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

Annual Report to the Governor & the General Assembly

Fiscal Year 2024
July 1, 2023 - June 30, 2024

Ann McIntyre
Inspector General

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

December 2024

To the Governor and Members of the General Assembly:

I respectfully submit the Fiscal Year 2024 Annual Report of the Office of the Inspector General (OIG) for the Department of Children and Family Services.

For over 30 years, the OIG has been committed to the mission of strengthening the child welfare system through independent, comprehensive investigations. Through these investigations, the OIG identifies areas for reform and holds the Department accountable for systemic deficiencies and individual employees accountable for instances of misconduct. This FY 2024 Annual Report contains the summaries of the 18 investigative reports submitted to the Director in FY 2024 and details the Department's responses and implementation plans for the 79 recommendations issued. Recognizing the complexities of the child welfare system, the OIG issues both case specific and systemic recommendations to strengthen the system charged with protecting our most vulnerable children and families.

Under the leadership of Director Mueller, the Department has demonstrated a strong commitment to implementing the recommendations issued by the OIG. To date, the Department has implemented 53 of the 79 recommendations made in FY 2024 and has submitted an implementation plan for the pending 26 recommendations. The OIG will continue to monitor the Department's implementation of the recommendations issued in FY 2024 as well as the pending recommendations from prior fiscal years (see Department Update on Prior Recommendations, page 153).

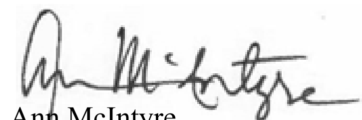
The objective, in-depth investigations conducted by the OIG uniquely position us to identify the challenges and complexities child welfare professionals face. In FY 2024, 33% of the recommendations issued addressed agency-wide as well as individual training needs. Child welfare professionals must be afforded enhanced training and supervisory support to manage the responsibilities of addressing multi-faceted family dynamics and navigating multiple external systems in their day-to-day work. Robust training and supervision are essential given the influx of new hires as the Department strives to increase its workforce. Included as Appendices to this Report are two FY 2024 reports demonstrating the breadth of the investigations conducted by the OIG. Appendix A highlights the critical need for internal Department controls to safeguard against fraud. The recommendations in this investigative report were issued in response to $3.2 million paid for fraudulent day care services. Appendix B explores the complex challenges encountered in the protection of vulnerable populations.

Pursuant to Illinois administrative rules, in FY 2024, the Office of the Inspector General conducted an investigatory review of prior Department involvement in 168 child death cases. Following review, 5 of the 168 cases were opened for a full investigation and 41 cases were identified for inclusion in a systemic issue report involving the care of medically complex children to be issued in FY 2025 (see Child Death Report, page 29). It is critical to note that a review of the Department's prior involvement with the deceased child's family does not necessarily indicate misconduct or failures on the part of the Department, Child Welfare Contributing Agencies (CWCA), or individual employees. Rather, the review of a family's prior involvement with the Department is an opportunity to identify practice errors, trends, and missed opportunities for intervention on behalf of children and families.

As Inspector General, I will continue to carry out the mission of this office to support and strengthen the child welfare system and to hold Department and contracted agency employees accountable for instances of misconduct. 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, 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 deep 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

CONTENTS

Introduction **1**

Investigations **7**

Part I: Death and Serious Injury Investigations 7

Part II: Child Death Report 29

Statistical Summary 31

Homicide 39

Suicide 54

Undetermined 56

Pending 71

Accident 75

Natural 97

Twenty-Year Death Retrospective 127

Part III: General Investigations 131

Part IV: Error Reduction Training 151

Department Update on Prior Systemic Recommendations **153**

Child Welfare Employee Licensure **167**

Criminal Background and Law Enforcement Coordination **171**

Glossary **173**

Appendix **175**

Daycare Fraud A-1

Amy Zinn, Sex Trafficking B-1

INTRODUCTION

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

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

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

A complainant to the OIG, or anyone providing information, may request that their identity be kept confidential. To protect the confidentiality of the complainant, the OIG will attempt to procure evidence through other means whenever possible. However, if the complainant does not provide enough information, the OIG may not be able to pursue the investigation. The OIG and the Department are mandated to ensure that no one will be retaliated against for making a good-faith complaint or providing information in good faith to the OIG.

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

General Investigations

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

In FY 2024, the OIG received 751 requests for investigation, 143 OEIG referrals, and 58 CWEL referrals, totaling 952 complaints, a 24% increase above FY 2023. In FY 2024, the OIG opened 670 general investigations.

FY 2024 Complaints	
Requests for Investigation	751
OEIG Referrals	143
CWEL Referrals	58
Total Complaints Received	**952**

The OIG received requests for investigation from throughout Illinois as demonstrated by the map below with the majority of complaints coming from Cook County. The map does not include the requests for investigation from anonymous or unknown complainants (45) and from out of state (23).

FY 2024 OIG Complainant Locations

Complaints per County

221

0

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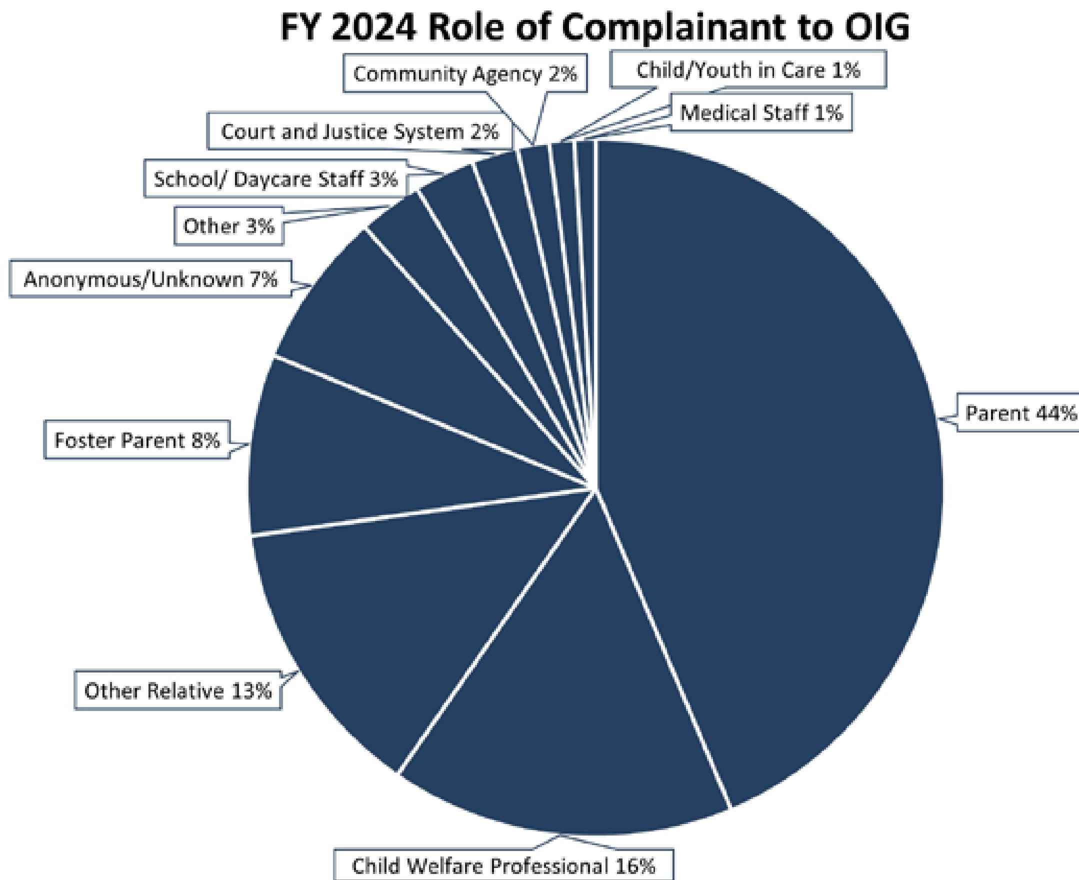
The OIG accepts requests for investigation from multiple sources. In FY 2024, 44% of requests for investigation came from parents or guardians. See below chart of the role of complainants for FY 2024.



OIG Hotline

In FY 2024, the OIG received 801 telephone inquiries through the OIG Hotline, a 12% increase from FY 2023.

Calls to the OIG Hotline in FY 2024	
Information and Referral	524
Referred to SCR Hotline	60
Request for OIG Investigation	217
Total Calls	**801**

See page 131 for summaries of General Investigations resulting in an investigative report submitted by the OIG to the DCFS Director in FY 2024.

Child Welfare Employee Licensure

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

In FY 2024, 58 cases were referred to the OIG for CWEL investigations.

FY 2024 CWEL Investigation Referrals and Dispositions	
Pending CWEL Investigation	8
Closed CWEL Investigation, No Licensure Action	4
Pending Monitoring of an SCR Report	7
Closed Monitoring of an SCR Report	30
Pending Pre-Licensing Investigation	2
Closed Pre-Licensing Investigation	3
Closed, CWEL Voluntarily Relinquished	2
Pending AHU Decision	1
Pending CWEL Board Final Decision	1
FY 2024 CWEL Investigation Referrals Received	**58**

See page 167 for further information on CWEL.

Deaths and Serious Injuries

According to Rule 430, the Inspector General investigates the death or serious injuries of a child where the child or the family has been involved with the Department, or its contracted agencies, within one year of the death or serious injury. The OIG maintains a database of child death statistics and information related to child deaths as reported to OIG. In FY 2024, OIG received notification of 721 child deaths, of which 168 met OIG criteria for review. The following chart summarizes the child death cases reviewed in FY 2024:

FY 2024 Child Death Cases Reviewed	
Investigatory Reviews of Records	122
Systemic Issue Report	41
Full Investigations	5
Child Deaths in FY 2024 Meeting OIG Criteria for Review	**168**

Summaries of death investigations where the OIG submitted a full investigative report to the DCFS Director in FY 2024 are included in the Investigations section of this report. The investigations section also contains summaries of all child deaths reviewed by the OIG in FY 2024.

See page 7 for further information on death and serious injury investigations.

Background Checks and Law Enforcement Liaison

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

In FY 2024, OIG's LEADS operators conducted 7,852 searches for criminal background information, an increase of more than 500 from FY 2023. Seven OIG staff members are LEADS certified.

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 assists law enforcement agencies with investigations, as requested. Following any criminal investigation, the OIG will determine if further administrative investigation or action is appropriate.

See page 171 for further information on criminal background investigations.

INVESTIGATIONS

This Annual Report covers the time period from July 1, 2023 to June 30, 2024 (FY 2024). The Investigations section is three parts. Part I includes summaries of full child death and serious injury investigations submitted to the Director of DCFS. Part II contains aggregate data and case summaries of child deaths in families who were involved with the Department in the preceding 12 months. Part III contains general investigation summaries conducted in response to complaints filed by the state and local judiciary, foster parents, biological parents, and the general public.

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

PART I: DEATH AND SERIOUS INJURY INVESTIGATIONS

Death and Serious Injury Investigation 1

DEATH An 8-year-old child was found submerged underwater and unresponsive in the bathtub by her mother. An ambulance transported the child to a hospital where she was pronounced deceased. The child had a diagnosis of cerebral palsy, was non-verbal, required a feeding tube, and was non-ambulatory. The coroner's office ruled the cause and manner of the death as undetermined. The Department investigated the child's death and indicated the mother for death by neglect (#51). Six weeks prior to the child's death, the Department initiated a child welfare services (CWS) referral that resulted in an intact family services referral the week prior to the child's death.

INVESTIGATION The family first came to the Department's attention after receiving a hotline report that the parents missed medical appointments and did not follow through with services for the then 5-year-old medically complex child and then 11-month-old sibling, who had a diagnosis of sickle-cell disease. The Department unfounded the parents for medical neglect (#79), citing that the children's doctor stated most of the issues with the appointments coincided with the family's housing instability and the child was not in immediate danger of harm. During the child protection investigation, the parents agreed to intact family services, but after the investigation's closure, the mother declined intact services.

Approximately one year after closing the investigation, the Department initiated a second investigation after law enforcement responded to a verbal altercation between the parents at their home in front of the then 7-year-old child, 2-year-old sibling, and 10-year-old and 15-year-old maternal siblings. The parents, who had separated, lived in the same home. The Department closed the investigation and unfounded the parents for substantial risk of physical injury/environment injurious to health and welfare (#10) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) due to insufficient evidence that the children were in imminent danger.

A year later, the Department received a hotline call reporting that the mother and her 8-year-old medically complex child struggled with housing instability after their landlord began eviction proceedings for failure to pay rent. The reporter stated that the child had a full-time nurse for complex medical needs. The Department took the report as a Child Welfare Services referral, and approximately three weeks later, assigned a caseworker to the case. The caseworker met with the mother, medically complex child and the child's nurse at a hotel where the mother was

staying with her medically complex child. The child's nurse reported that she provided 60 hours of care each week and that the mother met the child's needs. The caseworker returned to the hotel the next day to see the mother's 4-year-old child, as it was reported that the 4-year-old was at the maternal grandmother's home at the time of the caseworker's initial visit. After observing the 4-year-old sibling, the caseworker noted no concerns regarding the family. The mother reported that her two older children lived with other relatives. The mother agreed to intact family services and the caseworker referred the family.

The following week, the Department assigned a private agency to provide intact services to the family. However, the 8-year-old medically complex child died the day prior to the scheduled handoff meeting with the intact staff. Without talking to the family or the investigator assigned to the death, the caseworker for the child welfare services case notified the intact staff that intact family services was no longer needed due to the child's death. In separate interviews, the caseworker and supervisor reported to IG investigators that they cancelled the handoff because the 8-year-old child was the only minor listed on the CWS referral. The caseworker told IG investigators that the mother reported the other children were not in her care. However, at the time of the death, the mother's 4-year-old child and 12-year-old child were at the hotel. To date, the Department has not finalized procedural requirements related to child welfare services referrals.

The Department initiated a death investigation of the 8-year-old child. The child death investigator observed the 12-year-old and 16-year-old maternal siblings at their maternal aunt's residence. The 12-year-old reported that she lived with her mother at the hotel prior to the child's death. The child death investigator encountered difficulty locating the mother and her 4-year-old child after the mother moved out of the hotel where the death occurred. Following unsuccessful attempts to see the 4-year-old child at relatives' homes, the child death investigator did not document any investigative activity for almost four months. After a supervisor instructed the child death investigator to see the 4-year-old sibling, the child death investigator documented observing the 4-year-old while interviewing the mother and noted seeing no visible signs of abuse on the sibling. That was the first in-person contact with the 4-year-old documented in SACWIS for the death investigation.

The child death investigator met again with the mother to close the investigation and the mother agreed to intact family services as she wanted grief counseling. However, the mother never participated in intact family services as there was a four-week delay in submitting the intact referral, a three-week delay in assigning the intact case and scheduling a handoff staffing, and a six-week delay rescheduling the handoff staffing on multiple occasions. Despite the mother's Department history, failure to provide a stable home environment, and demands of her children's needs, this family did not receive critical supportive services. The Department closed the death investigation and indicated the mother for death by neglect (#51) and inadequate supervision (#74a). No criminal charges were filed.

While the child death investigation was pending, the Department initiated a subsequent child protection investigation after the then 5-year-old sibling arrived at school smelling strongly of marijuana and began to vomit, which also smelled of marijuana. The reporter stated the sibling appeared semi-conscious, lethargic and had dilated pupils. School officials contacted the mother and an ambulance, and the mother's paramour arrived at the school shortly after the ambulance. Emergency medical services personnel examined the sibling, recommending that they transport him to the hospital for further examination; however, the paramour agreed to take the sibling to the hospital.

The assigned child protection investigator went to the hospital later that day and learned no one brought the sibling to the hospital. The child protection investigator contacted the mother, who reported that they were on their way to the hospital. The child protection investigator instructed the mother to request a summary of the hospital visit and to contact her the following day. The child protection investigator also explained the allegations that the sibling arrived at school smelling of marijuana, and the mother denied the allegations and reported the school never provided that information. The child protection investigator obtained the sibling's medical records that confirmed the mother brought him to the emergency room that evening due to vomiting at school earlier that day. The medical records did not include any mention of possible marijuana consumption.

Child protection staff did not document any investigative activity for the following three weeks until a parallel child protection investigator observed the sibling at the mother's apartment. The parallel investigator noted observing no

concerns and that the mother reported that the sibling attended a new school and provided the contact information for the new school, the sibling's previous nurse, and two relatives as collateral contacts. No attempts were made to contact the new school or the collateral contacts. The Department closed the subsequent investigation and unfounded the mother and her paramour for medical neglect (#79) and substance misuse by neglect (#65a).

Child protection investigations involving children with medical complexities and those with developmental delays require heightened scrutiny and additional investigative activity to ensure these particularly vulnerable children are not being abused or neglected.

RECOMMENDATIONS **1. This report should be shared with the involved child protection investigator and supervisor and the area administrator. The area administrator should facilitate a discussion with the involved child protection investigator and supervisor and use the report as a teaching tool.**

The area administrator met with the child protection investigator and supervisor and used the report as a teaching tool.

2. A redacted copy of this report should be shared with the involved child protection investigator to be used as a teaching tool.

The report was shared with the child protection investigator and used as a teaching tool.

3. The Department should finalize and issue procedures for Child Welfare Services (CWS) Referrals. The procedures should require that in the event that a child protection investigation is initiated while a child welfare service referral is open, a staffing should be held with the CWS worker, the child protection investigator and their supervisors to discuss service needs for the family.

The recommendation has been incorporated into draft Procedures 302 Appendix M, CWS Services, Section H, Required Activities. Appendix M has been approved through the Executive Summary Process and will be posted for public comment.

Death and Serious Injury Investigation 2

DEATH A 9-year-old medically complex child was brought to the emergency room and died prior to admission. The child was born with congenital abnormalities and hydrocephalus with an extensive history of medical conditions and medical procedures. An autopsy was not completed due to the child's severe medical issues. The Department did not investigate the child's death, and the death was determined natural due to cardiac arrest. In the year prior to the child's death, the Department conducted two child protection investigations for medical neglect (#79) to the child.

INVESTIGATION The Department previously unfounded the parents for medical neglect (#79) to the then 7-year-old medically complex child, whose medical complexities included cerebral palsy, developmental delays, neurological deficits, cleft palate, hydrocephaly, and pulmonary valve stenosis with a shunt, after the parents left the hospital with the child against medical advice. During the investigation the mother stated they left against medical advice after the emergency room staff relieved the abdomen distension. The child had an appointment the next day with her gastroenterologist as the mother believed the gastroenterologist could better address the child's issues than the emergency room staff because the gastroenterologist knew the child's medical history. The child's primary care's office had no concerns of medical neglect and reported that the mother consistently followed through on recommendations for the child's complex medical care.

A year later, the Department initiated an investigation of medical neglect after receiving a report that the mother declined hospital admission for an annual MRI after the now 8-year-old child's dehydration precluded staff from administering medication as needed. According to the reporter, the mother cancelled the rescheduled MRI and

missed multiple appointments over the past 12-18 months, and the child had lost five pounds over the past year and now weighed 35 pounds.

The child protection investigator met with the child at her home and noted the child appeared non-verbal but interacted with family members. The mother told the child protection investigator that she rescheduled the MRI for the following week, and that she declined hospitalization because of potential exposure to COVID-19. The mother stated the pandemic added significant barriers to the child's medical care. The child protection investigator discussed Intact Family services and linkage with the Division of Specialized Care for Children (DSCC), a federally funded program that administers funds through Title V of the Social Security Act. The mother agreed to participate with both programs citing she had been trying to obtain a medical bed, a new wheelchair, leg braces, water therapy, and sign language for the child.

After visiting with the family, the child protection supervisor directed the investigator to complete a DCFS Nursing Referral and a referral to DSCC; however, the child protection investigator did not document any investigative activities for two months. The child protection supervisor told IG investigators that the child protection investigator used benefit time during this period of no investigative activity. The supervisor stated that the child protection investigator's duties were not reassigned during this time, but the supervisor triaged the pending investigations and addressed urgent matters.

Two months later, the Department initiated a second investigation for medical neglect in response to a report that the mother cancelled numerous neurology appointments. The Department assigned the investigation to a different child protection supervisor and investigator. The second child protection investigator went to the home and assessed the child and her two siblings as safe. The mother told the child protection investigator that she rescheduled the child's neurology appointment, which they attended. The mother reported she remained receptive to intact family services, despite not hearing an update since the first discussion about services two months earlier.

The child protection staff from both teams shared information during the separate investigations for medical neglect. The supervisor from the first investigation instructed the first child protection investigator to obtain medical records from all providers and complete referrals to DSCC, DCFS nursing, and intact family services. While the first child protection investigator sent the intact family services referral to both supervisors, neither supervisor responded, and no referral was made to the intact family services program.

Four days after the second hotline call, the second supervisor submitted the completed DCFS nursing referral, and the Department assigned a nurse who contacted both investigators and requested medical records from all medical providers. Over the next month, the DCFS nurse followed up on the status of the medical records and scheduling a home visit with both investigators. The child protection investigators responded that a home visit was no longer warranted but did not provide a reason.

The first child protection investigator spoke with DSCC staff, who reported the program no longer accepted referrals from DCFS. DSCC staff also stated the family previously received DSCC services, but their involvement ended in 2017 due to difficulty in contacting the mother. DSCC staff stated the child's medical insurance provided a care coordinator, and DSCC staff reported a plan to explore what could be done for the family; however, the first child protection investigator did not document any further contact with DSCC nor the insurance care coordinator.

While both investigations remained pending, the first child protection investigator spoke with the child's multiple medical providers. The primary care physician stated the mother had a history of intermittent no shows for medical appointments, in part impacted by the COVID-19 pandemic and difficulty with transportation. The doctor stated that due to the mitigating factors of COVID-19 and the lack of available resources, the primary care provider did not consider the child to be medically neglected. The child's cardiologist and gastroenterologist provided similar responses to the child protection investigator.

The nurse from the child's neurosurgeon's office reported to the first investigator that the mother's history of cancelling appointments over the past two years met the criteria for medical neglect. The nurse reported the neurosurgeon would send a letter documenting the opinion of medical neglect. Two weeks later, the first child

protection investigator spoke with the nurse who stated the neurosurgeon scheduled a telehealth appointment with the mother to give her another chance before making an opinion about medical neglect. That same day, the Department closed the first investigation and indicated the mother for medical neglect (#79), as the neurosurgeon's office cited the missed appointments and lack of care met the criteria for medical neglect. The first child protection investigation closed without the child protection investigator confirming the child's attendance at the telehealth appointment nor receiving the completed DCFS nurse referral.

Three days after the Department closed the first investigation, the mother and child participated in the telehealth appointment with the neurosurgeon, who noted being pleased with the child's progress, the MRI appeared stable, and scheduled follow-up in one year. The mother subsequently appealed the indicated finding in the first investigation and the Department granted the appeal and unfounded the investigation.

Two weeks after the closure of the first investigation, the DCFS nurse completed the referral after reviewing medical records and speaking with both child protection investigators. The assessment cited risk to the child due to ineffective health maintenance as evidenced by missed appointments and not following recommendations from medical providers. The assessment also included a 20-item list of tasks that did not appear to consider any of the information the mother provided to the child protection investigators regarding the pandemic's impact on the family or the lack of resources.

The second child protection investigator did not document discussing the nursing recommendations with the mother. Approximately three months after opening the second investigation, the child protection investigator conducted a final visit to the family's home. The mother stated that she no longer wanted intact family services and had spoken with the insurance care coordinator, who assisted in obtaining a wheelchair, additional supplies, and transportation assistance. That same day, the Department closed the second investigation as unfounded against the mother for medical neglect (#79) to the child citing that medical providers did not support an indicated finding.

RECOMMENDATIONS

1. The Department should explore the feasibility of electronic storage of attachments to child protection investigations, such as medical records obtained during the investigation, in the Department's new child welfare data system, IllinoisConnect.

IllinoisConnect will support the storage of all media types (documents, photos, video, and audio). Specific utilizations will be considered via each area's design and development phase. Implementation within IllinoisConnect will occur in 2025 to 2026.

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

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

3. The OIG reiterates the following recommendation from a prior OIG report, the Department should amend the CFS-531, Nursing Referral Form to differentiate the role of the DCFS Nurses in child protection investigations, intact family services and placement cases.

The CFS-531, *Nursing Referral Form* has been revised and is available to staff on the templates drive.

4. The Department should develop and maintain a tracking system for DCFS Nurse Referrals.

DCFS Clinical is working with the IllinoisConnect development team to develop and maintain a tracking system, not only for nurse referrals, but also for all clinical staffings and other processes. In the interim, DCFS Clinical is working to create an automated system to track nurse referrals until the IllinoisConnect is fully implemented.

5. The Department should update and maintain a resource guide with Illinois' Medicaid replacement/health maintenance organization plans and plan benefits available to clients. DCFS Nursing staff should assist the family in working with the insurance case manager. The guide should be available to the field through the D-Net.

The Department agrees and will develop written guidance to inform families and the field about Illinois' Medicaid replacement/health maintenance organization plans and plan benefits. In addition, YouthCare is available to walk a family through available resources and assist the family in connecting with an insurance case manager. DCFS Nursing staff are available to assist intact families in connecting with an insurance case manager.

6. The Department should share this report with the Regional Administrator of this region, the Area Administrator of the subregion, and the DCFS Medical Director to facilitate a discussion with the involved office of the child protection staff regarding weighing evidence when multiple medical providers are involved in investigations of medical neglect.

The report was shared with the Regional Administrator, Area Administrator and DCFS Medical Director and a discussion was facilitated with the identified staff.

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

The report was redacted and shared with the OIG's Error Reduction Training coordinator for use in Error Reduction trainings.

8. The Director of Nursing services should collaborate with the director of the Division of Specialized Care for Children to develop guidelines for appropriate referrals between the two agencies, including families involved with child protection investigations and intact family service cases.

The Division of Specialized Care for Children (DSCC) leaders and DCFS Chief of Nursing Services will continue to meet to strengthen and streamline the referral process between the two agencies. DCFS nursing will share updates regarding the DSCC referral process with the field.

Death and Serious Injury Investigation 3

DEATH Law enforcement responded to a report that an 11-year-old child was shot by a 19-year-old maternal sibling. Emergency services transported the child to a hospital where he died three days later. Law enforcement charged the maternal sibling with reckless conduct/great bodily harm, aggravated unlawful use of a weapon against a person, obstruction of justice/destroy evidence and involuntary manslaughter, and the criminal case remains pending. The Department indicated the maternal sibling for death by abuse (#1) and wounds by abuse (#7). The Department also indicated the mother for death by neglect (#51) to the child and for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the child's 5-year-old and 10-month-old maternal siblings. The Department took protective custody of the 5-year-old and 10-month-old and placed them with fictive kin after the court granted temporary custody of both children to the Department. During its review, the OIG learned the 19-year-old was a youth in care for over three years, and the court closed his child case 26 days before the 11-year-old's death. The OIG investigation addressed issues identified in the 19-year-old's placement case.

INVESTIGATION The mother had a significant history with the Department including 21 child protection investigations initiated between 2014 and 2021. The Department indicated two and unfounded 19 investigations involving allegations of substantial risk of injury, environmental neglect, inadequate shelter, inadequate supervision, and burns by neglect. The Department also provided intact family services to the mother for five months in 2021 and closed the intact case after the mother became involved with community agencies to address housing instability.

Within a year of the child's death, the family was involved in three unfounded child protection investigations, a pending child protection investigation and had an open high risk intact family case at the time of the child's death. At the time of the child's death, the mother, the 11-year-old deceased child, a 5-year-old sibling and a 4-month-old sibling lived in subsidized housing and the services included a mental health assessment, parenting classes, and therapy. These investigations and intact case did not involve the 19-year-old sibling, as the mother reported caring for him when he was young but later gave guardianship to a relative, who raised the maternal sibling in a different state.

In April 2019, the Department initiated an investigation after law enforcement responded to a call that the father hit the sibling in the head and the sibling fled the home. Law enforcement and the child protection investigator noted that the sibling appeared developmentally delayed and that the mother reported that he had a brain injury. The Department took protective custody of the sibling and placed him in a traditional foster home. The Department indicated the father for substantial risk of harm and inadequate supervision. The juvenile court granted the Department custody of the sibling, and the Department provided placement services and monitoring. Within the first months of placement in foster care, law enforcement arrested the sibling for stealing, threatening a neighbor and stealing a car with a peer that resulted in a high-speed chase. The state's attorney subsequently filed multiple delinquency petitions related to the criminal arrests.

In October 2019, a clinical screener completed an integrated assessment and noted that the then 16-year-old sibling experienced significant instability as a child with exposure to physical and emotional abuse. The clinical screener noted that the sibling presented as cognitively delayed, extremely impressionable, and impulsive, and therefore, he required consistent adult supervision. The clinical screener recommended that the Department refer the sibling for further assessments, including neurological, developmental, and psychological testing to identify any diagnoses and evaluate his overall functioning.

The following month, a delinquency court ordered the sibling to participate in an evaluation to determine fitness to stand trial in the multiple pending delinquency cases. The OIG found no evidence that Department staff provided this information to the juvenile court, as two weeks later, the juvenile court changed the sibling's permanency goal to Independence. The goal of Independence for the sibling did not reflect consideration of how his development, trauma history and behavioral issues impacted his ability to successfully gain Independence.

At the beginning of 2020 the sibling engaged in a physical altercation in school which resulted in additional delinquency involvement and a charge of aggravated battery to a peer. During an administrative case review three months later, the caseworker did not document the charges or that the delinquency court had ordered a competency exam that was delayed, in part, due to the pandemic.

In October 2020, almost one year after the delinquency court's order, a clinical psychologist conducted a competency evaluation with the then 17-year-old sibling that assessed he had the cognitive abilities of a 7-year-old with a moderate intellectual disability. The clinical psychologist subsequently assessed the sibling as unfit to stand trial, recommending further assessment and treatment. In response to the clinician's findings, the delinquency court ordered the sibling to inpatient treatment where he remained for seven months. The facility therapist reported to the Department caseworker that the sibling could never live independently. The caseworker requested a DCFS clinical staffing, and the clinical team recommended a referral to a developmentally delayed-mentally ill transitional living program for the sibling. However, OIG review found that the Department caseworker never referred the sibling to the recommended facility while a youth in care.

In July 2021, after the sibling turned 18, the sibling transferred to a medium security residential facility that provided 24-hour supervision in a structured environment and programming to assist the sibling in gaining legal fitness. The facility clinician assessed that the then 18-year-old sibling had the adaptive functioning of a 10-year-old. The sibling participated in programming at the facility until March 2022 when the delinquency court dismissed all charges against the sibling, as he had not attained legal fitness within the 12-month statutory timeframe. The placement worker documented no information about the court hearing in SACWIS, and the placement supervisor told IG investigators that the placement worker did not attend any delinquency court hearings. The placement supervisor stated that she was not aware of any information sharing between delinquency and juvenile courts, nor did she know if the court finding the sibling unfit to stand trial impacted the provision of Department services to him. The placement supervisor also reported no prior experience working with youth in care who were found unfit by the courts. Current Department procedures do not provide front line staff with guidance on managing cases involving dually involved youth, and the placement supervisor told IG investigators that the Department did not provide training on working with youth also involved in delinquency court.

After the delinquency court dismissed all charges against the sibling, the facility staff recommended to the Department case worker that the sibling would benefit from placement in a community integrated living arrangement (CILA) and would provide the Department with a list of options. However, Department staff did not pursue a CILA placement for the sibling and rather placed the sibling with the paternal grandmother at his request. The placement supervisor told IG investigators that they had no concerns about the grandmother meeting his needs. The OIG found that the placement with the grandmother did not adequately consider his intellectual functioning and need for continued support as he transitioned to adulthood.

Two months after the Department placed the sibling with his grandmother, the sibling ran from the home but because he was 19 years old, law enforcement could not require him to return to the placement. Department staff later located the sibling living with his mother, and three other siblings who began participating in intact family services four months earlier. The placement supervisor noted no concerns when she met with the mother and the sibling, and the Department changed the sibling's placement to unauthorized with his mother. The Department supervisor told IG investigators that she notified the assistant state's attorney regarding the sibling's status, including that she assessed him as safe with his mother. The next day, the court closed the sibling's Department case, and the court order noted that the 19-year-old lived in a self-selected placement, and he did not want Department services. The mother's intact worker documented seeing the 19-year-old during her visit to the home approximately two weeks later. Ten days later the 19-year-old sibling shot the 11-year-old child while living in the home.

The sibling was a youth in care for over three years, but the Department failed to provide services for his significant needs. The fitness evaluation, inpatient treatment therapist, and residential facility staff documented concerns regarding the sibling's cognitive functioning, however, it appeared that the involved Department staff lacked an understanding on the needs of adolescents with developmental delays. The Department updated Procedures 302, Appendix N, *Transition Planning for Adolescents in Care with Developmental Disabilities* on January 31, 2024. The prior Appendix had not been updated since 1999. The current guideline includes referring youth to the Department's Transition to Adult Services for determination of eligibility of future services through the Illinois Department of Human Services. Given the complexity of working with developmentally delayed youth front line staff would benefit from additional training about identifying and securing services as they transition to adulthood.

RECOMMENDATIONS

1. This report should be shared with the DCFS placement supervisor and her current supervisor. The current supervisor should review and discuss this report with the DCFS placement supervisor as a teaching tool. The current supervisor should also address the issues identified in on-going supervision with the DCFS placement supervisor.

The report was shared with the DCFS placement supervisor and her current supervisor and used as a teaching tool.

2. The youth in this report had delinquency involvement, psychiatric hospitalizations, and developmental disabilities. This report should be shared with the Deputy Director of Clinical and Child Services. The

Deputy should use the report to facilitate a discussion with Clinical staff about how the different clinical divisions can work together to assist the field in managing cases that involve youth with significant needs.

The report has been shared with the Deputy Director of Clinical and Child Services. In June 2024, the Deputy Director initiated discussions with the clinical division's management teams about the OIG findings and recommendations. Moving forward, all clinical division managers/associate deputies will engage in discussions with their respective teams on how DCFS Clinical can provide assistance in cases that involve youth with these significant needs. These discussions will now be a part of regular staff meetings. DCFS Clinical has also updated the referral forms to emphasize identifying significant needs when requesting support from the clinical team. DCFS Clinical will also clarify the specific role of coordinators when working with youth who have needs such as intellectual and/or developmental disabilities. In July 2024, DCFS Clinical began meeting with the field to provide education on handling cases with such diagnoses and the support that can be offered.

3. The Department should develop procedures and provide training to placement and intact family services staff on working with dually involved youth.

Intact administrators have begun working with the Clinical Division to develop trainings related to the use of clinical staffings completed by Intact Family Services staff. Intact will continue to work with the Office of Learning and Professional Development and the Dually Involved program to have a training delivered to both DCFS and CWCA staff by December 2024. Additionally, Intact will record this training and incorporate it into the ongoing training for new hires. This will occur for placement staff as well.

In addition to the supervision process above, in July 2024 Intact Family Services, along with Quality Assurance began statewide reviews of intact cases using the Q-EST tool. This tool will provide agency level data as well as statewide and regional summaries. This data was shared with the private sector in October 2024 and will continue to be reviewed with Child Welfare Contributing Agencies on a quarterly basis. These case reviews will prompt changes in training and policy as concerns are identified.

4. The Department should partner with the Illinois Department of Human Services (DHS) to provide training to DCFS placement staff on servicing developmentally delayed youth preparing to transition to adulthood. The training should include information on the availability and requirements of DCFS's Transition to Adult Services (TAS) program and the guidance set forth in Procedures 302, Appendix N, Transition Planning for Wards with Developmental Disabilities.

The Department's Transition to Adult Services (TAS) coordinator works in close collaboration with the DCFS Placement Division and DHS representatives weekly. This regular interaction ensures that all cases involving youth diagnosed with intellectual/developmental disabilities on the DCFS transition list are reviewed, and the transition to DHS Adult Services is smooth. In partnership with the DCFS Guardian's Office and Diversified Services Network, the TAS Coordinator also conducts four annual training sessions open for all staff (DCFS/CWCA) to attend. Training topics include reviewing the TAS process, main points from DCFS Procedure 302, Appendix N (Transition to Adult Services), obtaining an adult guardian, and how to transition to adult Medicaid. Additional training is available upon request. Coordinators will also discuss topics during the clinical presentation with the field.

Death and Serious Injury Investigation 4

DEATH An 8-year-old, 7-year-old, 2-year-old, and their mother suffered severe smoke inhalation from a house fire. Emergency services transported the mother and children to local hospitals, where the mother and all three children were later pronounced deceased. The cause of the fire was unknown, and the Department did not investigate the children's deaths for abuse or neglect. In the year prior to the children's deaths, the Department conducted two child protection investigations; the first unfounded the parents for inadequate supervision (#74),

and the second indicated the mother for environmental neglect (#82), inadequate supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

INVESTIGATION Approximately 10 months prior to the house fire, the Department initiated the first child protection investigation after receiving a report that the then 6-year-old child, who was nonverbal and diagnosed with a neurodevelopmental disorder, was found walking alone in the neighborhood. The child protection investigator met with the parents, who reported they previously installed a fence to prevent the child from leaving the yard. The father stated that on the day of the incident, the child played in the backyard with the then 7-year-old sibling, and the father believed the child climbed the fence to leave the yard.

Five days after the child protection investigator visited the family, the Department initiated a second investigation after law enforcement responded to a report that the then 6-year-old child was running outside naked and covered in feces without adult supervision. Emergency services found the mother incoherent in the home and administered Narcan (naloxone) to which she responded and transported her to the hospital. The DCFS hotline report noted that the home was covered in trash and feces, and that law enforcement left the children in the father's care, who lived in a separate residence on the property as the mother had an order of protection against the father.

Law enforcement informed the child protection investigator that the mother was unresponsive related to an opiate overdose, and she gained consciousness after administration of Narcan. Law enforcement also reported a plan to close the criminal investigation if the family received intact family services. The child protection investigator met with the family, and the mother denied drug use, stating she passed out after taking weight loss medication with alcohol that morning. The mother reported the 6-year-old child was never previously covered in feces, and she had no memory of what happened prior to waking up in the hospital. Both parents confirmed the father lived on the property while they worked on their marriage. The father stated he saw the mother and children earlier that day and that the mother appeared coherent.

The child protection investigator documented separately speaking with the 7-year-old, who believed she saw the mother drinking alcohol that day but did not remember when the mother passed out. The 7-year-old told the child protection investigator that she felt safe with her father but did not always feel safe in the mother's care; however, the child protection investigator did not document anything further regarding this statement. The child protection investigator noted the children appeared safe in their father's care, and that the home appeared free of garbage and feces.

The child protection supervisor approved the investigator's safety assessment, and the supervisor told IG investigators that because the father was not in the home when the incident took place, the father did not present a risk to the children. The child protection supervisor reported to IG investigators that she did not instruct the child protection investigator to request a drug screen because the mother admitted to taking diet pills with alcohol. The child protection supervisor stated she did not have familiarity with Narcan and that she did not know if the child protection investigator directly asked the mother about opioid usage.

