date of November 1, 2023.

FY 2019

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

FY 2023 Department Update: The recommendation has been incorporated in revisions to Procedures 302.388, *Intact Family Services* which is pending divisional approval and will then be posted for public comment. In the interim, a Practice Memo was issued to all DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors on October 20, 2023, with an effective date of November 1, 2023.

FY 2019 and FY 2017

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

FY 2023 Department Update: The recommendation has been incorporated in revisions to Procedures 302.388, *Intact Family Services* which is pending divisional approval and will then be posted for public comment. In the interim, a Practice Memo was issued to all DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors on October 20, 2023 with an effective date of November 1, 2023.

FY 2018

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

FY 2023 Department Update: The Department has contracted with Illinois State University (ISU) for a new Central Region simulation lab which will launch in 2024. ISU simulation leadership has met with the Office of Learning and Professional Development (OLPD) and Intact administration to identify practice areas to develop simulation content. Intact staff have received experiential learning as a target population through the Motivational Interviewing Trainings that began in 2023. In FY 2024 OLPD will continue to work with Intact leadership and subject matter experts to launch Intact simulations that will focus on areas including but not limited to worker safety; Child and Family Teams; engagement and assessment; and safe sleep.

PERSONNEL

FY 2022

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

FY 2023 Department Update: The Department continues to collaborate with staff, the union and across divisions to develop a written protocol related to restrictive duty status that will work effectively for various divisions and their respective job assignments. The restrictive duty status will allow for increased supervision when discipline may be pending. The updated protocol will be released later in FY 2024.

FY 2021

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 (from January 2022 OIG Annual Report, General Investigation 6).

FY 2023 Department Update: In FY 2022, the Office of Employee Services (OES) developed a process for verification of an applicant's Child Welfare Employee License. In addition, screening questions related to the applicant's CWEL were added to the CFS-717H, *preliminary hire form for candidates.* As part of the pre-employment application, OES asks if the employee has a CWEL license and if it is in good standing. The Office of Employee Services only checks if the applicant reports that they are not in good standing.

FY 2023 OIG Comment: A standard practice for the Department should be to ensure that a prospective employee's CWEL is in good standing. Relying on an applicant's self-report is concerning given that this information is easily accessible and for many positions in the Department a CWEL in good standing is required.

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 January 2021 OIG Annual Report, General Investigation 13).

FY 2023 Department Update: The Department contracts with Child Welfare Contributing Agencies (CWCA) for child welfare services through the use of a fixed rate agreement. Through that agreement, CWCAs are required to create and adopt a Conflict-of-Interest Policy that reflects the specifications and ethical standards outlined in Department Rule 437, Employee Conflict of Interest (89 III. Admin.Code 437). On May 5, 2022, an Informational Transmittal was provided to all CWCAs to remind them of their ethical obligations under Rule 437, and the transmittal was further communicated to both DCFS and CWCA staff through an announcement posted on the DCFS website from June 8, 2023, through August 31, 2023. Additionally, the Deputy Director of Permanency emailed the transmittal to the Chief Executive Officers of the Department's Child Welfare Contributing Agencies to ensure the reminders were delivered throughout the various levels within each agency. Section III of this transmittal provided a summary refresher of licensure restrictions for employees under Rule437.40 (j)(2)(3) which includes the requirement that if an employee seeks to become licensed as a foster family home, their license must be issued and monitored by an entirely different agency and by employees with no significant relationship to the employee seeking to provide care to a youth. Sections IV and V of the transmittal addressed conflicts of interest in placement under Rule 437.70 and stressed the importance of child welfare employees avoiding interpersonal relationships with clients.

SERVICES

FY 2022

The Department should develop procedures for monitoring unauthorized placements. The procedures should include frequency of required home visits, contact with school and other service providers, and GAL notification requirements. For youth in care under the age of 17, procedures should require a minimum of three visits per month (from January 2023 OIG Annual Report, General Investigation 2).

FY 2023 Department Update: In FY 2022, a multi-disciplinary workgroup met to review existing policy, current practice issues and barriers to make initial recommendations related to unauthorized placements. The committee completed their review and finalized recommendations for procedural changes related to unauthorized placements. These recommendations are currently with impacted units for review, including the State Central Register, DCFS Clinical and DCFS Licensing. Once approved, the recommended changes will be sent to the Office of Child and Family Policy to begin the process of making the needed procedural changes. This effort will continue through FY 2024.

FY 2022

Any unauthorized placements for youth in care under the age of 17 and that last more than one month should be referred for a Clinical Intervention Placement Preservation staffing (from January 2023 OIG Annual Report, General Investigation 2).

FY 2023 Department Update: In FY 2022, a multi-disciplinary workgroup met to review existing policy, current practice issues and barriers to make initial recommendations related to unauthorized placements. The committee completed their review and finalized recommendations for procedural changes related to unauthorized placements. These recommendations are currently with impacted units for review, including the State Central Register, DCFS Clinical and DCFS Licensing. Once approved, the recommended changes

will be sent to the Office of Child and Family Policy to begin the process of making the needed procedural changes. This effort will continue through FY 2024.

FY 2022

The Department should develop procedures to ensure youth in care who are placed in a private institution, not contracted with the Department, receive a monthly stipend for basic goods and necessities (from January 2023 OIG Annual Report, General Investigation 4).

FY 2023 Department Update: In FY 2022, a multi-disciplinary workgroup met to review existing policy, current practice issues and barriers to make initial recommendations related to unauthorized placements. The committee completed their review and finalized recommendations for procedural changes related to unauthorized placements including the recommendation related to youth receiving a monthly stipend for basic goods and necessities when placed in a private institution. These recommendations are currently with impacted units for review, including the State Central Register, DCFS Clinical and DCFS Licensing. Once approved, the recommended changes will be sent to the Office of Child and Family Policy to begin the process of making the needed procedural changes. This effort will continue through FY 2024.

FY 2022

The Department's Division of Clinical Practice's Behavioral Health Substance Use Group should use this report for the development of an informational reference guide for staff on recognizing signs of client substance misuse. The reference guide should also include information for both professionals and non-professionals in a supervisory role during parent child visitation (from January 2023 OIG Annual Report, General Investigation 5).

FY 2023 Department Update: In FY 2022, the redacted report was shared with the Deputy of Clinical Practice and the Statewide Administrator of Substance Use and Recovery for review. Following the review, the substance use recovery program staff developed several documents in their training components called the 440 series, one of which is entitled "guideline" (440-4). These tools were developed for workers and others to use in talking with clients to determine their level of substance use. The recommendation will also be incorporated into revisions of the CFS-440 forms related to substance use.

FY 2022

The Department should designate clinical consultants with expertise in mental health who caseworkers, supervisors, and child protection investigators can access for assistance, education, and information. The availability of clinical consultants as a resource should be communicated to child protection staff (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 8).

FY 2023 Department Update: The Clinical Division has a team of psychologists and clinical coordinators who provide ongoing support to the field as needed. The Child Protection Specialist can request clinical consultation with DCFS Regional Clinical by completing the CFS 399-1, *Office of Clinical Practice and Field Support Clinical Referral Form.* In addition, clinical consultants are available to provide consultations to caseworkers. Each Child Welfare Contributing Agency and field office staff have a consultant assigned to them. Consultants and agency assignments are available on the D-Net and consultants are available to provide assistance. DCFS Clinical also recently created a Trauma Informed Tip Sheet that will be available on the D-Net. DCFS Clinical has updated and revised the clinical presentation that will be presented to the field beginning January 2024.

FY 2022

This report should be shared with the Division of Clinical Practice Behavioral Health/Substance Use group. The group should develop guidelines around assessment of marijuana use and its impact on parenting (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 1).

FY 2023 Department Update: In FY 2022 the redacted report was shared with the Deputy of Clinical Practice and the Statewide Administrator of Substance Use and Recovery for review. Following the review, the substance use recovery program staff developed several documents in their training components called the 440 series, one of which is entitled "guideline" (440-4). These tools were developed for workers and others to use in talking with clients to determine their level of substance use. The recommendation will also be incorporated into revisions of the CFS-440 forms related to substance use.

FY 2021

The Department must review Procedures 307, *Indian Child Welfare Services*, to ensure compliance with the 2016 federal rule regarding the Indian Child Welfare Act (from January 2022 OIG Annual Report, General Investigation 5).

FY 2023 Department Update: The Office of Child and Family Policy has engaged the Division of Diversity, Equity and Inclusion to establish a workgroup to review and potentially revise Procedures 307 to ensure compliance with any federal rules and regulations and ensure the effective provision of services to the indigenous children who come into the Department's care.

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 January 2021 OIG Annual Report, Death and Serious Investigation 7).

FY 2023 Department Update: On February 9, 2023, the Department issued Policy Guide 2023.01, *Expanded Capacity Waiver Process.* The purpose of this Policy Guide is to incorporate how maximum capacity within a foster family home is determined and provide procedures regarding the process for requesting and granting expanded capacity waivers in licensed foster homes, unlicensed relative homes and fictive kin homes pursuant to changes in state law. The department is working on proposed amendments necessary to ensure affected rules and procedures align with this Policy Guide and will follow the established rule-making process. In addition, Rule 402–Non-Safety Standards Training is now available on the Virtual Training Center (VTC) as of August 15, 2022. The training covers expanded capacity and directs staff to Rule 402 and Appendix B, and C, which provides a break-down of how to determine capacity. In addition, the Office of Child and Family Policy will issue an informational transmittal informing staff of the available training.

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 January 2021 OIG Annual Report, General Investigation 11).

FY 2023 Department Update: The Office of Child and Family Policy has drafted a form for licensing representatives to use. Licensing will form a workgroup with the Office of Child and Family Policy to draft the procedure. The form is titled "Designation of Spanish Speaking Foster Family Home." It verifies that the licensing representative used substantial conversational Spanish with at least one Foster Parent while conducting a licensing study or monitoring visit. The Department is establishing a work group to revise Procedure 402, *Licensing Standards for Foster Family Homes* to include instructions for use of this new form.

FY 2019

The Department should create clear procedures for workers to have when confronted with an issue pertaining to the ever-growing field of electronic access to school records, particularly when the Department has custody and guardianship of a minor. Caseworkers should have clear direction as to when it would be appropriate to request a non-custodial parent's access be denied or restricted to school records. Further, the Department should determine whether caseworkers should request that the access be restricted from the school or through a court order. This should be developed in consultation with school districts and/or the Illinois State Board of Education (from January 2020 OIG Annual Report, General Investigation 13).

FY 2023 Department Update: Representatives from the Office of the Guardian, DCFS Office of Legal Services, Office of Education and Transition Services and the Office of Information Systems met and determined that the Department of Children and Family Services holds the authority to determine if a biological parent's access to electronic records should be disallowed. There is no need for court order intervention. The group also decided to assemble a workgroup comprised of representatives from the Office of the Guardian, the Office of Legal Services, the Office of Education and Transition Services, the Office of Information Systems, the Office of Permanency, the Office of Legislative Affairs, the Medical Director, the Office of Child and Family Policy, the Office of Clinical Services and the Department of Information Technology, to identify the necessary revisions to Department procedure and policy, practice implications and training, as well as the necessity for legislative change recommendations to address the growing area of access to electronic records (school, medical, etc.) for biological parents. The results of this workgroup will be shared with the Illinois State Board of Education (ISBE) at a later date.

FY 2019

All placement supervisors and caseworkers must be trained on Policy Guide 2019.04, *Requirements for Reunification and After Care Services* (from January 2020 OIG Annual Report, Death and Serious Investigation 1).

FY 2023 Department Update: Policy Guide 2019.04 was replaced with Policy Guide 2020.05, *Procedures 302.360, Heath Care Services; and Procedures 315, Permanency Planning* which was issued January 9, 2020. DCFS developed a trainer of trainer curriculum to train staff on after care/reunification planning, which included this policy guide, as a result of the Well Being audit in July 2022. All intact and placement agencies then trained their staff.

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 January 2018 OIG Annual Report, Death and Serious Injury Investigation 2).

FY 2023 Department Update: Policy Guide 2019.04 was replaced with Policy Guide 2020.05, *Procedures 302.360, Heath Care Services; and Procedures 315, Permanency Planning* which was issued January 9, 2020. DCFS developed a trainer of trainer curriculum to train staff on after care/reunification planning, which included this policy guide, as a result of the Well Being audit in July 2022. All intact and placement agencies then trained their staff. In addition, the Deputy Director of Permanency Services provided field education to DCFS and CWAC on September 15, 2023. Continued education to the field has been completed through D-Net announcements. These awareness efforts will continue through December 2023.

TECHNOLOGY

FY 2022

The Department's new data information system should include a mechanism for direct notification to licensing of a child protection investigation involving a facility (from January 2023 OIG Annual Report, General Investigation 6).