The child protection supervisor stated she knew about an order of protection in this case, but never instructed the child protection investigator to obtain a copy of the order. IG investigators obtained a copy of the order and found that order, filed by the mother less than three months prior to the initiation of the child protection investigations, required the father to refrain from physical abuse, harassment, and entering the home while under the influence of alcohol or other drugs, and that he must comply with the parameters of court ordered visitation.

The child protection investigator returned to the home approximately six weeks later. During the visit to the home, the mother reported she stopped taking diet pills and the mother slept on a mattress in the dining room to prevent the child from leaving their room at night. The 7-year-old sibling reported the father spent more time with them in the home and denied observing their mother drinking alcohol. The father reported that he remained living in the separate residence, but the couple continued to work on their marriage. The child protection investigator noted observing the children appeared happy and healthy and that the home appeared free of foul odors or excess trash. The child protection investigator documented that the parents agreed to intact family services, but child protection staff never referred the family for services.

The Department subsequently closed the investigation and unfounded the parents for inadequate supervision (#74), citing that the 6-year-old child climbed over the security fence on his own without his parents' knowledge. Two days later, the Department closed the second investigation and indicated the mother for environmental neglect (#82), inadequate supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the then 7-year-old, 6-year-old, and 1-year-old children.

Department Procedures Section 300.75 *Area Administrator Requirements* provides that area administrators must review investigations involving children under the age of 3; however, the Department closed the investigation without the area administrator's review, despite a 1-year-old child victim's involvement. During the OIG interview, the child protection supervisor stated that supervisors were responsible for manually requesting the review prior to the closure of the investigation. The child protection supervisor told IG investigators that she did not know why she did not request a review of the investigation.

The second child protection investigation was closed without obtaining the mother's medical records, despite the supervisor's instruction to obtain them. The OIG obtained the mother's medical records which documented that the mother initially reported to hospital staff that she used heroin that day but denied using alcohol or tobacco products. The treating physician documented that the mother's presenting state and symptoms aligned with heroin abuse; however, the mother refused further treatment or drug testing and left the hospital.

The OIG also obtained records from emergency services and law enforcement related to the second investigation. Emergency services ruled the incident as an opioid overdose and complaint as cardiac arrest. The mother also notified the emergency services personnel that the father abused her and that she had a restraining order against him. Law enforcement noted difficulty obtaining a response from the father at his separate residence on the property which resulted in responders prying the door open. The father reported to law enforcement he had been asleep and unaware that the child left the home while the mother was unresponsive.

The child protection staff failed to obtain and utilize available information throughout the investigations, including the order of protection, the mother's medical records, and the law enforcement report. Failure to obtain these records allowed for the child welfare professionals to make decisions, assess safety, and make final findings without critical information. The involved child protection staff failed to adequately assess the mother's reported substance use, never accurately identifying the substance being used, the extent of use, or how her use affected the safety and well-being of the children. Rather, the child protection investigator and supervisor accepted the mother's self-report that mixing a weight loss medication with alcohol caused her unresponsive state. Narcan is a life-saving medication that can reverse an overdose from opioids including heroin, fentanyl, and prescription opioid medications, and it would not treat the misusage of alcohol or diet pills. The widespread use of opioids among parents and the resulting impact on parental capacity raise major concerns regarding the well-being and safety of children, making it imperative that the field be trained on opioid use, the use of Narcan and the risk to children.

Additionally, the family had a reported history of domestic violence with an active order of protection against the father. Failure to fully assess parents' domestic violence history allows for errors in determining a parent's ability to care for or protect children. While child protection staff knew of third-party reports of domestic violence in the investigations, there was no discussion of this history. Rather than use information from collateral sources such as court records, child protection staff failed to assess the ongoing safety of the children in care of the father.

RECOMMENDATIONS

1. A redacted copy of this report should be shared and reviewed with the involved child protection supervisor as a training tool.

The area administrator met with the child protection supervisor and shared the report as a training tool.

2. A redacted copy of this report should be shared with the area administrator for use in supervision of the involved child protection supervisor.

The area administrator met with the child protection supervisor and shared the report as a training tool.

3. A redacted copy of this report should be shared with the Department's Substance Use and Recovery Program Statewide Director and Program Coordinators to inform training needs related to the rise of opioid overdose and the use of Narcan.

The report was shared with the Department's Substance Use and Recovery Program staff. DCFS Clinical has posted training opportunities for staff regarding opioid use and the use of Narcan. Additionally, on the D-Net, there are tip sheets on opioid use and the use of Narcan, alcohol awareness, medication assisted recovery and alcohol use disorder fact sheets, and the impact of opioid use for caregivers.

4. The Department's new data information system, Illinois Connect, should require approval of the area administrator in cases of an alleged child victim (ACV) 0-3 as a mandatory field that cannot be waived by a child protection supervisor.

The Department agrees and a request to the IllinoisConnect development team is in process.

Death and Serious Injury Investigation 5

DEATH A mother found her 10-month-old infant nonresponsive in a bathtub. The mother reported she left the infant unattended in the bath while she went into the laundry room, estimating that she returned within five minutes. Paramedics resuscitated the infant and upon arrival at the hospital, he was placed on a ventilator, but died three days later. The Department investigated and indicated the infant's mother for death by neglect (#51). The Department implemented an out-of-home safety plan for the infant's 1-year-old and 3-year-old surviving siblings and later indicated the mother for inadequate supervision (#74) of the siblings. In the year prior to the infant's death, the Department investigated and unfounded the mother for bone fractures (#9) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's sibling.

INVESTIGATION Prior to the infant's birth, the Department initiated an investigation after the 4-month-old sibling arrived at the emergency department with multiple fractured ribs for which the mother had no explanation. Medical staff completed a full body x-ray on the 4-month-old and the hospital social worker and treating emergency department physician told the child protection investigator that the fractured ribs were consistent with accidental injuries. The child protection investigator told IG investigators that the physician demonstrated with his hands how the 4-month-old sibling was likely picked up and squeezed, causing the fractures and that the physician noted the infant's prematurity at birth as a factor.

The child protection investigator told IG investigators that he also interviewed the mother and presumed father at the hospital. The child protection investigator stated he did not believe either parent abused the sibling as he assessed both parents as attentive to the then 4-month-old and 1-year-old siblings. The child protection investigator did not document his interview with the presumed father nor his identity in SACWIS, telling IG investigators that the presumed father did not live in the home and that the child protection investigator typically did not add anyone to his investigative reports who did not live in the home. Failing to include the father violated DCFS Procedures 300.50.e.8.C *Reports of Child Abuse and Neglect Initiation of the Investigation: Other Contacts, Other Persons*, which requires child protection staff to add involved non-custodial parents to the investigation report within 24 hours.

Prior to leaving the hospital, the child protection investigator and his supervisor staffed the investigation with the area administrator, who instructed the child protection investigator to obtain a written statement from the emergency physician that the injury was accidental, which the emergency physician provided. In separate interviews with IG investigators, the child protection investigator and his supervisor stated there was no discussion of obtaining a second medical opinion on the 4-month-old's fractures in their discussion with the area administrator.

According to SACWIS, the child protection investigator did not document any investigative activity for almost three months, when he then conducted a closing safety assessment at the mother's residence. The child protection

investigator noted no concerns in the home, that both siblings had appropriate sleeping arrangements, and that the child protection investigator discussed safe sleep and bathing practices with the mother. The child protection investigator told IG investigators that at the visit, the mother told him that the presumed father recently learned that he was not the 4-month-old's biological father. The child protection investigator stated that the mother asked the investigator not to include the presumed father in the investigation because he was upset about not being the father, and the child protection investigator complied with the mother's request.

The following month, the child protection investigator obtained the sibling's emergency department records and provided them to his supervisor for her review but did not read the records himself. IG investigators reviewed the emergency department records and found that after medical staff completed a full body x-ray on the 4-month-old, the pediatric radiology specialist confirmed the multiple fractures, noting that rib fractures in infants, absent of trauma, had high specificity for non-accidental trauma. The pediatric radiology specialist ordered an additional x-ray for a clearer image of the left chest, which showed no additional injuries but confirmed the previously seen rib fractures. Despite the pediatric radiologist's report, in the discharge summary the emergency physician noted that there were no clear signs of abuse, and that the mother would follow-up with the pediatrician that week. The child protection investigator told IG investigators that he did not know if the mother followed up with the pediatrician.

In a separate interview, the child protection supervisor informed IG investigators that she reviewed the emergency department records, but she did not recall specifically reading the radiologist's concerns regarding the association of rib fractures with non-accidental trauma. The area administrator separately reported to IG investigators that he did not review the medical records and did not know about the radiologist's concerns. The same day that the child protection supervisor received the emergency room records, the Department closed the investigation and unfounded the mother for bone fractures (#9) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) due to insufficient evidence.

Beginning in 1995, the Department entered into contractual arrangements with regionally based medical resource programs to ensure that children who are reported for serious physical abuse and neglect have access to physicians and nurses with specialized training and expertise in the area of child maltreatment. Each program provides expert medical evaluations, consultations, second opinions, and community education and training. The Department also contracts with child abuse physicians to provide the Medical Aspects of Child Maltreatment Training, which provides information about physical injuries encountered during child protection investigations. According to training transcripts obtained by the OIG, the child protection investigator never attended the training despite being registered twice. The child protection supervisor told IG investigators that her staff would register for the trainings, but investigative activities would prevent their attendance, consistent with the most recent training attendance data from that region's provider, which reported an average of 57% of registrants attended the seminars.

When investigating bone fracture allegations in infants, it is critical to understand the seriousness of the injuries considering the limited mobility of infants and their inherent vulnerability. Differentiating between accidental and abusive fractures can be difficult. All fractures should be interpreted in the context of the child's developmental ability and the history of the injury. When infants with fractures come to the Department's attention, it is imperative that all child welfare staff charged with investigating this vulnerable population receive training regarding the associations between fractures and child abuse.

The mother did not have an explanation for the infant's injuries nor provide any history of trauma or falls. The child protection investigator documented that the emergency physician provided the explanation that the fractures occurred from a squeezing motion, and that the sibling's prematurity was a possible contributing factor. However, the emergency physician did not appear to adequately assess the force required to break the ribs, and the sibling's medical records did not identify concerns about prematurity impacting his bone density.

The involved child welfare professionals focused on obtaining a written statement from the emergency department physician and did not obtain the medical records until the end of the investigation. Medical records, as in this case, can indicate concerns of other hospital staff, including specialists who may not be readily available for interviews. Additionally, emergency room physicians are often involved in the identification and diagnosis of fractures, some who are well-versed in pediatrics and presentations of abuse, but others are not. As such, investigators, supervisors,

and area administrators must have a base of knowledge for when a second medical opinion is needed for a suspicious injury, such as multiple rib fractures to a non-mobile infant. The contracted medical child abuse experts are available to assist child protection staff during their investigations.

RECOMMENDATIONS

1. The Department should ensure that the involved Field Office receives training on the use of the Department's contracted child abuse expert consultation programs.

To increase awareness of the Department's contracted child abuse expert consultation programs within the involved field office, the Regional Administrator provided staff information on the Medical Aspect of Child Maltreatment Training. To date, staff in the involved field office have attended at least one of the trainings.

2. The Department should provide ongoing guidance to child protection staff on the availability of the Department's contracted child abuse expert consultation programs.

Regional Administrators have held trainings with child protection staff on how the Department's contracted child abuse expert consultation programs can provide valuable education during child abuse and neglect investigations. The Department will ensure that child protection staff receive ongoing training on the availability of the Department's contracted child abuse expert consultation programs.

3. The involved child protection investigator, child protection supervisor, and area administrator should participate in the Medical Aspects of Child Abuse training.

The involved staff have registered for the training and the Department will ensure the staff have completed the training.

4. A copy of this report should be shared with the Regional Administrator to facilitate a discussion with the involved child protection investigator, child protection supervisor, and area administrator regarding errors in the investigation.

The regional administrator shared the report and facilitated a discussion with the involved staff regarding errors in the investigation.

5. This report should be shared with the involved child protection investigator's current supervisor to provide training to the child protection investigator regarding documenting interviews with non-custodial parents and household members.

The report was shared with the current supervisor and training was provided to the child protection investigator.

6. The OIG will share a redacted copy of this report with the involved hospital.

The identified issues were shared with the involved hospital.

7. The DCFS Medical Director should reach out to the Director of Emergency Services and the Director of Social Services at the involved hospital to offer consultation on medical indicators of abuse and neglect as per the Medical Director's contract.

The DCFS Medical Director sent a letter to the involved hospital in response to the recommendation. The Medical Director also included the attachment from the OIG report, *Bone Fractures in Infants: A Review of the Literature*.

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

The Department agrees. The Department will develop materials to educate the field on fractures.

DEATH The OIG reviewed the deaths of two unrelated children whose families each had significant history of Department involvement. In the first case, a 3-year-old was found unresponsive by the child's mother. Emergency services performed CPR and administered Narcan due to concerns of drug use in the home. An ambulance transported the child to the hospital where a doctor pronounced the child's death. The Department investigated and indicated the child's parents for death by neglect (#51), malnutrition (#83), and substantial risk of physical injury/environment injurious to health and safety (#60). The Department took protective custody of the child's seven surviving siblings and placed them in traditional foster care. In the year leading up to the child's death, the family had three unfounded child protection investigations and one pending investigation that the Department unfounded after the 3-year-old's death.

In the second case, a 3-week-old newborn died in a hospital after the mother gave birth prematurely. At birth, the newborn weighed 4 lbs., and medical staff transferred her to a specialty hospital after diagnosing the newborn with bi-lateral dysplastic kidney disorder. The infant's umbilical cord and the mother tested positive for methamphetamine, but the medical staff could not determine if the mother's drug use contributed to the newborn's medical issues. The doctors removed the newborn's life support and pronounced her death. The Department initiated an investigation at the time of the infant's birth and indicated the mother for substance misuse (#65) and unfounded her for medical neglect (#79). The Department did not investigate the infant's death for abuse or neglect. In the year prior to the newborn's death, the mother had four unfounded child protection investigations and four indicated investigations.

Given that both families shared common risk factors for chronic child neglect, the OIG issued a report to the Department addressing the challenges of safety assessment in chronic neglect cases and providing an analysis of data from the Department involving families with a history of involvement of an M or higher sequence child protection investigation.

INVESTIGATION Since 2009, the 3-year-old child's family had a total of 37 prior child protection investigations with seven indicated findings. These investigations included reports of environmental neglect (#82), inadequate supervision (#74), inadequate shelter (#77), and medical neglect (#79). Between 2009 and 2019, the Department opened four intact family cases totaling 55 months of services. One of the four intact cases closed unsuccessfully because of lack of cooperation.

Four of the 37 prior child protection investigations occurred in the year leading up to the 3-year-old child's death. The Department initiated these four child protection investigations within a two-month-period, after receiving reports of allegations regarding inadequate supervision (#74), inadequate food (#76), environmental neglect (#82), substantial risk of physical injury/environment injurious to health and welfare by abuse (#10), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), and medical neglect (#79).

In all four child protection investigations, the parents repeatedly refused to permit the child protection investigators into the home, occasionally allowing the child protection investigators to observe the siblings through the door or on the porch. The parents often prohibited the siblings from answering the child protection investigator's questions and never permitted the child protection investigator to interview the siblings without the parents present. The child protection supervisor instructed the investigator to interview the siblings at their school, but the father withdrew the siblings from school the following week. During the pending child protection investigations, the children were assessed as safe in the care of their parents, despite the family not allowing the child protection investigators in the home or to interview the children outside of the parents' presence. The child protection investigators failed to indicate the presence of a safety threat in which a caregiver, paramour or member of the household is hiding the child, refuses access, or there is some indication that a caregiver may flee with the child. Rather child protection staff relied on observing the children from a distance, which does not constitute an adequate safety assessment. Assessing children as safe based solely on superficial information fails to protect children and provides an inaccurate picture of the family.

Less than two months prior to the 3-year-old child's death, the child protection investigator left a message for the State's Attorney's Office regarding court ordered services for the family due to the parents' refusal to cooperate; however, the case contained no further documentation of attempts or conversations with the State's Attorney's Office. Prior to the child's death, the Department closed and unfounded three of the child protection investigations, citing insufficient evidence. The use of a binary finding system for child protection investigations limits the Department in adequately documenting situations that cannot be investigated because of parental refusal or other factors. The current practice to unfound allegations of abuse and neglect in these situations allows for future errors and impacts the safety and wellbeing of children.

In the case of the second child death reviewed, the 3-week-old newborn's family had a total of 31 prior child protection investigations with 11 indicated findings. These investigations included reports of inadequate clothing (#78), inadequate supervision (#74), environmental neglect (#82), inadequate shelter (#77), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Between 2012 and 2018, the Department opened three intact family cases totaling 28 months of service provision and monitoring. Two of the intact cases closed unsuccessfully for lack of cooperation and refusal of services.

Eight of the 31 prior child protection investigations occurred in the year leading up to the 3-week-old newborn's death. The Department initiated the first of the eight child protection investigations after receiving a report of the mother's methamphetamine use and the newborn's then 9-year-old and 11-year-old siblings' frequent school absences. Both siblings told the child protection investigator that they felt safe in the home, and the 9-year-old denied witnessing any drug use; however, the 11-year-old disclosed that he found needles in the mother's bedroom and overheard physical fighting between the mother and her paramour. The mother denied the allegations but refused to take a drug test. Citing insufficient evidence, the Department closed and unfounded the child protection investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Approximately one month into the initial investigation, the Department initiated two separate investigations of the mother's inadequate supervision of the siblings, the siblings staying with various people to avoid the worsening conditions of the home, and a bruise on the 9-year-old's head. The 9-year-old denied any issues at home and told the child protection investigator that he sustained the bruise at a sleepover; however, the 11-year-old disclosed he left the home because he saw the mother's paramour using needles. Two months after the Department initiated the second and third investigations, the child protection investigator submitted a request to the State's Attorney's Office for court ordered services, summarizing the mother's extensive history with the Department, the allegations of the pending child protection investigation, and the mother's refusal to cooperate with intact services and a drug test. SACWIS contained no documentation of a response from the State's Attorney's Office. The following week, the Department closed and unfounded the second and third investigations due to insufficient evidence.

Less than four months after the second and third investigations closed, the Department initiated another investigation after receiving a report that the mother's home was uninhabitable and without consistent electricity. The Department unfounded the investigation for inadequate shelter (#77) and environmental neglect (#82) after the child protection investigator observed that the home met the minimal standards and had working utilities.

Eight days into the pending investigation, the Department initiated a separate investigation after the 9-year-old sibling disclosed that the mother used methamphetamines in his presence. The assigned child protection investigator spoke with the 9-year-old at school, who reported staying at a friend's home for the past two weeks due to a fight with his mother. Before leaving the home, the 9-year-old found needles near the paramour's belongings and believed he saw his mother with a needle in her wrist. Three days later, the Department initiated two separate investigations after receiving reports of inadequate supervision and that the 9-year-old disclosed that he no longer felt safe in the home. The next day, the child protection investigator spoke with the State's Attorney, who reported a need for additional evidence of the mother's drug use to file a petition. As the investigations continued, the mother refused to cooperate, and the siblings disclosed staying with friends to have food and a safe place to sleep.

Three months prior to the newborn's death, and while two of the child protection investigations remained pending, the Department initiated a new investigation after receiving a report that the mother used methamphetamine and chronically neglected the siblings as the 9-year-old sought a neighbor's home for warmth after sleeping outside. The

child protection investigator discussed implementing a safety plan with the mother, contingent on her participation in drug tests, access to the home for assessment, and a substance abuse assessment, but the mother refused. The child protection investigator took protective custody of the siblings that same day, placing them with the maternal grandmother, and the court granted the Department temporary custody. The Department indicated the mother for inadequate supervision (#74), inadequate food (#76), substantial risk of physical injury/environment injurious (#10) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

RECOMMENDATIONS

1. The Department should explore how child protection and intact family services staff can recognize and intervene when a family has a significant history with the Department and develop a plan to guide staff on the use of a family's history to identify, assess and intervene. The plan should inform training needs and procedural changes that address this issue.

Procedures 300.50(a)(2), Pre-Commencement Activities for the Child Protection Specialist, instructs child protection staff to conduct a complete prior history search of all subjects of the report; analyze the information found; identify risks; and based on the Situation, Background and Assessment, make a Recommendation for next steps to ensure child safety. The OIG recommendation will also be incorporated in Procedures 302.388, Intact Family Services, which are currently being revised.

2. The Department should use this report in training staff on the Department's new safety decision tool, the SAFE model. This training should provide direction to staff when a child cannot be located or interviewed to assess their safety.

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

3. The Department's Office of Legal Services should provide training and guidance to child protection staff and intact family services staff on their options when encountering barriers when seeking court involvement including court ordered services and temporary custody. This guidance should include how DCFS attorneys can provide assistance to the field.

The Office of Legal Services is developing a workgroup to define the circumstances under which DCFS will consider filing a petition, when the State's Attorney has declined to do so, and what steps DCFS regional attorneys can take to assist the field.

4. The Department in conjunction with the Office of Legal Services and Division of Child Protection should explore the limitations of a binary system of indicated or unfounded for child protection findings and the feasibility of an alternative finding to address circumstances when child protection investigators are unable to obtain the needed information to make a determination of indicated or unfounded.

The Child Death Review Team and the Office of Legal Services have explored the feasibility of using the "undetermined" finding in circumstances when investigators are unable to obtain sufficient information to make a clear "indicated" or "unfounded" determination. While the current binary system has limitations, using "undetermined" as a final finding would be inconsistent with the requirements established in the Illinois Abused and Neglected Child Reporting Act, 325 ILCS 5/7.12 and therefore is not possible at this time. The Department continues to explore the feasibility of using variations of the Unfounded finding to distinguish, for example, when a report is Unfounded due to an inability to locate a family.

5. This report should be shared with the Child Death Review Team's Undetermined Finding Workgroup for consideration in their exploration of an undetermined finding.

The report was shared with the work group. The Child Death Review Team and the Office of Legal Services have explored the feasibility of using the "undetermined" finding in circumstances when investigators are unable to obtain sufficient information to make a clear "indicated" or "unfounded" determination. While the current binary system has limitations, using "undetermined" as a final finding would be inconsistent with the requirements established in the Illinois Abused and Neglected Child Reporting Act, 325 ILCS 5/7.12 and therefore is not possible

at this time. The Department continues to explore the feasibility of using variations of the Unfounded finding to distinguish, for example, when a report is Unfounded due to an inability to locate a family.

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

The report was redacted and shared with the OIG's Error Reduction Training coordinator for use in Error Reduction trainings.

Death and Serious Injury Investigation 7

DEATH An 8-year-old medically complex child with spastic quadriplegia cerebral palsy died in a hospital as the family awaited in-home nursing services. The cause of death was septic shock due to unknown organism and the manner of death was natural. The Department did not investigate the child's death for abuse or neglect. Three months prior to the child's death, the Department initiated a child protection investigation against the facility that provided in-home nursing services after the child sustained a fracture while in the care of her in-home nurse.

INVESTIGATION Prior to sustaining the fracture, the medically complex child lived at home with her mother and maternal grandmother. The child had a history of cerebral palsy, hypoxic ischemic injury, global developmental delay, scoliosis, and required a gastrostomy tube for feedings. Three months prior to the child's death, the Department initiated a child protection investigation after receiving a report that the child sustained a proximal metaphyseal fracture to her lower leg after the in-home nurse heard a "pop" while changing the child's clothes.

The day after the hotline report, the assigned child protection investigator observed the child at the hospital, noting the child was bedridden and unable to verbally communicate. The child protection investigator did not document speaking with anyone while at the hospital; however, the supervisor noted in a supervisory note that the investigator reported interviewing the child's mother at the hospital, and that the mother stated she argued with the child's in-home nurse about the child's heart monitor prior to the incident. The child protection investigator did document an interview with the mother occurring three weeks after the hotline call, noting the mother reported being in another room when the incident occurred. The mother stated that she did not believe the incident was accidental because the nurse was upset after their argument and the mother believed the nurse was rough with the child.

The child protection investigator told IG investigators that he misdated his contact note in SACWIS, stating his conversation with the mother took place while at the hospital the day after the hotline report. The child protection investigator stated the mother contacted him several times during the investigation for updates, but the child protection investigator did not document these contacts. The child protection investigator never went to the family's home, where the alleged maltreatment occurred.

Two months after the hotline call, the child protection investigator interviewed the in-home nurse, who stated that on the day of the incident, she used the usual pressure when putting on the child's pants and heard a pop. The in-home nurse stated that she regularly had trouble putting on the child's pants and did not intentionally harm the child.

Department Procedures provide that child protection staff should notify and interview the alleged perpetrator within 24 hours, however, the child protection investigator documented contacting the in-home nurse almost two months after the initial hotline call. The child protection investigator told IG investigators that he attempted to contact the in-home nurse several times but did not document these attempts in SACWIS. The child protection investigator reported he contacted the nurse's agency which provided her correct phone number and reported the in-home nurse had no prior reports against her; however, the child protection investigator did not document this conversation in SACWIS.

The child protection investigator did not contact the director of the facility that employed the in-home nurse, as required per Procedures 300.110 b)3)C, *Contact with the Facility Director or Designee*, which provides that at the onset of a child protection investigation, child protection staff must contact the facility director to notify them of the investigation and that the director should immediately take steps to restrict the alleged perpetrator from contact with children and facility staff/premises.

The child protection investigator documented in-person contact with the hospital physicians that examined the child's fracture, noting the child had chronic medical conditions that made her vulnerable to bone fractures, as the child did not have the bone density or structure of a typical ambulatory child. However, during an interview with IG Investigators, the child protection investigator acknowledged this SACWIS contact note reflected his review of the child's medical records he received from the hospital social worker and that, contrary to his contact note, he did not speak with the physicians, explaining the doctors at that hospital did not typically speak to child protection staff.

Approximately two months after initiating the child protection investigation, the Department closed the investigation and unfounded the in-home nurse for bone fractures by neglect (#59). The child protection supervisor noted the child sustained an accidental injury as the child was more vulnerable to fractures due to her presenting medical complications.

Unrelated to the child's death, the OIG identified significant deficiencies in the child protection investigation into the child's fracture. While in this case, these errors did not result in an inappropriate finding of unfounded or safety concerns for the child, there are circumstances in which such inaccuracies and oversights could jeopardize both the safety of a child and the integrity of the child protection investigation. The involved child protection investigator had only worked for the Department for eight months prior to his assignment to the investigation, and therefore, the OIG recommended the Department issue this OIG report as a teaching tool.

RECOMMENDATION **1. A redacted copy of this report should be shared with the child protection investigator and the child protection supervisor to be used as a teaching tool.**

The regional administrator met with the child protection investigator and supervisor and used the report as a teaching tool.

Death and Serious Injury Investigation 8

DEATH A 17-year-old youth was shot multiple times outside an apartment, and first responders brought the youth to a hospital where he was pronounced deceased on arrival. At the time of the youth's death, police did not have any suspects in custody, and the death was ruled a homicide with a cause of multiple gunshot wounds. The Department did not investigate the youth's death for abuse or neglect. In the year prior to the youth's death, the Department unfounded an investigation involving the youth's family for allegations of mental injury by abuse (#17), medical neglect (#79), substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

INVESTIGATION Six months prior to the youth's death, the Department initiated an investigation after a hotline report that the youth's 14-year-old sibling disclosed that his older siblings threatened him with their guns, the older siblings and mother bullied the 14-year-old, and the 14-year-old engaged in self-harm.

The next day, the child protection investigator met with the 14-year-old at school and noted no observable injuries; however, the child protection investigator did not document any attempts to verify reports of self-harm. The 14-year-old reported he did not feel safe at home, his mother and older siblings bullied him, and his mother did not know about the latest incident where his older sibling threatened him with a gun. The 14-year-old told the child protection investigator he wanted counseling and he used cutting as a coping mechanism. The 14-year-old reported he felt safe with his aunt and wanted to live with her.

The child protection investigator also met with the 13-year-old sibling at school, who reported he felt safe at home, denied he saw a gun in the home, and denied he witnessed his older siblings hurt the 14-year-old sibling. The child protection investigator also spoke with the reporter, who confirmed the narrative in the hotline report and denied the 14-year-old ever presented with marks or bruises.

Regarding the siblings' conflicting reports, the child protection investigator stated in an interview with IG investigators that she believed younger siblings were often more straightforward and honest compared to older children who had time to think about their statements. The child protection investigator also told IG investigators that she assessed the 14-year-old's statements about being bullied as consistent with typical sibling behavior. The child protection investigator appeared to develop an impression that what went on in the home was typical of sibling conflict. The child protection investigator minimized the 14-year-old's statements and allowed her biases to impact her assessment of the family.

Despite not observing the home nor speaking with the alleged perpetrators, the child protection investigator assessed the 14-year-old as safe after interviewing him at school, utilizing the Child Endangerment Risk Assessment Protocol (CERAP). The child protection investigator told IG investigators that her understanding was to assess the 14-year-old's safety at the point of interview, and that the CERAP did not pertain to what may happen if the child left school. However, according to DCFS Procedures 300, Appendix G(a), *Requirements for Use of the Child Endangerment Risk Assessment Protocol* provides that the CERAP assessment assists child welfare staff to determine if a child is safe in their home environment, and "the CERAP safety assessment is to be based on the child's return home."

Four days after the child protection investigator's initial interviews at school, the Department received a second hotline call after school staff requested Screening, Assessment, and Support Services (SASS) for the 14-year-old sibling for concerning behaviors, but the mother removed him from school to prevent the evaluation. The Department took the report for an allegation of medical neglect (#79) by the mother. The hotline coded the report as "Action Needed," which required the child protection supervisor and investigator to review the report within 60 minutes of transmission to determine necessary investigative actions. The Department assigned the same child protection investigator to this subsequent report, and the supervisor emailed the child protection investigator that the hotline reports might be merged into one investigation. The child protection investigator responded that she spoke to the 14-year-old the prior week at school. The child protection supervisor and investigator did not document in SACWIS any investigative activity that day. In separate interviews with IG investigators, the child protection investigator and supervisor did not recall if they staffed the new report that day.

The next day, the Department merged the reports into one investigation, and the child protection supervisor documented instructing the child protection investigator on the next steps, including contacting the subsequent reporter, interviewing the household members, and obtaining any reports to confirm the alleged incident. The child protection supervisor told IG investigators that these actions included contacting SASS, but the child protection investigator separately told IG investigators she never contacted SASS during the investigation.

Over the next three weeks, the child protection investigator documented two attempts to see the family at home with no response and sent a letter to the home requesting contact. The child protection investigator told IG investigators that she attempted visits at three addresses listed for the family, including the grandmother's home.

The child protection supervisor documented instructing the child protection investigator to complete a nursing referral as the 14-year-old sibling required a mental health evaluation. The child protection investigator told IG investigators that she did not submit the nursing referral because the family did not cooperate with the investigation. SACWIS did not contain any documentation about consulting with Clinical Services, and the child protection investigator told IG investigators that she did not recall if they considered consulting with Clinical Services. The child protection investigator and supervisor told IG investigators that they could not recall any trainings for child protection staff regarding children experiencing a mental health crisis, beyond foundations training.

After nearly two months, the child protection investigator had not located the family and the supervisor instructed the child protection investigator to request police assistance prior to documenting that the family refused to

cooperate. The child protection investigator made a final attempt to see the family at home but did not contact law enforcement as directed by the supervisor.

Five days later, the Department closed the investigation and unfounded all the allegations citing insufficient evidence and that the statements could not be corroborated, as there were no witnesses nor law enforcement involvement. The child protection supervisor approved numerous waived contacts required in child protection investigations. The child protection investigator did not contact the 14-year-old or his family after the subsequent hotline call, instead relying on the initial visit to the school following the initial hotline report.

The second report to the Department identified escalating concerns for the 14-year-old's mental health, and the mother's failure to have her child evaluated. Despite information that the 14-year-old went to the grandmother's home, the child protection investigator did not document any attempts to contact the grandmother or see the child in the grandmother's home in response to the action needed report. The child protection investigator and supervisor relied on the interview with the 14-year-old one week earlier and made no contact with him, the alleged perpetrator, the reporter, or any other family members. The child protection investigator did not complete basic tasks that are required for all child protection investigations regardless of the allegations, such as contacting school personnel, collaterals, and medical providers. These contacts could have provided information on the 14-year-old's mental health, insights regarding the family dynamics, and contact information to help locate the family. The supervisor also instructed the child protection investigator to submit a nursing referral for psychiatric evaluation and to contact law enforcement for assistance locating the family; however, there was no indication that these actions occurred, nor that the supervisor followed up on these instructions.

RECOMMENDATIONS

1. The area administrator should review this report with the involved child protection supervisor for training purposes to address supervision deficiencies and the waiver process for child protection investigations.

The area administrator reviewed this report with the child protection supervisor for training purposes to address supervision deficiencies and the waiver process for child protection investigations.

2. The area administrator should review this report with the involved child protection investigator for training purposes. The discussion should include the procedural requirements for seeing the child victim in a timely manner; biases in decision making; and assessing child safety.

The area administrator reviewed the report with the involved child protection investigator for training purposes including issues identified in the report.

3. The Department should provide training to all frontline staff on teenage mental health and suicide. The training should include the need for timely assessment and intervention for this vulnerable population.

The Clinical Division and Child Protection leadership met in August 2024 to discuss areas surrounding teenage mental health and suicide in order to develop a training for frontline staff. The training is currently in development.

4. In this particular case, the rationale provided by the child protection investigator for requesting waivers was not appropriate. The Department should consider requiring that both the investigator and supervisor enter the reason for requesting and/or approving waivers in the checklist tab of SACWIS. This requirement should be incorporated in the Department's new data information system.

The SACWIS team is making modifications to the current Not/Applicable – Waiver Request functionality for Checklist tasks in the December 2024 SACWIS release. These changes will not increase any data elements, but it will make these items easily visible and better understood by all users and readers of investigation information. The current 'radio buttons' will be changed to a single dropdown list containing Not Applicable/Waiver Request/None and when either Not Applicable or Waiver Request are selected it will expand the area just below the Checklist task being 'waived'. This is where another dropdown list will appear for the Contact Missing Reason and for Waiver Explanation narrative, both are required to have a complete record for an approval to take place and allow the investigation to be completed without the Checklist task being completed. Once a Waiver Request is approved,

it will complete the record (freeze) so the data elements selected and narrative written cannot be changed (this is current functionality). Current functionality will also remain where the Checklist task (Contact Note) can be completed even if a Waiver was requested and approved.

PART II: CHILD DEATH REPORT

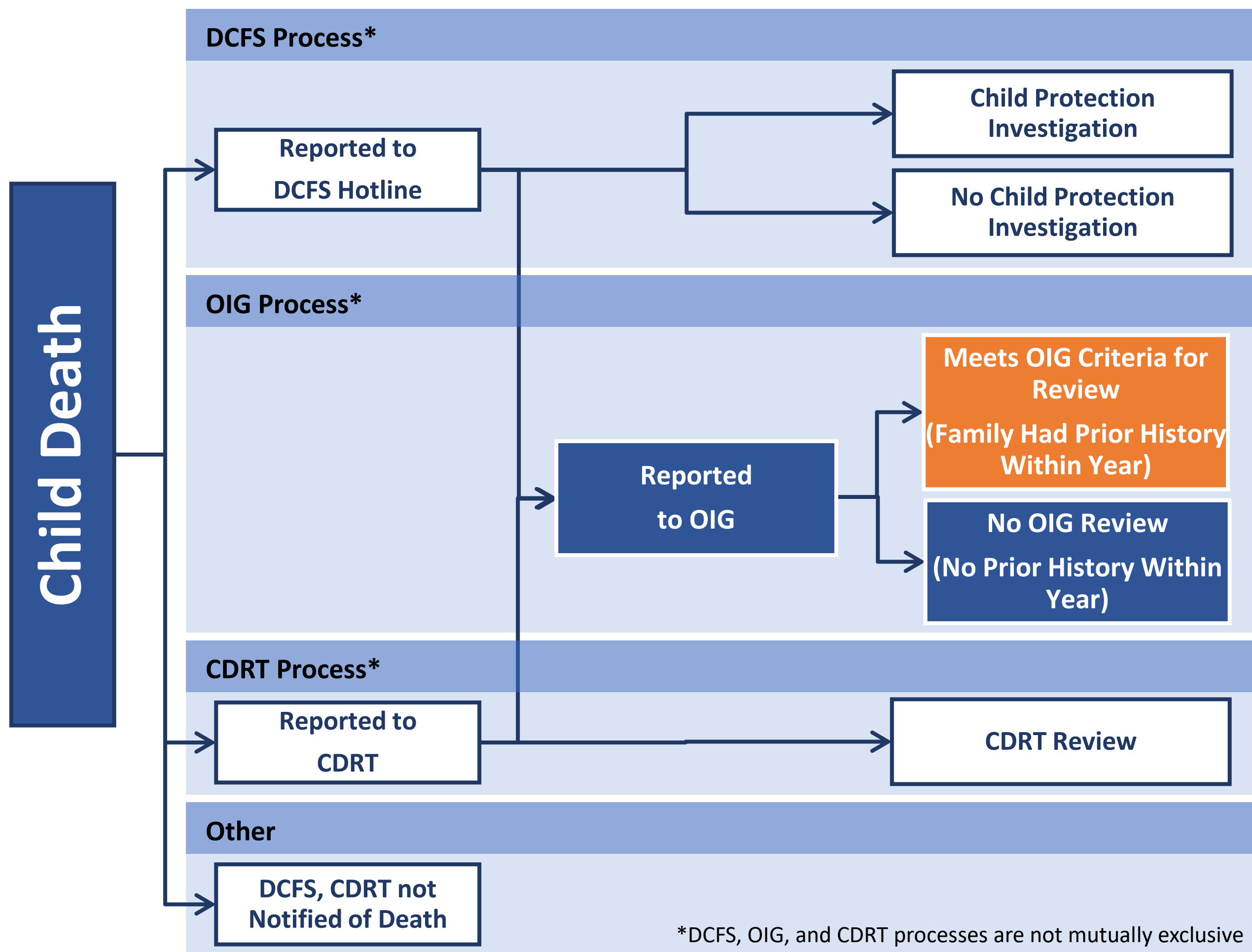
Pursuant to Illinois Register at 89 Ill. Admin. Code 430, the Inspector General investigates deaths of Illinois children whose families have been involved with the Department of Children and Family Services (DCFS or Department) within the preceding 12 months.