FY 2023 Department Update: In FY 2022, at Child Protection statewide meetings for supervisors and area administrators, the need for child protection to notify licensing at the onset of any facility report, licensed or unlicensed, was emphasized. In addition, notifications are a core part of the Department's new IllinoisConnect solution (formerly CCWIS). The release containing notifications for licensing, will be incorporated into IllinoisConnect. The targeted implementation date is in FY 2026.

FY 2021

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 Department's new data information system should accommodate social media files (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 9).

FY 2023 Department Update: The IllinoisConnect project (formerly known as CCWIS) began July 1, 2022. Storage of multimedia has been designed into the system. Research into the capturing of social media files is scheduled to be part of the case management functionality within the next 18 months. IllinoisConnect is currently targeting to implementation with this functionality in 2025.

FY 2021

There should be an automatic electronic notification process to notify the Area Administrator where there is physical abuse to a child under 3, and the Area Administrator must review the case prior to closure (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 3).

FY 2023 Department Update: The IllinoisConnect (formerly known as CCWIS) project began July 1, 2022. Notification through several channels (email, screen popups, text messages, Microsoft Teams messages, etc.) are a base capability of IllinoisConnect. IllinoisConnect also contains workflows as a base capability which will be used to trigger the required review by an Area Administrator. IllinoisConnect is currently targeting implementation with this functionality in 2025. In the meantime, the Area Administrators get a

weekly report of child protection investigation involving children under age 3 and are required, per procedure, to document their assessment at the time of the safety decision.

FY 2020

DCFS should ensure that the new data information system has an indicator to alert SCR 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 January 2021 OIG Annual Report, General Investigation 2).

FY 2023 Department Update: The IllinoisConnect (formerly known as CCWIS) project began July 1, 2022. The Department will ensure there is an indicator to alert State Central Register staff when a subject in a fotline report has had their parental rights terminated. IllinoisConnect is currently targeting to implementation with this functionality in 2025.

FY 2020

With the development of the Department's new data information system, the Department should request that the system be able to track the CANTS and LEADS searches of individual users (from January 2021 OIG Annual Report, General Investigation 3).

FY 2023 Department Update: The IllinoisConnect project (formerly known as CCWIS) began July 1, 2022. Tracking and automation of CANTS and LEADS searches will be part of IllinoisConnect. IllinoisConnect is currently targeting implementation with this functionality in 2025. The Department will ensure that the new system tracks CANTS and LEADS searches of individual users.

FY 2020

The Department should ensure that SACWIS and/or the Department's new data information system has the prior history of individuals linked to that person and accessible from clicking on the person's name (from January 2021 OIG Annual Report, General Investigation 4).

FY 2023 Department Update: The recommendation will be incorporated in the IllinoisConnect project (formerly known as CCWIS). The IllinoisConnect project began July 1, 2022. The Intake module (used by SCR) is targeted to go into production in 2024 with significantly improved relationship linking of individuals of intakes and full access to person histories with DCFS. IllinoisConnect will provide this same capability to case management functions which is currently targeting to implementation with this functionality in 2025.

FY 2019

The SACWIS version of the Adult Substance Abuse Screen should be amended so that the collateral section cannot be bypassed without a waiver. The waiver should only be given if there is no indication of substance abuse (from January 2020 OIG Annual Report, General Investigation 6).

FY 2023 Department Update: The recommendation will be incorporated in the IllinoisConnect project (formerly known as CCWIS). The IllinoisConnect project began July 1, 2022. As part of the implementation of IllinoisConnect, all forms are being reviewed and processes optimized. IllinoisConnect is currently targeting to implementation with this functionality in 2025.

FY 23 OIG Comment: This recommendation has been pending since FY 2019. The OIG agrees that the recommendation should be incorporated into the Department's new data information system. In the interim, the Department should issue communication to the field to ensure that the collateral section of the Adult Substance Abuse Screen is not being bypassed without approval.

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 January 2018 OIG Annual Report, General Investigation 4).

FY 2023 Department Update: The Department has started a project with the Department of Innovation and Technology@DCFS to research and determine a cyber safe method of accessing social media for the use of State Central Register staff, investigators and caseworkers. From a technology perspective, employees are not restricted from accessing social media platforms. A workgroup will be developed to draft a practice memo regarding the use of social media.

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 January 2012 OIG Annual Report, Death and Serious Injury Investigation 9).

FY 2023 Department Update: The Department's Clinical-Behavioral Health Division has monthly meetings with Healthworks lead agencies. Newborn genetic metabolic screenings have been added to the agenda and they will follow up with all 18 Healthworks lead agencies with an email ensuring that genetic screenings are completed regardless of age upon entering DCFS care during comprehensive health exams or by the child's primary care physician. In addition, the Department will ensure that newborn genetic metabolic screens are accessible in IllinoisConnect (formerly known as CCWIS). The IllinoisConnect project began July 1, 2022. Integration with medical information sources has a high priority within Illinois' requirements for IllinoisConnect. IllinoisConnect is currently targeting to implementation with this functionality in 2025.

CHILD WELFARE EMPLOYEE LICENSES

In 2000, the General Assembly mandated that the Department institute a system for licensing direct service child welfare employees (89 Ill. Adm. Code 412). The Child Welfare Employee License (CWEL) system permits centralized credentialing and monitoring of all persons providing direct child welfare services, whether employed with the Department or a Child Welfare Contributing Agency (CWCA). The employee 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 CWCA investigative, child welfare, and licensing workers and supervisors. The Department, through the Office of Employee Licensure, administers and issues CWELs. The Emergency Licensure Review Team (ELRT), a committee composed of a representative from the Office of Child Welfare Employee Licensure, a representative from the Office of the Inspector General, and the Chairperson of the CWEL Board screens CWEL Complaints for referral to the OIG for investigation. The committee reviews CWEL complaints to determine whether a 412.50 ground is alleged (89 Ill. Adm. Code 412.50). The OIG investigates CWEL complaints, and an IG attorney prosecutes CWEL cases.

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

When a CWEL investigation is completed, the OIG, as the Department's representative, determines whether the findings of the investigation support possible licensure action. Department Rule 412.50 (89 Ill. Adm. Code 412.50) specifies the grounds for licensure action. Allegations that could support licensure action include a criminal conviction of any offense stipulated under the Criminal Code of 2012 and listed in section 4.2 of the Child Care Act; making any material misrepresentation relevant to obtaining a CWEL; an egregious act that demonstrates incompetence, unfitness or blatant disregard for one's duties in providing direct child welfare services; a pattern of deviation from standard child welfare practice; failing to provide information or documents regarding a licensure investigation; falsification of case records, court reports or court testimony; failing to report an instance of suspected child abuse or neglect as required by ANCRA; or being named as a perpetrator in a report indicated by DCFS. When licensure action is appropriate, the licensee is provided an opportunity for a hearing. An administrative law judge presides over the hearing and reports findings and recommendations to the CWEL Board. The CWEL Board makes the final administrative decision regarding licensure action.

Department Rule 412.40 provides that a licensee may voluntarily relinquish his or her license at any time during a pending licensure or disciplinary investigation, administrative proceeding, or subsequent court action. Department Rule 412.100 allows a former licensee to request the reinstatement of his or her revoked, suspended, or relinquished license no earlier than 30 business days after receipt of the written notice of license revocation, suspension, or relinquishment. The OIG is notified within 10 days after receipt of a request for reinstatement of a license and may file a written objection to the request within 30 days after receipt of the notice.

In FY 2023, the ELRT referred 53 CWEL Complaints to the OIG for investigation and/or monitoring of an alleged Rule 412.50 violation.

FY 2023 CWEL Investigation Dispositions	
Pending OIG Investigation	**6**
Pending, OIG Monitoring	**1**
Closed, Monitored Only	**25**
Closed, No Adverse Licensure Action	**10**
Closed, CWEL Voluntarily Relinquished	**9**
Pending AHU	**2**
FY 2023 CWEL Investigation Referrals Received	**53**

FY 2023 CWEL Prosecutions

Of the 53 CWEL complaints referred to the OIG, 16 complaints were simultaneously referred to the CWEL Board for preliminary suspension pursuant to Rule 412.90. Of the 16 preliminary suspensions imposed by the Board, 7 workers requested a post-preliminary suspension hearing that was prosecuted by an IG attorney.

In two of the 53 CWEL complaints referred to the OIG, an IG attorney filed administrative charges seeking revocation of an individual's CWEL. In one of those cases, the charges were withdrawn after the individual began cooperating with the pending OIG investigation. The second case charged by the OIG is pending prosecution within the Administrative Hearings Unit (AHU).

There were 16 additional CWEL cases opened in previous fiscal years that were pending at the beginning of FY 2023. Of these 16 cases, 11 were closed in FY 2023. Five cases remain pending licensure action within the AHU. In two of these five cases, an IG attorney filed administrative charges seeking revocation of a CWEL.

Disposition Of Investigations Opened Prior To FY 2023	
Closed, No Adverse Licensure Action	**9**
Closed, CWEL Voluntarily relinquished	**2**
Pending Licensure Action Within the AHU	**5**

Child Welfare Employee Licenses

The following cases represent action taken against Child Welfare Employee Licenses (CWEL) in FY 2023

License Relinquishments (9)

In the following nine cases, a licensee relinquished their CWEL during a pending OIG investigation.

- A licensee allegedly sent inappropriate text messages and pictures to a subject of a child abuse/neglect investigation to which he was assigned.
- A licensee allegedly falsified case notes in several cases documenting home visits that had not occurred and falsified a letter allegedly written by a therapist.

- A licensee allegedly falsified a case note documenting that she completed a background check through the Placement Clearance Unit when she had not.
- A licensee allegedly engaged in an improper relationship with a client.
- A licensee allegedly falsified documents in the case records of at least six youths in care when she forged the signatures of individuals including the caseworker and the youth's foster parents.
- A licensee allegedly falsified case notes in several cases when she documented referrals that were never made and contacts that did not occur.
- A licensee allegedly falsified contact notes in two child protection investigations documenting visits that did not occur.
- A licensee allegedly falsified case notes documenting home visits that had not occurred.
- A licensee allegedly falsified case notes in several cases documenting home visits that foster parents reported did not occur.

CHARGES PENDING ADMINISTRATIVE HEARING (1)

The Office of the Inspector General issued charges based on falsification of records and egregious acts against a licensee who made untruthful statements and submitted falsified documents to secure foster placement in two cases. The CWEL matter is pending administrative hearing.

CHARGES WITHDRAWN (1)

Licensee was accused of falsification of records when licensee documented a good faith attempt to conduct an in-person visit when she did not do so. The Office of the Inspector General issued charges based on failure to cooperate with an Office of the Inspector General licensure investigation. The Office of the Inspector General withdrew the Charges after the licensee participated in an interview with Office of the Inspector General investigators.

COORDINATION WITH LAW ENFORCEMENT

Pursuant to statute, the Inspector General serves as the primary liaison between the Department and the Illinois State Police (20 ILCS 505/35.5). The Office of the Inspector General coordinates with law enforcement agencies referring criminal cases when indications of criminal activity are discovered in an investigation and responds to requests for assistance from law enforcement. Often the investigative efforts between law enforcement and the Office of the Inspector General are collaborative. Law enforcement investigations and prosecution may take several years before disposition. The monitoring unit of the Inspector General's Office follows the law enforcement referral and action until conclusion.

FY 2023 REFERRALS AND ASSISTANCE WITH CRIMINAL INVESTIGATIONS

- The OIG assisted the Illinois Attorney General's Special Litigation Bureau after referring the OIG investigative findings from an FY 2022 investigation regarding a Department-contracted vendor that had a $4.8 million, five-year contract to provide Supplemental Security Income (SSI) application services for youth in care (see January 2023 OIG Annual Report, General Investigation 1). The OIG found that the vendor fraudulently reported their compliance with the Illinois Department of Central Management Service's Business Enterprise Program, a provision contained within the department contract. As a result of the fraudulent reporting, the vendor fulfilled just 13% of the Business Enterprise Program obligation. In FY 2023, the Illinois Attorney General secured a settlement agreement, whereby the vendor agreed to pay a $1,000,000 fine to the state of Illinois and to voluntary abstention of participation in state contracts through August 1, 2025.