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

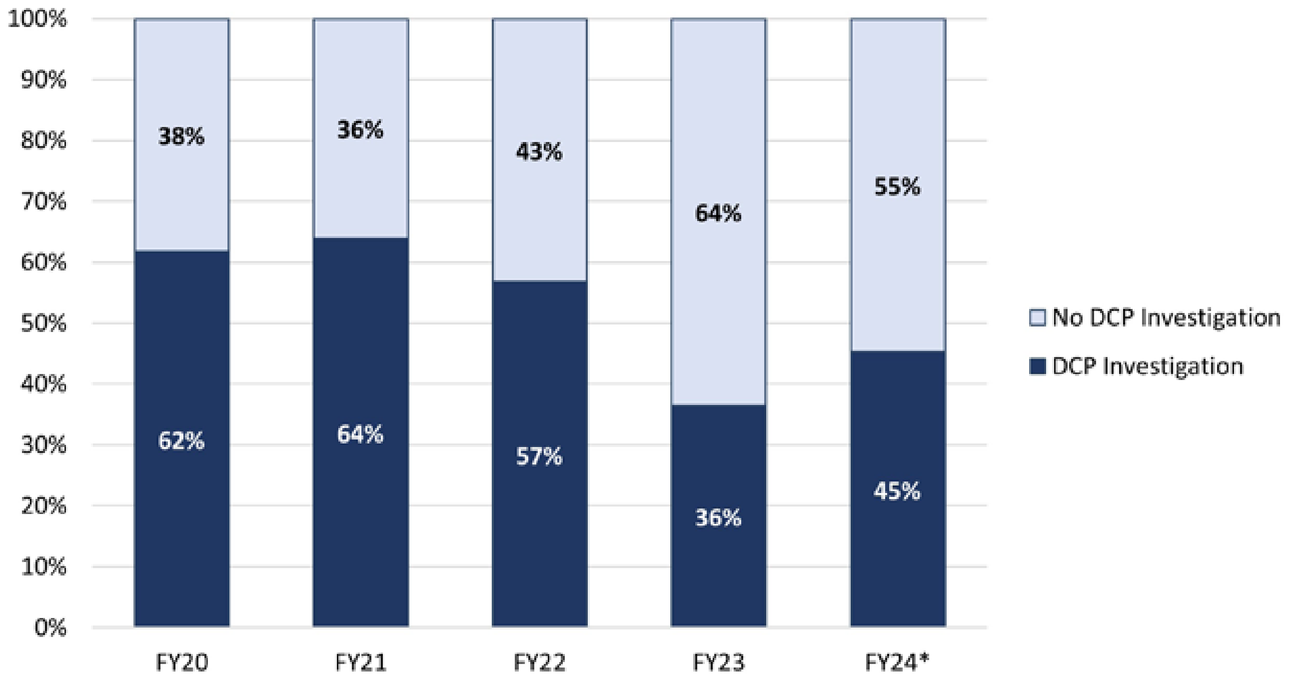
Notification of a child's death initiates an investigatory review of records. IG investigators review the death reports and information available through the Department's computerized records, DCFS and CWCA case records, and additional records as needed.

OIG conducts full investigations when it identifies malfeasance or misfeasance of Department and CWCA employees, or systemic issues are identified. The issues identified may or may not relate to the child's death. As part of a full investigation, IG staff may request additional records – often including social service, medical, police, and school records – and may conduct interviews. A full investigation may result in a report to the Director of DCFS.

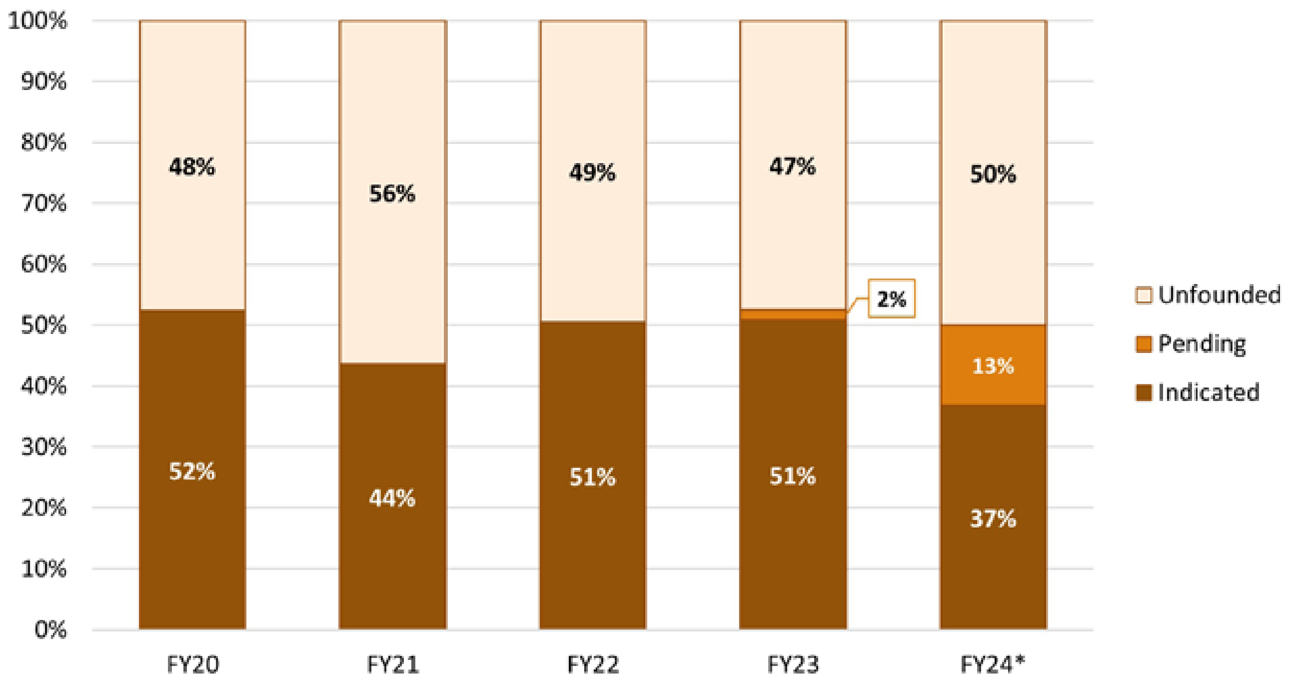
OIG received 721 notifications of child deaths between July 1, 2023 and June 30, 2024. Of those, 507 were reported to SCR, and 214 were reported to CDRT. Of the deaths reviewed, 168 met OIG criteria for review. A summary of each child's death and DCFS involvement is included in this Annual Report. IG investigators determined five deaths required full investigations, and 41 deaths will be reviewed in a pending systemic issue report. Comprehensive summaries of death investigations reported to the Director in FY 2024, which may include deaths that occurred in earlier fiscal years, are included in Part I: Death and Serious Injuries Investigations.



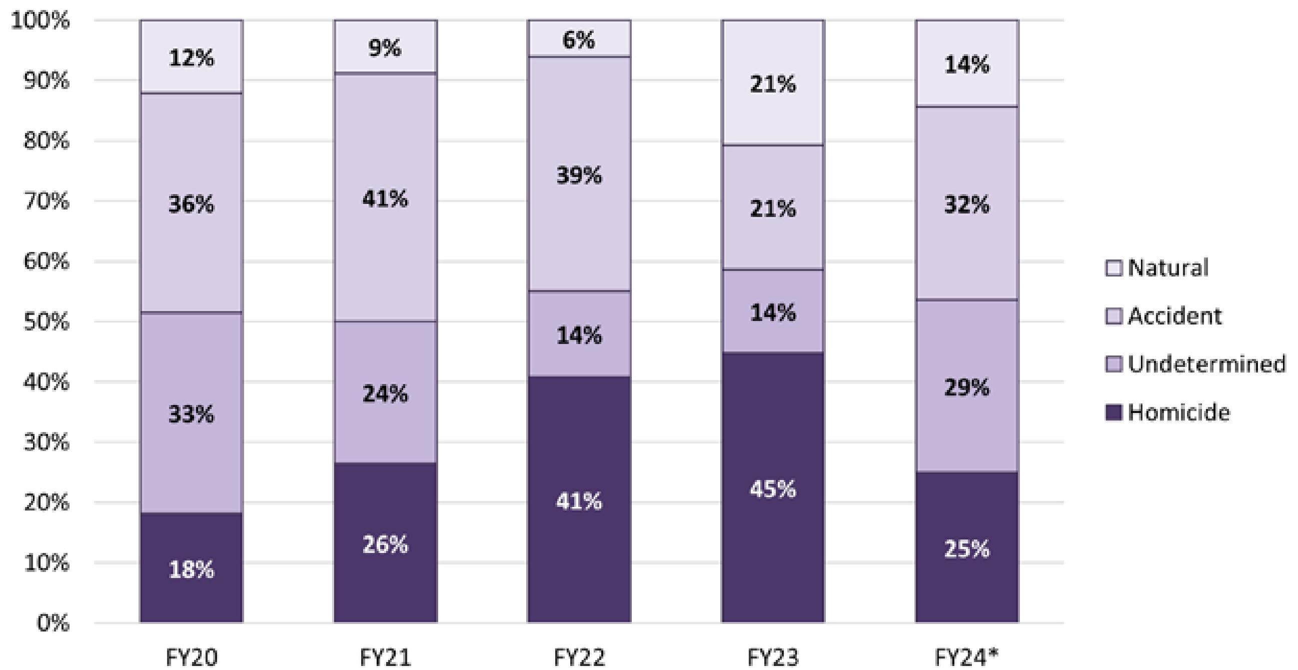
Of the 168 child deaths reviewed by OIG in FY 2024, the Department conducted a child protection investigation for allegations of death by abuse or neglect in 76 (45%) of the deaths. Of the 76 deaths investigated by the Department, ten of the deaths were ruled homicide in manner, one was ruled a suicide, 21 had an undetermined manner, 24 had a manner of accident, and 18 had a manner of natural. Autopsy results have not been released for two of these deaths.



Of those 76 deaths, the Department indicated a perpetrator for death by abuse or neglect in 28 deaths (37%) and unfounded an alleged perpetrator for death by abuse or neglect in 38 deaths (50%); 10 child protection death investigations (13%) remain pending at the time of this report.



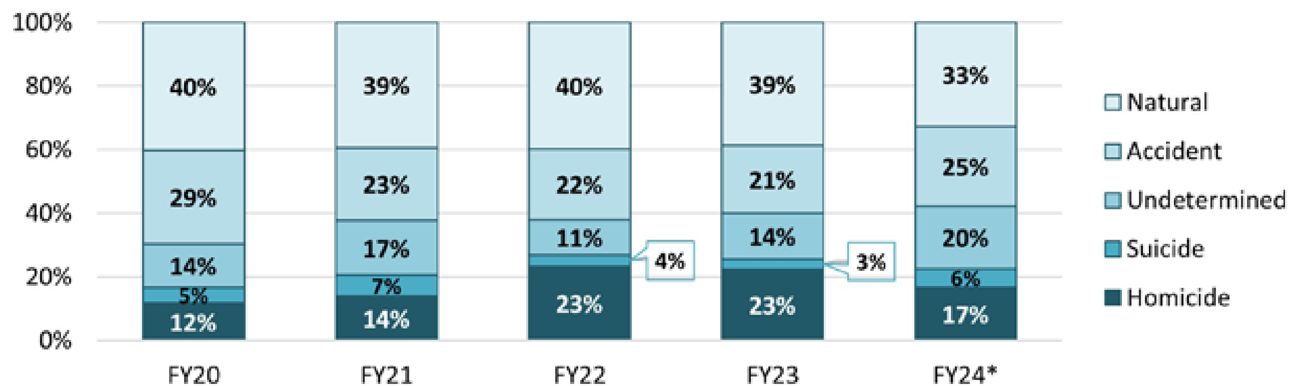
Of the 28 deaths in which the Department indicated a perpetrator for death by abuse or neglect, seven were ruled homicide in manner (25%), eight had an undetermined manner (29%), nine were ruled accidental in manner (32%), and four had a manner of natural (14%).



* In FY 2024, there are eight child deaths with pending manner included here in the undetermined category.

STATISTICAL SUMMARY

The following is a statistical summary of the 168 child deaths reviewed by OIG in FY 2024. 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 eight 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.



* In FY 2024, there are eight child deaths with pending manner included here in the undetermined category.

Table 1: Child Deaths by Age and Manner of Death									
	Child Age	Homicide	Suicide	Undetermined	Pending	Accident	Natural	Total	
Months of Age	At birth	0	0	0	1	0	1	**2**	**1%**
	0 to 3	1	0	12	5	7	14	**39**	**23%**
	4 to 6	0	0	3	0	6	2	**11**	**7%**
	7 to 11	1	0	3	0	3	3	**10**	**6%**
	12 to 24	2	0	2	1	1	8	**14**	**8%**
Year of Age	2	0	0	0	0	3	3	**6**	**4%**
	3	0	0	1	1	1	2	**5**	**3%**
	4	0	0	0	0	0	1	**1**	**1%**
	5	0	0	0	0	2	0	**2**	**1%**
	6	1	0	1	0	1	0	**3**	**2%**
	7	1	0	0	0	1	2	**4**	**2%**
	8	1	0	0	0	1	4	**6**	**4%**
	9	1	0	0	0	0	0	**1**	**1%**
	10	1	0	0	0	1	2	**4**	**2%**
	11	0	0	0	0	0	0	**0**	**0%**
	12	1	1	0	0	0	1	**3**	**2%**
	13	0	1	0	0	0	2	**3**	**2%**
	14	3	1	0	0	2	2	**8**	**5%**
	15	4	3	1	0	1	2	**11**	**7%**
	16	6	1	0	0	3	4	**14**	**8%**
	17	3	2	2	0	5	1	**13**	**8%**
	18 or older	2	1	0	0	4	1	**8**	**5%**
	Total	**28**	**10**	**25**	**8**	**42**	**55**	**168**	**100%**

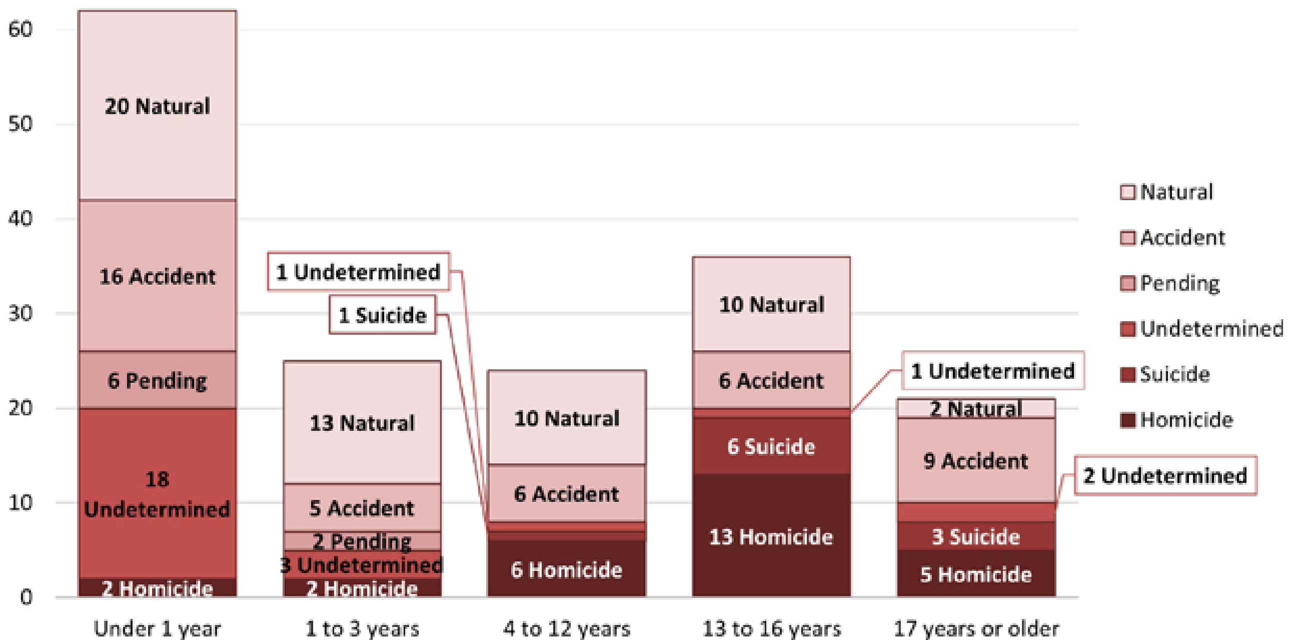


Table 2: Child Deaths by Case Status and Manner of Death									
Reason for OIG investigation*		**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	
DCP	**Pending**	3	4	3	1	7	7	**25**	**15%**
	Unfounded	16	4	7	2	11	13	**53**	**32%**
	Indicated	2	0	2	1	6	5	**16**	**10%**
Youth in Care		3	1	4	0	8	15	**31**	**18%**
Former Youth in Care		1	0	0	0	0	0	**1**	**1%**
Return Home/Closed Placement		0	0	0	0	1	0	**1**	**1%**
Open Placement/Split Custody		0	0	2	0	4	3	**9**	**5%**
Open Intact		2	0	3	1	4	8	**18**	**11%**
Closed Intact		1	1	4	0	0	1	**7**	**4%**
Child of a Youth in Care		0	0	0	1	0	0	**1**	**1%**
Child Welfare Services Referral		0	0	0	2	1	3	**6**	**4%**
Total		**28**	**10**	**25**	**8**	**42**	**55**	**168**	**100%**

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

Key for Case Status (see Table 2 above)	
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.

Table 3: Child Deaths by Region of Residence and Manner of Death								
Region	**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	
Central	4	3	5	1	17	16	**46**	**27%**
Cook	17	1	11	2	8	16	**55**	**33%**
Northern	2	2	8	0	9	15	**36**	**21%**
Southern	5	4	0	5	7	8	**29**	**17%**
Out of State	0	0	1	0	1	0	**2**	**1%**
Total	**28**	**10**	**25**	**8**	**42**	**55**	**168**	**100%**

Table 4: Child Deaths by County of Residence and Manner of Death								
County	**Homicide**	**Suicide**	**Undetermined**	**Pending**	**Accident**	**Natural**	**Total**	
Adams	1	0	0	0	0	0	**1**	**1%**
Boone	0	1	0	0	1	0	**2**	**1%**
Cass	1	0	0	0	0	0	**1**	**1%**
Champaign	0	0	0	0	2	6	**8**	**5%**
Clark	0	0	0	0	0	1	**1**	**1%**
Coles	0	0	0	0	1	0	**1**	**1%**
Cook	17	1	11	2	8	16	**55**	**33%**
DeKalb	0	0	2	0	0	0	**2**	**1%**
DuPage	0	0	0	0	0	2	**2**	**1%**
Effingham	0	0	0	0	0	1	**1**	**1%**
Fayette	0	0	0	0	1	0	**1**	**1%**
Franklin	0	0	0	1	0	2	**3**	**2%**
Fulton	0	0	0	0	0	1	**1**	**1%**
Grundy	0	0	0	0	0	1	**1**	**1%**
Jackson	0	1	0	0	0	0	**1**	**1%**
Johnson	0	0	0	1	0	0	**1**	**1%**
Kane	0	0	1	0	2	2	**5**	**3%**
Kankakee	0	1	0	0	1	1	**3**	**2%**
Kendall	0	0	0	0	1	0	**1**	**1%**
Lake	0	0	1	0	2	1	**4**	**2%**
LaSalle	0	1	0	0	1	2	**4**	**2%**
Logan	0	1	0	0	0	0	**1**	**1%**
Macon	0	0	0	0	1	1	**2**	**1%**
Macoupin	0	0	0	0	1	0	**1**	**1%**
Madison	2	1	0	2	2	1	**8**	**5%**
Marion	1	0	0	0	0	0	**1**	**1%**
Marshall	0	0	0	0	1	0	**1**	**1%**
McHenry	0	0	2	0	2	3	**7**	**4%**
McLean	0	0	0	0	1	1	**2**	**1%**
Montgomery	0	0	1	0	0	0	**1**	**1%**
Morgan	0	0	0	0	1	0	**1**	**1%**
Moultrie	0	0	0	1	0	0	**1**	**1%**

Peoria	1	1	0	0	3	2	**7**	**4%**
Randolph	0	0	0	0	1	0	**1**	**1%**
Rock Island	0	0	4	0	1	0	**5**	**3%**
Saline	0	0	0	0	1	0	**1**	**1%**
Sangamon	0	0	0	0	1	0	**1**	**1%**
Schuyler	0	0	0	0	2	0	**2**	**1%**
Scott	0	0	0	0	0	1	**1**	**1%**
St. Clair	2	2	0	1	1	4	**10**	**6%**
Stephenson	0	0	1	0	0	0	**1**	**1%**
Tazewell	1	0	0	0	1	0	**2**	**1%**
Vermilion	0	0	0	0	0	1	**1**	**1%**
Whiteside	0	0	0	0	0	1	**1**	**1%**
Will	1	0	1	0	0	0	**2**	**1%**
Williamson	0	0	0	0	1	0	**1**	**1%**
Winnebago	1	0	0	0	0	4	**5**	**3%**
Out of State	0	0	1	0	1	0	**2**	**1%**
Total	**28**	**10**	**25**	**8**	**42**	**55**	**168**	**100%**

Table 5: Child Protection Death Investigations by Result and Manner*

Final Finding	Homicide	Suicide	Undetermined	Pending	Accident	Natural	Total	
Indicated	7	0	8	0	9	4	**28**	**37%**
Unfounded	1	1	9	1	14	12	**38**	**50%**
Pending	2	0	4	1	1	2	**10**	**13%**
Total	**10**	**1**	**21**	**2**	**24**	**18**	**76**	**100%**

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

Homicide

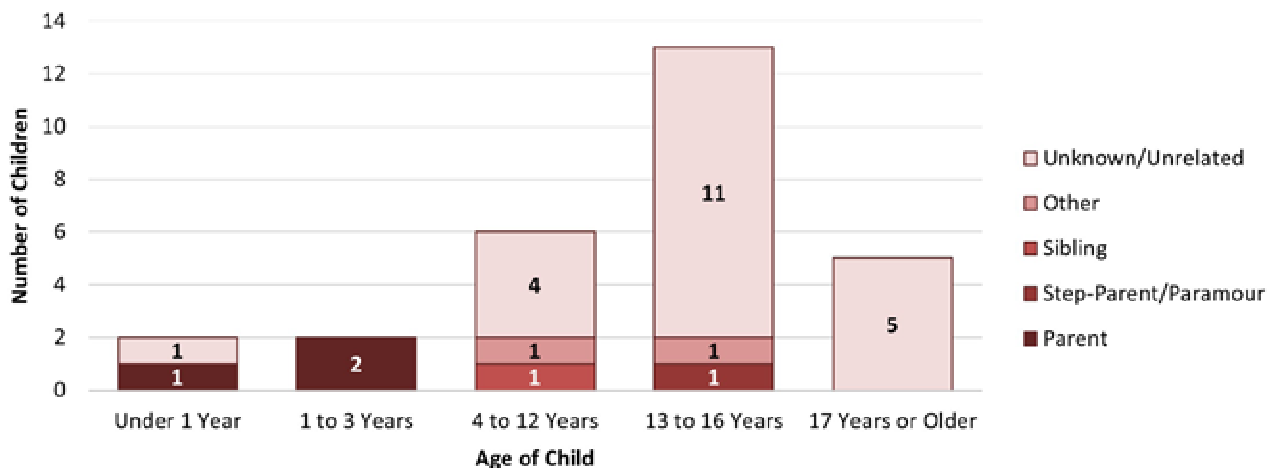
Twenty-eight deaths were classified as homicide in the manner of death.

Cause of Death	Number	Percent
Blunt force injuries	3	11%
Drug toxicity	2	7%
Gunshot wound(s)	19	68%
Stab wound(s)	2	7%
Strangulation	2	7%
Total	**28**	**100%**

Homicide Category	Number	Percent
Child Abuse	4	14%
Street Homicide	16	57%
Other	8	29%
Total	**28**	**100%**

Perpetrator	Number	Percent
Mother	2	7%
Father	1	4%
Mother's paramour	1	4%
Sibling	1	4%
Cousin	1	4%
Boyfriend	1	4%
Unknown	13	46%
Unrelated	8	29%

**Some deaths may have more than one perpetrator.*



Suicide

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

Cause of death	Number	Percent
Drug toxicity	1	10%
Hanging	5	50%
Gunshot wound	2	20%
Other	2	20%
Total	**10**	**100%**

Undetermined

Twenty-five deaths were classified as undetermined in the manner of death.

Cause of death	Number	Percent
Drug toxicity	2	8%
Gunshot wound	1	4%
SUID or undetermined (sleep related)	15	60%
Undetermined	6	24%
Other	1	4%
Total	**25**	**100%**

Accident

Forty-two deaths were classified as an accident in the manner of death.

Cause of death	Number	Percent
Asphyxiation	15	36%
Drowning	9	21%
Drug toxicity	7	17%
Motor vehicle accident	10	24%
Other	1	2%
Total	**42**	**100%**

Natural

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

Cause of death	Number	Percent
Cancer	1	2%
Cardiac condition	5	9%
Complications of multiple medical complexities	15	27%
Diabetes complications	2	4%
Neurological condition complications	4	7%
Pneumonia, sepsis, viral infection, or bacterial infection	16	29%
Prematurity complications	8	15%
Other	4	7%
Total	**55**	**100%**

HOMICIDE

Child No. 1	DOB: 07/2013	DOD: 07/2023	Homicide

Age at death: 9 years
Cause of death: Gunshot wound of chest
Alleged perpetrator: Unrelated (street homicide)
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Nine-year-old was riding in a car with his father when another vehicle approached and fired a gun, which hit the child. Police investigating the incident suspected the father was the intended target, and noted the father was cooperative with their efforts to identify a suspect. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Approximately six weeks before the child's death, DCFS received a report that the child's father kept a gun under his pillow and told the child to talk to him if he felt he needed to use it. The reporter also stated the child disclosed his father and the father's paramour fought in the home, and police had been involved. The child's mother reported the child primarily lived with her but visited his father. She reported the father had recently taken the child to a gun range and allowed him to shoot a gun. The CPI spoke with local law enforcement, who reported the father had a gun permit and noted it was not illegal to take a child to a gun range. The father stated he stored the gun in a locked safe and taught the child about gun safety. The father denied he slept with it under his pillow and denied the child had access to it. The CPI observed the gun safe and noted the key was stored in a different location. The child said he had only been close to a gun at the gun range. Household members denied any domestic violence. One month before the child's death, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 2	DOB: 06/2013	DOD: 07/2023	Homicide

Age at death: 10 years
Cause of death: Manual strangulation
Alleged perpetrator: Unrelated adult
Reason for review: Pending child protection investigation at time of child's death; one indicated and one unfounded child protection investigations within one year of child's death
Action taken: Investigatory review of records

Narrative: Ten-year-old was kidnapped when she and her 6-year-old sister went outside to pick up the paper. The mother called 911. A suspect was arrested and charged with first degree murder, aggravated battery by strangulation, and two counts of kidnapping. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Four months before the child's death, DCFS received a report that the children came to school dirty. The next day, the CPI saw the child and her 6-year-old and 7-year-old siblings at home and noted they appeared clean and appropriate, and they stated they felt safe. However, at the time the CPI arrived, the children reported they were home alone. The mother denied she knew the children were left home alone; the stepfather was supposed to be watching the children. DCFS indicated her stepfather for inadequate supervision (#74), but unfounded her mother and stepfather for environmental neglect (#82). Two months before the child's death, DCFS received another report that the child arrived at school dirty. The CPI met with the child and noted she had a foul odor and was wearing several layers of clothing. She stated her mother washed her clothes, she bathed and brushed her teeth daily, and she felt safe at home. The CPI also spoke with the child's 7-year-old sibling at school, who appeared clean, with adequate hygiene, and no visible marks or bruises. The mother reported the children bathed daily and she laid out their clothing. The stepfather reported he got the children ready for school in the mornings, and stated their routine was eating cereal and taking showers. He denied he ever noticed the child in the same

clothes. The investigation remained pending at the time of the child's death. DCFS unfounded the mother for environmental neglect (#82).

Child No. 3	**DOB: 01/2007**	**DOD: 07/2023**	**Homicide**
Age at death:	16 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown (street homicide)		
Reason for review:	One unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was shot three times by an unknown person. She was reportedly in an alley with a group of people engaged in a verbal dispute with the male who produced a gun, shot the teen, and then fled the scene. The teen was pronounced deceased at the hospital. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Three months before the teen's death, DCFS received a report that the teen's parents left the teen, her 10-year-old, and 11-year-old siblings alone at home. The CPI went to the home and met with the teen's 25-year-old sister, who stated she lived in the home with her mother and younger siblings. She denied the allegations and stated their landlord was in the process of evicting the family and made a false report. The teen's mother also denied the allegations, reported the children attended school, and stated the landlord threatened to call DCFS. The teen and her younger siblings also denied they were left unsupervised and stated they felt safe at home. DCFS unfounded the teen's mother and 25-year-old sister for inadequate supervision (#74).

Child No. 4	**DOB: 03/2022**	**DOD: 07/2023**	**Homicide**
Age at death:	16 months		
Cause of death:	Fentanyl intoxication		
Alleged perpetrator:	Mother		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-month-old was found unresponsive and not breathing by her 25-year-old mother. The toddler was transported to the hospital, where she was pronounced deceased. The toxicology screening showed the toddler had fentanyl in her system. Law enforcement charged the mother with one felony count of child endangerment resulting in a death. DCFS indicated the mother for death by abuse (#1) and substance misuse by neglect (#65) to the toddler, as well as substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler's 11-year-old maternal aunt, who was present during the incident.

Reason for Review: Four months prior to the toddler's death, DCFS received a report that the toddler's mother and maternal grandmother were using medication that was not prescribed to them, while in a caregiver role for the then 11-month-old toddler. The CPI went to the family's home and noted the toddler appeared well-nourished and free of signs of physical abuse. The mother denied the allegations and reported she only took Xanax once and under medical care. The CPI did not observe drug paraphernalia in the home and noted the mother did not appear under the influence during the visit. The child's grandmother and a maternal uncle denied they observed the mother use substances and denied any concerns with her parenting skills. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 5	DOB: 03/2011	DOD: 07/2023	Homicide

Age at death: 12 years
Cause of death: Sharp force injury of head
Alleged perpetrator: Sibling
Reason for review: Open intact family services case at time of child's death; two unfounded child protection investigations within one year of child's death
Action taken: Pending systemic issue report

Narrative: Twelve-year-old was found unresponsive on the couch, in the morning. The child was pronounced deceased at the scene. The mother's paramour cared for the child and his 14-month-old and 9-year-old siblings while she was out of the home. The paramour reported the child sustained injury to the back of his head after the 9-year-old sister hit the child with an object. The mother and her paramour did not seek medical attention for the child. DCFS later took custody of the child's siblings. The Department indicated the mother and paramour for death by neglect (#51) and medical neglect (#79) to the child. The Department also indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the sister and substantial risk of injury/environment injurious to health and welfare by neglect (#60) to the youngest sibling.

Reason for Review: Five months before the child's death, DCFS received a report that the then 11-year-old child had bruises on his legs and upper arm. The reporter noted the child was non-verbal and had an intellectual disability. The reporter stated the child also recently had a human bite mark on his back, which the mother stated was caused by his sister. The mother denied the allegations. The mother reported the children played, but the then 8-year-old sister sometimes tried to bite the child. The mother agreed to intact family services. A child abuse pediatrician noted no concerns for abuse or neglect. One month later, DCFS received a related information report of new bruises under the child's eyes and scratches to his face. DCFS unfounded the child's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and opened an intact family services case. The mother's paramour also lived in the home and cared for the children. The mother agreed to transfer the child to a school that could provide weekly services and sensory therapies. The mother also secured community respite services for after school care. While the intact family services case remained open, DCFS received a report that the child's sister reportedly told a peer that her mother hit her, which caused a mark. The CPI spoke with intact family services staff, and noted the mother participated in services, and reported no concerns. The sister showed the CPI scabs on her wrist and forearm. She denied she told a peer her mother hit her, but stated she showed the scabs to the school nurse and reported her mother hit her with a belt. The mother denied she used a belt to discipline the sister. The mother agreed to have the sister's injuries assessed at urgent care. The treating physician reported no concerns for abuse or neglect. DCFS unfounded the child's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). During the intact family services case, the mother reported she was still in school, began working two days per week, and began parenting classes.

Child No. 6	DOB: 12/2014	DOD: 08/2023	Homicide

Age at death: 8 years
Cause of death: Gunshot wound to chest
Alleged perpetrator: Cousin
Reason for review: Indicated child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Eight-year-old was found with a gunshot wound to the chest. Law enforcement officers found the child lying on his back with a gun next to him, and transported the child to the hospital, where he was pronounced deceased. The 9-year-old cousin reported he and the child were looking for a remote control when they found a loaded gun under the mattress. The cousin stated he told the child to put the gun away and pulled the gun to get it away from the child, but he accidentally pulled the trigger. All adult relatives that lived in the home refused to tell law enforcement who owned the gun. The cousin told law enforcement his father, the child's uncle, reported

he owned the gun for protection, but he had never seen the gun and did not know where it was stored. The child's mother reported she did not know there was a gun in the home. The child protection investigation remains pending.

Reason for Review: Ten months before the child's death, DCFS received a report that the child's mother was charged with felony shoplifting and the child's then 1-year-old sister was present at the time of the arrest. The mother designated the maternal grandmother to care for the sister who reported she was willing to help with the children's care. The mother denied she attempted to steal, denied she left the store with the items in her bag, and denied she ran from security. The CPI referred the mother for community-based counseling services. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 7	DOB: 10/2007	DOD: 08/2023	Homicide
Age at death:	15 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unrelated (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 found with gunshot wounds to his upper body and died several days later. Police arrested and charged another teen in connection with the shooting. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Five months before the teen's death, DCFS received a report that the teen's 10-year-old brother was regularly left in the care of his older siblings, who hit him. The mother stated she had spoken to the children about playing rough with the brother. She reported the teen's 17-year-old brother was the caregiver when she was not home. All family members denied the allegations. DCFS unfounded the mother for inadequate supervision (#74).

Child No. 8	DOB: 12/2022	DOD: 09/2023	Homicide
Age at death:	8 months		
Cause of death:	Combined drug (fentanyl, despropionyl fentanyl (4 ANPP), and heroin) toxicity; significant contributing factor of neglect		
Alleged perpetrator:	Unknown		
Reason for review:	Youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-month-old was found unresponsive by his foster mother/maternal aunt when she went to pick him up from his other aunt's home. He had been sitting in a baby bouncer and had a small plastic bag on his face, which appeared to be a drug baggie. The foster mother reported that she took the infant to the other aunt's home when she went to work, but he was asleep when she returned that night, so she allowed him to stay overnight. The other aunt reported she placed him in a bouncer before she went to take a shower; leaving the grandmother to watch the child. The infant's grandmother and uncles tested positive for cocaine, and the infant's aunt who lived in the home tested positive for marijuana. The infant's foster mother reported she was not aware of her family members' drug use. The State's Attorney declined to file charges against any family members. DCFS indicated the grandmother for death by neglect (#51) because she was in the caretaking role of the child when he was found unresponsive. DCFS unfounded allegations of death by abuse (#1), environmental neglect (#82), inadequate supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Several months before the infant's birth, the infant's siblings came into DCFS care due to the mother's failure to cooperate with intact family services and concerns related to her mental health. The children

were placed with a maternal aunt. When the infant was born, DCFS received a report of his birth due to his siblings being in care. The reporter noted there were no medical concerns for the infant. The mother stated she had not been involved with her caseworker or seen her other children in over a year. DCFS took protective custody of the infant and indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The infant was placed with a different maternal aunt, separate from his siblings. The placement workers visited the infant and his siblings regularly and the children were all doing well in their placements. The infant's mother continued not to have contact with the placement worker and did not engage in services. DCFS was pursuing termination of parental rights for his older siblings.

Child No. 9	**DOB: 01/2008**	**DOD: 09/2023**	**Homicide**
Age at death:	15 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: Fifteen-year-old was left at the emergency room with gunshot wounds. He was treated for the wounds but died of his injuries later that evening. DCFS did not investigate the teen's death for abuse or neglect, and no arrests have been made related to the shooting.

Reason for Review: Five months before the teen's death, DCFS received a report that the teen, a 12-year-old, and a 14-year-old were taken into police custody during a traffic stop. A rideshare driver was driving the car. Firearms and substances were found in the vehicle. The teen admitted that two of the firearms and some of the drugs were his. The other children denied knowledge of the firearms and drugs. Police released the other two children but arrested the teen. The mother told the CPI the teen had been staying with a cousin at the time of the incident, and the teen had previously been involved with law enforcement for similar behaviors. The teen stated he lived with his mother, who allowed him to go out that night with a 9:00pm curfew. The CPI later interviewed the teen and mother at home after he was released. The mother agreed to a referral for mentoring services, but the teen again stated he would not participate. DCFS unfounded the mother for inadequate supervision (#74).

Child No. 10	**DOB: 07/2008**	**DOD: 09/2023**	**Homicide**
Age at death:	15 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: Fifteen-year-old was shot multiple times and was pronounced deceased at the hospital. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: One year before the teen's death, DCFS received a report that the family home lacked food and running water, and the home was dirty. The next day, the CPI interviewed the teen's then 6-year-old and 15-year-old siblings at school, and both reported they had food at home. The CPI noted the children appeared clean and appropriately dressed. The CPI attempted to interview the then 14-year-old teen and his 12-year-old brother, but school personnel reported they attended a day treatment school. The CPI attempted to see the family at home but documented they found a note on the door that the home was condemned. The next day, the CPI met the mother at home and asked about the condemned notice. The mother stated the family was staying with a friend while they looked for a new home. She denied the allegations and stated the teen's adult brother was learning to use his Link card and was upset the mother only used her Link card to purchase food for the minor children. She confirmed they also used a food pantry. The next day, the CPI met with the teen and his 12-year-old brother, who reported they had enough to eat, and they felt safe at home. The CPI spoke with a collateral contact, who described the mother as a

good parent and the children had enough food. The family doctor denied concerns for malnourishment. The CPI later met with the adult brother, who stated his mother and his caseworker, who was also assisting with housing, helped him figure out how to use his Link card, and he confirmed he had enough food. The CPI attempted to see the friend's home where the mother said they lived, but the mother reported the friend refused to allow DCFS in her home. DCFS unfounded the mother for inadequate food (#76). Eight months before the teen's death, DCFS received a report that the teen's 6-year-old brother had scratches on his face but the explanation that he fell on the carpet was inconsistent with the marks. The reporter added the brother presented at school with dirty clothes, poor hygiene, often seemed hungry and his school attendance had significantly declined in recent months. School personnel told the CPI that the brother had been absent 61 days that school year. The mother and brother stated the 6-year-old sustained the scratches on his face while playing with a baby. The brother denied anyone hurt him and stated he felt safe at home. The 15-year-old sister denied any concerns, and the CPI documented the brother and sister appeared clean and healthy. The mother stated they bathed regularly, and she planned to launder the children's clothes. The mother stated they lived with a friend, but refused to provide the address and stated the friend would not allow the CPI into the home. The CPI attempted to meet with the family for a closing CERAP, but the mother stated she was out of town. Three months before the teen's death, DCFS received a report that the mother left the teen's siblings in the care of their adult sister, and the mother signed temporary guardianship papers, but the sister did not have birth certificates, medical cards, or other documents for the children. DCFS took the report as related information. The CPI spoke with the sister, who lived in a neighboring state, and she stated she needed help to care for her siblings. The CPI requested a courtesy child welfare visit from the neighboring state, and the worker documented the children felt safe with their sister, appeared happy and well-groomed, and denied their mother harmed them. The CPI later met with the teen, who appeared clean and healthy. The teen stated he lived with his godmother. The mother reported she arranged for the children to live with relatives until she could regain stability. Two months before the teen's death, DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and environmental neglect (#82).

Child No. 11	DOB: 02/2007	DOD: 10/2023	Homicide
Age at death:	16 years		
Cause of death:	Gunshot wound of the head		
Alleged perpetrator:	Unrelated (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 in the head during an armed robbery. Law enforcement arrested three people and charged them with felonies in connection to the incident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Five months before the teen's death, DCFS received reports that law enforcement brought the teen to the hospital for mental health concerns. The teen stated she had an altercation with her mother and an 18-year-old friend, during which the mother and friend held the teen down and pulled out clumps of her hair. The teen was observed to have marks on her neck, knees, and arms, and there was a large amount of loose hair on the floor. The mother told the CPI the teen started fighting the friend, who was pregnant, and the mother was concerned the teen would harm the friend's baby. She stated the teen and friend were both ticketed and she planned to send the teen to live with an aunt. DCFS 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).

Child No. 12	DOB: 10/2017	DOD: 10/2023	Homicide
Age at death:	6 years		
Cause of death:	Multiple stab and incised wounds		
Alleged perpetrator:	Unrelated adult		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old and his mother were stabbed in their home by an unrelated person. The child was killed but the mother survived the incident. The perpetrator has been charged with first-degree murder and first-degree attempted murder. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Four months before the child's death, DCFS received a report that the child was found wandering around the neighborhood without supervision. The reporter stated the child was diagnosed with autism and was unable to communicate where he lived, but led police to his street, where they found his mother looking for him. The CPI met with the mother at home, who stated she had been supervising the child outside by the swing set, but she went inside to get a sweater for the child, and he was missing when she returned. She stated she got in her car to search for him, and police found him shortly after. The CPI documented the mother had child-proofed the doors and denied anything like that had happened before. DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 13	DOB: 06/2009	DOD: 11/2023	Homicide
Age at death:	14 years		
Cause of death:	Gunshot wound to the 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: Thirteen-year-old was found deceased in an alley. Four teens were allegedly trying to break into a vehicle, were confronted, and ran into the alley, and then witnesses heard gunshots. It is unknown if the teen was involved in the alleged burglary attempt. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Five months before the teen's death, DCFS received a report that the teen's teacher slammed him to the floor, and the teen lost consciousness. His grandmother took him to the emergency room, where a doctor noted a small hematoma on his forehead, and the teen was discharged to his grandmother's care. Both the principal and the teacher stated the day before, the teen and another student were not following the teacher's instructions, so they were moved to a different room. The teen and two other students then began throwing water at each other, and the teen slipped and hit his head on the floor. The teacher stated the teen had told him he was not hurt, and he escorted the teen to detention. The other teacher who had been present denied there was any incident. The CPI observed surveillance video from a hallway that showed two boys running out of a classroom during a water fight, the teacher followed the boys as they ran through multiple hallways, and the teacher later held the back of the teen's jacket and walked him into another classroom. School staff denied there was video surveillance inside the classrooms. The teen told the CPI that he and a friend were play fighting when the teacher slammed him to the ground. DCFS unfounded the investigation for head injuries by abuse (#2).

Child No. 14	DOB: 09/2023	DOD: 11/2023	Homicide
Age at death:	2 months		
Cause of death:	Blunt force injuries of the head and neck		
Alleged perpetrator:	Father		
Reason for review:	One unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old arrived at the emergency room by ambulance for respiratory distress. Two days later, she was pronounced deceased. A child abuse pediatrician evaluated the infant and documented multiple injuries, including head and brain injuries, liver lacerations, and both healing and non-healing injuries to multiple ribs that happened over time. The mother reported she left the child in the father's care. The father's story changed multiple times, but he later admitted to law enforcement that he became frustrated with the infant and repeatedly hit her head on multiple hard surfaces. Her father was arrested and has been charged with first degree murder. DCFS indicated the father for death by abuse (#1); head injuries by abuse (#2); bone fractures by abuse (#9); and cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). DCFS unfounded the infant's mother for the same allegations.

Reason for Review: One year before the infant's death, DCFS received a report that the infant's then 17-year-old mother and her 18-year-old brother, the infant's uncle, were left home alone for two days, and the infant's mother had also been a primary caregiver for the uncle on prior occasions. The reporter stated the uncle had an intellectual disability and special needs, and the infant's mother was responsible for changing the uncle's diaper, feeding him, bathing him, putting him to bed, and getting him to school. The CPI spoke with school staff who worked with the infant's mother and uncle, who stated it was not appropriate for the mother, who also had intellectual disabilities, to be in a caregiver role for another person. The infant's maternal grandmother told the CPI the mother was capable of caring for the uncle, but the only time they were left home alone was for a few minutes in the mornings, after her paramour left for work and before she arrived home. The mother told the CPI she enjoyed caring for the uncle, but she denied she had to do so often. DCFS unfounded the maternal grandmother for inadequate supervision (#74).

Child No. 15	DOB: 05/2008	DOD: 12/2023	Homicide
Age at death:	15 years		
Cause of death:	Asphyxiation due to strangulation		
Alleged perpetrator:	Boyfriend		
Reason for review:	Pending child protection investigation 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: Fifteen-year-old was found unresponsive on the floor of an apartment. The teen had been on run for over two weeks. Law enforcement determined that the day before her death, she messaged her sister to pick her up because her boyfriend was physically assaulting her, but the sister was unable to locate her that evening. Police arrested the teen's 24-year-old boyfriend and charged him with murder. DCFS indicated the teen's boyfriend for death by abuse (#1).

Reason for Review: Six months before the teen's death, DCFS received a report that the teen made a delayed disclosure that her adult brother physically abused her. The teen and her mother both confirmed the brother lived out of state. The CPI spoke with the brother by phone, who denied the allegations and noted he had not lived in the mother's home in years. DCFS unfounded the brother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). Four months before the teen's death, DCFS received a report regarding concerns about the teen's mental health and that the teen and her 9-year-old sister were home alone. All household members reported the teen's adult sister was always home with the children if their mother was not home. The teen denied she told anyone she wanted to harm herself. DCFS unfounded the investigation for inadequate supervision (#74) and substantial

risk of physical injury/environment injurious to health and welfare by abuse (#10). Two months before the death, DCFS received a report that the teen disclosed that her mother choked and punched her. The mother stated the teen had been trying to run away from home, and she restrained the teen on the floor to stop the teen from biting her. The teen continuously went on run and the police would bring her to the hospital. Hospital staff told the CPI the 15-year-old teen may be pregnant and had a 24-year-old boyfriend, and DCFS opened an investigation against the boyfriend. The mother reported she was looking into a residential placement for the teen. The teen was later discharged from the hospital but went on run again five days after she returned home. The mother filed a missing person report. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). The other investigation remained pending at the time of the teen's death. DCFS later unfounded the teen's boyfriend for sexual penetration (#19) because the boyfriend was an ineligible perpetrator according to DCFS procedures.

Child No. 16	**DOB: 05/2007**	**DOD: 12/2023**	**Homicide**
Age at death:	16 years		
Cause of death:	Gunshot wounds of the head and chest		
Alleged perpetrator:	Mother's paramour		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was shot and killed by her mother's paramour, along with the teen's mother and adult sister. The paramour also shot the adult sister's boyfriend, who survived. The teen's brother was with their father at the time of the incident, and he remained in his father's care. A local law enforcement officer reported that police called the paramour when they learned of the shootings, and the paramour confessed he shot four people. The paramour then died by suicide. DCFS indicated the paramour for death by abuse (#1).

Reason for Review: Two weeks before the teen's death, DCFS received a report that the teen disclosed a domestic altercation between her mother and mother's paramour while the paramour was drunk, and the teen called police. The CPI met with the teen, who confirmed the report that the paramour had been drinking, became angry at the mother, then he started yelling, throwing objects, and he shoved the teen's mother. Law enforcement responded to the home but made no arrests. She added this was the first incident where an argument had turned physical. The teen and her brother reported their parents had split custody and they primarily lived with their mother and her paramour. The mother confirmed the narrative. The investigation remained pending at the time of the teen's death. DCFS later indicated the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 17	**DOB: 11/2022**	**DOD: 12/2023**	**Homicide**
Age at death:	13 months		
Cause of death:	Multiple injuries due to child abuse		
Alleged perpetrator:	Mother		
Reason for review:	Two indicated and three unfounded child protection investigations, and two child welfare services referrals, within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Thirteen-month-old was found unresponsive. First responders arrived at the scene and observed the toddler with bruises on his lower extremities, arms, chest, face, and head. First responders reported they found the toddler's 3-year-old brother in a fetal position on the floor, and there were drugs and drug paraphernalia in the home. Police arrested the mother. The toddler was pronounced deceased, and the toddler's brother was admitted to the hospital. The brother was observed to have multiple injuries, bruises and abrasions. DCFS took protective custody of the brother and placed him with his maternal aunt. Both children tested positive for cocaine and fentanyl. DCFS indicated the mother for death by abuse (#1) to the toddler. DCFS also indicated the mother for bone fractures by abuse (#9); cuts, bruises, welts, abrasions, and oral injuries by abuse (#11); substance misuse by

abuse (#15); and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler's 3-year-old brother.

Reason for Review: Nine months before the toddler's death, DCFS received a report that the toddler's father was arrested after an argument with the toddler's mother. DCFS opened companion investigations against each parent. The mother denied any physical altercations between her and the father, but she confirmed that police arrested the father and he no longer lived in the home. The father confirmed he was arrested but stated his case was dismissed, and he denied any physical altercations. DCFS indicated the investigation against the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS unfounded the investigation against the mother for the same allegation. Eight months before the toddler's death, while the previous companion investigations remained pending, DCFS received a report that the mother left the children home alone while she went to pick up food. The parents both reported that the father was home with the children, and the police observed the father in the home at the time of the incident. DCFS unfounded the mother for inadequate supervision (#74). Eight months before the toddler's death, while the previous three investigations remained pending, DCFS received multiple reports that emergency services responded to the family home following a call about children left home alone and in deplorable conditions. Police arrested the mother because she was intoxicated and aggressive, and the children were transported to the hospital. At the hospital, the mother had a blood alcohol content of 0.123. The CPI submitted the case to the Assistant States Attorney, who referred it back to DCFS for continued investigation. An aunt agreed to care for the children. DCFS indicated the mother for inadequate supervision (#74) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded her for environmental neglect (#82). Eight months before the toddler's death, while the previous four investigations remained pending, DCFS received a report that the mother arrived for a routine doctor's appointment without a diaper bag or food for the children, the children had dirty diapers, and their car seats were not the appropriate sizes. The aunt reported she was caring for the children at that time and went to the appointment with the mother. The CPI observed a diaper bag, food, and diapers for the children. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Six months before the toddler's death, DCFS received a report that police responded to the mother's home after she reported having breathing problems, which was taken for a child welfare services referral. DCFS received another report that the father alleged the mother drove while under the influence of alcohol, with the children in the car, which was taken as a child welfare service referral. The CWS worker made multiple efforts to contact the family but was unable to locate them.

Child No. 18	**DOB: 05/2006**	**DOD: 01/2024**	**Homicide**
Age at death:	17 years		
Cause of death:	Gunshot wound of chest		
Alleged perpetrator:	Unrelated persons		
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 shot in the chest at home while he and four friends were playing with a gun. At the time of the incident, the mother was at work, and the teen was responsible for caring for his 2-year-old and 13-year-old siblings. The mother denied she had a gun in the home. The mother agreed to intact family services. DCFS unfounded the investigation for death by neglect (#51).

Reason for Review: Three months before the teen's death, DCFS received a report that his 13-year-old sister disclosed their mother hit her with objects and that she had marks. The sister told the CPI her mother hit her with a belt and grabbed her by the neck to make her get in the car when she tried to run away. The CPI observed two small linear marks on the sister's neck. The mother stated she grabbed the sister by her hair when she tried to run away, but she was unaware the sister had a mark, and the CPI noted the mother had short nails. The teen denied he saw his mother hit his sister. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 19	DOB: 03/2009	DOD: 01/2024	Homicide
Age at death:	14 years		
Cause of death:	Gunshot wound of the chest and 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: Fourteen-year-old was shot to death. A criminal investigation is pending. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Seven months before the teen's death, DCFS received a report of a domestic violence incident between the teen's parents, while the teen's 8-year-old and 9-year-old siblings were present. The mother confirmed she had an argument with the father, during which the father pushed her chair, and she hit her head on the wall. The mother reported the siblings were asleep during the incident, and the teen and his 16-year-old sister were at friends' homes. The teen and his siblings denied any physical violence between their parents. The father denied he shoved the mother or intentionally flipped the mother's chair. Later that month, the mother reported the father moved out and only came to the home when she was out. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 20	DOB: 11/2007	DOD: 01/2024	Homicide
Age at death:	16 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: Sixteen-year-old and another student were shot while leaving school. The teen was pronounced deceased at the hospital. DCFS did not investigate his death for abuse or neglect.

Reason for Review: Nine months before the teen's death, DCFS received a report that the teen had been seen carrying guns in his home, and around his siblings. The reporter added that three months earlier, the home had rodents and the teen's mother left the children home alone. The teen, his mother, and his 10-year-old, 13-year-old, and 16-year-old siblings denied there were firearms in the home and denied the teen had carried a firearm. The children stated they felt safe at home, they denied being left home alone, and there were no signs of rodents in the home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 21	DOB: 06/2003	DOD: 02/2024	Homicide
Age at death:	20 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown (street homicide)		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Twenty-year-old was found shot multiple times in an abandoned lot and pronounced deceased at the hospital. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: The youth came into care when he was 15 years old after his parents and relative caregivers reported they could not care for him due to his behavior. In the year before his death, he was on run, then subsequently lived in two unauthorized placements, both homes of relatives. His permanency goal was independence. The placement worker made regular contact with the youth at school but noted the youth continued to exhibit

behavioral issues, including fighting, substance use, gang involvement, and eloping without notifying family or the placement worker of his whereabouts. He was engaged in therapy, reported he had employment, and was on track to receive a high school diploma. One week before the youth's death, the youth attended a permanency hearing by video conference, and stated he was not interested in any services unless he was given money immediately. Later that day, the placement worker met with the youth at school and noted no concerns. The youth's placement case remained open at the time of his death.

Child No. 22	DOB: 04/2009	DOD: 02/2024	Homicide
Age at death:	14 years		
Cause of death:	Gunshot wound to right shoulder		
Alleged perpetrator:	Unknown (street homicide)		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was one of four victims in a shooting. First responders transported him to the hospital, but he was pronounced deceased enroute. Police have not taken any suspected perpetrators into custody or identified a motive. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Over a year prior to the teen's death, DCFS opened an intact family services case following an unfounded child protection investigation. The teen and his siblings lived with their maternal aunt after the death of their mother. Recommended services through the intact case included grief counseling, housing assistance, and 0-3 assessment for the teen's younger sibling. The teen and his 15-year-old sister refused to engage in counseling services, refused to follow house rules, and frequently went on run. The intact worker documented concerns the teen was engaged in drug and gang activity. The aunt filed missing person reports when the teen and his sister were gone for long periods of time. While the intact case was open, the family reported they were in probate court to determine guardianship for the children. Several family members filed petitions that were pending in probate court while the intact case was open. The intact team noted that despite the teen and his 15-year-old sister frequently running away, there were no ongoing concerns for abuse or neglect. Later that month, the intact family services case closed unsuccessfully.

Child No. 23	DOB: 04/2006	DOD: 02/2024	Homicide
Age at death:	17 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown (street homicide)		
Reason for review:	Former youth in care and unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Seventeen-year-old was shot multiple times. The teen's sister went to the doorway of her apartment complex upon hearing gunshots and found him unresponsive. He was pronounced deceased at the scene. No one has been charged in connection with the teen's death, and DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The then 16-year-old teen came into DCFS care over a year before his death after a juvenile delinquency judge ordered him into custody of DCFS after he was arrested for stealing a car. DCFS placed him with his father until a residential placement could be located, but the teen immediately went on run. The following month, the teen returned to juvenile detention, and he was then placed at a residential facility. Approximately nine months before his death, the teen ran from the facility and DCFS initiated an investigation. The reporter stated a staff member at the facility had inappropriate and possibly sexual contact with the residents, and she had previously been fired for having a sexual relationship with a client. The reporter added the staff member did not intervene when the teen and another resident stole a van and eloped from the facility. Another youth in the

facility denied concerns about the staff member. The staff member denied she had been fired from her previous job and stated she left the job because she needed a different schedule, and she denied that she allowed the teen and another youth to steal the van. One month later, law enforcement picked up the teen and the other youth on juvenile arrest warrants. The CPI interviewed the youth, who stated he stole the van to be with family after several family members died. He denied he ever observed the staff member being inappropriate with residents and denied any other concerns about staff members. DCFS unfounded the facility staff member for inadequate supervision (#74). The teen remained in juvenile detention, and the teen's placement case was closed two weeks after the child protection investigation closed because the teen was sentenced to the Department of Juvenile Justice youth center.

Child No. 24	**DOB: 08/2006**	**DOD: 03/2024**	**Homicide**
Age at death:	17 years		
Cause of death:	Gunshot wound of back		
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 shot and pronounced deceased at the hospital. Reports stated a large number of teenagers had gathered at a location. Police officers heard shots fired and found six shell casings at the scene and a firearm in the bushes. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Eleven months before the teen's death, DCFS received a report that the teen's 7-year-old brother arrived at school with a pouch of cannabis and stated the teen told him to hold the pouch. The CPI met with the brother at school, who stated he found something when he got out of the car at school and put it in his pocket. The mother denied the 7-year-old brother used marijuana and stated he found the pouch outside his school and picked it up, and denied the teen told him to hold it. The teen denied he smoked marijuana or gave his brother marijuana. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 25	**DOB: 03/2008**	**DOD: 03/2024**	**Homicide**
Age at death:	16 years		
Cause of death:	Multiple gunshot wounds		
Alleged perpetrator:	Unknown (street homicide)		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; three unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation; report to Director on June 17, 2024 See General Investigation 10		

Narrative: Sixteen-year-old was shot on a street corner and pronounced deceased at the hospital. Police investigated the death but did not make any arrests. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen and his 13-year-old sister lived with a guardian and in the year prior to the teen's death, the guardian's health declined, and the teen and his sister continued to run from the home. The guardian had a terminal illness and pursued transfer of guardianship through probate court. The teen's adult sibling obtained temporary guardianship. Probate court ordered DCFS to provide intact services to the children and their adult sibling. Recommended services included assistance to address the children's behavior issues, the children's delinquency involvement, and the teen's substance use. The teen was court ordered to participate in services, but he never engaged in inpatient substance use disorder services. During the intact family case the Department unfounded three investigations involving the adult sibling's care of the teens for allegations of inadequate supervision (#74), inadequate food (#76) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three months before the teen's death, the teen went on run and did not return home. His adult sibling reported

him missing and delinquency court issued a juvenile arrest warrant. Two weeks before his death, the teen met with the intact worker in the community. The teen refused to return to his adult sibling's care and refused to provide information on his living situation. At the time of the teen's death the Department had a pending investigation for inadequate supervision (#74) against the adult sibling. After the death the investigation was unfounded. The intact family services case remained open at the time of the teen's death.

Child No. 26	**DOB: 07/2005**	**DOD: 05/2024**	**Homicide**
Age at death:	18 years		
Cause of death:	Pulmonary thromboembolism due to deep vein thrombosis of undetermined traumatic etiology; significant contributing factor of dehydration		
Alleged perpetrator:	Unknown		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

<u>Narrative:</u> Eighteen-year-old was found unresponsive in her foster home. The youth was pronounced deceased at the hospital. She had bruising to her neck, upper shoulder, legs, and face, and petechia in her eyes. The youth's 14-year-old foster sister reported the youth's injuries were caused by their foster grandmother. The DCFS investigation of the youth's death remains pending due to an ongoing criminal investigation.

<u>Reason for Review:</u> The youth came into DCFS care five years before her death after her mother left her and three younger siblings with a relative caregiver for an extended period, but she did not make long-term arrangements. The mother's parental rights were later terminated. In the year before her death, the youth was placed in a traditional foster home where she had resided for several years. Her permanency goal was adoption and she wished to be adopted by her foster mother, but the adoption was not completed before she turned 18. The youth had multiple mental health diagnoses and was under the care of a psychiatrist for medication management. She was also in therapy and had an IEP in school. The youth refused visits with her siblings and did not engage in life skills training. The youth's placement worker made regular visits and last saw the youth two days before her death.

Child No. 27	**DOB: 03/2017**	**DOD: 06/2024**	**Homicide**
Age at death:	7 years		
Cause of death:	Gunshot wound of torso		
Alleged perpetrator:	Unrelated (street homicide)		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

<u>Narrative:</u> Seven-year-old was shot multiple times. He was pronounced deceased at the hospital. The child's mother stated she sent the child to return an item to a neighbor in their apartment complex, and he was shot while he was out. Police arrested an unrelated teen, and he has been charged as an adult with first-degree murder. DCFS did not investigate the child's death for abuse or neglect.

<u>Reason for Review:</u> Eleven months before the child's death, DCFS received a report that the home was filthy, there were drugs and guns in the home, and the mother brought strange men to the home. The mother reported she used marijuana, but never around the child, and she denied all other allegations. The CPI completed the home safety checklist and observed the home was appropriate, and the mother completed a drug test that was positive only for marijuana. The then 6-year-old child denied he had ever observed drugs or drug paraphernalia in the home, denied men came to the home, denied he saw a gun in the home, and stated only he and his mother lived in the home. DCFS unfounded the mother for environmental neglect (#82) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 28	DOB: 12/2006	DOD: 06/2024	Homicide
Age at death:	17 years		
Cause of death:	Gunshot wounds of head and neck		
Alleged perpetrator:	Unrelated (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 a yard after he had been shot multiple times. Police arrested a person of interest. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Ten months before the teen's death, DCFS received a report that the then 16-year-old teen presented at the hospital and was cleared for discharge, but there was conflicting information regarding his guardianship. The reporter stated the teen's grandmother was unable to care for him due to his disabilities, and relatives were hesitant to allow them into their homes due to his behaviors. The grandmother reported she was the teen's primary caregiver because his mother had been paralyzed in a car accident several years earlier. The teen's aunt agreed to pick him up from the hospital. Two days later, DCFS received a report that the teen could no longer stay with the aunt. The family brought the teen to the police station and left him there, and no other family members were willing to care for the teen. Another family member was identified as a possible caregiver, and the provider brought the teen to the relative's home. The following month, a relative told the CPI the teen was incarcerated after he was caught in a stolen vehicle. The CPI met with the teen at the juvenile detention center. The teen stated he received a ride from a friend and did not know the car was stolen. The judge ordered the teen to attend a military school upon his release. DCFS unfounded the teen's mother for inadequate supervision (#74).

SUICIDE

Child No. 29	DOB: 05/2010	DOD: 07/2023	Suicide
Age at death:	13 years		
Cause of death:	Hanging		
Reason for review:	Closed intact family services case, and one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Child No. 30	DOB: 01/2008	DOD: 07/2023	Suicide
Age at death:	15 years		
Cause of death:	Gunshot wound of the head		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation within year of child's death		
Action taken:	Investigatory review of records		

Child No. 31	DOB: 08/2008	DOD: 10/2023	Suicide
Age at death:	15 years		
Cause of death:	Hanging		
Reason for review:	Pending child protection investigation and open intact family services case at time of child's death; four unfounded child protection investigations within one year of child's death		
Action taken:	Full investigation pending		

Child No. 32	DOB: 02/2008	DOD: 11/2023	Suicide
Age at death:	15 years		
Cause of death:	Hanging		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 33	DOB: 03/2011	DOD: 12/2023	Suicide
Age at death:	12 years		
Cause of death:	Complications of acute rejection of cardiac transplant		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 34	DOB: 01/06/2005	DOD: 03/2024	Suicide
Age at death:	19 years		
Cause of death:	Multiple injuries due to motor vehicle striking a pedestrian		
Reason for review:	Youth in care and pending child protection investigation at time of youth's death; unfounded child protection investigation within one year of youth's death		
Action taken:	Investigatory review of records		

Child No. 35	DOB: 08/2006	DOD: 03/2024	Suicide
Age at death:	17 years		
Cause of death:	Adverse effects of hydroxyzine and tramadol		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Child No. 36	DOB: 05/2009	DOD: 04/2024	Suicide
Age at death:	14 years		
Cause of death:	Asphyxia due to hanging		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 37	DOB: 03/2007	DOD: 05/2024	Suicide
Age at death:	17 years		
Cause of death:	Asphyxiation due to hanging by neck		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Child No. 38	DOB: 05/2008	DOD: 05/2024	Suicide
Age at death:	16 years		
Cause of death:	Intraoral shotgun wound		
Reason for review:	Pending child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

UNDETERMINED

Child No. 39	DOB: 04/2023	DOD: 07/2023	Undetermined

Age at death: 2 months
Cause of death: Sudden unexpected infant death associated with unsafe sleep environment (co-sleeping)
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Two-month-old was found unresponsive by her parents, who had been co-sleeping with the infant while on vacation. The infant was pronounced deceased at the hospital. The parents each reported there was no pack-and-play at the vacation home they rented, so they co-slept with the infant. They last saw her alive around midnight when the mother fed her a bottle. DCFS unfounded the infant's parents for death by neglect (#51).

Reason for Review: Before the infant's birth, DCFS received a report that the infant's 6-year-old sister and an 8-year-old peer engaged in sexual behavior on the school bus. The Department opened an investigation for substantial risk of sexual abuse against the 6-year-old as alleged perpetrator to her sibling as the alleged child victim. The 6-year-old and her sibling denied any inappropriate touching or sexual abuse. The mother declined to allow the 6-year-old to participate in a forensic interview, and stated the family moved and would no longer be around the peer. DCFS unfounded the infant's 6-year-old sister for substantial risk of sexual abuse (#22).

Child No. 40	DOB: 10/2022	DOD: 07/2023	Undetermined

Age at death: 9 months
Cause of death: Sudden unexpected infant death
Reason for review: Open intact family services case at time of child's death; two indicated and one unfounded child protection investigations, and closed intact family services case within one year of child's death
Action taken: Investigatory review of records

Narrative: Nine-month-old was found face-down unresponsive by his mother, in a playpen with his twin brother. The infant was pronounced deceased at the hospital. Drug paraphernalia was found in the home, and the mother tested positive for cocaine. DCFS took the twin brother into protective custody. DCFS unfounded the mother for death by neglect (#51) but indicated her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) due to the mother's substance use.

Reason for Review: In the year before the infant's death, the infant's mother had an intact family services case opened after an unfounded child protection investigation on the mother for inadequate supervision (#74) to the infant's then 7-year-old sister. The family initially participated in services, but the mother later opted out of intact family services, and the case closed one month before the infant's birth. A few days before the infant's birth, DCFS received a report that the infant's mother and great grandmother engaged in a physical altercation in the presence of the infant's 8-year-old sister. Family members denied a physical altercation occurred. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). DCFS received a report that the infant and his twin brother were born premature, and their meconium tests were positive for cocaine and benzoylecgonine. They remained hospitalized in the NICU but showed no signs of withdrawal. The mother's toxicology report was negative. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and opened an intact family services case. Less than two weeks after the intact case opened, DCFS initiated another investigation after the intact worker observed the children in the home unsupervised with the mother, in violation of a safety plan, when the grandfather left to go to the pharmacy. DCFS indicated the mother for inadequate supervision (#74) but unfounded the grandfather for the same allegation. During the intact family services case, the mother completed a

substance abuse assessment and parenting classes, and her toxicology screenings were negative. While the intact case remained open, the infant died.

Child No. 41	DOB: 06/2023	DOD: 07/2023	Undetermined
Age at death:	5 weeks		
Cause of death:	Undetermined		
Reason for review:	Closed intact family services case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found unresponsive in an adult bed with his mother. He was pronounced deceased at the hospital. Following autopsy findings, DCFS unfounded the mother and father for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Approximately one year before the infant's birth, DCFS opened an intact family services case during an unfounded investigation regarding the medical needs of a 2-year-old toddler, who was in the care of the infant's mother under a short-term guardianship agreement. The intact worker assisted the mother in locating new housing and referred her for therapy. The toddler received an early intervention assessment and began weekly in-home therapies for global developmental delay. The infant's mother ensured the toddler kept medical appointments and the intact worker consistently observed safe sleep arrangements. Four months before the infant's birth, the intact family services case closed successfully.

Child No. 42	DOB: 04/2023	DOD: 07/2023	Undetermined
Age at death:	3 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Three-month-old was found unresponsive by his mother after co-sleeping. The infant was pronounced deceased at the hospital. Law enforcement reported they found drug paraphernalia in the home. The mother disclosed past heroin use, but denied recent use and stated she was prescribed an opiate agonist. The mother tested negative for substances on an oral toxicology test. Law enforcement declined to file charges in the infant's death. DCFS unfounded the mother for death by neglect (#51) but indicated her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) because she had previously been instructed not to co-sleep.

Reason for Review: Seven weeks before the infant's death, DCFS received a report that the then 6-week-old infant presented for an appointment and had lost 14 ounces since birth. The reporter also stated the infant missed an appointment two weeks earlier. The mother disclosed her prescribed medications and history of substance use, but noted she had been sober for four years. The mother tested positive only for marijuana. The CPI spoke with staff at the primary care provider's office, who reported they would continue to monitor the infant's weight and they were awaiting screening results from a specialist. The mother reported she missed calls related to the infant's genetic testing and she rescheduled the testing for the following month. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 43	DOB: 05/2023	DOD: 08/2023	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was found unresponsive by his mother, face down. He was pronounced deceased at the hospital two days later. The infant was diagnosed with diffused cerebral edema (swelling of the brain), and the infant's parents did not provide medical staff with an explanation of his condition. The infant's parents and siblings reported the parents co-slept with the infant. Medical scans and a post-mortem skeletal survey found no definitive indications of trauma. DCFS unfounded the infant's mother and father for death by abuse (#1) and head injuries by abuse (#2).

Reason for Review: The year before the infant's death, DCFS received a report that the infant's father physically abused his then-paramour's 4-year-old child. The reporter added the infant's father had a history of physical violence and a judge had previously issued a no-contact order between the 4-year-old and the infant's father. The 4-year-old's mother told the CPI she was no longer in a relationship with the infant's father and denied the infant's father abused her 4-year-old. The 14-year-old sibling confirmed the infant's father was no longer around the home. DCFS unfounded the allegations against the infant's father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and unfounded the 4-year-old's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 44	DOB: 11/2019	DOD: 09/2023	Undetermined
Age at death:	3 years		
Cause of death:	Methadone toxicity; significant contributing factor of recent cocaine exposure		
Reason for review:	Youth in care; unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-year-old was found unresponsive by her 2-year-old sibling's father when he cared for the toddler and her sibling overnight. The toddler was pronounced deceased at the hospital. The sibling's father was not supposed to babysit the toddler because he was not approved for unsupervised visits. Autopsy findings noted the toddler had methadone and cocaine in her system. DCFS indicated the sibling's father for death by abuse (#1) to the toddler and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler's sibling. DCFS also indicated the toddler's maternal grandmother/foster parent for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) because she allowed the sibling's father to have unsupervised visits.

Reason for Review: The toddler had been born substance-exposed and came into DCFS care when she was 1 year old during a child protection investigation that DCFS later indicated for neglect. She remained in care at the time of her death. In the year before her death, the toddler and her 20-month-old, 2-year-old, and 9-year-old siblings were placed with their maternal grandmother. The toddler's 6-year-old brother was placed with fictive kin. The mother was inconsistent with her services but attended supervised visits. Three months before the toddler's death, DCFS received a report that her mother gave birth and had limited prenatal care, used tobacco during the pregnancy, and had not brought the newborn for follow-up medical appointments. The mother reported she had not used substances in over a year and had an appointment scheduled for the toddler's newborn sibling. The infant was allowed to remain in the mother's care. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The toddler and her siblings remained in care at the time of the toddler's death.

Child No. 45	DOB: 02/2022	DOD: 09/2023	Undetermined
Age at death:	19 months		
Cause of death:	Undetermined		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Nineteen-month-old was found unresponsive next to his 17-year-old mother. He was pronounced deceased at the hospital. First responders noted the toddler had bruises and what appeared to be petechiae on his neck. The pathologist noted the petechiae could be consistent with CPR, and the bruise was at a soft tissue level, with no underlying injury. The mother reported the toddler fell approximately one week earlier. The mother stated she typically co-slept with the toddler. The CPI noted there was a crib in the home, and the intact worker had discussed safe sleep with the family. An autopsy found the toddler tested positive for rhinovirus/enterovirus, but there was no evidence of pulmonary infection. DCFS unfounded the mother for death by abuse (#1) and death by neglect (#51).

Reason for Review: The toddler's mother lived with her great grandmother. They had a court-ordered intact family services case, and the mother was enrolled in a teen parent services network. The great grandmother cared for the toddler while the mother worked and attended school. Three weeks before the toddler's death, DCFS received a report that the great grandmother told the mother to leave the home on multiple occasions. The reporter stated the mother's caseworker had offered shelters, but the mother declined. The great grandmother stated she was willing to care for the toddler, but she wanted the mother to leave the home as she left the home for days at a time without making a care plan for the toddler. The great grandmother agreed to allow the mother to stay while the intact worker looked for options. The intact worker worked with the mother to secure her identification cards and other necessary documents, and referred her for mental health services, public aid benefits, and daycare for the toddler. While the investigation remained pending, the toddler died. DCFS later unfounded the mother for inadequate shelter (#77).

Child No. 46	DOB: 09/2022	DOD: 11/2023	Undetermined
Age at death:	13 months		
Cause of death:	Combined drug (fentanyl and despropionyl fentanyl [4-ANPP]) toxicity		
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: Thirteen-month-old was found unresponsive on his mother's bed by his aunt. He was pronounced deceased at the hospital. At autopsy, the toddler tested positive for fentanyl. The family reported they had been visiting the maternal grandmother's home, though she was not home at the time of the toddler's death. The mother left the children in the care of their aunt for approximately two hours. When the mother returned home, the toddler was asleep in bed. The aunt later found the toddler unresponsive. The family denied drugs or drug use in the home. The mother and the aunt completed toxicology screenings, which were positive for THC but no other substances. DCFS indicated an unknown perpetrator for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the mother for the same allegations. No criminal charges have been filed.

Reason for Review: Days after the toddler's birth, DCFS received a report that police arrested the toddler's father after he was identified as a registered sex offender. The father was arrested on multiple outstanding warrants, including failure to register as a sex offender. The siblings denied the toddler's father touched them inappropriately and denied they were uncomfortable in his presence. The mother denied she knew of his status as a registered sex offender. She reported the father moved into the home one week prior and had never been left alone with the children. The father stated he was charged in another state when he was 19 years old and left that state before completing his sex offender classes. He requested intact family services, and assistance with the sex offender

registry and classes. The mother noted the then-newborn toddler had been born seven weeks premature and remained hospitalized. DCFS opened an intact family services case and indicated the toddler's father for substantial risk of sexual abuse (#22). The intact worker met with the family weekly and consistently noted the mother was cooperative and there were no concerns. The intact worker also provided a pack-and-play for the toddler. During the case, the father's case in Illinois was dismissed, but he remained incarcerated due to pending legal matters in the other state. The mother requested closure of the intact family services case. Six months before the toddler's death, the intact family services case closed.

Child No. 47	**DOB: 09/2023**	**DOD: 11/2023**	**Undetermined**
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Two pending child protection investigations 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: Two-month-old was found unresponsive by his mother, who had been co-sleeping with him and his twin sibling in a twin-size bed in the shelter where they resided. The CPI noted the mother had pack-and-plays, but they were still in the boxes. The mother stated she took the infant and his twin to the emergency room three days earlier because they had been sick, they were discharged a few hours later with instructions to provide them Tylenol. The mother added the infant and twin received immunizations two days before the death, and the infant had been fussy afterward. The mother completed a toxicology screening, which was negative for all substances. The mother agreed to a safety plan, and the children went to live with two separate cousins. The cousins caring for the children reported the mother did not provide support and DCFS took custody of the children and remained placed with relatives. The child protection investigation of the infant's death remains pending.

Reason for Review: Eleven months before the twins' birth, DCFS received a report of a domestic violence incident between the mother and the father of the infant's then 2-year-old sister and 1-year-old brother. DCFS later unfounded 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 mother had brought the infant's then 1-year-old brother to the hospital for severe diaper rash after being in the care of his father. The siblings' father refused to cooperate with the investigation. DCFS later indicated him for medical neglect (#79). Seven months before the twins' birth, DCFS received a report that the 4-year-old brother sustained an injury to his eye. The family was living with fictive kin, and the fictive kin stated the brother ran into a table in the living room. The brother had limited vocabulary, but stated he hurt his head when he fell and pointed at the table. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). Three months before the twin's birth, DCFS received a report that the infant's 4-year-old brother had a bruise on his chest caused by an adult second cousin, with whom the family had been staying. After the incident, the 4-year-old's father and his paramour were caring for the children. The CPI did not observe any marks on the brother. DCFS unfounded the mother for environmental neglect (#82) and unfounded the cousin for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The following month, DCFS received two reports that the mother abused the children, but the reporter had no specific information. While these were pending, DCFS received a report that the mother left the children with fictive kin. The mother was hospitalized for the birth of the twins, and she reported the oldest child was with a cousin, and the younger children were with their father. After the twins' birth, one was discharged home and the infant remained hospitalized. While the investigation remained pending, DCFS received a report that the infant was ready for discharge. The mother stated the older children would remain with fictive kin, and she and the younger children would stay with her cousin. While both investigations remained pending, the infant died. DCFS later unfounded the mother in the first investigation for abandonment (#75) with the rationale that the mother was hospitalized and made a care plan for the children. DCFS later indicated the mother in the second investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 48	DOB: 09/2006	DOD: 11/2023	Undetermined

Age at death:	17 years
Cause of death:	Complications of restraint
Reason for review:	Youth in care and three pending child protection investigations 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: Seventeen-year-old died while living in an out-of-state residential facility. Facility staff documented she had to be restrained and struggled against the restraint, then dropped to the floor into a seated restraint and became unresponsive. She was taken to the hospital and four days later, she was pronounced deceased. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen came into DCFS care when she was 14 years old. The court ordered her into DCFS care on a dependency petition because her family struggled with the teen's elopement, behavior, substance use, and aggression. The court ordered her to be placed in long-term residential care. Her permanency goal was "cannot be provided for in the home environment." Seven months before the teen's death, DCFS received a report that the teen had sexually inappropriate conversations with a case aide that was on a bus the teen took to school. However, case aide did not initiate sexual contact or reply to the messages. After the teen's death, DCFS unfounded the case aide for sexual exploitation (#20). Approximately five months before the teen's death, DCFS received a report about an altercation between the teen and a staff member at the facility where she resided. The CPI observed video footage of the altercation and noted the security guard punched the teen. DCFS indicated the security guard for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). DCFS received another report that during an incident with another peer, a staff member put the teen in a restraint and covered her face with a pillow, and then punched the teen. The staff member denied she hit the teen during the restraint, and there was no video footage because the incident did not occur in a public area of the facility. After the teen's death, DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Three months before the teen's death, DCFS received a report that the teen disclosed she was sexually assaulted by a residential facility staff member. The CPI documented the staff member was terminated from his position the month after the report. The teen participated in a forensic interview where she confirmed the abuse, and the CPI observed video footage of the staff member entering and exiting her room. After the teen's death, DCFS indicated the staff member for sexual penetration (#19), sexual exploitation (#20), and sexual molestation (#21). Approximately two months before her death, the teen was placed in the out-of-state facility where she remained. The teen's mother had an additional child protection investigation within the year. Eight months before the teen's death, DCFS received a report that the teen's mother gave birth, and umbilical cord testing was positive for cocaine metabolites. DCFS indicated the mother for substance misuse by neglect (#65).