- After learning of a DCFS employee's alleged theft of state funds intended for childcare services, the OIG initiated an administrative investigation, while concurrently assisting the Federal Bureau of Investigations and the Illinois State Police on the criminal fraud investigation. The fraud investigation resulted in a 41-count indictment against the DCFS employee and 14 codefendants whose charges are pending for Honest Services Wire Fraud. According to an August 17, 2023, Press Release by the U.S. Attorney's Office, Northern District of Illinois, the indictment alleges that the DCFS employee orchestrated the fraud scheme from 2016 to 2022 while serving as a Community Social Service Planner for DCFS. The employee allegedly fraudulently entered the information of several co-defendants into the DCFS computer system and approved them to be paid as providers caring for foster children. The employee allegedly directed at least $3.2 million in State of Illinois funds to the co-defendants and others, each of whom agreed to receive the money, though no DCFS involved children actually attended their daycare. The co-defendants and others then paid bribes and kickbacks to the DCFS employee totaling approximately $1.6 million.[1]

- The Office of the Inspector General for DCFS and the Department of Healthcare and Family Services (HFS), Office of the Inspector General – Bureau of Internal Affairs initiated a joint investigation of a DCFS employee who had recent prior employment with HFS, for allegations of harassment of coworkers (see General Investigation 2). During the investigation, investigators

[1] U.S. Attorney's Office, Northern District of Illinois. (2023, August 17). *Press Release: Former Illinois Department of Children and Family Services Employee and 14 Others Charged in $3.2 Million Fraud Scheme*. United States Attorney's Office, Northern District of Illinois. https://www.justice.gov/usao-ndil/pr/former-illinois-department-children-and-family-services-employee-and-14-others-charged

obtained emails sent by the employee that were physically threatening, sexual, degrading and defaming in nature. The subject of the emails was a former co-worker. The DCFS OIG referred the matter to the Illinois State Police, Division of Internal Investigations, which subsequently opened a criminal investigation. The employee pleaded guilty to one count of Harassment Through Electronic Communications and was sentenced to one year of court supervision. On October 30, 2023, the state's attorney's office filed a petition to revoke supervision. The OIG continues to work with Illinois State Police, Division of Internal Investigations on further matters related to the now former employee.

- During an OIG investigation involving a DCFS employee who was detained by an out of state law enforcement agency in relation to a criminal traffic stop, it was learned that the employee's Department issued cell phone and laptop were confiscated by law enforcement (see General Investigation 3). The Department referred the matter to the Illinois State Police after finding that the employee later filed a false police report claiming that the employee's Department issued cell phone was stolen. The OIG subsequently worked with Illinois State Police during their investigation. The employee was arrested and charged with Misdemeanor Fraud against the Government, Less than $300.

- The OIG completed a referral to the Illinois State Police after finding that a daycare service provider fraudulently over-billed DCFS for daycare services that were never provided. The OIG investigation remains pending.

- The OIG provided the Illinois Attorney General's Office with requested assistance to obtain information on possible fraudulent payments to a daycare provider.

- The OIG provided the Federal Bureau of Investigations with requested assistance to obtain information related to possible fraudulent activities by a DCFS licensed daycare.

GLOSSARY

AA: Area administrator
AHU: Administrative Hearings Unit
ANCRA: Abused and Neglected Child Reporting Act
AOIC: Administrative Office of Illinois Courts
APME: Agency Performance Monitoring and Execution
ASL: American Sign Language
C-section: Cesarean section birth
CANTS: Child Abuse and Neglect Tracking System
CERAP: Child Endangerment Risk Assessment Protocol
CFTM: Child and Family Team Meeting
CMRN: Children's Medical Resource Network
CPAP: Continuous positive airway pressure
CPR: Cardiopulmonary resuscitation
CT scan: Computed tomography
CPI: Child protection investigator
CWCA: Child welfare contributing agency
CWEL: Child Welfare Employee Licensure
DNR: Do not resuscitate
DSCC: Division of Specialized Care for Children
DOB: Date of birth
DOD: Date of death
DUI: Driving under the influence
ELRT: Emergency Licensure Review Team
EMS: Emergency medical services
EMT: Emergency medical technician
ENT: Ear, nose, and throat specialist
ERT: Error Reduction Training
FOID: Firearm Owner's Identification
G-tube: gastrostomy tube or feeding tube
GAL: Guardian ad litem
HFS BIA: Dept. of Healthcare and Family Services, Office of Inspector General-Bureau of Internal Affairs
IDHS: Illinois Department of Human Services
IFR: Intact Family Recoery
IPS: Intensive Placement Stabilization Services
IV: intravenous medication administration
LEADS: Law Enforcement Agencies Data Systems
MERIT: Medical Evaluation Response Initiative Team
MPEEC: Multidisciplinary Pediatric Education and Evaluation Consortium
MRI: Magnetic resonance imaging
NICU: Neonatal intensive care unit
OEIG: Office of the Executive Inspector General
OIG: Office of the Inspector General for DCFS
OPWI: Other person with information
PCD: Placement clearance desk
PCP: Primary care provider

PRC: Pediatric Resource Center
PICU: Pediatric intensive care unit
RSV: Respiratory syncytial virus
SACWIS: Statewide Automated Child Welfare Information System
SAFE: Safe Assessment and Family Evaluation
SASS: Screening Assessment and Support Services
SCR: State Central Register
SUID: Sudden unexpected infant death
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX

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.

Child(ren):	Alayah Gardner	DOB: 09/2019	DOD: 02/2022
	Kobe Frost	DOB: 10/2014	
	Kaiden Gardner	DOB: 12/2015	
	Kevin Hudson	DOB: 10/2018	
	Otis Smith Jr.	DOB: 03/2023	

Subject: Child Death

SUMMARY OF COMPLAINT

In February 2022, Leslie Knight contacted 911 to report that her paramour's 2-year-old daughter, Alayah Gardner, was unresponsive. Emergency services personnel arrived at the home and found Alayah Gardner naked, unresponsive, and covered in bruising. Alayah was pronounced deceased at the home. Following postmortem examination, it was determined that Alayah's cause of death was blunt force trauma due to physical abuse and her death was ruled a homicide. The autopsy showed Alayah had multiple bruises, lacerations, severe organ damage, patterned marks on almost every area on her body, as well as deep tissue damage on her right arm and back. The Department investigated Alayah's death and indicated Alayah's father, Miles Kirkland, for allegations of death by abuse (#1); head injuries by abuse (#2); internal injuries by abuse (#4); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). Mr. Kirkland is currently in jail awaiting trial for charges of first-degree murder.

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. In December 2016, prior to Alayah's birth, a placement case opened for Alayah's mother, Mallory Gardner, and Alayah's older siblings Kobe and Kaiden. Alayah and her brother Kevin remained with their mother following their births but were brought into care in September 2019. Eight months prior to Alayah's death, Alayah, and her siblings Kobe, Kaiden, and Kevin were returned home to their mother. A month after the return home, the judge ordered that the agency close the placement case without after care services. The mother's housing later became unstable and she took the children to live with their fathers.

INVESTIGATION

Family Composition History

Mallory Gardner[1] (DOB: 10/1997), is the mother of four children: Kobe Frost (10/2014), Kaiden Gardner (DOB: 12/2015), Kevin Hudson (DOB: 10/2018), and Alayah Gardner (DOB: 9/2019; DOD: 2/2022). The father of Kaiden is Martin Lee (DOB: 5/1997), Kevin's father is Lucas Hudson (DOB: 4/1989), Alayah's father is Miles Kirkland (DOB: 11/1996), and Kobe's father remains unknown.[2] Mallory Gardner gave birth to Otis Smith, Jr. in March 2023. Otis Smith (DOB: 9/1991) is the father.

Father's Involvement During Placement Case

During the Alpha Agency's placement case, the placement worker documented conducting a diligent search for Kaiden's father, Martin Lee, and subsequently made phone contact. Mr. Lee told the placement worker that he was in "job court" out of state. Alpha Agency director, Brianna Delgado reported to IG investigators that placement workers tried to involve Mr. Lee in the placement case, however he was uncooperative and therefore not involved in the case. Immediately following Alayah's death, Ms. Gardner returned both Kaiden and Kobe to Mr. Lee's care. Mr. Lee later returned Kaiden and Kobe to Ms. Gardner's care, where they remain to date.

Lucas Hudson, Kevin's father, had been involved in Kevin's life since his birth. According to the Illinois State Police Sex Offender Registry, Mr. Hudson is required to register as a sexual predator for aggravated criminal sexual abuse of a victim under 13 and committed the offense at age 18. The investigator assigned to SCR#1111B confirmed that Mr. Hudson had received a sex offender assessment that determined he was unlikely to reoffend. According to the G-sequence investigation initiated in October 2022, Kevin remains in the care of his father.

Alpha Agency program director, Brianna Delgado reported to IG investigators that placement workers tried to involve Alayah's father, Miles Kirkland, in the placement case; however, he was uncooperative and therefore not involved in the case. IG investigators located a paternity test completed for Cedar County Court in the Alpha Agency case file attachments. According to the paternity test, the buccal sample was collected in August 2020 and the report was signed and dated by the laboratory director and a notary this same month. The paternity test states that the probability of paternity for the alleged father, Miles Kirkland of the child, Alayah Gardner, is 99.9999999999%. According to a criminal history search, Mr. Kirkland was arrested in March 2015 and charged with resisting arrest. In June 2021, Mr. Kirkland was arrested for armed violence, aggravated unlawful use of a weapon, possession of a firearm/invalid FOID, casual delivery of cannabis, and criminal trespassing on state land. Mr. Kirkland was charged with aggravated unlawful use of a weapon.

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[1] Mallory Gardner became a youth in care in 1999 following a child protection investigation against her biological parents in which they were indicated for substantial risk of harm and charged with cruelty to children.1 Mallory was adopted in 2002.

[2] According to SACWIS contact notes, Mallory Gardner reported to Alpha Agency placement workers that Kobe Frost's father was Kennedy Frost. Alpha Agency placement workers conducted a diligent search for Kennedy Frost, and called the number provided on the results. Mr. Frost told the caseworker that he was not the father of Kobe and had completed a paternity test in March of 2015. IG investigators located a copy of the paternity test in the case file attachments that stated the probability of paternity for Kennedy Frost of Kobe Frost is 0%.

History with the Department

SCR#3333A – Unfounded and expunged from SACWIS
In February 2015, the hotline was contacted alleging that 4-month-old Kobe was filthy and had a bad odor when he was picked up from his mother's home. DCFS unfounded the allegation of environmental neglect (#82) against the mother and the investigation has been expunged from SACWIS.

SCR#3333B – Unfounded and expunged from SACWIS
Two months later, in April 2015 a second call was made to the hotline alleging that there was a domestic disturbance between Ms. Gardner and her boyfriend, Anthony Armstrong. The reporter alleged that during the altercation, Mr. Armstrong threw bleach on Ms. Gardner. Ms. Gardner and Kobe were taken to the emergency room for examination. The report alleged that Kobe may have been harmed during the altercation. DCFS unfounded allegations of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and medical neglect (#79). The investigation was expunged from SACWIS.

SCR#3333C – Unfounded and expunged from SACWIS
Two weeks after the B-sequence investigation opened, a third report was taken for investigation which alleged that Ms. Gardner threw chemicals at her boyfriend, and some got on Kobe. The reporter alleged that Kobe was having difficulty breathing. It was also reported that the child did not have clean clothes or diapers, and the mother spent all her money on marijuana. DCFS unfounded the allegation of substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The investigation was expunged from SACWIS.

SCR#1111A – Indicated
In October 2016, a reporter called the hotline with concerns that 19-year-old Mallory Gardner was not following the doctor's plan for feeding 9-month-old Kaiden that was established due to his severe food allergies. The reporter stated that a family support worker from a postpartum home visiting program and a home health nurse conducted visits to the home. The reporter stated that Kaiden was recently admitted to the hospital related to possible malnutrition due to not gaining weight. Following his weeklong stay in the hospital, Kaiden had gained weight and was doing well but appeared to decline following discharge. The reporter was also concerned that Kaiden may not have been taken to follow-up appointments. DCFS took the report for investigation of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Following assignment, the child protection investigator contacted the family support worker and the home health nurse by phone. In separate interviews, both the family support worker and the nurse reported concerns that Kaiden had lost weight and that Ms. Gardner was provided instructions on feeding Kaiden special formula, baby food, and rice cereal, however there were times when they went to the home and Ms. Gardner did not have these foods. The support worker also reported that 9-month-old Kaiden was delayed and functioned at about a 4- or 5-month-old level. Both reported concerns about missed appointments for both of Ms. Gardner's children. The nurse also reported that Ms. Gardner always seemed to be sleeping when she went to the home.

CPI Barker also went to the family's home and interviewed Mallory Gardner. CPI Barker noted that Ms. Gardner was woken up by CPI Barker's arrival to the home. CPI Barker documented discussing Kaiden's lack of weight gain and noted that Ms. Gardner did not appear concerned. Ms. Gardner reported that she fed Kaiden formula 6 or 7 times a day. When asked if she fed him baby food and rice, Ms. Gardner reported that she did not have any but was going to get some. CPI Barker instructed Ms. Gardner to have Kaiden seen by a doctor. CPI Barker documented that she observed Kobe and Kaiden sleeping during the visit to the home and did not observe any apparent signs of abuse or neglect.