Child No. 49	DOB: 12/2016	DOD: 11/2023	Undetermined

Age at death:	6 years
Cause of death:	Undetermined
Reason for review:	Two unfounded child protection investigations within one year of child's death
Action taken:	Pending systemic issue report

Narrative: Six-year-old and his father were found deceased at home. Neighbors reported they last saw the child and his father several weeks earlier, and the father's roommate had moved out of the home two months earlier. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Eight months before the child's death, DCFS received a report that the child's father used drugs and alcohol while caring for the child, who was on the autism spectrum and non-verbal, and he slammed the child down while changing his diaper. The CPI noted the child did not speak but seemed to understand simple words and was very active. The father denied the allegations and tested negative for all substances. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Six months before the child's death, DCFS received a report that the child's father sold and used drugs in the home.

The father denied the allegations. The CPI noted the child's primary care physician had no medical concerns and the family had a month's supply of the child's prescribed food. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 50	DOB: 09/2023	DOD: 11/2023	Undetermined
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Youth in care and pending child protection investigation at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Two-month-old was found unresponsive in the morning by her maternal grandmother/foster parent. The infant was pronounced deceased at the hospital. The grandmother stated she changed the infant's diaper and fed her around midnight before she put the infant down to sleep on a bouncer. The grandmother reported she had been drinking the day before and first responders noted she smelled of alcohol when they arrived at the home. Prior to the death, the infant was seen by a gastroenterologist and was diagnosed with failure to thrive and GERD (gastroesophageal reflux disease without esophagitis) and provided care instructions. DCFS indicated the grandmother for death by neglect (#51).

Reason for Review: Six months before the infant's birth, DCFS received a report that her mother was pregnant, actively using methamphetamine, and in an abusive relationship. The CPI spoke with the father of the infant's then 7-year-old sister, who reported the sister lived with him but would no longer allow the 7-year-old to visit the mother due to her drug use. The 7-year-old's father reported that the infant's 15-year-old sister also visited the mother but did not live with her. The mother confirmed the 7-year-old lived with her father and stated the 15-year-old moved between her home and her grandparents' home. The mother reported she and the infant's father separated. The mother signed a release of information form for a treatment program she was engaged in at that time. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). When the infant was born, DCFS received a report that the infant's mother tested positive for methamphetamine and cocaine within the prior two weeks. The infant's cord test later came back negative for substances. DCFS took protective custody of the infant and placed her with her maternal grandmother. The CPI spoke with the mother's probation officer who reported the mother had tested negative for substances in the prior two months. The infant's father was incarcerated at that time. The mother entered an inpatient treatment program. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While the mother was in the inpatient program, DCFS received a report that the mother left the 15-year-old sibling in the care of a 19-year-old cousin. The mother told the CPI she arranged for the maternal grandmother to care for the 15-year-old. The grandmother agreed not to allow the cousin to care for the 15-year-old for the remainder of the mother's treatment. The 15-year-old returned to her mother's home following the mother's discharge. The investigation remained pending at the time of the infant's death. DCFS later unfounded the investigation for inadequate supervision (#74). The infant remained in foster care, in her grandmother's home, at the time of her death. The placement worker documented multiple discussions about safe sleep with the grandmother.

Child No. 51	DOB: 09/2023	DOD: 12/2023	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Three unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

<u>Narrative:</u> Two-month-old was found unresponsive in her crib by her mother. The infant had been in the care of her 20-year-old uncle, who stated he last saw her alive approximately two hours earlier. The uncle denied he placed the infant to sleep on her stomach. The DCFS investigation of the infant's death remains pending.

<u>Reason for Review:</u> One month before the infant's birth, DCFS received a report that the infant's 16-year-old maternal uncle was not enrolled in school, and his mother, the infant's maternal grandmother, had threatened to shoot the uncle. The infant's mother told the CPI she was trying to get the 16-year-old uncle, who had been living with her for over a month, enrolled in school. The grandmother denied she owned a gun and denied any alcohol or substance misuse. DCFS unfounded the grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#10) and inadequate supervision (#74). One week later, DCFS received a report of concerns about the infant's 3-year-old brother because the infant's mother had untreated mental health conditions, was pregnant, and the house was messy. The mother reported she had been hospitalized as a teen but was not on any medication. The CPI observed the home to be appropriate. DCFS unfounded the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and environmental neglect (#82). While both prior investigations remained pending, DCFS received a report that the infant's mother was involved in a gang, had a gun around the infant's 3-year-old brother, drove while intoxicated, and gave the 3-year-old brother alcohol. The mother's drug test was negative for all substances. The 16-year-old uncle denied the mother had guns in the home and denied she used drugs. One week after the infant's birth, the CPI documented a discussion about safe sleep. DCFS unfounded the mother for substance misuse by abuse (#15) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 52	DOB: 03/2023	DOD: 12/2023	Undetermined
Age at death:	8 months		
Cause of death:	Undetermined		
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		

<u>Narrative:</u> Eight-month-old was found unresponsive in the early morning hours by his 17-year-old father. He was pronounced deceased at the hospital. The infant's parents reported they last saw him alive one to two hours earlier, when the father changed the infant's diaper, and then placed him back to sleep, face-down, on top of blankets on the floor. The CPI observed a pack-and-play folded in the corner of the room. At autopsy, the infant's body was observed to have broken ribs that were in the process of healing, but no signs of head trauma, or congenital health issues. The parents denied knowing how the infant sustained the rib fractures. The infant attended a well child exam less than two weeks before his death, and the doctor denied there were any concerns for abuse. DCFS indicated the infant's mother and father for death by neglect (#51) and indicated an unknown perpetrator for bone fractures by abuse (#9).

<u>Reason for Review:</u> Four months before the infant's birth, DCFS received a report that the infant's then 14-year-old mother had a history of running away to a neighboring state to be with her boyfriend. Child protection workers in the neighboring state reported that the mother was staying with a paternal aunt, who had an investigation pending for her own children. They arranged for the mother to return to Illinois and stay with the infant's great grandmother. The mother told the CPI she received prenatal care and stopped using substances when she learned she was pregnant. She and the great grandmother agreed to intact family services. DCFS unfounded the infant's maternal grandfather for inadequate supervision to the infant's mother. During the intact case, the infant's mother reported she received care coordination services through the clinic where she received prenatal care. The great

grandmother accepted the intact worker's assistance to obtain legal guardianship of the mother. During the case, the mother reported a history of running away from home, drinking alcohol, and using THC. While the intact case remained open, DCFS received a report that upon the infant's birth, hospital staff were concerned with the mother's mental health and family support. The mother received regular prenatal care for the prior three months, and hospital staff reported the mother tested negative for substances at a recent appointment and upon admission to the hospital. The mother denied any current mental health concerns and stated she moved in with her mother, the infant's grandmother. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). After the investigation closed, the family refused to allow the intact worker into the home and refused to cooperate with services. Approximately two weeks later, DCFS took protective custody of an 11-year-old cousin and placed her with the infant's grandmother. The placement worker informed the intact worker of the 11-year-old's placement in the home and documented no concerns in the household. The following month, DCFS received a report that the infant's grandmother watched the infant so the 15-year-old mother and 16-year-old father could smoke marijuana in the family's backyard. The mother denied she smoked in the presence of the infant or the grandparents. DCFS unfounded the infant's grandmother and her paramour for substance misuse by abuse (#15). The family met with the intact worker a few additional times, but continued to decline intact family services, and the court declined to take the case for court-ordered intact services. The intact family services case closed unsuccessfully. The 11-year-old cousin remained placed in the home, and the placement worker continued to document no concerns regarding the parents and the infant.

Child No. 53	DOB: 08/2023	DOD: 12/2023	Undetermined
Age at death:	3 months		
Cause of death:	Sudden unexpected infant death		
Reason for review:	Pending child protection investigation at time of child's death; one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive buckled into a car seat, by his parents. The infant was pronounced deceased at the scene. The parents reported the infant had been buckled into his car seat since the prior evening because he cried in his playpen and crib, but they removed him for diaper changes, play, and cuddling. The infant had been fed with a propped bottle while in the car seat. The infant's autopsy documented no evidence of injury, but the toxicology report was positive for nicotine and cannabinoids. DCFS indicated the infant's parents for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Seven months before the infant's birth, DCFS received a report that the infant's parents did not have employment, drank heavily, there were garbage and beer cans lying all over the home, and the infant's then 8-month-old and 2-year-old siblings were confined to their highchairs. The home appeared clean but with some clutter. The parents denied the allegations. DCFS unfounded the parents for environmental neglect (#82). Approximately two months before the infant's death, DCFS received a report that there was trash and beer cans throughout the home; the mother drank while breastfeeding the then 7-week-old infant and the marijuana she used was in reach of the children. The mother denied all allegations. The investigation remained pending at the time of the infant's death. DCFS later unfounded the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82).

Child No. 54	DOB: 08/2023	DOD: 12/2023	Undetermined

Age at death:	3 months
Cause of death:	Undetermined causes
Reason for review:	Indicated child protection investigation within year of child's death
Action taken:	Investigatory review of records

Narrative: Three-month-old was found unresponsive in the morning by her mother. The infant was pronounced deceased at the hospital. The mother stated she had last seen the infant alive late the previous night, and she had been co-sleeping with the infant, the infant's 14-month-old brother, and an adult friend. The CPI observed a crib in the home that had clothing in it. The infant's maternal great-grandmother stated she cared for the infant and her brother while the mother and her friend went out earlier that evening. 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: Two days after the infant's birth, DCFS received a report that the infant's mother tested positive for cocaine and THC upon intake at the hospital, but the infant tested negative for substances at delivery and did not show signs of withdrawal. The mother stated she had used THC but denied she used cocaine. She told hospital staff and the CPI she lived with the infant's maternal grandmother and paramour, who both used cocaine. Upon discharge from the hospital, the mother, infant, and infant's brother went to live with the infant's maternal great-grandmother. The mother agreed to attend inpatient substance use disorder treatment. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 55	DOB: 08/2023	DOD: 01/2024	Undetermined

Age at death:	4 months
Cause of death:	Sudden unexpected infant death; significant contributing factor of bouncer chair sleeping
Reason for review:	Split custody and 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: Four-month-old was found unresponsive by his mother after he had been sleeping in a bouncer chair. The mother stated the infant's 20-month-old sister went to her father's home after the infant's death, but the father did not cooperate with the investigation or allow the CPI to see the sister. The father later faxed the CPI a letter in which the mother had signed over guardianship of the sister. The mother did not cooperate with the investigation or allow the CPI to see the home. 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 infant's 6-year-old sister came into DCFS care when she was 2 years old. Upon the birth of the 20-month-old sister, the court denied DCFS temporary custody, and the sister remained in the mother's care. The mother did not cooperate with services and did not allow the placement team to monitor the child who remained in her care. Five months before the infant's birth, the older sister's permanency goal changed to substitute care, pending termination of parental rights. One month before the infant's birth, DCFS received a report that the infant's mother tried to convince her 8-year-old sister to fight a peer, and the infant's maternal grandmother then grabbed the 8-year-old by the neck and threw her to the ground. The reporter added concerns about drug use in the home and stated the mother was pregnant. The CPI observed the infant's 8-year-old aunt had bruises and scratches, which she reported were from playing outside and from kittens in the home. DCFS unfounded the maternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While that investigation remained pending, DCFS received a report that the infant was born and was transferred to another hospital for medical issues and the mother tested positive for THC. The infant was discharged to the mother's care, and the CPI observed the infant and his then 16-month-old sister and assessed them safe. DCFS unfounded the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). One month before the infant's death, DCFS received a report that when the mother attended court for termination of parental rights on the 6-year-old's placement case, both she and the

maternal grandmother were arrested on outstanding warrants for possession and delivery of a controlled substance. The mother stated the children were out of state with relatives, but she could not leave Illinois due to the pending felony charges. The mother denied the allegations regarding drug possession and sale. Four days later, while the investigation remained pending, the infant died. DCFS later indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 56	**DOB: 07/2023**	**DOD: 02/2024**	**Undetermined**
Age at death:	6 months		
Cause of death:	Undetermined		
Reason for review:	Open intact family services case at time of child's death; one indicated child protection investigation and two child welfare services referrals within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-month-old was found unresponsive, on her back, in an adult bed, by her mother. The infant was pronounced deceased at the hospital. The mother stayed at a friend's home the prior night and the infant slept on one side of a king-sized bed, and the mother's friend slept on the other end of the bed. The mother stated she placed the infant on her back, without pillows, blankets, or stuffed animals. The mother stated the infant awoke in the middle of the night but refused a bottle, so she again placed the infant in the bed, on her back. She stated she had been told about safe sleep, but she co-slept with the infant at the friend's home because she did not have a pack-and-play. DCFS unfounded the mother for death by neglect (#51).

Reason for Review: Six months before the infant's birth, DCFS received a report that the infant's then 6-year-old brother stated he did not have food at home. DCFS opened a child welfare services referral. The caseworker met with the mother at home and offered services, but the mother declined services and DCFS closed the referral. Three months before the infant's birth, DCFS opened another child welfare services referral following a report that the infant's then 6-year-old brother had missed 30% of school days that year, was falling behind in academics, and his behavior had escalated. The mother again declined services and DCFS closed the referral. Five months before the infant's death, DCFS opened a child protection investigation after a report that the mother left the then 5-week-old infant and her 2-year-old, 4-year-old, and 7-year-old siblings alone in a car, in the summer. The reporter noted the car was on and the air conditioner was running. The police arrived when the infant began to cry. The mother stated she had a bloodwork appointment, so she signed in, waited in the car with the children until it was her turn, and she was gone from the car for fewer than five minutes. She agreed to intact family services. DCFS indicated the mother for inadequate supervision (#74). The family received Norman funds for a security deposit on a home and to pay an existing water bill, the mother followed up with medical appointments for the children, and she obtained employment. In the month before the infant's death, the mother was engaged in parenting classes and visits were reduced to twice per month. The intact worker documented multiple discussions of safe sleep. The intact family services case remained open at the time of the infant's death.

Child No. 57	**DOB: 09/2006**	**DOD: 02/2024**	**Undetermined**
Age at death:	17 years		
Cause of death:	Gunshot wound of chest		
Reason for review:	Pending child protection investigation at time of child's death; closed intact family services case, one indicated child protection investigation, and one unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was at her boyfriend's home with friends when she was shot in the chest. The teen's boyfriend reported he was in another room when he heard a loud noise. A friend reported he was in the room with the teen where she was making a video, he heard a gunshot and then saw the teen fall. Police questioned the boyfriend and friend but the circumstances surrounding the teen's death were unclear. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: One year before the teen's death, DCFS had an open intact family services case after the teen's mother's paramour was indicated for sexual abuse to the teen, and the mother continued to allow the paramour to come to the home. The family was not compliant with services. The then 16-year-old teen was pregnant, receiving prenatal care and living with a relative, but the mother would not provide contact information for the relative. Eight months before the teen's death, the intact family services case closed unsuccessfully. Four months before the teen's death, DCFS received a report that the mother's paramour, who had been indicated for sexual abuse of the teen, lived in the mother's home with the teen and her 7-week-old son. The teen stated she moved in with her son's paternal grandparents, and she did not plan to return to her mother's home. The CPI noted the teen's son appeared clean and healthy. DCFS indicated the teen's mother and her paramour for substantial risk of sexual abuse (#22) to the teen and her son. Three weeks before the teen's death, DCFS received a report that the teen's teenage boyfriend was arrested, and it had been reported that the teen's mother had guardianship. The CPI found the boyfriend had been staying in the home with the teen's mother and her paramour. The family denied the teen's mother had guardianship of the boyfriend, but he had been staying in the home since his arrest because his mother refused to pick him up. DCFS unfounded the teen and her mother for substantial risk of sexual abuse (#22) to the boyfriend. The day after the previous investigation opened, DCFS received a report that police arrested the teen's mother after she hit the teen with a closed fist. The teen refused emergency medical care and left the home to stay with her grandfather. The mother reported the teen became aggressive after a disagreement about the teen's boyfriend. Two days before the teen's death, the mother reported she did not know the teen and her infant son's whereabouts. The investigation remained pending at the time of the teen's death. The teen's mother stated the teen's son was in her care at the time of the incident. Following the teen's death, DCFS indicated the teen's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 58	DOB: 02/2024	DOD: 03/2024	Undetermined
Age at death:	Six weeks		
Cause of death:	Undetermined		
Reason for review:	Two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-week-old was found unresponsive by his mother. He was pronounced deceased at the hospital. The infant's parents reported they slept on the couch with the infant because their room was being painted. The family reported that the night before, the parents went to the bar, and left the infant in the care of her 15-year-old aunt. Both parents reported they drank while at the bar and returned home around 2:00am. The father stated the infant had a crib, and that was the first time he had slept on the couch. The aunt reported she fed the infant shortly before the parents returned home and then gave him to his father. The mother tested positive for THC and the father negative for all substances. DCFS indicated the infant's parents for death by neglect (#51).

Reason for Review: The infant's parents lived with the infant's maternal grandparents. Approximately six months before the infant's birth, DCFS received a report that the infant's then 14-year-old maternal aunt disclosed a man who was living in the home sexually abused her. The grandmother told the CPI the man was a friend of the infant's mother. During a forensic interview, the aunt stated she awoke to the man sexually assaulting her. The family had cameras in the home and provided the footage to police. Police arrested the man and charged him with three counts of criminal sexual assault. DCFS indicated the man for sexual penetration (#19), sexual molestation (#21), and substantial risk of sexual abuse (#22). Two months before the infant's birth, DCFS received a report that police responded to a domestic battery call and arrested the infant's grandfather after they learned that the grandfather shoved the infant's 15-year-old aunt to the ground. The grandfather stated that after the aunt became upset and broke a window, he bearhugged the aunt to stop her from breaking more and they both fell into a shoe rack on the floor. The family reported the aunt had not been getting along with the father recently. The aunt said her father attacked her. DCFS indicated the infant's grandfather for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60).

Child No. 59	DOB: 01/2024	DOD: 03/2024	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Split custody 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-month-old was found unresponsive by her mother. The infant was pronounced deceased at the hospital. The mother stated she last saw the infant alive around 4:00am or 5:00am, when she fed her a bottle, burped her, and placed her down to sleep on a pillow, in a shared bed. The mother disclosed she had been drinking. DCFS took protective custody of the infant's 3-year-old sister and placed her in a relative foster home. The placement worker for the mother's older children and CPIs who previously investigated the family had discussed safe sleep practices with the mother. DCFS indicated the mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), but unfounded her for environmental neglect (#82).

Reason for Review: Four years before the infant's birth, the two older siblings came into DCFS care because of dependency and were placed in a traditional foster home. The 3-year-old sibling, who was born after the placement case opened, remained in the mother's care at the time of her birth. In the year before the infant's death, the mother was not in regular contact with the placement worker, missed scheduled visits, and lived in a shelter. The permanency goal for the siblings in care was changed to substitute care pending termination of parental rights. Eight months before the infant's birth, DCFS received a report that the mother, who had the infant's then 2-year-old sister in her care, had stopped participating in services. The mother had been on probation but had not been in contact with her probation officer in several months, and police had an active warrant out for her. The mother was unable to be located and DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The infant's older siblings remained in the traditional foster home, and both were enrolled in early Head Start and received early intervention services and play therapy. Two weeks before the infant's birth, the mother contacted the placement worker and disclosed she was pregnant, due soon, and resided in a shelter. DCFS received a report that the mother gave birth to the infant. The CPI met with the family at the hotel, provided through a shelter program, that the mother had moved into. The mother said she participated in alcohol use disorder classes for her probation. The CPI observed the infant sleeping in a bassinet, and the mother stated she sometimes placed the 3-year-old on an adult bed for naps. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The placement case for the infant's older siblings remained open.

Child No. 60	DOB: 02/2024	DOD: 04/2024	Undetermined
Age at death:	5 weeks		
Cause of death:	Unexplained sudden death (extrinsic factor identified)		
Reason for review:	Closed intact family services case and unfounded child protection investigation within one year of infant's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found unresponsive by his mother. The infant was pronounced deceased at the hospital. The mother had been co-sleeping with the infant and his 2-year-old brother in a twin bed. She reported she last saw him alive around 9:00pm the night before, when she fed him, and she found him unresponsive around 6:00am. The mother completed an oral toxicology screening, which was negative for all substances. 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: Over a year before the infant's birth, an intact family services case opened following an indicated investigation for environmental concerns in the home. Recommended services included early intervention assessment for the infant's then 1-year-old and 2-year-old maternal half-siblings, and housing advocacy services for

the mother. Eight months before the infant's birth, and during the open intact family services case, DCFS received a report that the infant's mother became involved with a man who was abusive and used methamphetamine. The reporter added concerns about the home environment. The CPI spoke with the intact worker, who reported no concerns. The CPI documented the home though cluttered, was free of environmental hazards, but did not have electricity. The mother reported the intact worker was working on helping the family pay the electric bill, and the mother planned for the children to stay with their father until they had power again. The man named in the report stated he was in a relationship with the mother; upon the infant's birth, the man was named as the infant's father. The infant's mother and father both completed oral toxicology screenings. The father was positive only for marijuana. DCFS unfounded the mother for environmental neglect (#82). The mother completed parenting classes and applied for subsidized housing, the infant's 3-year-old brother was enrolled in school, and the intact worker documented the home was consistently acceptable. Seven months before his death, the intact family services case closed.

Child No. 61	**DOB: 03/2009**	**DOD: 05/2024**	**Undetermined**
Age at death:	15 years		
Cause of death:	Undetermined		
Reason for review:	Youth in care and pending child protection investigation at time of child's death; closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

<u>Narrative:</u> Fifteen-year-old was found deceased, with drugs on her body. She went on run five days earlier, and a missing person report was filed. DCFS did not investigate the teen's death for abuse or neglect.

<u>Reason for Review:</u> One year before the teen's death, DCFS opened an intact family services case for the family following an unfounded investigation. During the intact family services case, the teen went on run. The adoptive mother filed a missing person report. In the following months, the teen communicated with her adoptive family but refused to provide her location. Six months after the teen went on run, she went to her birth mother's home. The adoptive mother, birth mother, and intact supervisor met at the birth mother's home. The teen stated she wished to remain in her birth mother's home, and the home was assessed safe. Five months before the teen's death, while the intact family services case remained open, DCFS received a report that the teen's birth mother and stepfather allowed the teen to use drugs and drink alcohol, the birth mother gave her children melatonin to sleep because she could not handle them, the teen and stepfather had a sexual relationship, the home was unsanitary, and the teen did not attend school. The CPI met with the family at home and noted the teen and her siblings appeared free of overt signs of abuse or neglect. Three weeks after the investigation opened, the CPI was informed the family moved out of state. The CPI contacted that state's child protective services and requested a wellbeing check from police. Police reported no concerns for the children's wellbeing and stated the children attended school. DCFS unfounded the teen's stepfather for sexual penetration (#19) and substantial risk of sexual abuse (#22), and unfounded the teen's birth mother and stepfather for substance misuse by abuse (#15) and environmental neglect (#82).Three months before the teen's death, the intact family services case closed unsuccessfully after the adoptive mother requested the case be closed. Less than three weeks before the teen's death, DCFS received a report that the teen presented at the hospital due to a heroin overdose. The CPI met with the teen at the hospital, who stated she and her birth mother lived out of state but were in Illinois for a visit and admitted to using heroin with her boyfriend. The birth mother stated the teen was not welcome to return to her home because she was a bad influence on her siblings. The teen's adoptive mother reported she had not seen the teen in almost a year, and she declined to allow the teen to return to her home. DCFS took protective custody. The teen was initially placed in a shelter, and shortly after the teen went on run. The child protection investigation remained pending at the time of the teen's death. DCFS later indicated the teen's adoptive mother for inadequate supervision (#74).

Child No. 62	DOB: 10/2023	DOD: 06/2024	Undetermined
Age at death:	7 months		
Cause of death:	Sudden Unexpected Infant Death		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-month-old was found unresponsive in a child swing by her mother. She was pronounced deceased at the hospital. The mother stated she had placed the infant in the swing and left the home to visit friends for 10 to 15 minutes, but neighbors reported the mother was gone for an hour. The DCFS investigation of the infant's death remains pending.

Reason for Review: Four months before the infant's death, DCFS received a report that the infant's father sold drugs out of the family home and both parents used drugs until they passed out in the presence of the children. The reporter added the home was cluttered and they had very little food. The mother denied the allegations. She denied the infant's father lived with her though she relied on him to assist with the children. The mother stated the infant's 8-year-old and 11-year-old siblings lived with their grandmother. She denied she used or sold drugs and completed an oral toxicology screening that was negative for all substances. The CPI observed food in the home, observed a safe sleeping arrangement for the infant, discussed safe sleep with the mother. The mother declined needing services. The 8-year-old and 11-year-old siblings stated they lived with their grandmother but visited the mother's home on the weekends, and there was always food in the home. They denied the parents used drugs and denied the father lived in the mother's home. The grandmother confirmed she was the guardian of the older children and denied any knowledge of the mother using or selling drugs. DCFS unfounded the infant's mother and father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and inadequate supervision (#74).

Child No. 63	DOB: 12/2023	DOD: 06/2024	Undetermined
Age at death:	5 months		
Cause of death:	Undetermined		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-month-old was found unresponsive by her mother. The infant was pronounced deceased at the hospital. The DCFS investigation of the infant's death remains pending.

Reason for Review: Three weeks after the infant's birth, DCFS received a report that the mother brought the infant to the emergency room after she put the infant in bed with her and dozed off. She woke when she heard a cry and saw the infant had fallen on the floor. The CPI visited the home in person and again observed safe sleep arrangements. DCFS unfounded the mother for inadequate supervision (#74).

PENDING

Child No. 64	DOB: 06/2022	DOD: 08/2023	Pending
Age at death:	13 months		
Cause of death:	Pending autopsy		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Thirteen-month-old, medically complex toddler died at the hospital one week after she had been admitted for scheduled surgery. The toddler had multiple medical diagnoses including congenital heart disease, DiGeorge syndrome (a chromosomal disorder), and heart disease. While in the hospital, the toddler had a negative reaction to anesthesia, and she went into cardiac arrest. Her parents later opted to withdraw treatment, and she was pronounced deceased. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: Eight months before the toddler's death, DCFS received a report that the toddler's mother did not meet her medical needs, and the home was unsanitary. The mother stated the children lived with their grandmother and she declined intact family services. The grandmother confirmed she cared for the children full-time, but they had not completed a formal guardianship arrangement. The grandmother's home was appropriate. The following month, the mother wanted the children returned to her home, but the CPI observed the home was unsafe and unsanitary. Before the investigation closed, the grandmother agreed not to allow the children to return to their mother's home until it was deemed safe and had working utilities. DCFS indicated the mother and father for environmental neglect (#82).

Child No. 65	DOB: 07/2023	DOD: 08/2023	Pending
Age at death:	5 weeks		
Cause of death:	Pending autopsy		
Reason for review:	Two unfounded child protection investigations and one child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old died at a hospital due to medical complications. Medical staff reported the infant exhibited no initial concerns at birth, but she remained hospitalized because the family reported that two years earlier, the infant's older sibling died of an inherited medical disorder at 6 weeks old. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Five months before the infant's birth, DCFS received a report that police had been to the family home several times for reports regarding the mental health of the mother's 17-year-old sibling, and the infant's 22-year-old mother did not want the sibling to return to the home. The report was taken as a child welfare services referral. The CWS met with the infant's parents and maternal grandmother, who reported the mother's sibling was hospitalized, and a worker was helping the family locate a group home for the sibling. The CWS noted environmental concerns in the home and informed the family she would need to make a call to the DCFS hotline, which resulted in two companion child protection investigations because two households resided in the home. The CWS referral closed due to the pending investigations. The grandmother reported the home was in disarray because the infant's parents and their three children moved into the home suddenly. She noted garbage bags in the home contained items to take to a consignment shop, not trash. The CPI learned the mother's sibling would stay in the hospital until they could locate an appropriate residential facility. Before closing the investigation, the CPI completed another home visit and noted the home was messy but appeared free of hazards. DCFS closed both investigations and unfounded both the infant's father and maternal grandmother for environmental neglect (#82).

Child No. 66	DOB: 10/2023	DOD: 10/2023	Pending
Age at death:	11 days		
Cause of death:	Pending autopsy		
Reason for review:	Closed child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eleven-day-old was born premature, at 24 weeks gestation, and remained in the hospital until his death. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: Seven months before the newborn's birth, DCFS received a report that the newborn's father expressed mental health concerns during an argument with the mother, while the newborn's 4-year-old brother was present. DCFS took the report for a child welfare services referral. The father stated he received counseling and began taking medication to assist with his alcohol use disorder. Both parents denied the argument turned physical and they denied there were weapons in the home. DCFS closed the child welfare services referral with no action needed.

Child No. 67	DOB: 02/2024	DOD: 03/2024	Pending
Age at death:	4 weeks		
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: Four-week-old died in the hospital, where she had been hospitalized since birth due to complex congenital heart disease. DCFS did not investigate her death for abuse or neglect.

Reason for Review: One year before the infant's death, DCFS received a report that the infant's father had previously been accused of sexual abuse to a minor, and the infant's 4-year-old maternal half-sister stated the infant's father got into bed with the mother and sister. Local police told the CPI their most recent contact with the father was in 2010, when he received one year of probation for distribution of harmful materials. Additional charges of exploitation of a minor and contributing to the delinquency of a minor were dismissed. The sister denied she slept in the same bed as the infant's father and denied she was afraid of anyone at home. The mother and father also denied the allegations. DCFS unfounded the investigation for substantial risk of sexual abuse (#22).

Child No. 68	DOB: 04/2024	DOD: 04/2024	Pending
Age at death:	0 days		
Cause of death:	Pending autopsy		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Newborn, who had been born premature, died at the hospital the day he was born. His twin sister survived and was treated in the NICU. The mother had been hospitalized on bedrest for three weeks prior to the birth due to complications with the pregnancy. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: Sixteen months before the newborn's birth, an intact family services case opened for the family. In the year prior to his birth, the newborn's mother obtained employment, engaged in outpatient substance use disorder counseling, and the intact worker noted the newborn's siblings were doing well. The family moved into a new home, the children began to attend a new school, and the newborn's infant sibling had surgery to remove a kidney due to low function. Three weeks before the newborn's birth, the mother contacted the intact worker to report she was in the hospital after one of the twin's sacs ruptured, and she remained in the hospital on bedrest. The intact family services case remained open when the newborn was born and died.

Child No. 69	DOB: 02/2024	DOD: 05/2024	Pending
Age at death:	3 months		
Cause of death:	Pending autopsy		
Reason for review:	Child of a youth in care and 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 in his crib in his father's home. The infant was pronounced deceased at the hospital. The mother reported playing with the infant earlier that morning. She later placed the infant in his crib, on his back, and she slept as well. Approximately one to two hours later, the father woke her after he found the infant was not breathing. DCFS unfounded the infant's mother for death by neglect (#51).

Reason for Review: The infant's mother came into DCFS care when she was 16 years old related to an investigation in which her father was indicated for inadequate supervision. In the year before the infant's death, the mother's permanency goal was independence. The placement worker noted the mother was not always compliant with services, went on run several times, and had criminal involvement. Eight months before the infant's birth, while the mother was in an unauthorized placement with the infant's father, DCFS received a report that law enforcement responded to a domestic violence incident during which the infant's then 21-year-old father hit the infant's then 18-year-old mother, and the mother presented with bruises from prior domestic violence incidents. Law enforcement arrested the infant's father. The CPI spoke with the placement worker, who arranged a fictive kin foster care placement. DCFS unfounded the investigation against the infant's father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#10) because the father was an ineligible perpetrator. During the child protection investigation, the mother learned she was pregnant with the infant. The placement worker documented the mother was compliant with prenatal care. Following the infant's birth, the placement worker discussed safe sleep with the mother. One month before the infant's death, DCFS received a report that the infant's mother continued to spend time with the infant's father, including staying with him overnight, against the instructions of her foster parent, placement worker, and GAL. The reporter stated there had been a domestic violence incident a few weeks prior, during which the mother was holding the infant, but no one was injured, and police arrested the father. The reporter also expressed concern that the infant was ill and the mother did not take him to the doctor. The foster parent stated the father was not welcome in her home due to the domestic violence history. The mother and foster parent denied the infant was sick and stated the infant was up to date with his medical providers and the infant. The CPI observed the infant appeared appropriate and there were safe sleep arrangements in the home. While the investigation remained pending, DCFS received two related information reports on subsequent days that the mother left her placement and her whereabouts were unknown. While the investigation remained pending, the infant was found unresponsive at the father's home. DCFS later unfounded the mother for medical neglect (#79) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 70	DOB: 03/2024	DOD: 06/2024	Pending
Age at death:	2 months		
Cause of death:	Pending autopsy		
Reason for review:	Closed child welfare services referral and unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-month-old was in the care of her maternal great aunt when first responders were dispatched to the home for a "child not feeling well." The infant was pronounced deceased at the hospital. The great aunt stated she agreed to care for the infant for a few days. She reported the infant was having trouble breathing since she first arrived at the great aunt's home, and family encouraged the 14-year-old mother to take the infant to the doctor, but the mother refused. The DCFS investigation of the infant's death remains pending.

Reason for Review: Nine months before the infant's birth, DCFS received a report that the infant's 16-year-old maternal cousin disclosed his mother, the infant's maternal great aunt who was caring for the infant at the time

of death, left him alone at home while she went on vacation when he was 13 years old, the cousin had sex with a 32-year-old woman at that time, and his mother condoned the relationship. The CPI spoke with the cousin at the detention center where he was incarcerated. He stated his mother kicked the woman out of her home when she learned of the sexual nature of their relationship. The cousin declined a forensic interview and declined to provide the woman's full name. The cousin stated he lived with his mother and her paramour and felt safe at home. The CPI was unable to locate the cousin's mother. DCFS unfounded the cousin's mother for sexual penetration (#19) and inadequate supervision (#74). Three months before the infant's birth, DCFS received a report that law enforcement responded to the family home after the infant's 14-year-old mother threatened to kill her mother and 18-month-old sister. The infant's mother was charged with assault. The family told the reporter the mother's behavior had been ongoing for two years and the grandmother wanted to relinquish custody of the infant's mother, who was pregnant. The report was taken as a child welfare services referral. The maternal grandmother stated the mother stayed out past curfew and did not follow house rules, but she hoped the behavior would improve after the infant's birth, and she did not want to give up on the mother. The CWS worker documented no additional referrals or services were needed at that time, and the child welfare services referral case was closed.

Child No. 71	**DOB: 04/2021**	**DOD: 06/2024**	**Pending**
Age at death:	3 years		
Cause of death:	Pending autopsy		
Reason for review:	Two pending child protection investigations at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Three-year-old was found unresponsive by his aunt around 10:00am. First responders arrived and pronounced him deceased at the scene. The aunt reported she last saw him alive around 6:00am. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: Three months before the toddler's death, DCFS received a report that the toddler was hospitalized related to his sickle cell disease and there were concerns about the mother's mental health. The reporter stated the mother had a mental health diagnosis but did not take any medications. The mother confirmed she had a mental health diagnosis but did not take her prescribed medication because it made her drowsy. The mother completed a mental health intake assessment and the mother's home was assessed safe. Before the investigation closed, the mother began psychiatric treatment. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While that investigation remained pending, DCFS received a report of a domestic violence incident between the toddler's mother and father, while the toddler's 6-year-old paternal half-sister was present. DCFS opened separate investigations against the toddler's mother and father. Both parents denied they were in a current relationship and denied they fought in the children's presence. The father stated he only saw the mother in public places and the mother had an order of protection against him. The half-sister stated she recently observed the toddler's mother slap the father, and the father then punched the mother. DCFS unfounded the investigation against the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The investigation against the father remained pending until after the toddler's death. DCFS received a related information report that the half-sister stated her father hit her with a belt. The CPI observed a healed loop mark on her leg. DCFS was later granted temporary custody of the paternal half-sister and placed her with the paternal grandmother. The toddler's mother also agreed not to allow the father to have unsupervised contact with the toddler. Following the toddler's death, DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). Two days before the toddler's death, DCFS received reports that when the toddler presented at the hospital for surgery, the mother appeared intoxicated, fell, was bleeding and was treated at the emergency room. Later that day, the CPI went to the hospital and met with the mother, who did not appear intoxicated, but the mother stated she did not know how her injuries occurred. The mother reported she last took her medication the day before and she denied misusing any substances. The CPI placed the toddler with a maternal aunt under a safety plan. While the investigation remained pending, the toddler died. The DCFS investigation against the mother remains pending for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

ACCIDENT

Child No. 72	DOB: 12/2022	DOD: 07/2023	Accident
Age at death:	6 months		
Cause of death:	Drowning in a bathtub at home		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-month-old was found unresponsive in a bathtub and died one week later. At the time of the incident, the paternal grandmother was babysitting the infant and her 3-year-old sister. The paternal grandmother placed the infant in a bath chair, that did not have a buckle, in the bathtub along with her sister, then ran the water. She left the bathroom and when she returned, she saw the infant unresponsive and floating. The mother and the children lived with the paternal grandmother who cared for the children while the mother worked. DCFS indicated the paternal grandmother for death by neglect (#51) and inadequate supervision (#74).

Reason for Review: Four months before the infant's birth, DCFS received a report that the infant's paternal grandmother grabbed the infant's then 2-year-old sister by the shirt collar and choked her, and the paternal grandmother assaulted the infant's mother. The mother stated the incident happened over a week earlier, after she left the sister with the paternal grandmother to retrieve items from another relative's home. She stated while she was gone, the sister opened a baby gate that was on the deck and got out of the home. When the mother returned, an altercation ensued. The mother stated she left with the sister, and she did not plan to return to the paternal grandmother's home. DCFS unfounded the paternal grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 73	DOB: 09/2021	DOD: 07/2023	Accident
Age at death:	21 months		
Cause of death:	Asphyxiation due to compression and entrapment within dresser		
Reason for review:	One indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Twenty-one-month-old was found underneath a toppled dresser after attempting to climb on it. She was pronounced deceased at the hospital. The toddler's sister participated in a forensic interview and reported that a dresser fell on the toddler and their father helped them. DCFS unfounded the toddler's mother and father for death by neglect (#51).

Reason for Review: Four months before the toddler's death, DCFS received a report that the mother hit the toddler's 6-year-old sister leaving marks on her hands and legs. The sister stated the mother hit her with a shoe, because she told school staff that she did not want to go home with the mother's paramour. The CPI observed crisscross-like scratches and bruising on the sister's hand and a large mark on her thigh that resembled the bottom of a shoe. The mother admitted she spanked the sister on two separate occasions, including with a shoe, but did not intend to hurt her. DCFS indicated the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 74	DOB: 04/2005	DOD: 07/2023	Accident
Age at death:	18 years		
Cause of death:	Acute fentanyl toxicity due to fentanyl abuse		
Reason for review:	Youth in care; indicated child protection investigation within one year of youth's death		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was found unresponsive in the foster home of his maternal grandmother who called 911. Law enforcement found pills in the youth's bag that tested positive for fentanyl. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: Five months before the youth's death, DCFS received a report that the mother's home had animal feces throughout the house. The brother stated he lived with his grandparents due to the condition of the home. He added that his mother had mental health issues and misused her medication. The maternal grandmother stated the mother had a history of mental health concerns, the youth had not attended school in over four years and the sister had not attended school at all that year. DCFS took protective custody of the children placed them with the grandmother. DCFS indicated the youth's parents for environmental neglect (#82). During the placement case, the children reported their mother gave them drugs and alcohol, they had witnessed domestic violence, and did not attend school regularly. The children were recommended to participate in therapy, and the youth was also recommended independent housing support and medical evaluation. It was recommended the mother participate in a home safety assessment, connect with homemaker services, participate in therapy, and complete a substance use disorder assessment. The placement case remained open at the time of the youth's death.

Child No. 75	DOB: 06/2023	DOD: 08/2023	Accident
Age at death:	7 weeks		
Cause of death:	Asphyxiation due to unsafe sleep environment		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive in the home of her maternal grandmother. The grandmother reported she last saw the infant alive approximately four hours earlier, after she fed him and placed him on his side, with his back against a couch cushion, along with his 5-year-old brother. The grandmother reported the children were staying with her temporarily. DCFS unfounded the grandmother for death by neglect (#51).

Reason for Review: Three weeks before the infant's death, DCFS received a report that law enforcement responded to the parents' home for reports of a physical altercation in the presence of the children. Police arrested the father and observed the mother was injured. The mother stated she was planning to move, and she was not going to be involved with the father. DCFS later indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 76	DOB: 03/2004	DOD: 08/2023	Accident
Age at death:	19 years		
Cause of death:	Fentanyl, clonazepam, and olanzapine toxicity		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old was found unresponsive, due to suspected overdose, in the community. He had a history of overdoses and had been hospitalized multiple times for substance use disorder. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: The youth came into the care of DCFS when he was 15 years old after he was found unresponsive at a shopping mall and first responders administered Narcan (naloxone), and his father refused to

come to the hospital. Within the year before the youth's death, his permanency goal was changed to independence. The youth was not cooperative with services and refused to meet with his caseworker. Eleven months before his death, he was incarcerated. Four days before his death, the youth was released from jail and told his placement worker he was going to his father's home.

Child No. 77	**DOB: 08/2017**	**DOD: 09/2023**	**Accident**
Age at death:	6 years		
Cause of death:	Drowning		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-year-old was found at the bottom of a pond approximately 15 minutes after his family reported him missing. The mother took her children to the lake that day with their aunt and family friends. The child and her friend's child took their shoes off and began to go toward the lake but were told to stay on shore. DCFS indicated the child's mother for death by neglect (#51) and inadequate supervision (#74).

Reason for Review: Five weeks before the child's death, DCFS received two reports of an altercation between the child's mother and stepfather after law enforcement responded to the home. The child's mother reported the stepfather had a history of becoming angry and escalating arguments, so she obtained an order of protection, and made an appointment for services. The CPI completed a domestic violence consultation that resulted in a recommendation for the stepfather to continue services, and for the mother to engage in anger management and individual counseling. Less than two weeks before the child's death, DCFS indicated the stepfather for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 78	**DOB: 03/2023**	**DOD: 09/2023**	**Accident**
Age at death:	5 months		
Cause of death:	Asphyxia due to wedging		
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 after the18-year-old father fed the infant then put her down for a nap in an adult bed. The week before the infant's death, the infant's grandparents obtained emergency guardianship. The day of the infant's death, the grandparents went to work and left the infant in the care of the father. The father reported the infant was fussy and he placed her to sleep at the head of the grandparents' bed, and placed pillows on the edge of the bed to prevent her from rolling off. DCFS unfounded the investigation for death by neglect (#51).

Reason for Review: The infant's father was adopted when he was 6 years old. He continued to live with his adoptive parents, who fostered and adopted other children. Two months before the infant's birth, DCFS received a report that the grandfather hit the then 17-year-old father and kicked him out of the home. The father reported he chose to leave home after a verbal argument and his parents knew where he was. He denied any physical altercations with the grandfather. They all denied the grandfather became physical with the father, and the foster siblings reported they felt safe in the home. DCFS unfounded the grandfather for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10); cuts, bruises, welts, abrasions, and oral injuries by abuse (#11), and inadequate supervision (#74) to the father.

Child No. 79	DOB: 02/2018	DOD: 09/2023	Accident
Age at death:	5 years		
Cause of death:	Asphyxia due to ligature compression of neck		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-year-old was found unresponsive, with ligature marks and something around his neck, which was tied to the bed. The family reported the last person to see him alive was his 8-year-old brother, approximately 40 minutes earlier. The child's brother participated in a victim sensitive interview and stated he and his brother had been playing with loose nylon cording coming off the bed, which they called rope, and tied it around their bodies. He stated he left the room and returned to find the child unresponsive. The brother reported his parents were asleep during the incident. DCFS indicated both parents 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: Eight months before the child's death, DCFS received a report that the child's father grabbed and sprained the hand of the child's then 6-year-old sister when police attempted to arrest the father because he refused to leave an establishment. The CPI observed a cast on her wrist. The mother agreed not to allow the father to have contact with the sister. The mother declined intact family services. DCFS indicated the child's father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 80	DOB: 02/2006	DOD: 09/2023	Accident
Age at death:	17 years		
Cause of death:	Multiple injuries due to pedestrian struck by motor vehicle		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was found lying in the road, late at night, with indications he had been hit by a car. The teen was pronounced deceased at the hospital. DCFS did not investigate the teen's death for abuse or neglect. The autopsy report noted an elevated level of blood alcohol and surveillance videos showed the teen walking at an uncertain gait shortly before the incident.

Reason for Review: Three weeks before the teen's death, DCFS received a report that the teen had not been attending school, said he had been kicked out of his home and was staying with a friend. The friend's sister confirmed the teen was staying in the home and reported they had an agreement with the teen's mother. The mother stated the teen left the home because she did not allow him to bring friends over to smoke marijuana while she was away. She added she filed a missing person report, and police returned the teen home, but he left again. She stated she had contact with the friend's sister, but the friend's father was unresponsive. She added the teen's school notified her of his absences. Four days before the teen's death, DCFS received two additional related information reports about the teen being on run and absent from school. The mother filed a new missing person report. DCFS unfounded the investigation for inadequate supervision (#74).

Child No. 81	DOB: 08/2023	DOD: 10/2023	Accident
Age at death:	7 weeks		
Cause of death:	Suffocation		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old was found unresponsive by her mother in the morning. The mother reported she nursed the infant late that night, then fell asleep, and awoke to find the infant unresponsive next to her. The family's intact worker reported previous discussions about safe sleep. 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: Over a year before the infant's birth, DCFS opened an intact family services case for the infant's mother and the infant's then 3 month old sibling, during an investigation that DCFS later unfounded. The intact worker documented multiple discussions of safe sleep with the family during the case. The mother was engaged in parenting classes and domestic violence counseling, but her father was not engaged in services. Five months before the infant's death, the parents ended their relationship. The mother moved in with the infant's maternal grandmother. Both parents requested emergency orders of protection against each other. The parents continued to live apart and exchanged the children at the police station. Two weeks before the infant's birth, the intact worker visited the mother's new home, observed the mother had a crib and bassinet, discussed safe sleep with her, and documented she had received prenatal care throughout her pregnancy. Less than two weeks before the infant's death, the parents and intact worker attended court regarding the custody case and the parents agreed to an equal care arrangement for the children. The intact family services case remained open at the time of the infant's death.

Child No. 82	**DOB: 04/2009**	**DOD: 10/2023**	**Accident**
Age at death:	14 years		
Cause of death:	Combined drug [fentanyl, despropionyl fentanyl (4-ANPP), and volatile compound (Acetaldehyde)] toxicity		
Reason for review:	Two unfounded child protection investigations and five child welfare services referrals within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was found deceased in his bed. The teen had been heard coming into the home around 4:30am the day of his death. His mother last saw him asleep in bed before she went to work that morning. The teen had a history of substance use and a bag of white, powdery substance was found at the scene. There were no other children living in the home and no evidence of foul play. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Eighteen months before the teen's death, DCFS received a report that the then almost 13-year-old teen had been brought to the hospital with a blood alcohol content of 0.196. The teen was noted to have a history of hospitalizations for mental health and substance use. The mother reported that the teen had been out with friends. He called her upset and in crisis, so she called law enforcement. He reported his friends supplied the alcohol as his mother did not condone his consumption and never provided him with substances. DCFS received two related information reports of subsequent hospitalizations. Before the investigation closed the family reported the teen was in a substance use disorder treatment program and had a pending mental health assessment. DCFS unfounded the mother for substance misuse by neglect (#65). DCFS subsequently received two reports that the teen continued to go on run, get arrests, and use substances. They were taken as child welfare services referrals and DCFS submitted referrals for the teen. The mother confirmed she attempted to engage the teen in community-based services. A month before the teen's death, DCFS received a report that police brought the teen home after he was found in violation of curfew, then the teen left the home again, assaulted a newspaper delivery driver, caused a disturbance, and consumed alcohol. The mother reported she was asleep when the teen was out past curfew, and she did not have transportation to pick the teen up. She noted the teen continued to leave the home without permission and would not follow household rules. DCFS unfounded the mother for substance misuse by neglect (#65) and inadequate supervision (#74). DCFS received three additional reports regarding the teens behaviors, which were taken for child welfare service referrals, and closed prior to his death.

Child No. 83	DOB: 05/2004	DOD: 10/2023	Accident
Age at death:	19 years		
Cause of death:	Combined cocaine, fentanyl, despropionyl fentanyl (4-ANPP), and probable heroin toxicity		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Nineteen-year-old was found deceased in an abandoned building. The youth had a history of illicit substance use. The youth was pregnant at the time of her death, and hospital staff performed a c-section, but the baby did not survive. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: The youth came into DCFS care when she was 15 years old after her adoptive mother refused to pick her up following a hospitalization. While in care, the youth lacked stable placement. She often went on run with her whereabouts unknown, and she cycled between emergency foster homes, group homes, hospitalizations, and unauthorized self-selected placements. In the year before her death, the youth's permanency goal was independence, and she sometimes lived with her birth mother as an unauthorized placement. The placement worker continued to offer the youth services for housing stability and education, but the youth was inconsistent with the services she accepted. The youth had a daughter in DCFS care and sometimes attended supervised visits with her. Five months before her death, during a hospitalization, the placement worker learned the youth was 15 weeks pregnant. Throughout the year, the worker continued efforts to contact the youth, but her whereabouts were often unknown.

Child No. 84	DOB: 04/2006	DOD: 11/2023	Accident
Age at death:	17 years		
Cause of death:	Blunt force injuries		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old was a passenger in a vehicle, with three friends, that was involved in an accident. The teen was pronounced deceased at the hospital. Two of the friends were in critical condition following the accident. The teen's caregiver stated the vehicle was t-boned by another vehicle. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen came into DCFS care when he was 14 years old. The teen's parents were non-compliant with services, and later agreed to surrender their parental rights. In the year before the teen's death, he was placed in a traditional foster home, a residential program for at risk youth, another traditional foster home, and an unauthorized placement. The teen self-selected to live with other caregivers in an unauthorized placement in a different state. The caregivers contacted the placement worker to report they were willing to be a placement option for the teen. The caregivers traveled to Illinois to receive the teen into their care. Later, due to a marital separation of the caregivers, the teen self-selected a second unauthorized placement in a different state. In the following months, the placement worker contacted the teen several times and documented the teen appeared happy and well. The teen reported school was going well and he was maintaining good grades. The placement worker documented no concerns of abuse or neglect. Three weeks before the teen's death, the placement worker traveled to see the teen in his new placement. The placement worker conducted one video conference call with the teen and his caregiver following the visit.

Child No. 85	DOB: 01/2023	DOD: 11/2023	Accident

Age at death:	10 months
Cause of death:	Drowning
Reason for review:	Unfounded child protection investigation within one year of child's death
Action taken:	Full investigation; report to Director on June 20, 2024 **See Death and Serious Injury Investigation 5**

<u>Narrative:</u> Ten-month-old was found unresponsive in a bathtub after his mother left him unattended. Medical providers resuscitated the infant, but he died, in the hospital, three days later. The treating physician stated the infant was likely under the water for more than five minutes. Law enforcement declined to press criminal charges. The mother agreed to intact family services. DCFS indicated the mother for death by neglect (#51) and inadequate supervision (#74).

<u>Reason for Review:</u> Approximately five months before the infant's birth, DCFS received a report that the infant's then 4-month-old brother presented at the hospital with coughing and vomiting, and medical staff took x-rays. Once medical staff analyzed the x-rays, they found rib fractures. The reporter stated the mother did not provide any explanation for the injuries, and the brother did not attend daycare. The treating physician told the CPI the brother was discharged the same night he presented at the hospital, but they called the mother to bring the brother back to the hospital after they found the x-rays showed rib fractures. One month before the infant's birth, and eleven months before his death, the CPI again assessed the brother as safe and documented discussions about safe sleep and bathing with the mother. DCFS unfounded the investigation for bone fractures by abuse (#9) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 86	DOB: 05/2021	DOD: 12/2023	Accident

Age at death:	2 years
Cause of death:	Complications of drowning in washing machine
Reason for review:	Youth in care and an indicated child protection investigation within one year of child's death
Action taken:	Investigatory review of records

<u>Narrative:</u> Two-year-old was playing near a washing machine, turned it on, and fell inside. The toddler was transported to the hospital, where he died approximately one month later. The toddler and his twin brother were placed with their paternal grandparents, and the toddler was in the care of his grandfather while his grandmother was at work. The grandfather reported he took a shower while the twins were sleeping, and when he got out he saw the toddler was not in bed. He searched the home and found the toddler in the washing machine, with the lid closed. The twin brother was removed from the grandparents' home and placed with another relative. DCFS unfounded the grandfather for death by neglect (#51), inadequate supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

<u>Reason for Review:</u> In the year before the toddler's death, the family had an open intact family services case following an indicated investigation related to domestic violence and the mother's mental health. The father of the toddler and his twin brother refused services, but the children's mother participated in services, including counseling and mental health services. Eleven months before the toddler's death, DCFS received a report that the toddler's parents had a physical altercation, the father stole the mother's car, and the mother left the children unsupervised when she attempted to retrieve the car from the father. The father came to the home upset about not seeing the twins, and an argument ensued. A few weeks later, the mother sustained a black eye, broken hand, and stitches to the head due to another domestic violence incident with the toddler's father. That day, DCFS took protective custody of the children. The toddler's older half-sisters were later placed with their father, and their placement cases closed. The toddler and his twin brother were placed with their paternal grandparents. DCFS indicated his mother for inadequate supervision (#74) and indicated both the mother and toddler's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The mother continued to engage in

services, and the toddler's father was recommended to engage in domestic violence services and substance use disorder services.

Child No. 87	DOB: 04/2006	DOD: 12/2023	Accident
Age at death:	17 years		
Cause of death:	Drowning in retention pond; significant contributing condition of ethanol intoxication		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seventeen-year-old plunged into a retention pond in her car. Her body and car were later recovered, and toxicology reports indicated she had a high level of alcohol in her system as well as THC. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Two months before the teen's death, DCFS received a report that the teen's father punched her in the face after the teen got into a car accident. The father and teen both confirmed the teen wrecked the car, and the father pushed or grabbed the teen's head because he was upset. Both denied the father hit the teen, and the teen denied she was afraid of her father. The father stated he believed the teen was under the influence of alcohol at the time and she did not understand the severity of the accident. He noted she had a history of coming home intoxicated and this was the second time she had wrecked a car. DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 88	DOB: 05/2005	DOD: 12/2023	Accident
Age at death:	18 years		
Cause of death:	Combined fentanyl, methamphetamine, despropionyl fentanyl (4-ANPP), and probably heroin toxicity		
Reason for review:	Youth in care		
Action taken:	Investigatory review of records		

Narrative: Eighteen-year-old was found unresponsive and cold to the touch, in his bedroom, by staff of the transitional living program where he resided, and they called 911. It was reported the youth had been taking over the counter medication for a cold prior to his death. The youth had a history of substance use and was known to smoke marijuana. No illicit drugs or alcohol were found in his room. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: The youth came into care when he was 9 years old. In the year prior to his death, the youth's permanency goal was independence. Approximately six weeks before his death, he moved from a traditional foster home to a transitional living program. The youth had graduated high school, had employment, was also involved in a mentoring program, and had an education coach. He was also referred for counseling but was not engaged in counseling services.

Child No. 89	DOB: 03/2009	DOD: 01/2024	Accident
Age at death:	14 years		
Cause of death:	Adverse effects of fentanyl and xylazine		
Reason for review:	Split custody case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Fourteen-year-old was found unresponsive by his father and pronounced deceased at the hospital. During a criminal investigation, the mother reported she came to visit, and she brought two bags of fentanyl into the home, one of which was found in the teen's room. The teen's 13-year-old brother was taken into protective custody. DCFS indicated the teen's parents for death by abuse (#1), substance misuse by abuse (#15), inadequate

supervision (#74), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The teen's parents have each been charged with first degree murder, involuntary manslaughter, and child endangerment.

Reason for Review: At the time of the teen's death, the teen's 18-year-old maternal half-sister was a youth in care. The teen and his brother had also been youth in care but had returned home to their father two years prior after the father completed services. The sister's goal was independence. The sister also had a child and was involved with the teen parent services network. The placement worker met with the sister and her daughter regularly, and noted the daughter met her developmental milestones and attended well child checks. The father and grandmother cared for the child while the sister worked and studied for her GED. The sister's placement case remained open at the time of the teen's death.

Child No. 90	DOB: 07/2023	DOD: 01/2024	Accident
Age at death:	5 months		
Cause of death:	Suffocation		
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 by her mother and was pronounced deceased at the hospital. The mother placed the infant in an adult bed, propped up with a bottle, swaddled, and surrounded by pillows. The infant's 2-year-old and 9-year-old sisters each had a bedroom in the home, but there were no cribs present and the mother reported she usually co-slept with the infant. DCFS unfounded her mother for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Four months before the infant's birth, DCFS received a report that police responded to the home after the infant's then 8-year-old maternal half-sister went to a neighbor's home to request police for the mother. The mother told the reporter her ex-paramour, the infant's father, came to the home and assaulted her. She added the father stopped the battery when the sister woke and went into the living room, and she escorted the sister back to her bedroom and asked her to climb out the window and ask her aunt to call police. Police arrested the infant's father. The CPI interviewed the mother, who stated she was no longer in a relationship with the infant's father, and stated he entered the home with a spare key that was in the backyard. The mother obtained an order of protection. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 91	DOB: 03/2021	DOD: 01/2024	Accident
Age at death:	2 years		
Cause of death:	Peritonitis due to spilled stomach contents in the peritoneal cavity due to gastric wall defect; significant contributing conditions of prematurity and failure to thrive		
Reason for review:	Open intact family services case at time of child's death; closed intact family services case and unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Two-year-old medically complex toddler had a seizure and was later pronounced deceased at the hospital. The toddler's diagnoses included cleft palate, hyperinsulinism, prematurity, cardiac abnormalities, and a history of failure to thrive. He had presented at the hospital two days earlier after he pulled out his feeding tube. DCFS did not investigate his death for abuse or neglect.

Reason for Review: One year before the toddler's death, DCFS opened an intact family services case following an indicated investigation against his mother. The intact worker met with the family weekly and seven months before the toddler's death, the intact case closed successfully. Approximately two months before the toddler's death, DCFS received a report that the toddler was hospitalized after he arrived at the hospital while hypoglycemic, and

his mother did not have his feeding supplies. The toddler was diagnosed with hyperinsulinism. He remained in the PICU until his glucose was stabilized. The mother requested assistance with daycare and agreed to intact family services. Before closing the investigation, the treating physician confirmed the toddler's medical conditions were not caused by the mother, and the mother ensured he received the necessary medical care. The day before the toddler's death, DCFS unfounded the investigation for medical neglect (#79) and failure to thrive (#81). During the intact case that had opened one month earlier, the intact worker requested the hospital social worker to initiate a referral to DSCC to help the mother with home nursing services. The intact case remained open at the time of the toddler's death.

Child No. 92	DOB: 10/2023	DOD: 01/2024	Accident
Age at death:	3 months		
Cause of death:	Positional asphyxia due to sleeping within a car seat; significant contributing condition of influenza A infection		
Reason for review:	Split custody and pending child protection investigation at time of child's death; one indicated and one unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Three-month-old was found unresponsive in a car seat where he had been sleeping overnight and pronounced deceased at the hospital. The parents last saw him alive three hours earlier, when they fed him, and he then fell asleep. They stated he had been sick with a runny nose for a few days, and they had not sought medical attention. The parents stated they moved frequently and had difficulty moving the pack-and-play. The mother denied he regularly slept in his car seat. DCFS indicated the infant's mother and father for death by neglect (#51).

Reason for Review: Six months before the infant's birth, DCFS received a report that the infant's then 11-month-old sister was in the hospital in a neighboring state with concerns about failure to thrive. Medical staff reported the sister had a neurological disorder and the parents needed training to care for her. The parents did not have stable housing and agreed to intact services. DCFS unfounded the parents for failure to thrive (#81) to the sister. The sister was discharged from the hospital shortly after the intact case opened, and hospital staff reported she was on the wait list for a complex care clinic. The intact worker also discussed, and the parents agreed to, the Safe Families program the following week. The sister was placed with a host family, where she received services. While the host family went out of town the sister went to the parents in the week before the infant's birth. When she returned to the host family DCFS received a report that the sister presented at the hospital with bilateral distal femur fractures and a possible fibula fracture in one arm. A child abuse pediatrician reported the sister's fractures appeared to be accidental related to her medical complexity and brittle bones. The court granted DCFS temporary custody of the sister due to the parents' inability to care for her medical needs. DCFS indicated the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the investigation for bone fractures by neglect (#59). The infant's sister remained in DCFS custody. At a clinical staffing, the team recommended specialized foster care for the sister due to her complex medical needs. One month before the infant's death, DCFS received a report that law enforcement responded to a motel regarding an argument and that the infant slept in a car seat. The CPI provided a pack-and-play and discussed safe sleep with the father. While the investigation remained pending, the infant died. DCFS later indicated the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) due to unsafe sleep practices despite receiving multiple pack-and-plays and multiple discussions of safe sleep. The placement case remained open, and the placement worker last saw the infant one week before his death. The parents continued to have unstable housing, mostly staying in motels.

Child No. 93	DOB: 11/2023	DOD: 02/2024	Accident
Age at death:	3 months		
Cause of death:	Asphyxia due to unsafe sleep environment		
Reason for review:	Closed placement case within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Three-month-old was found unresponsive by her mother and was pronounced deceased at the hospital. The mother stated she last saw the infant alive that morning, when she placed her on her side on a pregnancy pillow. She noted the infant had been congested and she took the infant to the pediatrician the day before, where they received a referral for a cardiologist. 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: The infant's 2-year-old, 4-year-old, and 7-year-old siblings were youth in care for two years and returned home six months before the infant's birth. In the year before the infant's death, the siblings were placed with a paternal aunt. The court granted the mother unsupervised visits and overnight visits in the foster home after the mother completed required services. The mother was living with her sister, the children's maternal aunt, and the placement worker completed a home safety checklist prior to the children's return to their mother's care. When the children returned to their mother's care, the paternal aunt, the former foster parent, continued to provide support. The family received aftercare services. After the infant was born prematurely, the infant was referred for early intervention services, the family moved into the new home, and the worker completed a home safety checklist. The worker noted the children all had safe sleeping arrangements. One month before the infant's death, the placement case was closed.

Child No. 94	DOB: 02/2015	DOD: 02/2024	Accident
Age at death:	9 years		
Cause of death:	Complications of ligature hanging		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Full investigation pending		

Narrative: Nine-year-old died in the hospital five days after his parents found him hanging by his neck from his bunk bed. The child's siblings completed forensic interviews and reported the child had a bra strap and wrapped it around his neck while the children were playing in the bedroom, and their parents and aunt were in another room. The children stated the child choked, and they tried to remove the strap from the child's neck and then got help from their parents and aunt. DCFS unfounded the child's mother and stepfather for death by neglect (#51), head injuries by neglect (#52), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Approximately four months before the child's death, DCFS received a report that police responded to the family home after the child's mother and stepfather both punched his 13-year-old stepsister, the stepfather's daughter, in the face. The sister lived out of state and asked the parents if she could return, which they declined, then they physically attacked her. The parents were arrested after the father shot a hole in the wall and pointed a gun at the sister. The sister's maternal aunt returned her home. The father was criminally charged. The child's parents refused to cooperate with the investigation and the stepsister returned to live with her mother. DCFS indicated the child's parents for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's stepsister.

Child No. 95	DOB: 11/2007	DOD: 02/2024	Accident

Age at death: 16 years
Cause of death: Multiple blunt force trauma injuries due to motor vehicle collision
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 from injuries sustained in a motor vehicle accident in which he was the driver. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Five months before the teen's death, DCFS received a report that law enforcement arrested the teen's mother for domestic battery to the teen's almost 15-year-old sister following an incident in which the mother pulled out some of the sister's hair. The sister told the CPI she went to her mother's home that weekend, and she and her mother had verbal arguments, her mother made verbal threats, and her mother later locked her out of the house. The sister stated police arrested her mother following an incident at a hair salon, when the mother yelled at the sister to leave, then yanked on her hair, that resulted in her head bleeding. The sister stated she did not feel safe going back to her mother's home, but she lived primarily with her father and felt safe with him. School staff and the father both noted the sister had a lengthy history of mental health issues and they did not know when to believe her. Two months before the teen's death, while the investigation was pending, the sister was hospitalized. The father later told the CPI he saw security footage of the alleged incident and the mother had not assaulted the sister. He declined to press charges and noted he was seeking treatment for the sister. Two months before the teen's death, DCFS unfounded the teen's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Two months before the teen's death, while the previous investigation remained pending, DCFS received a report that the 15-year-old sister disclosed her father made her sleep in a locked pantry. The CPI met with the sister at the hospital where she was admitted. The sister reported she was disciplined by being locked in a small bedroom, sent to the pantry, or loss of privileges. She added her bedroom was taken away and the door removed for safety reasons. The sister denied her siblings were put in the pantry. Four days later, DCFS opened a subsequent report after a hotline call that the 15-year-old sister disclosed her father molested her and her younger sister on multiple occasions until she was 12 years. When the CPI spoke to the 15-year-old sister at the hospital, she stated her father touched her inappropriately one time. The CPI then met with the stepmother at home, who reported the father was a registered sex offender. The father had been indicated for sexual abuse in 2012 but completed services and regained custody of his children several years earlier. The CPI later spoke to the father, who stated the sister had been making false accusations against staff at the hospital and was on video surveillance to protect herself and staff. A doctor at the hospital later told the CPI the sister regularly made up stories about other patients and staff. The following week, the sister moved to a residential facility. When the CPI interviewed the 14-year-old half-sister, she reported she felt safe with the teen's father, her stepfather. The teen and his 11-year-old half-brother also reported they felt safe at home. The siblings denied the allegations that the sister was locked in the pantry and the CPI did not observe any locks on the pantry door. The family declined additional services. In the three weeks before the teen's death, DCFS unfounded the father for tying/close confinement (#14), sexual penetration (#19) and sexual molestation (#21).

Child No. 96	DOB: 01/2024	DOD: 03/2024	Accident

Age at death: 8 weeks
Cause of death: Asphyxiation due to unsafe sleep environment with bed sharing
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: Four-week-old infant died in the hospital where she had remained since her birth due to Trisomy 18 (see child number 146). DCFS did not investigate her death for abuse or neglect. The following month, DCFS received a report that her mother found her surviving 8-week-old twin sister unresponsive after she slept in the

same bed as the infant. The mother reported she placed the infant to sleep on her back, on the opposite side of the bed. DCFS unfounded the infant's mother for death by neglect (#51).

Reason for Review: Approximately eight months before the twins' birth, DCFS received a report that the twins' 8-year-old sister disclosed her mother was not home when she woke that morning, and she had to feed and diaper her 13-month-old brother. The sister told the CPI her mother woke her and stated she was taking the other children to school, and her 13-year-old brother was supposed to be home, but he left. She reported that was the only time she had been left home alone. The other children denied their mother left them home alone. The CPI provided the mother a pack-and-play for the 1-year-old. The mother later reported she co-slept with the 1-year-old because he flipped the pack-and-play. She also disclosed she was pregnant with the twins. DCFS unfounded the mother for inadequate supervision (#74). Two months before the twins' birth, DCFS received a report that the children's 19-year-old sister was supposed to be watching them while their mother was at work, but the 19-year-old left the home when the 12-year-old sister took a shower. While the 12-year-old was in the shower, the 6-year-old and 8-year-old siblings mixed a cleaning product with water and another liquid, and the 1-year-old sibling ate some of the substance. Emergency medical services responded to the home and took the 1-year-old to the hospital. The 1-year-old grabbed the bottle, and the 6-year-old smacked it out of his hand and spilled it over him and he may have ingested some. The 19-year-old reportedly left the home for 15 minutes and the 1-year-old was running around when she returned. DCFS unfounded the 19-year-old sibling for poison/noxious substances by neglect (#56) and inadequate supervision (#74). Two weeks before the twins' birth, while the previous investigation remained pending, DCFS received a report that the 12-year-old sister disclosed the father of 6-year-old, 7-year-old, and 10-year-old siblings raped her over the past 10 years, and he had molested her as recently as the month prior. The 12-year-old participated in a forensic interview during which she stated she lied about the siblings' father raping her. Police interviewed the siblings' father, who stated the older children had become resentful since he got engaged. He added the 12-year-old messaged him about going to a party, and he asked the 12-year-old to watch his 3-year-old child after the party ended, but she got upset and refused to do so. The investigation remained pending at the time of the twins' birth and deaths. DCFS later unfounded the siblings' father for sexual penetration (#19) and substantial risk of sexual abuse (#22).

Child No. 97	**DOB: 04/2020**	**DOD 03/2024**	**Accident**
Child No. 98	**DOB: 02/2019**	**DOD: 03/2024**	**Accident**

Age at death:	Child No. 97 - 3 years
Age at death:	Child No. 98 - 5 years
Cause of death:	Child No. 97 - Blunt force injuries of the spine, thermal burns and smoke inhalation
Cause of death:	Child No. 98 - Blunt force injuries of the head and neck, thermal burns, and smoke inhalation
Reason for review:	Split custody at time of children's deaths; children were former youths in care
Action taken:	Investigatory review of records

Narrative: Three-year-old and five-year-old were passengers on a school bus when the bus collided with a semi-truck. Both children and one other child, the only passengers on the bus, and the semi-truck driver, died in the collision. DCFS did not investigate the children's deaths for abuse or neglect.

Reason for Review: Both children were born substance-exposed, and each came into DCFS care shortly after birth. The 5-year-old was placed with fictive kin and the 3-year-old was placed in the same home following his birth. The children had an 18-month-old brother who also came into care following his birth. He was initially placed with his siblings, but later moved to the home of the foster parents' relative. The foster families facilitated sibling visits. Eleven months before the deaths, their fictive kin foster parents adopted them. Their birth parents had not been involved since their births, and they previously signed specific consents for the fictive kin to adopt them. Their younger brother remained in care. At the time of the 3-year-old and 5-year-old's deaths, the 18-month-old's permanency goal was substitute care pending termination of parental rights.

Child No. 99	DOB: 11/2016	DOD: 03/2024	Accident

Age at death: 7 years
Cause of death: Drowning
Reason for review: Youth in care and 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: Seven-year-old drowned in a pool at his foster home, when his foster parents were out of the home. One foster father left for work earlier that morning, and the other foster father later left the child and his 4-year-old brother in the care of their 10-year-old foster brother for approximately one hour. While the foster parents were gone, the children went into the backyard to play. The pool was only partially filled with water and the child was in the empty shallow end of the pool when he slipped into the deep end which had water in it. The foster brother flagged down someone on the street to call 911. The child was pronounced deceased at the hospital. The foster parents reported the pool ladder was in storage, and the pool had been emptied and not used in a few years. One foster father has been charged in connection with the child's death. DCFS indicated the foster father for death by neglect (#51) and indicated both foster parents for inadequate supervision (#74).

Reason for Review: The child and his 4-year-old and 14-year-old brothers came into care due to their mother's housing instability. During the placement case, the mother moved into and maintained a new home. As of the last service plan before the child's death, the mother was making progress toward all goals, and the children's permanency goal remained return home. The child's 14-year-old brother had been living with his grandmother prior to protective custody and remained in her care. One month before the child's death, he and his brother moved to the foster home where the child resided when he died. There were also two child protection investigations regarding the family in the year before the child's death. Approximately five months before the child's death, DCFS received a report that the child's then 3-year-old brother disclosed his mother touched him inappropriately. The brother and the child both completed interviews at the CAC. The brother did not make any disclosures. DCFS unfounded the mother for sexual molestation (#21). One month before the child's death, DCFS received a report that the grandmother had a mental health episode and left the child's 14-year-old brother home alone. The brother and the grandmother denied the allegations. The investigation remained pending at the time of the child's death. DCFS later unfounded the grandmother for inadequate supervision (#74).

Child No. 100	DOB: 03/2007	DOD: 03/2024	Accident

Age at death: 17 years
Cause of death: Methamphetamine, 3,4-methylenedioxyamphetamine (MDMA), and fentanyl toxicity
Reason for review: Indicated child protection investigation within one year of child's death
Action taken: Investigatory review of records

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

Reason for Review: Five months before the teen's death, DCFS received a report that the teen's 16-year-old adoptive sister was in a physical altercation with their adoptive mother. The reporter added the teen often arrived at school intoxicated. The teen denied a history of drug or alcohol use. The teen's sister also denied the allegations. The CPI later spoke with the mother, who stated the teen used drugs, ran away, and she did not feel safe with him in the home because he had become aggressive. One month later, the teen moved in with his grandmother. The grandfather wanted to discuss guardianship because the teen had been living with him for two weeks. The CPI later attempted to set up a meeting to sign temporary guardianship paperwork, but the mother declined and stated she would have the teen return home, as she believed the grandfather wanted money. Two months before the teen's death, the CPI submitted a referral for extended family support services and indicated the mother for inadequate supervision (#74). DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 101	DOB: 11/2023	DOD: 04/2024	Accident
Age at death:	4 months		
Cause of death:	Bedding asphyxia due to co-sleeping		
Reason for review:	Two child welfare services referrals within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Four-month-old was found unresponsive by her father, who stated he had laid down with her in an adult bed to take a nap. The parents denied the father had previously co-slept with the infant; the infant usually slept in her pack-and-play. The father stated the infant was not making noises or movements upon waking. She was pronounced deceased at the hospital. DCFS unfounded the father for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: DCFS received a report when the infant was born that the mother disclosed a history with DCFS. The reporter stated the mother was appropriate with the infant, and DCFS took the call for a child welfare services referral. The CWS worker met with the family at home and observed the home was appropriate, the infant was asleep in her bassinet, and the infant's then 16-month-old brother also had a crib in his room. The CWS worker discussed safe sleep and offered community resources. DCFS closed the child welfare services referral with no services needed. Three weeks before the infant's death, DCFS received a report that the father yelled at the infant when she cried. DCFS took the report for a child welfare services referral. The father reported he occasionally became frustrated and yelled while playing video games but denied the yelling was aimed at the children. The CWS worker observed the home was appropriate with safe sleeping arrangements. The mother declined intact family services and reported she worked with community-based services. DCFS closed the child welfare services referral with no additional services needed.

Child No. 102	DOB: 11/2023	DOD: 04/2024	Accident
Age at death:	5 months		
Cause of death:	Positional asphyxia due to sleeping prone on an adult bed; significant contributing conditions of aspiration of upper respiratory bacteria and staphylococcus aureus, recent, without pneumonia		
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: Five-month-old was found unresponsive on an adult bed by her babysitter, who placed her down on her stomach for a nap. The babysitter did not check on the infant for approximately five hours. The infant was pronounced deceased at the hospital. Law enforcement reported they found drug paraphernalia in the babysitter's bedroom. The babysitter tested positive for cocaine and THC but denied that she used any substances while caring for the infant. Law enforcement closed the investigation without criminal charges. DCFS unfounded the babysitter for death by neglect (#51) but indicated her for substantial risk of physical injury/environment injurious to health welfare by neglect (#60) to her four grandchildren who she was also babysitting at the time of the infant's death.

Reason for Review: The day the infant was born, DCFS received a report that her 17-year-old mother presented at the hospital for preterm labor and exhibited some mental health issues. During the investigation the mother reported the mental health concerns had resolved. She later had a clean toxicology and received a mental health evaluation which determined the mother did not need services. The mother stated she planned to live with a relative who was supportive. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Less than two weeks later, DCFS received a report that the mother left the infant in the care of her maternal grandmother, who did not have stable housing. The CPI spoke with the grandmother, who stated the infant was in her care, and the mother had mental health concerns. The next day, the grandmother called the CPI and stated the mother retrieved the infant. The mother stated she asked the grandmother to care for the infant while she had the flu. The mother and grandmother both reported that they got into an altercation when the mother came to pick up the infant. The mother told the CPI she lived with a friend, and the CPI observed the

mother had formula and a bassinet. The mother declined intact family services. The friend denied she had observed any mental health or substance use concerns. The friend confirmed the mother used the bassinet. The investigation remained pending at the time the infant died. DCFS later unfounded the mother for inadequate supervision (#74).

Child No. 103	**DOB: 02/2024**	**DOD: 04/2024**	**Accident**

Age at death:	2 months
Cause of death:	Positional asphyxia due to unsafe sleep environment
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: Two-month-old was found not breathing and he was pronounced deceased at the hospital. The mother stated she saw him alive a few hours earlier, sleeping in his crib. The reporter stated the home was in poor condition. The CPI observed a bassinet in the home and noted no concerns. DCFS unfounded the infant's mother for death by neglect (#51).