On October 2016, CPI Barker spoke to Dr. Bell[3] regarding her medical opinion of Kaiden's case. CPI Barker documented that Dr. Bell reviewed the medical records and noted there was not severe malnutrition at the time Kaiden was hospitalized and noted that Kaiden was allergic to chicken, wheat, soy, milk, eggs, nuts, and corn. Dr. Bell reported that Kaiden was referred to an allergist and needed allergy testing, and the mother needed allergy education. Dr. Bell stated that there was no evidence of medical neglect at the time, however, if the mother did not follow up with the allergist and recommendations, there could be evidence of medical neglect. Dr. Bell also noted possible failure to thrive but could not say whether it was all non-organic failure to thrive due to Kaiden's allergies.

About two weeks after the hotline call, an intact family services case was opened and assigned to a Child Welfare Contributing Agency (CWCA) to provide intact services. According to supervisory contact notes, the reason for case opening noted, "…18-year-old[4] mother and a child with food allergies- mom missed several doctor's appointments for both kids, including specialist for Kaiden..."

In November 2016, while the child protection investigation was still pending, CPI Barker contacted the intact worker to let her know that there were prescriptions that Ms. Gardner needed to fill for Kaiden. The intact worker reported that Ms. Gardner was not cooperative. The intact worker reported that she had a home visit scheduled for Monday, but Ms. Gardner called and rescheduled.

In December 2016, CPI Barker took protective custody of 1-year-old Kaiden and 2-year-old Kobe due to ongoing concerns related to missed doctor's appointments, not calling in prescriptions, failing to have the medication on hand for Kaiden, not feeding him properly, not following through with early intervention when both children were delayed, and not cooperating with intact family services. The court granted the Department temporary custody.

In January 2017, DCFS closed the child protection investigation. DCFS indicated Mallory Gardner for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The rationale for the indicated finding documented the following:

> …She had an open intact family case for 2 months and continued to not adequately provide for or care for her children. Help with transportation was provided to her and she continued to miss appointments. Instructions on feeding, bathing and skin care were given to her and she would argue about it and not follow through with the recommended care. She failed to get prescriptions in a timely fashion and would not get refills when needed. There are concerns with her not having adequate food for Kaiden as she on several occasions did not have any formula for him which he was to be eating every 3 hours. Both children are developmentally delayed, and Mallory refused to meet with Early Intervention after 2 referrals were made. Mallory admitted that she and [her boyfriend] Anthony had a physical altercation where she sustained injuries to her face with the children near them. She also reported that they have pushed each other a lot in the past and failed to make a police report. Mallory has created an environment which was injurious to the children's health and welfare.

Alpha Agency Placement Case

In December 2016, the family's placement services case was opened with Alpha Agency. Kaiden and Kobe were initially placed in a traditional foster home. In February 2017, they were moved to a relative foster home.

[3] Dr. Bell is a board-certified Child Abuse Pediatrician.

[4] Mallory Gardner turned 19 years old in October 2016.

According to SACWIS placement records, at a February 2017 permanency hearing in Cedar County, Ms. Gardner was found fit to parent while DCFS remained the guardian. Kaiden and Kobe were returned to their mother's care in March 2017. In August 2017, after learning that Ms. Gardner attempted suicide, Alpha Agency placement workers requested that Ms. Gardner bring the children to the agency. Once at the agency, Ms. Gardner tried to elope with her children and the children were taken into protective custody.

From August 2017 to September 2017, Kobe and Kaiden were placed in a traditional foster home. According to the Family Service Plan, the foster parent requested that the children be removed because she felt the children were too young for her to care for. From September 2017 to October 2017, the children were placed in another traditional foster home, however, they were again removed because the foster parent decided the children were too young for her to care for. From October 2017 to December 2017, the children were placed in another traditional foster home. The placement disrupted because the foster parents reported that the children's doctor's appointments and Kaiden's food allergies were "too much" for the family. In December 2017, the children were again moved to another traditional foster care placement.

The May 2018 Family Service Plan also stated that Ms. Gardner had been working two jobs from the end of 2017 until May 2018. Ms. Gardner left one of the part time jobs and was let go from the other part time job. Ms. Gardner reported that she was set to get back to work after she was cleared medically, due to a sprained ankle. Until the end of April 2018, Ms. Gardner was residing with her mother. Ms. Gardner stated that someone in her mother's household stole the money she was saving for moving into her own place. Ms. Gardner reported that she was beginning to save again and then her parents requested $200 more per month in rent, or she had to leave. Ms. Gardner moved in with her boyfriend. Ms. Gardner and her boyfriend got into an altercation, and he threw an object at her. In May 2018, Ms. Gardner admitted herself to the hospital for thoughts of self-harm. Ms. Gardner was discharged. Ms. Gardner was looking for housing and employment. The goal of maintaining stable housing and employment was rated unsatisfactory progress. According to the service plan, Ms. Gardner was attending parenting classes, counseling, and parent-child visitations during the reporting period. The plan noted that Ms. Gardner was cooperative with services and appropriately engaged during visits with her children.

In May 2018, according to Cedar Police Department records, Mallory Gardner again attempted suicide while pregnant with her third child. The report stated that police responded to a report of "a female who had just cut her wrist intentionally." On arrival, police officers found Ms. Gardner with several lacerations on her left wrist and forearm. Ms. Gardner reported to police officers that she "wanted to die and not be here anymore." The police officers then transported Ms. Gardner to Dreyfus Medical Center for treatment.

SCR#5555B[5]
In August 2018, a reporter contacted the hotline with concerns that Mallory Gardner and her paramour Lucas Hudson got into a verbal argument, and Mr. Hudson threw Ms. Gardner's phone against the wall and choked her. The reporter stated that Ms. Gardner and Mr. Hudson were babysitting Mr. Hudson's 1-year-old and 2-year-old nephews at the time of the altercation. The reporter also stated that Lucas Hudson was a registered sex offender. The Department opened an investigation for allegations of substantial risk of sexual abuse – sex offender has access (#22a) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

According to the Illinois State Police Sex Offender Registry website, Lucas Hudson was required to register as a sexual predator for aggravated criminal sexual abuse of a victim under 13 and committed the offense at age 18.

[5] According to the hotline narrative of SCR#5555A, in June 2016, the hotline received a call alleging that Lucas Hudson, a registered sex offender, was living with his mother and 12-year-old sister. DCFS took the report for investigation and indicated Mr. Hudson. The full investigation has been expunged from SACWIS.

Child protection staff determined that neither Ms. Gardner nor Mr. Hudson were ever left in a caretaking role, and the environment did not pose a risk to the children. In August 2018, DCFS unfounded and closed the investigation.

Alpha Agency Placement Case Continued
In October 2018, Ms. Gardner gave birth to her third child, Kevin Hudson. Following Kevin's birth, Kevin remained in the care of his mother, while Kobe and Kaiden remained in their foster home. Following Kevin's birth, Ms. Gardner reported that Kevin's father, Lucas Hudson, was not living in the home.

According to a supervisory contact note dated December 2018, Alpha Agency Supervisor Brianna Delgado documented the following regarding the placement case:

> Mother continues to have some issues in having her children returned home. She has corrected the original safety issue of the case of medical neglect of Kaiden's issues; she currently attends all doctor appointments and is well versed in how to care for him and what his allergies are. She is fit and currently visits unsupervised. She recently had her new baby, who has sickle cell. CW [caseworker] reports she attends all dr. appts and is taking good care of the baby. Main issues that still exist are housing and who she has around. She needs stable housing and to refrain from relationships with unhealthy people. She does not have many supports. She continues to attend counseling and is making progress on her goals but is currently working mainly on housing and employment. She is still on leave but returns to work soon. She is looking at a house but there are concerns over whether she can afford to maintain it. CW reports no concerns during unsupervised visits; supervisor advised to do an unannounced during unsupervised to ensure safety and that no one else is present. Mother needs to obtain and maintain stable housing and show that she can provide a stable home environment for her children. Permanency Review Hearing is this month.

According to the December 2018, Family Service Plan, Alpha Agency placement worker Daxton Chambers documented the following regarding parent-child visitation:

> Ms. Gardner currently receives unsupervised visits. Her visitation is on Tuesdays and Thursdays from 11a- 5p. Ms. Gardner began receiving unsupervised visits in October 2018. There have been 14 scheduled visits. Ms. Gardner did have trouble providing transportation to pick up the boys and drop them off during the month of October and the beginning of November. It was explained to her that this is a step towards return home and it allows the agency to observe how you will navigate the community with all the children in your care. However, she has been able to figure out the transportation routine. During the visits, she displays love and affection through words of affirmation, hugs, and playfulness. She brings appropriate snacks for the boys. This worker has observed Ms. Gardner provide age-appropriate supervision.

SCR#1111B – Unfounded
In March 2019, a reporter contacted the hotline with concerns that Mallory Gardner had been told that her boyfriend, Lucas Hudson, could not be around the children until he contacted the Alpha Agency to be assessed for appropriateness; however, Ms. Gardner continued to allow Mr. Hudson unsupervised contact with Kevin. The reporter stated that she also believed Ms. Gardner allowed Mr. Hudson to live in the home. The report was taken for investigation of allegation substantial risk of sexual abuse – sex offender has access (#22a).

Following assignment, the child protection investigator interviewed Lucas Hudson and Mallory Gardner. Mr. Hudson reported that he was convicted of a sex offense to a 12-year-old when he was 18 years old and served time in prison. Mr. Hudson reported that he completed his probation, however, it was marked incomplete because he did not complete sex offender treatment because he could not afford the class. Mr.

Hudson reported that he had not re-offended and had stayed out of trouble. Mr. Hudson stated that he knew he could not be around Ms. Gardner's other children but was never told that he could not be a caregiver to his own child, Kevin. Mr. Gardner reported that he recently signed up for the sex offender treatment class. Ms. Gardner and Mr. Hudson denied living together.

The child protection supervisor contacted the Cedar Police Department by phone. Cedar Police Department staff reported that the only record they had for Mr. Hudson was the sex offense that occurred when he was 18. Police staff reported that Mr. Hudson could be around his own child unsupervised but could only be around other children if there was another adult present.

In May 2019, the child protection investigation was unfounded and closed. The rationale for the finding noted that according to law enforcement, the father was allowed to be around his own child as a caregiver without any supervision. Prior to closing the investigation, the child protection investigator verified that Mr. Hudson was enrolled in a sex offender treatment course and encouraged Mr. Hudson to finish the course.

SCR#1111C – Unfounded
In September 2019, a reporter contacted the hotline with concerns that Mallory Gardner gave birth to her fourth child, Alayah Gardner. The reporter stated she contacted the hotline because Ms. Gardner reported that she had two children in DCFS custody and one child in her custody. The reporter stated the baby was born full term and was healthy. The reporter stated that Ms. Gardner bonded with the baby, and she appropriately cared for the infant. The report was taken for investigation of allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

The child protection investigation was assigned to CPI Phillip Lopez and supervised by Lillian Hunter. Following assignment, CPI Lopez requested court orders related to Kobe and Kaiden. CPI Lopez documented the following regarding the court orders:

> Received court orders in Cedar County cases, regarding Kaiden Gardner and Kobe Frost, on July 2019, State and GAL asks that mother be found unfit, denied. State asks for unsupervised visitation to be suspended, denied but agency has discretion regarding unsupervised visitation. It was also found on this date that father [of Kaiden Gardner], Martin Lee is failing to make reasonable efforts. It appears Mallory was found fit in these cases in February 2017.

Following assignment, CPI Lopez contacted the Alpha Agency placement worker. The placement worker reported that Ms. Gardner had unsupervised visits with her two children Kobe and Kaiden and was working on return home.

This same day, CPI Lopez met with Ms. Gardner and Alayah at the hospital. Ms. Gardner reported that Kobe was scheduled to return home in October and Kaiden was scheduled to return home in November. Ms. Gardner reported that she completed parenting classes and attended counseling once a week through Alpha Agency. Ms. Gardner reported that Alayah's father was either Martin Lee or Lucas Hudson.[6] Ms. Gardner reported that she had a diagnosis of depression and took Zoloft (sertraline). Ms. Gardner reported that she and Kevin had been living with her biological brother.

CPI Lopez conducted an in-person home visit with Mallory Gardner and her two children, Kevin, and Alayah, at her brother's home where she lived at that time. During the visit, Ms. Gardner denied that Mr. Hudson had been around the children. CPI Lopez reminded Ms. Gardner that she was told in court that Mr. Hudson could not have contact with any of the children including his own since he stopped attending sex

[6] Alayah Gardner's father is Miles Kirkland.

offender counseling. Ms. Gardner reported that she understood and stated that she did not want to do anything to mess up her children coming home.