Reason for Review: Six months before the infant's birth, DCFS received multiple reports that the infant's then 2-year-old sister was found bleeding from her genitals after she had been left in the care of the boyfriend of her godmother's daughter, and she stated the man hurt her. She was taken to the hospital for a rape kit and discharged to her mother. The mother told the CPI she was upset the godmother left the sister in the man's care, and she did not know the man was in the home. The sister participated in a forensic interview, and she did not disclose any sexual contact. The godmother's daughter and her boyfriend denied he was ever left alone with the sister. A child abuse pediatrician completed a child sex abuse exam, which was normal, and the sister did not have any abrasions. The doctor stated the sister had urethral prolapse which could explain the bleeding. DCFS unfounded the man for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and sexual penetration (#19). While the prior investigation remained pending, DCFS received a report that the infant's then 5-year-old brother arrived at school with a burn on his wrist, and reported he frequently made his own dinner, unsupervised, because his mother was at work. The brother told the CPI that he burned himself when he removed his noodles from the microwave, while his mother was in the hallway. The CPI instructed the mother to take the brother for medical care. A child abuse pediatrician noted the burn was consistent with the explanation. The mother declined intact family services. DCFS indicated the mother for burns by neglect (#55) and inadequate supervision (#74) to the brother. While the previous investigation remained pending, DCFS received a report that the infant's 6-year-old brother and two young children were seen exiting a city bus without adult supervision, however the brother stated he was with his uncles, as did the mother. The CPI contacted the bussing company, which reviewed surveillance footage and did not find evidence of unaccompanied children riding the bus. DCFS unfounded the mother for inadequate supervision (#74).

Child No. 104	**DOB: 09/2023**	**DOD: 04/2024**	**Accident**

Age at death:	7 months
Cause of death:	Craniocerebral injuries and compressional asphyxia due to dump truck striking and coming to rest upon an automobile due to motor vehicle crash
Reason for review:	Pending child protection investigation at time of child's death
Action taken:	Investigatory review of records

Narrative: Seven-month-old was pronounced deceased after the car his father was driving stopped at a stop sign and a truck struck them. The infant was properly restrained in his car seat. The father sustained injuries but survived. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: One month before the infant's death, DCFS received a report that the family's home was filthy; cats urinated and defecated on the floor, and there was trash throughout the home. The maternal grandfather would not allow the CPI into the home due to the number of cats in the home and stated the parents were not the best housekeepers, but the home was livable. The father stated they were staying with the grandfather while their

trailer was repaired prior to moving in. The great-aunt agreed to allow the family to stay with her and the CPI completed a home safety checklist on her home. The CPI met with the family at home and documented the home met minimal standards, the infant's toys appeared clean, and the home did not have an odor from the animals. While the investigation remained pending, the infant died. DCFS later unfounded the parents and grandfather for environmental neglect (#82).

Child No. 105	**DOB: 12/2006**	**DOD: 04/2024**	**Accident**

Age at death:	17 years
Cause of death:	Multiple blunt force injuries; significant contributing condition of unrestrained driver of a motor vehicle that left the roadway and collided with a home, cars, and a power line pole
Reason for review:	Open intact family services case at time of child's death; one indicated and five unfounded child protection investigations within one year of child's death
Action taken:	Pending systemic issue report

Narrative: Seventeen-year-old hit stationary objects when driving his mother's car and was pronounced deceased at the scene. The teen's mother stated the teen asked her for the keys so he could retrieve something from the car, then he drove off. The mother stated she ran after him and witnessed the accident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Twelve months before the teen's death, DCFS received a report that police arrested the teen's adult sister following an altercation between the sister and the then 16-year-old teen, during which the sister restrained the teen. Law enforcement had frequent contact with the family related to the teen's mental health and anger issues. The mother stated that on the day of the incident, the teen became upset and went to his room to calm down, then his sister went to his room and an altercation ensued. DCFS indicated the teen's sister for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Six months before the teen's death, DCFS received a report that the teen repeatedly ran from the home and the teen's mother was drinking. The mother denied the teen ran away, denied any recent issues with substance use, and reported both she and the teen each attended therapy. DCFS unfounded the teen's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Two days later, DCFS received a similar report of the teen running from the home and the mother drinking. The mother noted the teen had a history of aggression when he became angry and had a history of running from the home since he was a toddler. The mother noted the teen received therapy and was prescribed medication, as well as additional services with community providers. The mother agreed to intact family services. DCFS unfounded the mother for inadequate supervision (#74). The intact worker documented the teen received services from multiple providers, including therapy, psychiatry, and he had an IEP with school. The intact worker visited the home weekly, worked to secure a day program for the teen, accessed Norman funds to help the mother with back rent, and assisted the mother to locate public housing. Three months before the teen's death, DCFS received a report that the mother was hospitalized, and the teen stayed with his sister. The mother confirmed she checked herself into the hospital and left the teen in his sister's care because she had no one else to care for him. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three months before the death DCFS received a report that law enforcement responded to the family home two days earlier for domestic violence. The reporter stated the teen became agitated by an argument between the sister and her friend, and the teen went to defend the sister. The mother and sister both stated police were present when the mother arrived home due to an argument between the sister and her friend. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While the previous investigation remained pending, DCFS received a report that the mother was hospitalized, and the sister called relatives for assistance with food. The reporter added the home was dirty and the teen had strong body odor. The CPI did not observe insects, garbage, dirt, or clutter in the home and noted the home met minimal standards. The CPI noted the home had food and the sister planned to go grocery shopping the next day. The sister confirmed the mother was hospitalized and she would care for the teen until the mother was discharged. The mother stated she began a new monthly medication to assist her with sobriety. DCFS unfounded the mother for inadequate supervision (#74), environmental neglect (#82), and substantial risk of physical injury/environment

injurious to health and welfare by neglect (#60). Intact family services continued throughout the child protection investigations, and the intact worker met with the family every other week. Approximately one week before the teen's death, during a child and family team meeting, the mother reported the teen's aggression and agitation had increased. She stated she called police three times and SASS once, and the teen's service providers were looking into adult group homes for the teen to live once he turned 18. The intact family services case remained open at the time of the teen's death.

Child No. 106	DOB: 07/2007	DOD: 04/2024	Accident
Age at death:	16 years		
Cause of death:	Multiple blunt force trauma		
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 in a car with three other youths when the driver lost control of the car and it crashed into a tree. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Three months before the teen's death, DCFS received a report that police responded to the family home after the teen's 17-year-old brother returned to the home after being gone for three weeks. The brother had been arrested following an altercation in front of the home, during which the brother stabbed a peer. He was charged, given a court date, released and had not been back since then. Upon his return, the brother and teen began to argue, and the mother called police. Police arrested the brother. The mother arranged for the brother to stay with a friend. She stated he had been staying with friends since the incident and she was concerned about keeping her other children safe after the incident. The mother added she worked nights and would need to arrange for another adult to watch the children while she worked before allowing the brother to return home. The CPI then met with the brother at his friend's home. The friend's family stated he could stay until the end of the week, when the mother agreed to allow him to return home. Three days after the investigation opened, DCFS unfounded the mother for lock out (#84).

Child No. 107	DOB: 06/2021	DOD: 05/2024	Accident
Age at death:	2 years		
Cause of death:	Drowning		
Reason for review:	Two pending child protection investigations at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was found floating in a pond behind the family home and was pronounced deceased at the hospital. His parents stated he had been missing for 10 minutes when they found him in the lake. The toddler's father stated the mother was asleep at the time of the incident. The father reported he was checking his email on the couch when he realized he had not heard the toddler in several minutes. He then observed the internal and external garage doors were open, and he found the toddler floating in the pond. DCFS unfounded the toddler's parents for death by neglect (#51).

Reason for Review: Eight months before the toddler's death, DCFS received a report that a staff member at the toddler's daycare had been observed holding a child down in a seat and she was angry, yelling, and throwing young children on their cots. The daycare facility reported the alleged perpetrator was dismissed and no longer worked there. Another staff member reported she observed the alleged perpetrator restrain one child in a tied blanket and restrain another child in her cot. The investigation remained pending at the time of the toddler's death. DCFS later indicated the alleged perpetrator of the daycare facility for tying/close confinement (#14) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). During that investigation, DCFS received a report that a different staff member at the daycare wrapped the toddler in a weighted blanket, and he could not move. The director of the daycare told the CPI the second alleged perpetrator had been terminated approximately two weeks earlier for not completing paperwork. She denied prior knowledge of the incident. The

CPI reviewed surveillance footage that showed the second alleged perpetrator wrap the toddler in a blanket, restrain him for several minutes with her leg, and pat his upper back close to his neck. The second alleged perpetrator did not cooperate with the CPI or with a DuPuy hearing. The investigation remained pending at the time of the toddler's death. DCFS later indicated the second alleged perpetrator for tying/close confinement (#14).

Child No. 108	**DOB: 10/2008**	**DOD: 06/2024**	**Accident**
Age at death:	15 years		
Cause of death:	Blunt force trauma to skull due to blunt force trauma to chest		
Reason for review:	Two unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Fifteen-year-old died in a car accident. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Four months before the teen's death, DCFS received a report that the teen's aunt verbally attacked him, hit him in the arm, then hit the teen's uncle when he stood between the teen and his aunt. The family members reported that the incident occurred over a month earlier. Family members reported that the aunt and the mother had a verbal argument and the teen got involved and the aunt scratched him when trying to get him out of the way. DCFS unfounded the aunt for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). While the investigation remained pending, DCFS received a report that the teen had a verbal altercation with his father which escalated into a physical altercation. The police denied there were any arrests and there was no police report completed. The teen stated his father began a verbal argument with him, he hit his father, then his father slammed him on the ground and punched him once. The teen stated his father drank alcohol and used drugs. The teen's paternal grandfather witnessed the altercation and saw the father restrain the teen and hold him to the ground, but he did not know what it was about. The teen and his grandfather reported the teen was staying with a family friend following the incident. Three weeks later, the mother told the CPI the father was in a drug treatment program; the father later reported completing the program successfully. The teen moved back in with his father and grandfather a month later, and things were going well. The CPI noted the father completed a drug test that was negative for all substances. DCFS unfounded the teen's father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 109	**DOB: 07/2023**	**DOD: 06/2024**	**Accident**
Age at death:	10 months		
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: Ten-month-old was found unresponsive in the bathtub by her mother. The infant was pronounced deceased at the hospital. The mother reported she used methamphetamine and tested positive for the substance. The infant tested positive for methamphetamine at birth and was previously diagnosed with cat eye syndrome, a rare genetic disorder. The DCFS investigation of the infant's death remains pending.

Reason for Review: Eight months before the infant's death, DCFS received a report that the mother accidentally hit the then 2-month-old infant's head on a door. At the time, the mother reported concerns about her mental health. The reporter also noted the home had roaches, the infant had been born premature, and the mother fed the infant three bottles and solid foods. The mother reported she was taking medication for mental health diagnoses and seeing a therapist, but there was an issue with the medication. She denied any thoughts of harming the infant and stated she accidentally hit her elbow, not the infant's head, on a door. The CPI did not observe any roaches and noted the home appeared clean and free of hazards. The mother denied she fed the infant solid foods. The CPI observed a bassinet and pack-and-play in the home and the mother denied she co-slept with the infant. The CPI

also documented a discussion about water safety. DCFS unfounded the investigation for environmental neglect (#82) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 110	DOB: 07/2013	DOD: 06/2024	Accident
Age at death:	10 years		
Cause of death:	Drowning		
Reason for review:	Pending child protection investigation at time of child's death; unfounded child protection investigation and return home within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Ten-year-old was pronounced deceased in the hospital after he and his 9-year-old sister were rescued from a river by paramedics. His sister was treated and survived. The child and his sister were reportedly playing with two other children, and the sister fell into the water. The child jumped in to attempt to help her, but neither child knew how to swim. The mother stated the children were playing outside since that morning, and the child typically came and went from the home. DCFS indicated the child's mother for death by neglect (#51) and inadequate supervision (#74).

Reason for Review: The child came into DCFS care when he was 8 years old, along with his then 11-month-old and 11-year-old siblings. The mother completed recommended services. Approximately ten months before the child's death, the court returned the children to their mother's care and recommended she continue oral toxicology screenings and therapy services. Approximately four months before the child's death, the court closed the family's placement case and the children remained in their mother's care. Two months before the child's death, DCFS received a report that the child's 9-year-old sister cared for the child's 1-year-old and 3-year-old brothers while the parents and older siblings were out of the home. That day, the CPI spoke with the placement worker, who noted the 9-year-old had not been involved in the recently closed placement case because she was in the care of her father and grandparents. The 13-year-old sister stated she had been left in charge of her younger siblings and denied the younger children were home alone. The mother and stepfather reported they typically brought the younger children with them when they left home but chose to leave the children in the care of the 13-year-old sister while they ran an errand. DCFS unfounded the mother and stepfather for inadequate supervision (#74). The day after the investigation closed, DCFS received a report that the 10-year-old child and his 13-year-old sister got into a fight, during which the 13-year-old bit the child twice. The family members all stated the child and 13-year-old sister fought and the mother separated them. The mother took the child to the emergency room to have the bite marks treated and he was prescribed antibiotics. The investigation remained pending at the time of the child's death. DCFS later unfounded the child's 13-year-old sister for human bites by abuse (#12).

Child No. 111	DOB: 04/2008	DOD: 06/2024	Accident
Age at death:	16 years		
Cause of death:	Craniocerebral injuries due to pickup truck crash		
Reason for review:	Seven unfounded child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old died due to a motor vehicle crash. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Approximately one year before the teen's death, DCFS received a report that the teen disclosed that several months earlier, she visited her father's home, and her father grabbed her vagina over her clothing. The teen later recanted her statements. DCFS unfounded the teen's father for sexual molestation (#21) and substantial risk of sexual abuse (#22). One week later, DCFS received a report that the teen was at the police station because her paternal grandmother and paternal aunt no longer wanted to care for her. DCFS opened companion investigations against the teen's grandmother and aunt. The grandmother and the aunt both told the CPI they struggled with caring for the teen because she often ran away. The grandmother adopted the teen when she was a

toddler, but the teen frequently stayed with the aunt as well though the teen recently eloped from the aunt's home. The grandmother arranged for another relative to have temporary guardianship of the teen. DCFS unfounded both investigations for inadequate supervision (#74). Three weeks later, DCFS received a report that the teen did not receive her medications because her grandmother did not provide the teen's medical card to the other relatives caring for the teen. The teen's temporary guardian stated the teen had been to the doctor in recent months, denied the teen was refused medical care, and denied the teen recently asked for her medications. The teen later stated she refused to take medications or attend appointments, and she denied the grandmother neglected her. DCFS unfounded the teen's grandmother for medical neglect (#79). While that investigation remained pending, DCFS received a report that the teen was not attending school and the teen's temporary guardian gave her prescription pills. The temporary guardian denied the allegations. DCFS unfounded the temporary guardian for substance misuse by abuse (#15) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). While that investigation remained pending, DCFS received a report that the teen went on run and police located her, but her grandmother refused to retrieve her. The teen was then hospitalized after she reported she used substances. The grandmother worked with hospital staff and two weeks later the teen was discharged to her grandmother's care. DCFS unfounded the teen's grandmother for lock out (#84). One month before the teen's death, DCFS received a report that the teen's grandmother refused to allow the teen to return home from detention where she had been sent after being caught stealing. The teen's probation officer stated he planned to recommend a continued stay in detention because the teen did well with structure. The teen stated she wanted to go home to her grandmother, who stated she also wanted the teen to return home, but she wanted the teen to follow rules. The teen and her grandmother agreed to intact family services, but the grandmother later changed her mind. DCFS unfounded the grandmother for lock out (#84).

Child No. 112	**DOB: 06/2024**	**DOD: 06/2024**	**Accident**
Age at death:	2 weeks		
Cause of death:	Asphyxia due to unsafe sleep environment		
Reason for review:	Youth in care and pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old was found unresponsive by his foster parent, his maternal grandmother, after she fell asleep with the newborn in her arms. He was pronounced deceased at the hospital. The grandmother stated the newborn's 15-year-old cousin woke her, and she found the newborn unresponsive, with blood under his nose. The cousin confirmed she found the newborn between the grandmother and the couch. DCFS indicated the infant's maternal grandmother for death by abuse (#1) but unfounded her for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: The newborn's family had an intact family services case that opened over a year before the newborn's birth related to concerns about substance use. Within the year before the newborn's death, the mother continued to test positive for substances, and the intact worker entered an in-home safety plan that disallowed the mother from being alone with the newborn's then 15-year-old sister. The safety plan ended two months later, after the mother completed mental health and substance use evaluations and completed three negative toxicology screenings. The day after the newborn's birth, DCFS received a report that the mother and newborn tested positive for cocaine and marijuana at the hospital. The CPI took protective custody of the newborn and his sister and notified the newborn's father, who denied knowledge of the mother's drug use. The sister was placed with the grandmother and great-aunt, who obtained an order of protection against the mother. The newborn was discharged to the grandmother and great-aunt, and the CPI documented a discussion about safe sleep. The child protection investigation remained pending at the time of the newborn's death. DCFS later indicated the newborn's mother for substance misuse by abuse (#15) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three days before the newborn's death, the handoff and transitional visit between the intact team and placement team was held. The placement worker completed a safety checklist and documented a discussion about safe sleep after the grandmother placed the newborn down in a loose blanket. The placement case remained open at the time of the newborn's death, three days later.

Child No. 113	DOB: 02/2024	DOD: 06/2024	Accident

Age at death: 4 months
Cause of death: Positional asphyxia due to unsafe sleep environment with bedsharing
Reason for review: Open intact family services case at time of child's death
Action taken: Investigatory review of records.

Narrative: Four-month-old was found unresponsive by his father and he was pronounced deceased at the scene. The infant's parents reported they co-slept with the infant. During the child protection investigation, the CPI observed a crib next to the parents' bed. The autopsy report noted there was no evidence of abuse or neglect. DCFS unfounded the infant's parents for death by neglect (#51).

Reason for Review: Over a year before the infant's birth, DCFS opened an intact family services case. In the year before the infant's death, the intact worker continued to make biweekly visits at the home and noted no concerns of abuse or neglect to the infant's then 3-year-old sister. Three months before the infant's birth, the mother disclosed her pregnancy. The mother completed a mental health assessment, parenting classes and participated in therapy. The worker noted the mother needed to complete a psychological evaluation. The intact worker documented the mother was employed and obtained housing with the help of Norman funds for the deposit. The sister was on the waitlist for daycare and a developmental screening. She had discontinued speech therapy due to insurance issues, and the mother reported she would pursue speech therapy services again when the sister began preschool. The family's visits were reduced to once per month. One month before the infant's birth, the intact worker completed a home safety checklist, noted the children had appropriate sleeping arrangements, and the home was safe. Following the infant's birth, the mother refused to provide the infant's full name or birthdate and requested the intact case be closed. The intact worker continued to meet with the family monthly and observed safe sleep arrangements for the children. The intact worker noted the mother was not working and the father was the family's sole provider. The intact family services case remained open at the time of the infant's death.

NATURAL

Child No. 114	DOB: 10/2014	DOD: 07/2023	Natural

Age at death: 8 years
Cause of death: Intracerebral hemorrhage due to ruptured arteriovenous malformation
Reason for review: Youth in care; pending child protection investigation at time of child's death
Action taken: Investigatory review of records

Narrative: Eight-year-old was found unresponsive in the morning by her foster mother/paternal sister. The child was pronounced deceased at the hospital. Family members reported the child had recently been complaining of headaches. The autopsy showed the child had a brain bleed that was not trauma-induced and would have caused headaches. The CPI spoke with the child's pediatrician, who denied concerns for medical neglect. DCFS unfounded the child's foster parents for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the other children in the home.

Reason for Review: The child and her maternal brother had been in foster care since they were 3 years old and 5 years old respectively. They were placed with the child's paternal sister approximately three years before the child's death. In the year before the child's death, the permanency goal was changed to guardianship. Approximately six weeks before the child's death, DCFS received a report that the child's 9-year-old brother disclosed the foster mother had physically abused him. The CPI met with the child and her brother at school. The child denied the foster parents hit her or her brother. The foster parents denied they hit the children. The investigation remained pending at the time of the child's death. DCFS later unfounded the foster mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) to the child's brother.

Child No. 115	DOB: 07/2023	DOD: 07/2023	Natural

Age at death: 11 days
Cause of death: Status epilepticus due to pulmonary hemorrhage due to intracranial hemorrhage
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Eleven-day-old died. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: Prior to the newborn's birth, DCFS received a report that the newborn's 3-year-old paternal half-sister had been physically and sexually abused by her father, who cared for her one night a week. The sister's mother filed a police report. Medical staff who examined the sister reported no signs of physical abuse or trauma. The CPI contacted the father, who agreed not to have contact with the sister during the investigation. The sister completed a victim sensitive interview and did not make any outcries, and her mother informed the CPI she allowed the father's visits, which were court-ordered by family court, to resume. Eleven months before the newborn's birth and death, DCFS unfounded the father for sexual molestation (#21) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 116	DOB: 11/2022	DOD: 07/2023	Natural
Age at death:	8 months		
Cause of death:	Respiratory failure due to placental abruption and secondary cardiac arrest non traumatic; significant contributing condition of chronic respiratory failure status post tracheotomy gastrostomy tube dependent		
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:	Pending systemic issue report		

Narrative: Eight-month-old died in the hospital after he was removed from the life support, he had been placed on six days earlier, because of lung failure. The medically complex infant had been born premature and remained hospitalized following his birth. Hospital staff noted there had been no improvement in his health since his birth. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Five months before the infant's death, DCFS received a report that his then 22-year-old mother left his 2-year-old and 4-year-old siblings home alone when she worked. The mother told the CPI she awoke late for work, did not have time to take the children to daycare, did not have anyone else who could care for the children, and she had never left them home alone before that day. The mother informed the CPI that her then 4-month-old infant, was born premature and had been in the hospital since his birth. The mother agreed to intact family services. The mother moved and the children moved in with the maternal aunt while the mother worked to secure housing. DCFS indicated the infant's mother for inadequate supervision (#74). The family's intact worker completed weekly visits and recommended the mother participate in individual and family therapy, protective daycare, and parenting classes. During the intact case the mother engaged in trainings at the hospital and began parenting classes, and the infant's siblings attended daycare. The month before the infant's death, the mother moved into a new apartment, which the intact worker assessed as safe.

Child No. 117	DOB: 11/2020	DOD: 07/2023	Natural
Age at death:	2 years		
Cause of death:	Viral myocarditis with viral meningitis, laryngitis, tracheitis, and bronchitis		
Reason for review:	Closed child welfare services referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-year-old was found unresponsive by his father when he awoke in the morning. The father reported the toddler went to urgent care two days earlier for fever and was diagnosed with pharyngitis, a cough and fever, and given dexamethasone then sent home. The father reported the toddler woke up crying and coughing the night before. DCFS unfounded the investigation into the infant's death for death by neglect (#51).

Reason for Review: Approximately six months before the toddler's death, DCFS received a report of a physical altercation between the toddler's mother and grandmother, while the toddler and his brother were present. DCFS took the report for a child welfare services referral to ensure the mother and children were safe and provide domestic violence resources. The worker made multiple attempts to locate the family but was unsuccessful. One month later, DCFS closed the child welfare services referral.

Child No. 118	DOB: 04/2019	DOD: 08/2023	Natural
Age at death:	4 years		
Cause of death:	Bronchopneumonia; significant contributing condition of complications of prematurity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Four-year-old medically complex child was found unresponsive at home by her father. The child was pronounced deceased at the hospital. The child had been born premature, at 24 weeks gestation, with cerebral

palsy, congenital malformation of the brain, atrial septal defect, and hemangioma of skin and subcutaneous tissue. She had been hospitalized multiple times and required a g-tube and tracheotomy. DCFS did not investigate her death for abuse or neglect.

Reason for Review: Eleven months before the child's death, DCFS received a report that the parents of the then-3-year-old child did not provide necessary oxygen treatments when home health care workers were not present, did not adhere to feeding precautions to prevent aspiration, and did not notify the doctor as needed. Additionally, it was reported that the mother hit the child's 5-year-old brother. The child's parents denied the allegations. The parents stated they were trained and provided the necessary medical care for the child. During the visit, the CPI observed the mother suction the child's tracheotomy, and the child appeared comfortable with the parents. The CPI noted the brother appeared free of observable injuries. The child's nursing agency told the CPI that the family had an in-home nurse who worked 12-hour shifts. The child's doctor reported she had been seen during the investigation and there were no concerns. DCFS unfounded the child's parents for medical neglect (#79), and for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60).

Child No. 119	DOB: 03/2022	DOD: 08/2023	Natural
Age at death:	16 months		
Cause of death:	Complications of prematurity; significant contributing factor of maternal substance abuse		
Reason for review:	Youth in care; indicated child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Sixteen-month-old, medically complex toddler died in the hospital. He had been born premature and substance-exposed, had diagnoses of chronic lung disease and pulmonary hypertension, and required a trach, ventilator, and feeding tube. He remained hospitalized until his death. DCFS indicated the toddler's mother for death by neglect (#51).

Reason for Review: The toddler came into DCFS care at two months old, during two child protection investigations that were later indicated for allegations of substance misuse by neglect (#65) to the toddler and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and his siblings. The toddler's siblings were placed with their maternal grandmother. The toddler's parents did not have regular contact with the placement worker. The placement worker documented that the mother had visited the toddler in the hospital a few times. Three months before the toddler's death, the mother gave birth to another substance-exposed infant. DCFS initiated an investigation. The mother stated she used drugs in the days before the birth and did not receive prenatal care. The brother came into DCFS care and placed with the maternal grandmother. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler's newborn brother. Following the investigation, the toddler was transferred to a different children's hospital with a plan to find a foster home.

Child No. 120	DOB: 09/2021	DOD: 08/2023	Natural
Age at death:	22 months		
Cause of death:	Complications of prematurity; significant contributing conditions of pre-mortem aspiration of gastric contents and oral flora; bronchopulmonary dysplasia, chronic lung disease/ chronic respiratory failure; failure to thrive/poor feeding; and gastro-esophageal reflux disease		
Reason for review:	Youth in care		
Action taken:	Pending systemic issue report		

Narrative: Twenty-two-month-old became unresponsive during her g-tube feeding and an ambulance transported her to the hospital, where she was later pronounced deceased. The toddler had been in the care of a respite

caregiver while her foster parents were out of state. A child protection investigation of the toddler's death remains pending.

Reason for Review: The toddler was born substance-exposed and came into DCFS care following her birth. She remained hospitalized for four months and was released to the care of fictive kin. In the year prior to her death, the toddler's placement worker visited the foster home monthly, and the agency also provided nursing consultations. Five months before her death, the toddler was placed in a specialized foster home. The toddler's father initially had weekly supervised visits, participated in drug tests that were consistently negative, and requested to be involved in her medical appointments when possible. In the months before her death the father was living out of state but did video visits and frequently contacted the placement worker. The toddler's mother initially did not engage in services but four months before the toddler's death, the mother began to engage in services, but then stopped contact. The placement worker last saw the toddler in her foster home eleven days before her death. A few days later, her foster parents went on a planned vacation, and the toddler went to a respite caregiver, an unlicensed fictive kin foster home.

Child No. 121	DOB: 02/2016	DOD: 09/2023	Natural
Age at death:	7 years		
Cause of death:	Respiratory failure due to spinal muscle atrophy type 1; significant contributing condition of hypoxic ischemic encephalopathy		
Reason for review:	Youth in care		
Action taken:	Pending systemic issue report		

Narrative: Seven-year-old, medically complex child died in the long-term care facility where he resided. The child had a terminal medical condition, and his health appeared to be worsening in recent months. Approximately one month before his death, he was hospitalized, and his medical care team, facility staff, placement team, and GAL discussed end of life care. The DCFS guardian approved hospice care, and the child returned to the long-term care facility, where he died approximately one week later. DCFS did not investigate his death for abuse or neglect.

Reason for Review: The child came into DCFS care when he was three months old. The child's older sister came into care a year prior. The child was diagnosed with pneumonia and spinal muscular atrophy, a fatal condition that required specialty care, and his parents did not participate in services. In the year prior to his death, the child was placed in a long-term care facility and had a DNR order. In that year, he was hospitalized several times, including a three-month hospitalization that ended two months before his death. His sister's adoptive parents also took the sister to the facility for monthly visits. The child's parents did not have contact with the child. The child participated in school through the homebound school program and worked with his teacher three days per week. His placement worker last saw him in the hospital, approximately two weeks before his death.

Child No. 122	DOB: 01/2022	DOD: 09/2023	Natural
Age at death:	20 months		
Cause of death:	Complications of congenital central hypoventilation syndrome		
Reason for review:	Open intact family services case and pending child protection investigation at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Twenty-month-old medically complex toddler was found unresponsive while in the care of her home health nurse. She was pronounced deceased three days later, after she was removed from life support. DCFS unfounded the in-home nurse for death by neglect (#51) and medical neglect (#79). The criminal investigation remains pending.

Reason for Review: Four months after the toddler's birth, DCFS received a report that the mother physically abused the toddler's then 16-month-old sister. The mother denied the allegations. The toddler, who was born with multiple medical complications and required a feeding tube and ventilator, remained hospitalized following her birth. The toddler was discharged home while the investigation remained pending. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and opened an intact family services case. The toddler received daily nursing care, multiple therapies, and monthly dietician visits. While the intact family services case remained open, DCFS received a report with concerns about the mother's care of the toddler. The mother denied the allegations and stated she ensured the toddler received all needed care. DCFS unfounded the mother for inadequate food (#76) and medical neglect (#79). The intact worker documented the mother continued to engage in services and ensure her children attended all recommended therapies and appointments. The family reported issues with receiving adequate nursing hours for the toddler's care and the mother requested help from the nursing agency and DSCC. Less than two weeks before the toddler's death, DCFS received a report that the mother did not provide adequate care for the children, and the mother left the toddler alone while she smoked marijuana in the garage. The mother denied the allegations and the home did not smell of marijuana. Intact staff denied concerns for abuse or neglect in the home. The investigation and intact family services case both remained open at the time of the toddler's death. DCFS later unfounded the mother for inadequate supervision (#74) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 123	**DOB: 08/2023**	**DOD: 09/2023**	**Natural**
Age at death:	7 weeks		
Cause of death:	Complications of rhinovirus/enterovirus infection; significant contributing condition of prematurity		
Reason for review:	Open intact family services case at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-week-old died in the NICU two days after she was found unresponsive and brought to the hospital by family. The infant and her twin brother were born premature, at 35 weeks gestation, with respiratory issues. DCFS unfounded the mother and father for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: At the time of the infant's death, the family had an open intact family services case that had opened over one year earlier. The intact worker made regular visits to the home. Three months before the infant's birth, the intact worker documented the mother had obtained stable housing and was cooperative with services. The infant and her twin brother remained in the NICU for weeks following their birth. The intact worker provided the family pack-and-plays following their discharge from the hospital and placed an order for cribs using Norman funds. The intact worker last saw the family at a home visit nine days before the infant's death. The intact family services case remained open at the time of the infant's death.

Child No. 124	**DOB: 05/2015**	**DOD: 10/2023**	**Natural**
Age at death:	8 years		
Cause of death:	Complications of morbid obesity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Eight-year-old was found unresponsive in the morning, when her mother attempted to wake her. The child was pronounced deceased at the hospital. DCFS did not investigate her death for abuse or neglect.

Reason for Review: Eight months before the child's death, DCFS received a report that the then 7-year-old child stated her then 12-year-old brother hit her when he babysat her the prior evening. Family members reported the children's aunts cared for the children when the mother worked, and the adults denied they had seen the brother

hit the younger children. The brother denied hitting his siblings. The CPI observed no injuries to the children. DCFS received a related information report that the child did not have adequate clothing and the brother was not attending school and was left unsupervised. The school reported to the CPI that they were assisting the family with clothing. The mother confirmed the brother refused to attend school and reported the school referred him to a day treatment program. DCFS unfounded the child's mother for inadequate supervision (#74).

Child No. 125	DOB: 04/2007	DOD: 10/2023	Natural
Age at death:	16 years		
Cause of death:	Cardiac arrythmia due to hypertrophic cardiomyopathy		
Reason for review:	CWS referral within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Sixteen-year-old was found unresponsive in her bedroom. The teen's mother reported she last saw her alive approximately two hours earlier. First responders reported the teen did not have a bed or mattress in her bedroom and the home was cluttered and unsafe. DCFS indicated the teen's mother for death by neglect (#51) and environmental neglect (#82).

Reason for Review: One month before the teen's death, DCFS received a report that the teen sent inappropriate photos, was impulsive and had an intellectual disability. DCFS opened a child welfare services referral. One week after the report, the mother informed the CWS worker that the issue had been handled. The CWS worker offered to assist the family with resources, but the mother was non-responsive. One week before the teen's death, DCFS closed the CWS referral.

Child No. 126	DOB: 05/2022	DOD: 11/2023	Natural
Age at death:	17 months		
Cause of death:	Complications of acute necrotizing hemorrhagic encephalopathy		
Reason for review:	Closed intact family services case and three unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Seventeen-month-old medically complex toddler was found unresponsive by his parents, who reported they gave him a bottle, then placed him to sleep next to them on an adult-sized air mattress. The toddler was pronounced deceased at the hospital. DCFS unfounded the toddler's mother and father for death by neglect (#51) and cuts, bruises, welts, abrasions, and oral injuries by neglect (#61).

Reason for Review: When the toddler was 2 months old, DCFS received a report that his mother abused substances, there were incidents of domestic violence between the parents, and the toddler and his then 3-year-old and 5-year-old maternal siblings were frequently dirty and hungry. The toddler's mother and father denied the allegations and each completed toxicology screenings that were negative for all substances. DCFS unfounded the toddler's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82) and the parents agreed to intact family services. While the prior investigation remained pending, DCFS received a report that the then 3-month-old toddler presented at the emergency department after his paternal great aunt gave him baking soda to treat thrush and his father found the toddler lethargic. The toddler was hospitalized, and medical tests revealed an organic diagnosis of acute necrotizing encephalitis with metabolic etiology. DCFS unfounded the aunt for poison/noxious substances by abuse (#6) and substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). While the intact case was open, DCFS received a report that the toddler's 5-year-old sister had a swollen eye and a mark on her face but would not disclose how the injury happened. The mother reported the sister had been hit in the eye with a belt while playing with her 4-year-old sister. A treating physician reported the children provided the same explanation which was consistent with the injury and had no concerns for abuse or neglect. DCFS unfounded the toddler's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The family's intact case worker attempted to

engage the family in services and provided housing resources. The parents were not cooperative, and the intact case closed as the family was moving out of the area.

Child No. 127	DOB: 09/2023	DOD: 11/2023	Natural
Age at death:	5 weeks		
Cause of death:	Acute pneumonia		
Reason for review:	Youth in care and pending child protection investigation at time of child's death; two indicated child protection investigations within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Five-week-old was found not breathing by his foster mother in a car seat where he had been sleeping. The infant was pronounced deceased at the hospital. His foster parent reported she last saw him alive approximately one hour earlier. The DCFS investigation of the infant's death remains pending.

Reason for Review: Nine months before the infant's birth, DCFS received reports that his then 2-week-old brother had missed a medical appointment, his umbilical cord tested positive for cocaine, his mother received limited prenatal care, and his mother had untreated mental health issues. The mother reported she lacked transportation to take the brother to his appointments and denied she used cocaine. Medical staff confirmed the brother's umbilical cord tested positive for cocaine and his primary care physician opined that the brother was medically neglected. DCFS indicated the infant's mother for substance misuse by neglect (#65) and medical neglect (#79). While that investigation was pending, DCFS received a report that the infant's then 4-month-old brother presented for a medical appointment in the care of a babysitter and was underweight and malnourished. Medical providers found the brother gained weight while being cared for by fictive kin and his failure to thrive appeared to be the result of lack of caloric intake. An intact family case opened, but two weeks later, DCFS took protective custody of the children after the father became aggressive towards the mother and worker. DCFS indicated the mother for inadequate food (#76) and malnutrition (#83) and indicated both parents for substantial risk of physical injury/ environment injurious to health and welfare by neglect (#60). Following the infant's birth, DCFS received a report due to his siblings being in care. He could not swallow on his own, and he remained in the hospital for three weeks. The placement worker informed the CPI that the mother had not made progress on services, and DCFS took protective custody of the infant upon his release from the hospital and placed him with his siblings in the relative foster parent's home. The child protection investigation remained open at the time of the infant's death. DCFS later indicated the infant's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 128	DOB: 07/2022	DOD: 11/2023	Natural
Age at death:	15 months		
Cause of death:	Complications of schizencephaly; significant contributing conditions of hydrocephalus; sympathetic storming		
Reason for review:	Youth in care; pending child protection investigation at time of child's death		
Action taken:	Pending systemic issue report		

Narrative: Fifteen-month-old, medically complex child was found unresponsive in her crib at the long-term care facility where she had been admitted approximately two weeks earlier. She was transported to the hospital, where she was pronounced deceased. The toddler had multiple medical complexities, including congenital hydrocephalus, congenital hypertonia, cerebral cyst, dysphagia, and seizures. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: At the time of the toddler's birth, her siblings were in DCFS care, placed with their maternal grandmother. The toddler also came into care but remained hospitalized, and her mother had supervised visits. In the year prior to the toddler's death, her grandmother completed training on her medical care and received needed equipment. Ten months before the toddler's death, she was discharged to her grandmother's care. The

grandmother agreed to pursue adoption of all three children. The toddler was under the care of a neurologist, optometrist, and received physical therapy; and was approved for specialized foster care. In the two months before her death, the toddler was admitted to the hospital due to issues with her feeding tube. DCFS later received a report that the toddler was behind on both well-child visits and specialist visits, early intervention services had not started, and the grandmother did not use prescribed eyedrops on the toddler because the pharmacy did not carry them. The toddler's pediatrician stated the grandmother took the toddler to multiple specialists, and the doctor did not believe the situation met criteria for medical neglect. One month after the pending child protection investigation opened, the toddler was moved to a long-term care facility due to her extensive medical needs. She remained at the facility until her death. At the time of her death, the placement case remained open, and the child protection investigation remained pending. DCFS later unfounded her grandmother for medical neglect (#79).

Child No. 129	DOB: 06/2010	DOD: 11/2023	Natural

Age at death: 13 years
Cause of death: Respiratory Failure due to Metastatic Rhabdoid Pleuropulmonary Blastoma
Reason for review: Pending child protection investigation at time of child's death
Action taken: Investigatory review of records

Narrative: Thirteen-year-old had been diagnosed with rhabdomyosarcoma and pleuropulmonary blastoma when he was a toddler. In the years leading up to his death, the teen received in-home hospice care. The teen's legal guardian was his maternal grandmother, and hospice workers reported the maternal grandmother took excellent care of him. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Ten days before the teen's death, DCFS received a report that the teen's maternal grandmother married a registered sex offender, and the grandmother's spouse was living in the family home. The reporter added the home did not have running water for three days, and the teen's 6-year-old brother had a documented seizure disorder, but the maternal grandmother had not made an action plan with his school. The maternal grandmother reported she had guardianship of the teen and his 6-year-old, 7-year-old, 10-year-old, and 17-year-old siblings. She confirmed the 6-year-old brother had a seizure disorder and stated he was scheduled to see his physician in three days to renew his seizure action plan. The maternal grandmother reported they had issues with the water because the home's well had not been working, but the landlord had fixed it. The maternal grandmother reported her spouse was a registered sex offender, but they were permitted to have contact with children. The teen's hospice nurse reported the teen had terminal cancer and his doctor expected him to die within the coming weeks. She noted the maternal grandmother took exceptional care of the teen. The investigation remained pending at the time of the teen's death. DCFS unfounded the maternal grandmother's spouse for substantial risk of sexual abuse (#22) and unfounded the maternal grandmother for inadequate shelter (#77).