Alayah Gardner was discharged home from the hospital to her mother. In November 2019, DCFS unfounded and closed SCR# 1111C. The rationale for unfounding the allegation of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) against Ms. Gardner stated that Ms. Gardner was, "found fit in her open Cedar County court cases regarding Kaiden Gardner and Kobe Frost."

SCR#1111D and SCR#5555C
In December 2019, almost two months after the prior investigation closed, a reporter contacted the hotline and stated that when the Alpha Agency placement worker arrived at Ms. Gardner's home for an unannounced home visit, Lucas Hudson was at the home with Kobe, Kaiden, Kevin and Alayah. The reporter stated that Mr. Hudson was a registered sex offender and was not allowed to be alone around children. The reporter stated that there was also a teenager at the home for a birthday party. The reporter stated that the Alpha Agency placement worker waited at the home until Ms. Gardner returned. SCR#1111D against Ms. Gardner and companion report SCR#5555C against Mr. Hudson were taken for investigation of allegation substantial risk of sexual abuse – sex offender has access (#22a).

Following assignment, Mallory Gardner explained to the child protection investigator that when the placement worker made the unannounced visit to her home, she had gone to the store because she was planning a birthday party for her son. Ms. Gardner denied leaving Mr. Hudson alone with the children and reported that her two adult sisters were also at the home helping to plan for the party. Ms. Gardner stated that she had never been shown paperwork informing her that Mr. Hudson was not allowed to be in the home around the children and she had requested this information from Alpha Agency staff, and they have never shown her the paperwork.

The child protection investigator interviewed Ms. Gardner's sister, Lexi Daniels, who confirmed that she was at the home preparing for the birthday party when the Alpha Agency worker came to the home. Ms. Daniels reported that Mr. Hudson was never alone with the children.

When the child protection investigator interviewed Alpha Agency placement staff, they reported that Mr. Hudson was allowed to be around his own children, Kevin, and Alayah, but he was not allowed to be in the home when Kobe and Kaiden were there for unsupervised visits. It was also reported that when the placement worker went to the home, Ms. Gardner's sister was at the home and Mr. Hudson was not alone with the children. Placement staff reported that there was no paperwork specifying that Mr. Hudson could not be alone unsupervised with Kobe and Kaiden, but that Mr. Hudson had not engaged in services. When child protection staff interviewed 5-year-old Kobe 4-year-old and Kaiden, both reported that they had never been left alone with Mr. Hudson.

In March 2020, DCFS unfounded investigations SCR#1111D and SCR#5555C for allegation substantial risk of sexual abuse – sex offender has access (#22a). The rationale noted "there is no evidence that leads one to believe that Mallory left Lucas in a caretaker role. It was stated that there were other adults in the home and that Lucas was not left alone with the children. At no time were the children left unsupervised with Lucas. There is also no court documentation that is in place that states that Lucas cannot be around his own children."

SCR#2222A (Mallory Gardner) and companion report SCR#7777J (Lexi Daniels)
In May 2020, a reporter contacted the hotline with concerns that while a caseworker was on a video call with her client, Lexi Daniels, she overheard a baby crying. The reporter stated she was concerned because Lexi Daniels had been found unfit and her biological children were removed from her care. Lexi told the

caseworker that she was watching her niece, 7-month-old Alayah Gardner, while her sister, Mallory Gardner went to the store. DCFS took the report for investigation. Ms. Gardner and her sister denied that her sister was ever left alone in a caretaker role. In June 2020, DCFS unfounded and closed the companion investigations for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

According to Cedar County Court Records, in July 2020, Alpha Agency placement staff were given discretion to facilitate overnight visits between Ms. Gardner and her children, Kobe and Kaiden. The agency began overnight visits following the court hearing and in August 2020 at court the agency was given discretion to return the children home. In September 2020, Kobe Frost and Kaiden Gardner were returned to the care of their mother, Mallory Gardner, while the placement case remained open to provide after care services.

SCR#1111E
Also in September 2020, two days after Kobe and Kaiden were returned home, a reporter contacted the hotline and stated that while watching the news, the reporter learned of a shooting that occurred at Ms. Gardner's home while Kevin was present. The reporter stated that Ms. Gardner's paramour, Gabe Dickerson, was the shooter, and the police were still looking for him. The reporter stated that Mr. Dickerson had an extensive law enforcement history and may have been gang affiliated. The report was taken for investigation of allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

When the child protection investigator interviewed Mallory Gardner, Ms. Gardner reported that her four children were asleep in the home when the shooting occurred. Ms. Gardner stated that her friend Gary [last name unknown] had come to her house after he got off work at 3:00am. Ms. Gardner stated that when Gary was leaving, and she had gone inside, she heard gunshots. Ms. Gardner reported that when she looked outside, she saw a man with a gun shoot Gary in both legs. Ms. Gardner reported that she had heard the shooter may have been Gabe Dickerson. Ms. Gardner stated that she knew Mr. Dickerson and he was last at her house a week and a half prior. Ms. Gardner denied being in a relationship with either Mr. Dickerson or Gary. The CPI documented that neither Ms. Gardner nor Ms. Gardner's sister who was at the home at the time of the interview was forthcoming with information about the shooting incident.

A CERAP was completed and determined that the children were unsafe. A safety plan was initially implemented, and Ms. Gardner and her children were required to stay at her sister's home.

The day after the hotline call, child protection staff documented the critical decision to remove all four children from their mother's care because there was a shooting at the home only two days after the children were returned to their mother's care. According to SACWIS placement screens, 5-year-old Kobe, 2-year-old Kevin, and 11-month-old Alayah were placed in a traditional foster home and 4-year-old Kaiden was placed in a specialized foster home.[7]

The Alpha Agency placement worker documented the following regarding a conversation she had with Ms. Gardner when the caseworker transported Ms. Gardner to court:

> Mallory and [CWS] talked about the recent shooting at her home. Mallory stated that this guy from Las Vegas that she met and wanted to meet in person. Mallory invited this man to her home in Cedar. Once this man came to her home Mallory no longer wanted him to be around. This man continued to come around looking for Mallory. Mallory stated that over the weekend she had her

[7] The Department was granted temporary custody of Kobe and Alayah in September 2020. The Department already had temporary custody of Kaiden and Kevin.

> other friend over that was a male and this guy from out of state showed up and began to physically beat on the other guy at her home. They fought outside and then Mallory stated that the guy from Las Vegas stated that he was going to come back to the home and shoot it up. Mallory stated that she was sitting outside with the other guy when the guy from Las Vegas came into the yard with a gun and shot the other guy once in both legs. Mallory stated that she ran inside and told her sister to take the children downstairs. They called 911 and police came but they had still not found the shooter.

In October 2020, Alpha Agency Supervisor Ember Evans met with caseworker Ismael Jameson for supervision. Supervisor Evans documented the following regarding the meeting:

> The children were returned home to mom on in September 2020 as the court ordered the return and discretion. DCFS removed the children two days later as someone was shot at the mother's home and the children were present. Mom has finished her services and continues to be enrolled in counseling. The therapist is leaving the agency and she will be re-assigned to therapist Grace. Worker to encourage mom to schedule therapy sessions with the new therapist. Mom is not happy that her children are in care and feels that they should be returned home to her. Sibling visits will be completed by the foster parent for Kaiden-worker to obtain 502's and document into SACWIS. Kaiden needs counseling as he speaks of the shooting-worker to complete the counseling intake and send off the consents for DCFS to approve for counseling at Alpha Agency. Kobe is reportedly doing well at this time-worker to follow up with foster mom to ensure he is doing well. Kevin and Alayah are also now in care due to the recent investigation, and they are now added to this case. They are also reportedly doing well currently. Kevin's dad, Lucas Hudson has been cooperative and has visits. He is in parenting at Fischer and worker reports having multiple weekly contact with dad. Dad is buying everything for Kevin, and child could return home to dad in the future-worker to assure that all services are being completed and obtain 502's and document in SACWIS.

In November 2020, a court hearing was held. According to SACWIS case documentation, the court order issued by the presiding judge noted that the "agency is ordered to assist mother with housing. Agency has discretion to determine whether visits with mother shall be supervised or unsupervised." According to Cedar Court Records included in the case file attachments, "Fathers Martin Lee and Kennedy Frost are barred from visitation until further court order."

DCFS indicated SCR#1111E for allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) against Mallory Gardner on all four children. The rationale for indicating the investigation notes:

> a shooting occurred on the front porch of Mallory's home while all four of her children were present. Mallory already has an open case for neglect and her two oldest children had just recently returned home. Although Mallory denies being in a relationship with the shooter (Gabe) or Gary, she admits to having them frequent the home. There is sufficient evidence to suggest that mother's choice of people who frequent her home created a real, significant, and imminent risk of harm to her children.

In December 2020, Alpha Agency caseworker Jayda Forbes documented in a SACWIS contact note that Alpha Agency director, Brianna Delgado, and Ms. Gardner's attorney Jimmy Gibes received an email from Ms. Gardner requesting unsupervised visitation with her children. Caseworker Forbes documented that Alpha Agency staff explained to Ms. Gardner that the agency has discretion to allow unsupervised visits and due to her lack of attendance at supervised visits and her children returning to care quickly, the agency was not ready to begin unsupervised visitation. Caseworker Forbes also documented that she received a voicemail from Ms. Gardner threatening to come down to the agency and punch someone.

In January 2021, Alpha Agency Program Director Brianna Delgado documented the following in a supervisory contact note:

> Director met with Jayda Forbes to discuss case after worker left agency without notice. Case has held three workers over the past two months that have all left the agency abruptly and did not enter notes. Director and SV [supervisor] reviewed the file. Supervisor is aware of contact made with the family, but it was not noted by the worker. Mother is currently uncooperative. She stated she will not participate in services due to having done services already. Mother is recommended to complete counseling, domestic violence, parenting, and possibly find new housing as safety is the biggest concern with the home right now. Agency was ordered to assist mother with finding housing. This Director contacted mother with housing options including the Beta Center and BluJay House, mother was not interested in these options and stated they have too many rules. She would prefer the agency pay for her housing, but this is not an option. Mother refuses access to her current home. …Father Hudson has been somewhat engaged but reports to court he calls agency daily, but he has not contacted this director or the supervisor. The oldest children have been in care for a few years and need permanency. The agency has attempted to return home on three separate occasions.

That same month, following a dispositional hearing, the court removed Alpha Agency from the case. The Alpha Agency worker documented the following regarding the court's decision:

> Lucas, Mallory, and caregivers to Kaiden were in attendance. Lucas was yelling and angry. He was yelling at Mallory about the agency and caregivers to his son, Kevin. CW Jayda and caregivers sat quietly. The judge asked if they were sure they wanted a removal of the agency and parents stated yes. The judge state to CW that this was not due to her work but due to the agency having a high turnover the last six months and the lack of trust from the parents that would now be more difficult to earn. The judge gave 7 days for the transfer. Caregivers were concerned that due to them being licensed through Alpha Agency, Kaiden would be removed. CW Jayda explained that that would not be the case and they could remain licensed through Alpha Agency. Mallory shook hands with Carmen and thanked her for taking care of her son. Lucas continued to yell in the lobby. CW Jayda was escorted out of the courthouse by security.

In an interview with IG investigators, Alpha Agency Director Brianna Delgado reported that after the children were removed from Ms. Gardner following the shooting, the court was pushing to begin unsupervised visits again. Director Delgado stated that Alpha Agency staff were not in agreement due to ongoing safety concerns and dishonesty by Ms. Gardner. Director Delgado explained that throughout the case, even when Ms. Gardner was cooperative, there was always an underlying issue related to the men in her life that had violent backgrounds or were sex offenders. Director Delgado stated that Ms. Gardner was not honest about who she was allowing to be around the children, which posed an ongoing safety concern. Director Delgado also stated that there were times that Ms. Gardner would not allow staff in her home. Director Delgado reported that Ms. Gardner was court ordered to participate in counseling which she was cooperative with throughout her time with Alpha Agency. Director Delgado reported that case management staff had a lot of meetings with Ms. Gardner and her therapist to address concerns regarding Ms. Gardner's romantic partners. Director Delgado reported that Ms. Gardner did not have stable housing for any length of time. Alpha Agency staff assisted Ms. Gardner with Norman funds and helped pay for a deposit on an apartment, but she moved around frequently. Director Delgado reported that at the time Alpha Agency was removed from the case, Alpha Agency had experienced high turnover however noted that she was familiar with the case because she had been the supervisor on the case for most of the time that Alpha Agency was assigned the case. Director Delgado reported that staffing levels at Alpha Agency's placement program had greatly improved, and they were near fully staffed.

Omega Agency's Placement Services Case

In a supervisory contact note, Omega Agency's Supervisor Francesca Esperanza documented that a transitional staffing was held in January 2021. Alpha Agency supervisor Jayda Forbes, Alpha Agency program director Brianna Delgado, APT monitor Jack Gibbs, Omega Agency case manager Brooklyn Butler, Omega Agency licensing supervisor Imani Freeman and Omega Agency supervisor Francesca Esperanza were in attendance. Supervisor Esperanza documented the following regarding the staffing:

> This case is being transferred from Alpha Agency to Omega Agency per court order.
>
> Kobe 6 & Alayah 1 reside with fictive kin- who is a friend of mothers. The children were returned home in September 2020 and returned to foster care two days later. …The kids were not seen at all in January. No behavioral problems, no medication, no medical concerns. Kobe is in school- North Star primary school and will return to in person this week.
>
> Kaiden 5 is placed in a licensed foster home. He is approved for medical specialized level of care due to allergies that are life threatening and has lots of things he can't eat. He sees an Allergist, but the previous foster parents weren't following up with the doctor. He was moved in December 2020 to a licensed foster home. The current foster parents got him to an Allergist and Pediatrician right away. He will be assigned to our Omega Agency nurse. He goes to Cygnus school and has an IEP for developmental delays…
>
> Kevin 2 lives with paternal uncle, Keon. He has sickle cell anemia. Alpha Agency had no documented contact with this child between September and January. Imani spoke to Hattie (uncle's girlfriend) earlier today, but they have not been responsive for the past week. Keon works during the day and Hatti is his paramour who lives in the home…
>
> Mom, Mallory Gardner, had previously completed services. In the service plan and dispositional report - DV counseling, mental health counseling and parenting. Mom says she won't engage in any services since she already completed services. She won't answer the phone but will only email the case manager. Mom still lives in the house where the shooting occurred, and Alpha Agency doesn't know who lives there. Brianna Delgado has offered the Beta Center and BluJay house as options, but she's not interested.
>
> Dads - Lucas Hudson is the father of Kevin. None of the other Dads have ever shown up for court and have not been involved - Kennedy Frost, Kobe, and Martin Lee, Kaiden; no info on Alayah 's dad…, Miles Kirkland

In January 2021, the case was transferred from Alpha Agency to Omega Agency. The case was assigned to Brooklyn Butler, supervised by Francesca Esperanza.8

In February 2021, Lucas Hudson phoned the new caseworker, Brooklyn Butler, to introduce himself and share his frustrations with the way the case had been going. According to SACWIS contact notes, Ms. Butler told Mr. Hudson that she would schedule a Child and Family Team Meeting (CFTM) to discuss services and expectations. Two separate CFTM's were then held in February 2021: one with Lucas Hudson regarding Kevin and the other with Mallory Gardner regarding all her children.

CWS Butler documented that during the February 2021 CFTM with Lucas Hudson, Mr. Hudson reported that he had not been able to visit with Kevin for quite some time and stated that he missed his child. Mr. Hudson reported that he was unsure if the court had ever addressed visitation. CWS Butler documented that

[8] Francesca Esperanza no longer works for Omega Agency.

she would find out if visits could occur in the foster home. During the meeting Mr. Hudson discussed in detail Kevin's sickle cell diagnoses and medications. Mr. Hudson reported that he had completed parenting classes but had not attended sex offender treatment since December 2020 due to the case being transferred to a new agency.

During the February 2021 CFTM with Mallory Gardner, Ms. Gardner reported that she had successfully completed counseling and parenting classes. Ms. Gardner agreed to continue counseling. Ms. Gardner reported that she received unemployment after being laid-off from a local door and window replacement company. Ms. Gardner stated that she was looking for employment and recently had an interview at a restaurant. Mallory reported that she felt safe at her home and reported that there had been no other incidents since the shooting five months earlier.

In February 2021, CWS Butler met with Mallory Gardner at her home in Cedar, where the prior shooting occurred. CWS Butler completed the home safety checklist while at the home. CWS Butler documented that Ms. Gardner reported that she ordered two additional beds for the children and would ensure that electrical outlets had covers and the home had a working smoke detector prior to the children's return home. Ms. Gardner reported feeling safe in the home.

According to SACWIS contact notes, supervised parent-child visitation occurred at the agency weekly from February 2021 thru March 2021. According to DCFS Visiting Records (CFS-502), Ms. Gardner was engaged and encouraging towards the children during visits.

According to a March 2021 contact note, placement worker Butler conducted a home visit at Mallory Gardner's home. During the visit, Ms. Gardner showed Ms. Butler the children's new beds and the new smoke detector. Ms. Gardner also reported that she had attended two virtual counseling appointments and noted that she enjoyed meeting her new counselor. Ms. Gardner reported that she was working with a temp agency to help her find a job and had also applied to multiple fast-food restaurants nearby. Ms. Gardner reported that her uncle lived across the street and stated that her family would help her watch the children while she worked when the children returned. Ms. Gardner reported that she was doing well and did not need anything at this time.

Eight days later, supervised parent-child visitation occurred at Ms. Gardner's home. In March 2021, unsupervised two-hour parent-child visits were held at Ms. Gardner's home, one week apart. In April 2021, the critical decision was documented in a supervisory contact note that visits would be increased to four hours. From April 2021 thru May 2021, four-hour unsupervised visits were then held each week. Following a May 2021 visit, Kaiden had an unsupervised overnight visit at his mother's home. CWS Butler conducted an unannounced visit to Ms. Gardner's home during the unsupervised parent-child visit. CWS Butler documented that Ms. Gardner continued to do well and the children appeared happy and safe. During the visit, Ms. Gardner provided CWS Butler with the completed monthly budget for Norman Funds. CWS Butler documented that Ms. Gardner needed help with dressers for the children, a washer and dryer, and help with a month of rent.

Supervisor Francesca Esperanza conducted supervision with CWS Brooklyn Butler. Supervisor Esperanza documented that at court in May 2021, Omega Agency was given discretion to return the children home to their mother. The decision was made to return Kaiden home to his mother in May 2021 since his foster parents were moving out of state and had requested that he be moved prior to their vacation in May 2021. Supervisor Esperanza also documented that overnight weekend parent-child visits with Kevin, Kobe and Alayah would start on May 2021. Supervisor Esperanza documented that Lucas Hudson visited with his son Kevin in his foster home. Supervisor Esperanza also noted that CWS Butler had attempted to contact Kobe's father, Kennedy Frost, and Kaiden's father, Martin Lee, but received no response. Supervisor Esperanza documented that the placement team did not have information on Alayah's father.

Kaiden was returned home to his mother at the end of May 2021. Kobe, Kevin, and Alayah had their first overnight weekend visit with their mother on the same weekend Kaiden was returned home and had another overnight visit with their mother the following weekend. In June 2021, two weeks after Kaiden was returned home, Kobe, Kevin, and Alayah were returned home to their mother. Following the return home, CWS Butler conducted an unannounced home visit one week apart; a virtual visit one week later due to an exposure to COVID-19; and completed two in-person visits in July 2021.

In an interview with IG investigators, CWS Butler reported that the unsupervised visits had been going well for a while and the court was being progressive with wanting the children returned home so the decision was made to begin transitioning the kids home. CWS Butler reported that Kaiden was returned home first as his foster parents were moving to Alaska, and it was in his best interests to be returned home to his mother at that point instead of being placed in a new foster home. Ms. Butler reported that Ms. Gardner was doing well with Kaiden in the home, and the decision was made to return all the children to her care.

Following a July 2020 home visit to see Ms. Gardner and her four children, CWS Butler documented the following regarding the visit:

> …Present in the home were Mallory Gardner, Kobe Frost, Kaiden Gardner, Kevin Gardner, Alayah Gardner, and Ms. Gardner's younger sister. All four of the children were playing in the dining room, they were kicking and throwing around a soccer ball. Kobe showed this worker his new scooter and a transformers toy. Kevin ran to the bedroom to show this worker a light up car. Ms. Gardner picked up Alayah and held her for the remainder of the visit. Kaiden and Kobe reported they feel safe in the home. Alayah and Kevin are too young to verbalize, but they appeared safe and happy. All four of the children were dressed appropriately, grooming and hygiene were also appropriate. The house was clean and free of any visible safety concerns…

Closure of Placement Case

In July 2021, a permanency hearing[9] was held in Cedar County. Prior to the July 2021 court hearing, the Omega Agency placement team submitted a status update to the court. The status update document summarized Omega Agency's work on the case and detailed Ms. Gardner's progress. The update noted that Ms. Gardner continued to work at a fast-food restaurant, was engaged in weekly therapy sessions, and the home remained safe and suitable. The update also noted, "Mallory is not in need of any other services. This worker [CWS Butler] believes it would benefit Ms. Gardner and her children to be involved in at least 5-6 months of aftercare monitoring." Present at the court hearing was the Presiding Judge Lance Hernandez; Assistant State's Attorney Noel Patterson; Ms. Gardner's attorney, Jimmy Gibes; and Viola Parker, the children's guardian ad litem. Omega Agency permanency worker Brooklyn Butler reported to IG investigators that she attended by way of video conferencing. The court order provided the following:

> Case Closure Order: The Court finds that DCFS and the Agency made reasonable efforts and provided appropriate services. Court retains jurisdiction over all the fathers' fitness statuses. The Court finds that Permanency has been achieved through reunification with Mother. The Court terminates wardship, appoints Mother as the Guardian of the Minors, and removes DCFS as Guardian of the Minors. Cases closed.

Omega Agency placement staff closed the case in SACWIS the same day. The reason for closure documented, "All four children were successfully returned home, court ordered the case to be closed and wardship was terminated. No after care plan."

[9] IG Investigators requested a court transcript for the July 2021 court hearing however the Court Reporting Supervisor advised IG investigators that since a court reporter was not present during the hearing and no recording was made of the hearing a transcript could not be provided.

Procedural and Statutory Requirements Regarding After Care
705 ILCS 405/2-28 (Court Review) provides that, "When the court orders a child restored to the custody of the parent or parents, the court shall order the parent or parents to cooperate with the Department of Children and Family Services and comply with the terms of an after-care plan or risk the loss of custody of the child and possible termination of their parental rights. The court may also enter an order of protective supervision in accordance with Section 2-24."

In 2019, in response to the horrific death of a 2-year-old child who was severely neglected by her mother following her return home from DCFS custody, the Department issued Policy Guide 2019.04, *Requirements for Reunification and After Care Services.* Policy Guide 2019.04 directed and clarified that DCFS and POS Permanency staff were, "…to provide services to the family for at least 6 months following return home of each child from substitute care…The 6-month time period shall begin on the day the child is returned home." In the case of the 2-year-old child, the family received after care services, however the six months of after care services began when the child's sibling was returned home in April 2018. Since the 2-year-old was returned home to her mother in August 2018, only two months of after care services were provided following the 2-year-old child's return home.

Following the 2-year-old child's death, the DCFS Office of Inspector General conducted an investigation and issued a report. The Inspector General's report recommended that all placement supervisors and caseworkers be trained on Policy Guide 2019.04 and recommended that the policy guide be shared with juvenile court personnel.

Also, in response to the child's death, legislation was introduced to ensure after care services were provided to families following the return home of each child in substitute care. On January 1, 2020, 20 ILCS 505/7.8 became effective. The statute requires:

> …(d) When a court determines that a child should return to the custody or guardianship of a parent or guardian, any after care services provided to the child and the child's family by the Department or a purchase of service agency shall commence on the date upon which the child is returned to the custody or guardianship of his or her parent or guardian. If children are returned to the custody of a parent at different times, the Department or purchase of service agency shall provide a minimum of 6 months of after care services to each child commencing on the date each individual child is returned home.

On December 28, 2020, the Department issued Policy Transmittal 2020.21, *Procedures 315.250, Reunification, Planning for After Care and Termination of Services.* The revised procedures require that:

> When a child will be returned home from substitute care, the Permanency Worker shall provide services to the family for at least 6 months following return home of the child. The 6-month time shall begin on the day the child is returned home. When more than one child in a family is in substitute care and the children are not returned home on the same day, the 6-month period shall restart on the day each additional child is returned home to that parent.

Mallory Gardner – Permanency Hearing Continued
In an interview with IG investigators, Omega Agency placement worker, CWS Butler reported that at the time of the July 2021 permanency hearing, she did not have concerns about Ms. Gardner caring for the children and noted that Ms. Gardner had been cooperative and had been following through since the case was transferred to Omega Agency. CWS Butler reported that she requested after care services because she wanted to provide Ms. Gardner with some support since she was going from having no children in her care to four young children. CWS Butler reported that while at court, she asked the judge if they could at least discuss after care services, and the judge declined and ordered the case closed. CWS Butler reported that it

was not a "huge shock" that the case closed since the judge was "very aggressive to return these kids home from the beginning." CWS Butler reported that during, "that year we had a lot of return homes [in other placement cases], and it did seem to be quick and aggressive" and that "after care gets denied pretty frequently on our cases." When asked about what after care services the agency was planning to provide the family, Ms. Butler told IG investigators that she planned to work with Ms. Gardner to ensure the school-aged children were enrolled in school in the fall and that the younger children had childcare. Additionally, CWS Butler reported that she was going to assist Ms. Gardner with housing and monitor medical appointments. CWS Butler stated that prior to the court hearing she let Ms. Gardner know about after care services and how the agency could assist her, but Ms. Gardner was not interested. CWS Butler stated that it is her understanding that once wardship is terminated the agency was no longer able to provide services even if the parent wanted services.

IG investigators contacted the children's guardian ad litem (GAL), Viola Parker. When asked about the hearing at which case closure took place, the GAL provided the IG investigators her notes from the day and informed IG investigators that she did not recall specifics from the hearing. The GAL's notes for the hearing dated July 2021 documented, "recommendation: M RE; Fs no RE; close case guardianship to m and reserving fs' fitness." When asked what was discussed at court regarding after care services for the family, Ms. Parker replied "I don't recall if there was any discussion on that particular issue."

In an interview with Omega Agency Director of Operations Catherine Dunlap and Omega Agency Regional Director-Central Region Gabrielle Malone, both reported that it is not common for the court to reject the agency's recommendation for additional after care services, but it has happened. The Omega Agency Directors reported that it is their understanding that once the court closes the case, the agency has no authority to provide services. Both reported that to their knowledge, Omega Agency staff had never requested assistance from DCFS Office of Legal Services to appeal the court's decision. When asked if they were familiar with procedural and statutory requirements regarding after care that requires 6 months of after care services following the return home of a child, both reported that they were familiar with the procedural requirement but were not familiar with the law. The Omega Agency Directors stated that as a rule, Omega Agency staff always recommend after care services and noted that even if unsupervised overnight visits have gone well, it is different when all kids or even one kid is home full time.

IG investigators contacted Assistant State's Attorney Noel Patterson. Ms. Patterson reported that she could not recall specifics about the hearing in July 2021. When asked about after care services, Ms. Patterson reported that she was familiar with the requirement to provide 6 months of after care services and recalls hearing about the requirement in a meeting. When asked if the requirement of after care services are followed, Ms. Patterson reported that after care services are usually provided.

Office of Legal Services – Central Region

In an interview with IG investigators, Assistant Deputy General Counsel of Central Region Abby Castillo[10] reported that in her experience in Ceres County, after care services were typically supported by the court and DCFS Office of Legal Services would request that the court keep the wardship open to ensure the parent's participation in after care services. When asked what recourse the agency has if the case is ordered closed without after care services, Ms. Castillo reported that the permanency worker could request that DCFS Office of Legal Services file a motion to reconsider to allow for after care services. Ms. Castillo noted that after care services are important to making sure families have the support they need. Ms. Castillo stated that she believed DCFS workers and attorneys were familiar with the requirement of after care services, but she was not sure how familiar judges, assistant state's attorneys, and guardians ad litem were

[10] Abby Castillo was not involved in the Mallory Gardner case.

with the requirement. Ms. Castillo stated that she would discuss the issue of after care services at a stakeholder meeting with court personnel.

In an interview with Eddie Fernandez, DCFS Supervisory Regional Counsel in Central Region and Cedar County, Mr. Fernandez stated that although he was not involved in Mallory Gardner's case, he surmised that the case was closed quickly without after care services due to pressure from the Illinois Supreme Court to close cases faster including in Juvenile Court. Mr. Fernandez stated that after care services are not always highly valued in court and when a parent is meeting minimal parenting standards and have been found fit, the court will close the case and after care services are not always provided. When asked about how knowledgeable court personnel are about the procedural and statutory requirements regarding after care, Mr. Castillo reported that he did not think private attorneys or judges were aware of the law requiring after care services for six months. Mr. Castillo recalled a recent conversation with a guardian ad litem that thought the parent could just refuse after care services without recourse.

Death of Alayah Gardner

Following the closure of the placement case in July 2021, the family had no Department involvement until February 2022, when the death of 2-year-old Alayah Gardner was reported to the hotline. Emergency personnel stated that Alayah was found in a bedroom, naked, with bruises and injuries across multiple planes of her body.[11]

According to Cedar Police Department records, when police officers interviewed Miles Kirkland, Miles reported that Alayah's mother, Mallory Gardner, had custody of Alayah but Ms. Gardner's housing became unstable around Christmas time, and she left Alayah with him. Mr. Kirkland reported on the day of Alayah's death, he woke up in the morning and Alayah had peed on the couch so he "popped her a couple of times" and put her back on the other couch. Mr. Kirkland reported that Alayah peed on the couch again, so he whooped her again with a brown belt. Mr. Kirkland reported that after he washed her off in the shower, she was walking back to the bedroom and she was staggering. Mr. Kirkland stated that he heard a thump then saw Alayah had fallen flat on her face. Mr. Kirkland reported that he picked Alayah up and put her on the bed and she was looking at him weird. Mr. Kirkland reported that she looked like she was trying to go to sleep. When officers asked why he did not immediately call 911, Mr. Kirkland stated that he was afraid that she would get taken from him.

CPI Barker documented that after she observed the Cedar Police Department's interview of Miles Kirkland, she met with Miles Kirkland. CPI Barker documented the following regarding her interview with Mr. Kirkland:

> Miles reported that he found out that Alayah was his child about a month before she turned 2 years old. he stated that he was not involved when Mallory had her last DCFS case. He stated he didn't know if Mallory has other children as he does not talk to her, and Mallory talks to his mother. He stated that Mallory saw Alayah about 2 times over the last month. One time she brought over food for her and one time he let her spend the day with her. Miles reported that Alayah fell off the little couch yesterday while he was whooping her and hit her mouth on the floor and split her lip, but he doctored it up. CPSW asked him if Alayah was crying after she fell this morning but [he said she] was just making a "I just fucked myself up face." He stated that her eyes were wandering, and she was dazed. He denied that Alayah ate or drank anything today and stated that she last ate around 10:00 or 11:00 pm and had a burger and fries. Miles reported that he whooped Alayah yesterday

[11] The report from the Cedar Police Department was taken for investigation. The reports from the fire department and medical transport company were taken as related information.

> for lying about taking a juice box. Miles stated that he has another child, Angel Coleman, DOB:12/2016.[12]

This same day, CPI Barker observed Cedar Police Officers' interview of Leslie Knight, Miles Kirkland's paramour, at the Cedar Police Department. CPI Barker documented the following regarding the interview:

> …CPSW observed the interview of Leslie at the Cedar Police Department done by Detective Flynn. In summary, Leslie reported that she woke up at 8:00 am. She and Miles were in the bed and Alayah was sleeping on the couch in their bedroom. She stated that Miles got up and checked on Alayah and asked her if she peed the bed because she has a habit of lying. She stated that she left the home at 9:50 am to go to a therapy appointment. She was there for an hour and was walking home when Miles called her and said that he whooped and put her the tub and then when he got her out, he stated that she fainted. He told her that he called Alayah 's mother who stated that she faints all the time. She got home and Alayah was wrapped in a towel with no clothes on laying on the bed. She stated that she looked for her stethoscope. She stated that she used it and didn't know if she was hearing her heartbeat or Alayah 's. She stated that she felt for a pulse and tried to elevate her to see if she could breathe. She stated that she saw bruises on her everywhere and asked Miles how she got the marks and he stated that he didn't know. Detective Flynn spoke to Leslie again and she reported that Miles whooped her yesterday. She stated that Miles was using his hand to whoop her, but she felt that it wasn't working so she had given him a belt to start using and she told him to turn the music on when he whoops her, so it doesn't sound like he was beating her. She stated that Miles would whoop her 10 to 15 times and have her stand in the corner with her hands up. Leslie stated that Alayah has been staying with her and Miles for the last 3-4 months….

According to the Report of Postmortem Examination issued in May 2022, the cause of Alayah's death was ruled blunt force trauma due to physical abuse. The report revealed that Alayah had multiple bruises, lacerations, and patterned marks on almost every area on her body. The diagnosis to support the blunt force trauma finding included: Bilateral subdural and subarachnoid hemorrhages; Eyes with optic nerve sheath hemorrhages and retinal hemorrhages; Bilateral lung contusions, lower lobes; Liver lacerations and contusion; Pancreatic contusion; Contusions, abrasions, and scars about the body in various stages of healing.

In February 2022, Miles Kirkland was arrested for first degree murder. Mr. Kirkland is currently in jail awaiting trial for two counts of first-degree murder.

In June 2022, DCFS closed and indicated SCR#4444A for allegations death by abuse (#1); head injuries by abuse (#2); internal injuries by abuse (#4); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) by Miles Kirkland to Alayah Gardner.

SCR#1111F, SCR#5555D, and SCR #6666A

In February 2022, two days after the death of Alayah Gardner, a reporter contacted the hotline with concerns that following Alayah's death, Ms. Gardner reported that her other children, Kaiden and Kobe were living with Martin Lee, and Kevin was living with Lucas Hudson. The reporter stated that there were concerns due to Kaiden having nutritional allergies and Kevin had been diagnosed with sickle cell anemia. The reporter also stated that Lucas Hudson was a registered sex offender and had not completed sex offender treatment.

The hotline took three separate reports for investigation. SCR#5555D was opened against Lucas Hudson for allegation substantial risk of sexual abuse – sex offender has access (#22a); SCR#6666A was opened

[12] IG investigators conducted a person search for Angel Coleman and results were negative.

against Martin Lee for allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60); and SCR#1111F was opened against Mallory Gardner for allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). All investigations were assigned to CPI Barker, who was also assigned to the death investigation.

SCR#1111F (Mallory Gardner)
Throughout the investigation, Mallory Gardner remained uncooperative with child protection staff. CPI Barker contacted Detective Flynn from the Cedar Police Department to try and contact Ms. Gardner. Detective Flynn relayed that Ms. Gardner stated that CPI Barker could contact her sister, Eva Goodman. CPI Barker documented that when she contacted Ms. Gardner's sister, she yelled at CPI Barker and told her that she needed to leave Ms. Gardner alone as they are going through a lot. Ms. Goodman also stated that Ms. Gardner had been staying place to place and had support from her family. Ms. Goodman reported that Kaiden and Kobe were living with Martin Lee and Kevin was living with Lucas Hudson. CPI Barker asked Ms. Goodman if Ms. Gardner needed supportive services and Ms. Goodman stated no.

In March 2022, DCFS unfounded the allegations against Mallory Gardner and closed the investigation. The rationale for the finding noted that there was no credible evidence to substantiate the allegation as Ms. Gardner had made appropriate care plans for her children with their fathers.

SCR#5555D (Lucas Hudson)
Following the hotline call, CPI Barker contacted Lucas Hudson by phone. Mr. Hudson reported that he had been caring for Kevin since September 2021. Mr. Hudson reported that his sister, also Kevin's previous foster parent, cared for Kevin when he worked. Mr. Hudson reported that he took Kevin to his primary doctor as needed and the sickle cell clinic every three to six months. Mr. Hudson, who was 33 years old, stated that he was allowed to care for his child and that he had not had any sexually related charges since he was charged when he was 17. Mr. Hudson reported that he had been having a hard time with the loss of Alayah because he considered her a daughter. Mr. Hudson reported that Ms. Gardner was also struggling as well. CPI Barker documented that Kevin appeared very well cared for and was observed to be very bonded to his father.

CPI Barker contacted Kevin's primary care physician's office. Staff reported that Mr. Hudson did a great job following up with all necessary medical care for Kevin made sure Kevin got to his medical appointments; called with any questions; ensured medications were refilled; and kept Kevin on a good diet. CPI Barker also contacted the Cedar Police Department. Police Department staff confirmed that Mr. Hudson was allowed to be around his own child but must be supervised around other children.

In March 2022, DCFS unfounded the allegations against Lucas Hudson and closed the investigation.

SCR#6666A (Martin Lee)
Following the hotline call, CPI Barker went to the home of Martin Lee and met with Mr. Lee, Kobe and Kaiden. Mr. Lee reported that Kobe and Kaiden had been living with him since the day after Christmas. Mr. Lee reported that he switched the children to the school near his home and reported that Kaiden received speech therapy at school, and he just signed off on an Individual Education Plan (IEP). Mr. Lee agreed to make an appointment with the allergist for Kaiden. Mr. Lee reported the children could stay with him as long as possible. Mr. Lee reported that he never had concerns regarding Ms. Gardner's parenting and reported that Ms. Gardner was really going to have a hard time with the death of Alayah. CPI Barker documented that Kaiden and Kobe appeared clean and well cared for, and both children reported that Mr. Lee took good care of them.

In March 2022, DCFS unfounded the allegations against Martin Lee and closed the investigation.

Current Update
In October 2022, officers from the Cedar Police Department responded to a domestic disturbance between Mallory Gardner and her paramour, Otis Smith. According to the hotline narrative, when police arrived, it was reported that Ms. Gardner and Mr. Smith got into a verbal argument and Ms. Gardner scratched Mr. Smith and reportedly attempted to stab him with a knife. Kaiden, Kobe and Kevin were in the home at the time of the altercation. Ms. Gardner was arrested for domestic battery. DCFS took the report and opened SCR#1111G for investigation into allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) by Mallory Gardner to Kaiden, Kobe, and Kevin.

On October 2022, following assignment, CPI Lionel went to the Cedar County Jail to interview Mallory Gardner. Ms. Gardner denied having a knife or trying to assault anyone during the altercation. Ms. Gardner reported that she and Mr. Smith were arguing, and the children were in a different room during the altercation. Ms. Gardner reported that she bit Mr. Smith when he tried to force her from her apartment. Ms. Gardner reported that she was trying to get Mr. Smith to leave the residence when the incident occurred. Ms. Gardner reported that she was pregnant and due in March 2023 with Mr. Smith's child. Ms. Gardner admitted to feeling depressed and reported that she had lost her mother, grandmother, and daughter in the last year. Ms. Gardner reported that the children were staying with their maternal grandfather.

CPI Lionel interviewed Kaiden, Kobe and Kevin at the maternal grandfather's home. Kaiden and Kobe reported that during the incident, they heard their mother and Mr. Smith yelling, however they did not see anything because they were in the bedroom and their mom shut the door to the bedroom.

This same day, CPI Lionel contacted Mr. Smith by phone. Mr. Smith reported that he was no longer staying at the apartment and stated that he and Ms. Gardner were no longer in a relationship. Mr. Smith reported that he was untruthful when he told the police there was a knife involved.

Mallory Gardner initially agreed to intact family services. According to Department emails, in December 2022, CPI Lionel sent the intact referral to supervisor Lily Long for approval. Supervisor Long then sent in the intact referral to the intact referral email box later the same day. The reason for the intact referral noted, "There are no services in place at this time. The family would benefit from general support and advocacy. Mallory admits to feeling depressed and having financial concerns. She would benefit from counseling and linkage to community services." The intact family services case was assigned to a Child Welfare Contributing Agency to provide intact family services.

CPI Lionel documented in a contact note that after sending Ms. Gardner a text message letting her know that the intact family services case had been assigned to an intact worker, Ms. Gardner responded with a text message stating that since intact family services are voluntary, she did not want to participate in the program.

In January 2023, Public Service Administrator Lily Long documented the following in a supervisory contact note, "Ms. Gardner originally agreed to intact services, but she is now refusing and stating she is being harassed by DCFS. DCFS will request a first appearance and hopefully get services court ordered."

CPI Lionel submitted a petition request for court ordered services that detailed Mallory Gardner's history with the Department and the pending G-sequence investigation. In addition, the petition noted the following:

> CPI ran a check for recent police reports and found that there was an incident in November 2022 in which Mallory called the police after Otis hit her in the face and her eye was swollen. Police took pictures of her swollen eye. Mallory told police that the children were not home during this incident.

> DCFS has tremendous concern about the children in this family, as well as Ms. Gardner's mental health. Services were repeatedly offered to keep this family together, but Ms. Gardner continually declined stating DCFS is just trying to take her children. She has had extensive involvement with our department and the children were previously in care. At this point, she has two children in her care and is pregnant by the male involved in the most recent investigation (Otis) and is due in March 2023. DCFS cannot even determine where her other children are at this point.
>
> Ms. Gardner's placement case closed in July of 2021, and shortly after she basically gave one of the kids to their father and he subsequently murdered that child. Ms. Gardner admits she is struggling with the death of that child and there are no services in place. She continues to have DCFS involvement despite extensive services that were offered and completed in her placement case. She seems to struggle with reality-based thinking and is generally paranoid about receiving any type of help. DCFS notes that she has two children, one on the way and is living in a one-bedroom apartment.
>
> CPI met with Kobe and Kaiden at school in January 2023. Both boys report that Otis still comes to their home and spends the night sometimes but does not live there.

The Cedar County State's Attorney's Office did not file a first appearance prior to the close of SCR#1111G in January 2023. DCFS indicated allegation substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) against Mallory Gardner. The rationale for the indicated finding noted:

> …DCFS found sufficient evidence that she showed blatant disregard of her parental responsibilities and created an injurious environment for Kaiden. Mallory was arrested for domestic battery in October 2022 and the children were present in the home. Mallory then continued in a relationship with Otis Smith as evidenced by Cedar Police report from November 2022 in which Otis hit Mallory in the face and police documented that her eye was swollen. Kobe and Kaiden told CPI on January 2023 that Otis is still around and comes over to their home.

Mallory Gardner gave birth to Otis Smith Jr. on March 2023. According to Department emails, in March 2023, supervisor Lily Long sent the following email to staff at the Cedar County State's Attorney's Office:

> So, we have immense concerns about Mallory's mental health. She got her children back from DCFS/court, handed one over to the father shortly after and he murdered the child. She has been living in a one bedroom with multiple children and now gave birth to another. She was interviewed on the last report while incarcerated due to a domestic violence incident. She claimed she was done with this person, but just gave birth to his child and named the child after him. She initially agreed to intact services, but then declined…We sent this up some time ago and are hoping you will look and file. Let me know if you have any questions.

Update Following Issuance of the OIG Report

A subsequent report of child abuse and neglect was made to the DCFS hotline regarding a physical altercation between Mallory and Otis Smith, alleging Otis Smith strangled Mallory and threatened to kill her. The Department investigated the report and indicated both Mallory and Otis were indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The Department took protective custody of Otis Smith Jr., Kevin Hudson, and Kobe Frost. Kaiden Gardner remained in the care of his biological father. In July 2023, the court granted the Department temporary custody of the three children and a placement case was opened for the family.

ANALYSIS

Mallory Gardner was just 19 years old when her 1-year-old and 2-year-old children first came into care. During the four-year placement case, Ms. Gardner had two additional children who were initially allowed to remain with her but were later removed from her care. Throughout the placement case, Ms. Gardner was involved in ongoing intimate partner violence with multiple partners, most of whom had serious criminal backgrounds. In addition, Ms. Gardner was often untruthful with placement workers regarding whom she allowed to stay in her home. Ms. Gardner also struggled to maintain stable employment and housing throughout the case. At the time the court closed the placement case in July 2021, Ms. Gardner had only been caring full-time for all four of her children for just over a month. Her children were then 1, 2, 5 and 6 years old, and two of had specialized medical needs. Although the permanency worker in this case recommended after care services for the family at court, the judge ordered the case closed without after care services. Five months later, Ms. Gardner lost stable housing and gave 2-year-old Alayah Gardner to her biological father, whom the child had never met. Tragically, Alayah's father beat Alayah to death.

After Care Services

In this case, the optimism associated with a potentially successful reunification appeared to blind the court to the acute environmental stresses associated with a young mother caring for her four young children with little support. Reunification, although a positive milestone for the family, is also a time of readjustment for the family. The provision of supportive services and monitoring of the family can be critical following the children's return home and the family's needs may be greater than when the children were in foster care. Support networks such as daycare, Head Start, respite care, peer support groups, linkages with the health and education systems, and other community-based services can provide families with protection from the possibility of further disruption. In addition, when return home coincides with major life events, such as the birth of a child, start or loss of a job, change in housing, or identification of a health condition, the family should receive additional supports and services. Given Mallory Gardner's history of intimate partner abuse as well as housing and vocational instability, after care services could have provided the family with the support they needed while also monitoring the safety of the children.

Although the permanency workers in Ms. Gardner's case recommended in their status update to the court that Ms. Gardner would benefit from after care services, there was a failure by multiple involved parties, including the judge, assistant state's attorney, and the children's guardian ad litem, to ensure that the statute requiring six months of after care services was followed.

Procedural and Statutory Requirements Regarding After Care

705 ILCS 405/2-28 (Court Review) provides that, "When the court orders a child restored to the custody of the parent or parents, the court shall order the parent or parents to cooperate with the Department of Children and Family Services and comply with the terms of an after-care plan or risk the loss of custody of the child and possible termination of their parental rights. The court may also enter an order of protective supervision in accordance with Section 2-24."

In 2019, in response to the horrific death of a 2-year-old child who was severely neglected by her mother following her return home from DCFS custody, the Department issued Policy Guide 2019.04, *Requirements for Reunification and After Care Services.* Policy Guide 2019.04 directed and clarified that DCFS and POS Permanency staff were, "…to provide services to the family for at least 6 months following return home of each child from substitute care…The 6-month time period shall begin on the day the child is returned home." In this case, the family received after care services, however the six months of after care services began when the child's older sibling was returned home in April 2018 and since the younger child was returned home to her mother in August 2018, only two months of after care services were provided following the younger child's return home.

Following the child's death, the DCFS Office of Inspector General investigated the death and issued 2019 IG 2157. The Inspector General's report recommended that all placement supervisors and caseworkers be trained on Policy Guide 2019.04 and recommended that the policy guide be shared with juvenile court personnel.

Also, in response to the child's death, legislation was introduced to ensure after care services were provided to families following the return home of each child in substitute care. On January 1, 2020, 20 ILCS 505/7.8 became effective. The statute requires:

> …(d) When a court determines that a child should return to the custody or guardianship of a parent or guardian, any after care services provided to the child and the child's family by the Department or a purchase of service agency shall commence on the date upon which the child is returned to the custody or guardianship of his or her parent or guardian. If children are returned to the custody of a parent at different times, the Department or purchase of service agency shall provide a minimum of 6 months of after care services to each child commencing on the date each individual child is returned home.

On December 28, 2020, the Department issued Policy Transmittal 2020.21, *Procedures 315.250, Reunification, Planning for After Care and Termination of Services.* The revised procedures require that:

> When a child will be returned home from substitute care, the Permanency Worker shall provide services to the family for at least 6 months following return home of the child. The 6-month time shall begin on the day the child is returned home. When more than one child in a family is in substitute care and the children are not returned home on the same day, the 6-month period shall restart on the day each additional child is returned home to that parent.

The statute (20 ILCS 505/7.8) also required the IL Office of the Auditor General to conduct an audit regarding after care services. On May 12, 2022, the IL Office of the Auditor General issued a performance audit of the Department of Children and Family Services. The audit found that of the 50 placement cases reviewed, 29 (58%) of the cases did not include at least six months of documented after care services. The audit stated:

> Auditors determined that there was a total population of 822 cases with a calendar year 2020 return home date within SACWIS that were required to receive after care services within the requirements of Public Act 101-0237. From this population, a random sample of 50 cases was selected to test for compliance. All 50 cases contained a Service Plan. Digest Exhibit 5 shows the results for after care service testing. Thirty cases (60%) contained at least one exception. Of the 50 cases tested, 29 (58%) did not have at least six months of documented after care services, according to SACWIS. Additionally, 9 of the 50 cases (18%) had no documented confirmation that services had been utilized, such as a narrative description of service updates, or contact notes with the service provider.

The audit findings reflect that the failure to provide after care services following the return home of children a systemic issue, not specific to a particular county in a particular court room. Guidance as well as training and outreach to court personnel on the requirement of after care services is a critical step in ensuring that the statute is followed. Currently, Procedures 315, *Reunification, Planning for After Care and Termination of Services,* does not address what permanency staff can do if after care services are not supported by the court. DCFS has regional counsel to support the field. DCFS Office of Legal Services and regional counsel should be contacted by the field when the field believes that a decision by the court does not have the child's best interest in mind. Permanency staff should be directed to contact the Office of Legal Services when the court denies or does not support after care.

RECOMMENDATIONS

1. When a case is closed in court prior to the completion of the six months of required after care services in violation of Illinois law, the assigned caseworker and supervisor should contact the Office of Legal Services for assistance. Office of Legal Services is encouraged to request the court to keep the case open during the six months of after care services. This recommendation should be incorporated in Procedures 315.250 and the Department should provide education to the field regarding this issue.

2. The Department should collaborate with the Administrative Office of Illinois Courts (AOIC) to provide training and education on the procedural and statutory requirements of after care services to court personnel statewide. A redacted copy of this report should be shared with the AOIC and the Department's Office of Legal Services to assist with the training.

3. The Office of Legal Services should convene meetings with local state's attorneys to discuss the procedural and statutory requirements of after care services.

4. The report should be shared with the Department's Office of Legal Services.

5. This report should be shared with the involved Area Administrator for the purpose of future case planning.

6. The OIG will share a redacted copy of the report with Alpha Agency.

7. The OIG will share a redacted copy of the report with Omega Agency.

8. The OIG will share a redacted copy of the report for training purposes with the Cedar County State's Attorney's Office, and the involved circuit's chief judge.