Child No. 130	DOB: 11/2023	DOD: 12/2023	Natural

Age at death: 3 days
Cause of death: Multiple congenital anomalies due to refractory hyperkalemia due to cardiac arrhythmia
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Investigatory review of records

Narrative: Three-day-old died at the hospital. She had been born premature, at 31 weeks gestation, with multiple abnormalities. She was transferred to the NICU in a children's hospital and was never discharged home. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: Six months before the newborn's birth, DCFS received a report that the newborn's mother was living with her 13-month-old son in maternal grandmother's home, which was dirty and in disrepair. Family members reported the mother and newborn's brother lived out of state with other relatives but had visited the grandmother's home the day before with the brother's father, and an altercation ensued between the brother's

parents. The mother confirmed she had visited family and argued with the brother's father who pushed her. DCFS unfounded the investigation for environmental neglect (#82).

Child No. 131	DOB: 12/2014	DOD: 12/2023	Natural
Age at death:	8 years		
Cause of death:	Stroke due to Covid infection; significant contributing condition of mitral stenosis		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Eight-year-old, medically complex child died at the hospital. DCFS did not investigate her death for abuse or neglect.

Reason for Review: One month before the child's death, DCFS received a report that the child's g-tube site leaked, she vomited after feedings at school, and she appeared malnourished. The reporter stated they urged the mother to take the child to the doctor and the child had missed eight consecutive days of school because she was sick, but the mother had not sought medical care. Four days after the report, the CPI learned the family left the country. The child's primary care provider told the CPI there were no concerns for the child in the mother's care, and the mother followed the doctor's recommendations, followed through on testing, had enough food for the child, and requested prescription formula as needed. The doctor denied this was a case of medical neglect or malnutrition, as the child's health was complex, and her recent weight loss was due to illness. DCFS unfounded the parents for inadequate food (#76), medical neglect (#79), and malnutrition (#83).

Child No. 132	DOB: 02/2023	DOD: 12/2023	Natural
Age at death:	9 months		
Cause of death:	Respiratory failure due to COVID-19; significant contributing condition of hypoxic ischemic encephalopathy		
Reason for review:	Youth in care; one indicated child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Nine-month-old died of COVID-19 in the residential nursing care facility where he had been receiving palliative care. The infant remained in the NICU for the first nine months of his life after he sustained brain damage during birth due to placental abruption and loss of oxygen. He was transferred to the residential facility a few weeks before his death. DCFS did not investigate his death for abuse or neglect.

Reason for Review: Nine days after the infant's birth, DCFS received a report that the meconium drug screen was positive for a cocaine metabolite. Medical staff stated the infant was receiving care in the NICU at a children's hospital in a neighboring state. He was in critical condition from hypoxia, but not because of his mother's drug use. The mother reported taking two ecstasy pills when she was 12-14 weeks pregnant and denied other drug or alcohol use. She stated the infant's siblings were not home when she took the pills. DCFS took protective custody of the children and placed the half-siblings with their father, and the court granted temporary custody. The infant remained in the NICU. DCFS indicated the infant's mother for substance misuse by neglect (#65) to the infant and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the infant's siblings. The mother participated in visits with the children but never engaged in services. The father of the siblings was granted guardianship and their cases closed. The infant remained in the neighboring state children's hospital for nine months before transferring to a residential nursing care facility in Illinois.

Child No. 133	DOB: 08/2007	DOD: 12/2023	Natural

Age at death:	16 years
Cause of death:	Sudden unexpected death in epilepsy
Reason for review:	Youth in care
Action taken:	Pending systemic issue report

Narrative: Sixteen-year-old went into cardiac arrest and was found by his foster parent/sister. He was pronounced deceased at the hospital. The teen had a seizure disorder for which he received medical treatment. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Five years prior to the teen's death, the teen and his then 12-year-old and 15-year-old siblings came into care because their parents were non-compliant with intact family services. They were placed with their adult sister. The teen had a seizure disorder but was free of seizures on his prescribed medication. Eight months before the teen's death, he had gone without his seizure medication due to an issue with his insurance and was hospitalized following a seizure. He was later discharged from the hospital and had his medication refilled. The teen awaited placement in a school that could accommodate his needs and the placement worker referred the case to an educational liaison for assistance. The educational liaison continued to work with the family to help them re-enroll the teen in school. In the months prior to his death, the teen had multiple seizures and ended up in the hospital. The sister reported she planned to meet with a neurologist. She also noted she found a few pills of the teen's seizure medication in his pocket, and she informed the placement worker she would oversee the teen's medication regimen.

Child No. 134	DOB: 12/2023	DOD: 12/2023	Natural

Age at death:	5 hours
Cause of death:	Acute respiratory failure with severe pulmonary hypertension due to metabolic acidosis due to severe pulmonary hypertension
Reason for review:	Open placement case at time of child's death; two indicated child protection investigations within one year of child's death
Action taken:	Investigatory review of records

Narrative: Newborn died in the hospital five hours after her birth. The mother disclosed she used drugs during the pregnancy, and she tested positive for cocaine and marijuana at the hospital. She also stated she did not receive prenatal care. DCFS indicated the mother for death by neglect (#51) and substance misuse by neglect (#65).

Reason for Review: Nine months before the newborn's birth, DCFS received multiple reports that the newborn's 16-year-old maternal half-sister threatened self-harm after a verbal altercation with her mother, the mother reportedly did not respond to the sister's mental health needs; and the mother used substances. After an initial visit, the parents refused to cooperate or allow the CPI to see the children. The grandmother stated she cared for the 16-year-old. DCFS indicated the mother and newborn's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the mother for mental injury by abuse (#17). One week later, DCFS received a report that police stopped the newborn's father after they observed a narcotics transaction, and the newborn's parents admitted they purchased cocaine while the newborn's then 8-month-old brother was in the car. The CPI observed the home to be unkempt and the parents reported they co-slept with the 8-month-old. DCFS took protective custody of all three children, and the court granted DCFS temporary custody. The children were placed with their maternal grandparents. DCFS indicated the mother and newborn's father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The mother and newborn's father were not compliant with services, did not communicate with the placement worker, and did not attend supervised visits. The placement worker conducted regular visits at the grandparents' home. The newborn's siblings remained in the care of their grandparents at the time of the newborn's birth and death.

Child No. 135	DOB: 10/2023	DOD: 12/2023	Natural

Age at death:	2 months
Cause of death:	Sudden unexplained infant death
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 by his mother, who was sharing a bed with him. The infant was pronounced deceased at the hospital. DCFS unfounded the infant's parents for death by neglect (#51).

Reason for Review: Nine months before the infant's birth, DCFS received a report that the infant's 9-month-old, 6-year-old, and 8-year-old siblings were left home alone, and the father arrived a few minutes after the reporter went to the home. The father told the CPI that the mother, who was out of the home, had left the children in his care and he left the children alone for a few minutes to get food. The CPI later spoke with the 6-year-old and 8-year-old siblings who stated they had only been left home alone once. The CPI noted the children appeared healthy. The family declined services. DCFS indicated the infant's father for inadequate supervision (#74).

Child No. 136	DOB: 10/2022	DOD: 12/2023	Natural

Age at death:	14 months
Cause of death:	Viral pneumonia due to adenovirus and respiratory syncytial viral infections; significant contributing condition of chronic lung disease of prematurity
Reason for review:	Youth in care; indicated child protection investigation within one year of child's death
Action taken:	Pending systemic issue report

Narrative: Fourteen-month-old medically complex toddler was found unresponsive in his crib wearing his oxygen cannula. The family called 911 and began CPR. The toddler was pronounced deceased at the hospital. The family reported the toddler had a mild cold with a cough and runny nose and had been lethargic the night before. The child had been born premature, at 22 weeks gestation, and spent the first nine months of his life in the hospital. They stated he had last been seen alive and sleeping, six hours earlier. DCFS unfounded the toddler's mother, grandmother, and grandfather for death by neglect (#51).

Reason for Review: Four months before the toddler's death, DCFS received a report that the then-10-month-old toddler was being treated for partial and full thickness burns after his father placed him in a bath but was not taken to the hospital until hours later. The CPI observed the toddler at the hospital and took protective custody. The toddler remained hospitalized for more than three months for burns over 29% of his body. The treating physician reported that skin does not always blister immediately, the story was plausible, but could not account for every burn. The physician noted concern about the toddler's low weight. Staff at the primary provider's hospital expressed concern about whether the child's feeding plan was followed at home. The physician treating the toddler's burns did not conclude medical neglect due to the delay in seeking care, but stated the burns and failure to thrive were due to neglect. Police closed their investigation after they determined the burns were accidental. DCFS indicated the toddler's father for burns by neglect (#55) and indicated both parents for failure to thrive (#81). The placement case remained open at the time of the toddler's death. His mother participated in parenting classes and specialized medical training. The father initially participated in parenting classes but stopped attending and disengaged from the placement case. Less than two weeks before his death, the toddler was discharged to the care of his maternal grandmother. The placement worker last saw the toddler two days before his death.

Child No. 137	DOB: 07/2015	DOD: 12/2023	Natural
Age at death:	8 years		
Cause of death:	Septic shock with multiorgan failure		
Reason for review:	Open intact family services case at time of child's death; two indicated and six unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Eight-year-old, medically complex child died at the hospital one day after admission. The family brought the child to the hospital after noting a difference in her activity and other members of the home tested positive for COVID-19. She had a history of congenital hydrocephalus with multiple seizures and received in-home nursing services eight hours per day. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: In the year prior to the child's death, DCFS conducted eight child protection investigations involving the child and her three siblings, a 14-year-old brother, a 4-year-old brother, and a 2-year-old sister. DCFS received a report that the then 14-year-old brother had been hospitalized for behavioral issues. The 14-year-old's physician did not support the allegation of mental injury, and DCFS unfounded both parents for an allegation of mental injury by neglect (#67) and substantial risk of sexual abuse (#22). While the previous investigation remained pending, DCFS received a report that the 14-year-old fell down the stairs during an argument with the mother, but he did not sustain any injuries. DCFS indicated the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). While this investigation remained pending, DCFS initiated a third investigation after a report that the 14-year-old alleged his father abused him. School staff reported the 14-year-old demonstrated aggressive behaviors and denied they had witnessed evidence of physical injury to him. The parents reported concern about the 14-year-old remaining in the home due to his behaviors and were seeking residential treatment. DCFS unfounded the father for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Approximately one month later, DCFS received a report that the 8-year-old medically complex child had bruising to the left side of her face, and a human bite mark on her thigh. The mother believed the 4-year-old sibling injured the child because the 4-year-old had a missing tooth that matched the bite mark. DCFS unfounded the parents for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61); human bites by neglect (#62); inadequate supervision (#74); and medical neglect (#79). While the previous investigation remained pending, DCFS received a report that the 14-year-old was arrested for domestic battery and the parents refused to pick him up. The parents told the CPI they initially did not want to allow the 14-year-old to return to the home, but then agreed while continuing to seek residential treatment for him. DCFS unfounded the 14-year-old for substantial risk of sexual abuse (#22) and unfounded the father for lock out (#84). DCFS opened an intact services case. The intact worker conducted both announced and unannounced weekly visits. The child had an in-home nurse as she required significant care related to a feeding tube and ventilator. The intact worker referred the 14-year-old, the 17-year-old, and the mother to a community agency for therapy services. Three months before the child's death, DCFS received a report that the 4-year-old bit the child while the mother slept in a chair next to the crib. While the prior investigation remained pending, DCFS initiated another investigation following a new report of bite marks and bruising to the child, caused by the 4-year-old. The mother stated she fell asleep in the room with the child but did not wake when the 4-year-old reportedly injured the child. The parents agreed to always supervise the medically complex child and add a lock to the door. The intact worker later observed a keypad to prevent the 4-year-old from entering the room unsupervised. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61) and human bites by neglect (#62) and DCFS unfounded the mother for inadequate supervision (#74) and cuts, bruises, welts, abrasions, and oral injuries by neglect (#61). During the pending investigations, DCFS received multiple related information reports involving the 14-year-old's aggressive behavior. Two months before the child's death, DCFS received a report that the parents refused to allow the 14-year-old to return home from a treatment facility. The parents stated they completed paperwork for residential treatment and agreed to speak with the facility about treatment planning. DCFS indicated both parents for medical neglect (#79) but unfounded them for lock out (#84). The intact worker continued to visit the home and noted no concerns. The intact worker last saw the child during a home visit approximately one week before her death. The intact family services case remained open at the time of the child's death.

Child No. 138	DOB: 05/2013	DOD: 12/2023	Natural

Age at death:	10 years
Cause of death:	Cerebral palsy, obstructive sleep apnea
Reason for review:	Indicated child protection investigation within one year of child's death
Action taken:	Pending systemic issue report

Narrative: Ten-year-old, medically complex child was found unresponsive by his mother. Paramedics responded, intubated the child, and transported him to the hospital. The child regained a pulse but later experienced complications and was pronounced deceased. The child's medical diagnoses included cerebral palsy, epilepsy, neuromuscular sclerosis, and asthma. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Ten months before the child's death, DCFS received a report that the mother sought medical care after the child's leg was swollen. The reporter said they found the child sustained a broken femur, but they did not know how or when the injury occurred. During the investigation, school staff reported the child appeared fine at school that day and had constant supervision. The child's parents provided consistent statements that the child did not appear to be in pain when the mother picked him up from the bus, the mother left him with his father when she picked the other children up from school, and the in-home nurse later arrived and noticed the child's leg was swollen. The in-home nurse instructed the parents to bring the child to the emergency room if the leg did not improve by the following day, and they took him the next morning. They later followed up with an orthopedist. The child's primary care physician denied concerns about the parents' care for the child and stated children with cerebral palsy can sustain spontaneous bone fractures. DCFS indicated an unknown perpetrator for bone fractures by abuse (#9).

Child No. 139	DOB: 03/2016	DOD: 01/2024	Natural

Age at death:	7 years
Cause of death:	Septic shock due to influenza B virus infection
Reason for review:	Split custody at time of child's death; closed intact family services case and six unfounded child protection investigations within one year of child's death
Action taken:	Investigatory review of records

Narrative: Seven-year-old became ill and had a high fever. The child was pronounced deceased at the hospital a few days later. It was reported that the family delayed seeking treatment because they did not want DCFS to become involved again. DCFS indicated the mother and stepfather for environmental neglect (#82) but unfounded them for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: At the time of the child's death, the child's 3-year-old stepsister, the stepfather's daughter, had been a youth in care for over two years. She attended weekly supervised visits at his home. The stepfather's progress with other recommended services was inconsistent. Approximately twelve months before the child's death, DCFS opened four concurrent child protection investigations related to the family. The first report alleged the mother threw a phone at the child's then 4-year-old sister, resulting in a black eye and the mother and stepfather had a history of domestic violence. The mother and children reported the mother accidentally dropped the phone on the sister's face when they were watching videos while lying down. The children denied any domestic violence. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The second report alleged the children's aunt, who had temporary guardianship of the child and her then 4-year-old and 8-year-old sisters, was sending the children back to live with their mother. All family members denied the allegations. DCFS unfounded the aunt for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The third report alleged that the child's 8-year-old cousin, had recently visited the aunt, observed the aunt smoke something, then fall asleep, and it was difficult to wake her. The aunt completed a drug screening that was negative for all substances. DCFS unfounded the aunt for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The fourth report alleged the aunt physically abused an 8-year-old cousin. The

family members reported the aunt sent the 8-year-old cousin to her room for a timeout and stood in the doorway to prevent her from leaving. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60). Eleven months before the child's death, the mother and stepfather's intact family services case opened. At the case's start, the child and her then 4-year-old and 8-year-old sisters continued to live with their aunt. The family moved into a new home during the intact case, and the child and her then 4-year-old sister returned to their mother's care. The 8-year-old sister returned to the mother's care a few months later. Shortly after returning to their mother's care, DCFS received a report that the children complained of hunger, the home had insects and mice, and the mother threw objects at them. The children stated they had enough to eat and denied their mother ever threw anything at them. The CPI noted the home appeared clean, free of infestations, and was stocked with food. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10), inadequate food (#76), and environmental neglect (#82). Throughout the intact case, the intact worker visited the home regularly and noted the home was often cluttered and sometimes dirty but met minimal standards. The mother and stepfather engaged in recommended services. Eight months before the child's death, DCFS received a report that the child's sister, who had turned 5 years old, had a black eye and stated someone hit her. The child and her 5-year-old sister denied the adults in the home harmed them. DCFS unfounded the mother and stepfather for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). Five months before the child's death, DCFS closed the intact family services case successfully, and the intact worker documented the stepfather would continue to receive services through the stepsister's placement.

Child No. 140	**DOB: 07/2020**	**DOD: 01/2024**	**Natural**
Age at death:	3 years		
Cause of death:	Cardiogenic shock due to pulmonary hypertension due to acute onset chronic respiratory failure		
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:	Pending systemic issue report		

Narrative: Three-year-old medically complex toddler was pronounced deceased at the hospital after being taken there two days earlier for stomach pain. She was diagnosed with pneumonia and a mass in her abdomen that caused an infection. The infection prevented the toddler from regulating her temperature and weakened blood flow to her heart, and the toddler had been scheduled for a surgery, but her heart failed before the surgery. The toddler had been diagnosed with congenital diaphragmatic hernia and hypertension, and she required a feeding tube and oxygen. She received in-home nursing services three times per week and the family worked with DSCC. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: Ten months before the toddler's death, DCFS received a report that the toddler's then 14-year-old brother disclosed that his stepfather, the toddler's father, locked the brother outside in the rain, and when allowed back inside, the father kicked him. The reporter added the brother disclosed this type of punishment had been used before. The CPI met with the brother and noted he provided inconsistent reports. The toddler's 17-year-old brother, mother, and father all denied the father ever abused the14-year-old; they noted the 14-year-old sometimes went outside to calm down but denied he had been locked out of the home. They all reported the 14-year-old had recently exhibited escalating behaviors. The 14-year-old's primary care physician's office shared he had multiple mental health and behavioral diagnoses and had medication prescribed. DCFS unfounded the investigation for torture (#16). Four months before the toddler's death, DCFS received a report that the toddler's brother, who had turned 15, reported during a mental health evaluation that he did not feel safe at home and the parents tried to physically abuse him. During the investigation, the CPI documented the 15-year-old recanted and stated he had been upset about a fishing trip that was canceled due to covid. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Two weeks before the investigation closed, DCFS received a report that the 15-year-old disclosed he was afraid of the father because the father threatened him, and his mother did not intervene. The parents denied the allegations, and the

17-year-old brother reported the 15-year-old was regularly the aggressor. The parents agreed to intact family services. The intact worker reported the family was cooperative, the 15-year-old received therapeutic services but continued to have outbursts, and they were exploring residential placements. DCFS unfounded the investigation for mental injury (#17) and environmental neglect (#82). The family's intact case was opened three months before the toddler's death, while both investigations were pending. The family was cooperative, the 15-year-old participated in services, but they were exploring residential placements. During the intact case, the toddler was hospitalized for three days after she pulled the feeding tube out. Approximately a week before the toddler's death, the intact team determined visits could move from weekly to biweekly because the family was engaged in wraparound services and the 15-year-old was attending counseling regularly. The intact family services remained open when the toddler died the next day.

Child No. 141	**DOB: 02/2021**	**DOD: 01/2024**	**Natural**
Age at death:	2 years		
Cause of death:	Aspiration; significant contributing conditions of cerebral palsy, mental retardation; g-tube feed		
Reason for review:	Open intact family services case at time of child's death; one indicated and two unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Two-year-old was found unresponsive by his father, who stated he woke the toddler, gave him his medications, and began feeding through his feeding tube, then left the room briefly. The toddler was later pronounced deceased at the hospital. The toddler was medically complex, with diagnoses of cerebral palsy, epilepsy, and tethered cord syndrome. DCFS did not investigate his death for abuse or neglect.

Reason for Review: Thirteen months before the toddler's death, DCFS received a report that his grandparents, who lived with the father and cared for the toddler and his 5-year-old and 9-year-old siblings, used drugs, had incidents of domestic violence, and the home was dirty. Police confirmed calls to the address, including a domestic violence incident five months earlier, and an eviction one month earlier. The grandparents confirmed they argued frequently but denied physical altercations and denied substance use. They reported that the father was the main caretaker of the children. They explained the clutter in the home was because they were in the process of moving out of the home. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82). While the previous investigation remained pending, DCFS received a report that the toddler's mother left him and his siblings at home alone overnight, gave the toddler over the counter medications to sedate him, used substances and the children did not attend school. The toddler was hospitalized related to cerebral palsy and epilepsy. Hospital staff denied concerns about the parents' care for the toddler and stated the mother stayed at the hospital with the toddler. The mother denied substance use. The father denied any concerns about the mother using substances. While the investigation remained pending, the toddler pulled out his feeding tube and was transferred to the children's hospital. That evening, DCFS received a report that the toddler had been alone at the children's hospital for six hours, as his mother had not yet arrived, and hospital staff were unable to reach her by phone. The CPI spoke to the mother, who stated she was on her way to the hospital but had to borrow a car for the three-hour drive. Approximately two months later, the mother was arrested for possession of methamphetamine. The mother denied she used drugs and agreed to an oral drug test, which was positive for methamphetamine, amphetamine, and THC. She then admitted to using drugs and agreed to enter substance use disorder treatment and participate in intact family services. The mother entered treatment but did not complete treatment. DCFS indicated the toddler's mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the toddler and his siblings but unfounded the investigation for inadequate supervision (#74). The intact worker met with the family weekly and documented that the father appeared able to meet the toddler's medical needs. One month after the intact case opened, DCFS received a report that the mother used methamphetamine in front of the children. The CPI spoke to the intact worker, who stated the mother had completed a negative drug test one week earlier and the current safety plan did not allow the mother unsupervised contact with the children. The toddler's father and sister stated the children

only saw their mother supervised. The mother denied the allegations and stated she had completed substance use disorder treatment. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). One month before the toddler's death, the father initiated proceedings to obtain sole custody of the children. The intact worker documented the toddler's siblings were doing well in their father's care.

Child No. 142	DOB: 11/2023	DOD: 01/2024	Natural
Age at death:	8 weeks		
Cause of death:	Hypoxic respiratory failure due to severe neonatal encephalopathy		
Reason for review:	Youth in care and pending child protection investigation at time of child's death		
Action taken:	Pending systemic issue report		

Narrative: Eight-week-old died in the hospital, where he had remained since his birth, after life support was removed. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Following the infant's birth, DCFS received a report that he had been born premature, at 28 weeks gestation, and he and his mother tested positive for cocaine. The infant remained in the PICU. The next day, DCFS received a related information report that the mother left the hospital and had not returned, and staff had no way to contact her. The infant had signs of neurological damage and low brain activity. The CPI also spoke with the infant's paternal grandmother, who had custody of the 10-year-old sister, but could not care for the infant. The grandmother reported the mother lacked stable housing and had a mental health diagnosis. The court granted DCFS temporary custody of the infant. Hospital staff told the placement worker the infant had severe damage to the brain stem from birth trauma, four brain bleeds, a gut infection, and he required oxygen and ventilation to breathe as his health declined. Two weeks before the infant's death, DCFS held a child and family team meeting with the infant's maternal aunt to discuss his prognosis. One week later, while the placement case and child protection investigation remained open, the infant's maternal aunt agreed to remove life support. The infant died that day. DCFS indicated the mother for substance misuse by neglect (#65), abandonment/desertion (#75), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded her for inadequate supervision (#74).

Child No. 143	DOB: 07/2008	DOD: 01/2024	Natural
Age at death:	15 years		
Cause of death:	Diabetic ketoacidosis due to diabetes mellitus		
Reason for review:	Youth in care		
Action taken:	Pending systemic issue report		

Narrative: Fifteen-year-old was found lying unresponsive in the home of her boyfriend's grandparents. She was pronounced deceased on the scene. DCFS did not investigate her death for abuse or neglect.

Reason for Review: The teen came into DCFS care when she was 10 years old, after DCFS indicated her mother for medical neglect (#79) for improper management of the teen's diabetes. In the year prior to the teen's death, the teen had been going on run from her foster home. Eight months before the teen's death, she was accepted in a residential placement, but she went on run after one day in the placement, and again returned to a relative's home and her former foster home for periods of time. Throughout her absences from her placement, the teen would often contact her placement worker and report she was safe, but she declined to say where she was. The placement worker and supervisor followed the protocol for missing and on run youth and kept in touch with law enforcement, relatives, and other contacts. She went on run again less than two weeks before she was found deceased.

Child No. 144	DOB: 08/2007	DOD: 02/2024	Natural

Age at death:	16 years
Cause of death:	Diabetic ketoacidosis due to type 1 diabetes mellitus due to sickle cell anemia
Reason for review:	Two unfounded child protection investigations and closed intact family services case within one year of child's death
Action taken:	Pending systemic issue report

Narrative: Sixteen-year-old, medically complex teen was found unresponsive by his grandparents. The teen was pronounced deceased at the hospital. The teen had been diagnosed with sickle cell anemia and type 1 diabetes. The teen had a history of non-compliance with treatment, and his grandparents discussed his non-compliance with his medical providers and social workers. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Over a year before the teen's death, DCFS opened an intact family services case following a child welfare services referral due to the then 15-year-old teen's behavior including damaging his medical equipment, and his grandparents' frustration with the behavior. Approximately one year prior to the teen's death, the teen was hospitalized with complications of sickle cell. Later that month, the intact supervisor documented a critical decision to close the case as the family were no longer reporting the problems and did not want the services. Ten months before the teen's death, DCFS received reports that the teen's 17-year-old sister disclosed the grandmother previously beat her with a wooden spoon and left bruises. The teen and the 17-year-old sister stated the grandmother hit the sister with a wooden spoon but did not leave any marks. The grandmother stated she once tapped the sister with the spoon after the sister hit the teen with it but left no marks. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10). Three months before the teen's death, DCFS received a report that the 16-year-old teen had an argument with his grandparents, during which the teen kicked them, and the grandparents restrained him, pushed him and threatened him. The family reported the altercation ensued after the grandparents removed the teen's gaming controller because he took snacks without permission which was concerning because the teen had type 1 diabetes. The teen's 13-year-old and 17-year-old sisters stated the teen hit and kicked his grandparents, and the grandparents restrained the teen by his arms until police arrived. The grandfather and teen both denied the grandparents pushed the teen. The teen stated he could not control his anger when his blood sugar got out of control. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 145	DOB: 12/2023	DOD: 02/2024	Natural

Age at death:	5 weeks
Cause of death:	Cardiac arrest due to respiratory arrest due to encephalopathy secondary to placental abruption
Reason for review:	Pending child protection investigation at time of infant's death
Action taken:	Investigatory review of records

Narrative: Five-week-old, medically complex infant died in the hospital. His medical diagnoses included hypoxic ischemic encephalopathy, seizures, respiratory failure, anemia, placental abruption, EEG abnormality, and copious oral secretions. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Three weeks before the infant's birth, DCFS received a report that the mother disclosed she punished her children by hitting them with a belt. The mother was pregnant with the infant and was being treated at the hospital after she took an excess amount of over-the-counter medication. The mother disclosed a mental health diagnosis for which she took medication. The mother confirmed she hit the children when they were in trouble at school using an open hand, but denied she used a belt. She reported she punched the infant's 10-year-old brother once but did not leave a mark. The 9-year-old brother stated the mother hit him and his sister two or three times with a belt. The infant's 12-year-old sister denied the mother hit either child with a belt. One week before the infant's death, the grandmother notified the CPI the infant had been born but was in poor medical condition. The CPI spoke with the attending physician, who denied the infant's medical condition was caused by the mother taking medication. The investigation remained pending at the time of the infant's death. DCFS later

unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) to the infant's siblings.

Child No. 146	DOB: 01/2024	DOD: 02/2024	Natural

Age at death: 4 weeks
Cause of death: Trisomy 18
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: Four-week-old infant died in the hospital where she had remained since her birth due to trisomy 18. DCFS did not investigate her death for abuse or neglect. The following month, DCFS received a report that her mother found her surviving 8-week-old twin sister unresponsive after she slept in the same bed as the infant (see child number 96). The mother reported she placed the infant to sleep on her back, on the opposite side of the bed. DCFS unfounded the infant's mother for death by neglect (#51).

Reason for Review: Approximately eight months before the twins' birth, DCFS received a report that the twins' 8-year-old sister disclosed her mother was not home when she woke that morning, and she had to feed and diaper her 13-month-old brother. The sister told the CPI her mother woke her and stated she was taking the other children to school, and her 13-year-old brother was supposed to be home, but he left. The children denied their mother had ever left them home alone. The CPI provided the mother a pack-and-play for the 1-year-old. The mother later reported she co-slept with the 1-year-old because he flipped the pack-and-play. She also disclosed she was pregnant with the twins. DCFS unfounded the mother for inadequate supervision (#74). Two months before the twins' birth, DCFS received a report that the children's 19-year-old sister was supposed to be watching them while their mother was at work, but the 19-year-old left the home when the 12-year-old sister took a shower. While the 12-year-old was in the shower, the 6-year-old and 8-year-old siblings mixed a cleaning product with water and another liquid, and the 1-year-old sibling ate some of the substance. Emergency medical services responded to the home and took the 1-year-old to the hospital. The 19-year-old reported she left the home for 15 minutes and the 1-year-old was running around when she returned. DCFS unfounded the 19-year-old sibling for poison/ noxious substances by neglect (#56) and inadequate supervision (#74). Two weeks before the twins' birth, while the previous investigation remained pending, DCFS received a report that the 12-year-old sister disclosed the father of 6-year-old, 7-year-old, and 10-year-old siblings raped her over the past 10 years, and he had molested her as recently as the month prior. The 12-year-old participated in a forensic interview during which she stated she lied about the siblings' father raping her. Police interviewed the siblings' father, who stated the older children had become resentful since he got engaged. He added the 12-year-old messaged him about going to a party, and he asked the 12-year-old to watch his 3-year-old child after the party ended, but she got upset and refused to do so. The investigation remained pending at the time of the twins' birth and deaths. DCFS later unfounded siblings' father for sexual penetration (#19) and substantial risk of sexual abuse (#22).

Child No. 147	DOB: 01/2014	DOD: 02/2024	Natural

Age at death: 10 years
Cause of death: Cardiopulmonary arrest due to sepsis due to chromosomal abnormality
Reason for review: Unfounded child protection investigation within one year of child's death
Action taken: Pending systemic issue report

Narrative: Ten-year-old, medically complex child died after her mother brought her to the hospital. Her diagnoses included dysphagia, pulmonary hypertension, horseshoe kidney, and disorders of the lungs, and she required a tracheostomy, ventilator, and g-tube. DCFS did not investigate the child's death for abuse or neglect.

Reason for Review: Eleven months before the child's death, DCFS received a report that the child's then 5-year-old maternal sister returned from a visit at the mother's home and had unexplained bruising on her legs.

The sister's father told the CPI he requested a wellbeing check after the sister had new bruises. Police told the CPI the mother cooperated with the wellbeing check, and they did not have concerns about bruises on the sister's shin, but there were some concerns about bruising to her thigh. The mother reported the child did not have bruises before she went to the father's home that he said were from a fall. The sister stated she could not remember how she received the bruises, and she and her 6-year-old brother stated they lost electronics privileges when they were in trouble. The child's adult brother reported the same. The child's siblings appeared free of signs of abuse or neglect and stated they felt safe at home. The mother stated the child was in a residential care facility due to a shortage of in-home nursing care. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

Child No. 148	**DOB: 09/2010**	**DOD: 02/2024**	**Natural**
Age at death:	13 years		
Cause of death:	Streptococcus pyogenes group A bronchopneumonia and sepsis due to respiratory syncytial infection; significant contributing condition of morbid obesity		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

<u>Narrative:</u> Thirteen-year-old was brought to the hospital after her lips and limbs were seen turning blue. The father told police that in the week before her death, the teen complained of sore throat, neck, and ear, and two days before her death, they took her for medical treatment. She tested positive for influenza but was not prescribed any medications, and medical staff stated she was likely at the end of her illness. The father stated the teen woke him that morning and asked if her lips were blue, and he and the teen's mother noticed her fingers were also bluish. The father took the teen to the emergency room. DCFS unfounded the mother and father for death by neglect (#51) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

<u>Reason for Review:</u> Eight months before the teen's death, DCFS received a report that the teen's father had a history of violence toward the teen and her mother. The reporter stated the father also drank, used drugs, and both parents had mental health issues but refused medication. The reporter stated the parents also called police and asked them to remove the teen because they could not control her. Local police documented four calls regarding the teen in the prior six months, including the incident reported to the hotline. The report stated the teen hit the father with a closed fist, and she was arrested, processed at the station, and released to her mother. The teen reported that she had hit her father and denied that her father hit her. The teen's 6-year-old and 9-year-old sisters denied their parents physically fought. The 9-year-old stated she and the teen punched holes in the wall, and denied their father did so. The father stated he previously used marijuana but had stopped. The teen's mother reported she participated in mental health treatment and both she and the father took prescribed medications. DCFS unfounded the investigation for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and by neglect (#60).

Child No. 149	**DOB: 09/2021**	**DOD: 02/2024**	**Natural**
Age at death:	2 years		
Cause of death:	Acute hypoxic respiratory failure due to tracheostomy displacement due to complications of extreme prematurity; significant contributing conditions of cerebral palsy; obstructive sleep apnea		
Reason for review:	Open intact family services case at time of child's death; two indicated and one unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

<u>Narrative:</u> Two-year-old, medically complex child was found unresponsive by his mother, with his trach dislodged. The toddler was pronounced deceased at the hospital. The mother stated she and her three children had been staying with a family friend for three days due to a power outage at their home. The mother completed an oral swab toxicology screening that was negative for all substances. The home health agency that provided care

for the toddler three days per week stated they were last in the home one week earlier. The mother told the CPI she canceled services when they left the home. DCFS unfounded the toddler's mother for death by neglect (#51).

Reason for Review: Thirteen months before the toddler's death, DCFS received a report that law enforcement arrested the father after a domestic violence incident during which the toddler was present. The CPI met with the mother and children; the toddler's then 5-year-old brother denied he witnessed the altercation but knew police came to the home. The CPI documented the toddler had a trach and feeding tube. The mother stated the toddler was born premature and had a twin brother who died at 2 months old, and the father struggled with the twin's loss. The mother stated the father became upset and tried to punch her but hit the wall and then struck a relative after the relative tried to intervene. The relative confirmed the mother's report of the incident. The mother agreed to intact family services. During the investigation, the toddler was hospitalized for a respiratory virus and MRSA. Hospital staff told the CPI the mother met all the toddler's medical needs. DCFS indicated the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) but unfounded the mother for the same allegation and an intact family services case was opened. The mother reported she was no longer romantically involved with the father and wanted to obtain other housing. The father had limited contact with the intact worker and did not participate in services. Three months before the toddler's death, the mother reported she completed a job training program, participated in domestic violence services, and obtained an order of protection that required the father to move out of the home. Two months before the toddler's death, DCFS received a report that during an unannounced visit by the intact worker, the father was caring for the children. DCFS opened two companion investigations, one against each parent. The mother stated she sometimes had the father care for the children, including that day while she took the toddler to an appointment. The mother later told the intact worker she planned to drop the order of protection because she needed the father's help with the children. The father did not cooperate with the investigation. DCFS indicated both parents for inadequate supervision (#74) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). The father's indicated allegations were later unfounded on appeal. The intact family services case remained open at the time the toddler died.

Child No. 150	DOB: 12/2007	DOD: 02/2024	Natural
Age at death:	16 years		
Cause of death:	Intraventricular hemorrhage due to systemic lupus erythematosus		
Reason for review:	Youth in care		
Action taken:	Pending systemic issue report		

Narrative: Sixteen-year-old, medically complex teen, died after she was removed from life support. Approximately two weeks earlier, her foster mother called 911 after the teen woke early in the morning and complained of a headache. While the foster mother went to get the teen's blood pressure kit, the teen became unresponsive. At the hospital, medical staff found she had a brain bleed and placed a shunt in her brain. She remained unresponsive and on life support. The teen's condition did not improve, she developed blood clots in her lungs, and had very low brain functioning. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen and her siblings came into DCFS care when the teen was 6 years old. She was medically complex, and was under care of specialists in nephrology, allergy and immunology, neurology, hematology, pulmonology, and ophthalmology. In the year prior to her death, she remained in a traditional placement, and was working toward a permanency goal of independence. The then 15-year-old teen was compliant with her medications. She attended school via e-learning and had sibling visits. The teen's father began to engage in supervised visits and services, including parenting classes and a substance abuse assessment. Ten months before her death, she reported she wanted to return to her father's care, and the court granted her father unsupervised visits. However, the teen became noncompliant with her medications, and the placement worker learned of concerns that the father did not follow the teen's diet. The placement team suspended unsupervised visitation. Six months before her death, the teen's medical team reported she had a lupus flare and her current medication did not work. In the four months before the teen's death, her medical team reported she remained medication compliant and worked hard to become eligible for a kidney transplant. The teen attended dialysis appointments three times weekly. The month before her death, the teen was placed on the kidney transplant list.

Child No. 151	DOB: 10/2011	DOD: 02/2024	Natural

Age at death: 12 years
Cause of death: Suspected cardiac arrhythmia due to underlying electrolyte abnormality due to respiratory syncytial viral infection due to gastroesophageal reflux due to gastrointestinal bleed
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: Pending systemic issue report

Narrative: Twelve-year-old, medically complex child was found unresponsive at home by family. The child was pronounced deceased at the hospital, and medical staff noted no signs of trauma, abuse, or recent infection. The child had been born premature and was diagnosed with hypoxic ischemic encephalopathy, intraventricular hemorrhage, cerebral palsy and epilepsy, and he was non-ambulatory, non-verbal, and required a g-tube for feeding. DCFS did not investigate his death for abuse or neglect.

Reason for Review: Seven months before the child's death, DCFS received a report that the child appeared frail and malnourished, and he had lost five pounds in the prior year and the mother did not send formula and medication to school. The school nurse stated the child's treating physician had called the school because of 10 missed appointments. The CPI observed the child at home and noted he was non-verbal and non-ambulatory, and had a healing sore on his elbow. The child's mother stated they missed the child's medical appointments due to a death in the family, she worked with the child's doctor to reschedule, and the child attended an appointment the previous week. She added she followed the school's instructions for sending his formula and medications to school. The mother agreed to intact family services. The child's primary care physician told the CPI the family had missed appointments due to family issues, but there were no concerns for medical neglect following his rescheduled appointment the week prior. DCFS unfounded the mother for medical neglect (#79) and malnutrition (#83). During the intact family services case the mother stated she was not comfortable with in-home nursing services but was interested in transportation assistance for medical appointments and assistance with utility bills and home repairs. The intact worker provided the family with Norman funds. Three months before the child's death, he was admitted to the hospital with RSV. He remained hospitalized for two months, until approximately six weeks before his death. The intact worker continued twice-monthly visits and last saw the child three weeks before his death. The intact family services case remained open at the time of the child's death.

Child No. 152	DOB: 04/2022	DOD: 02/2024	Natural

Age at death: 21 months
Cause of death: Sepsis due to streptococcus pneumoniae; significant contributing conditions of sickle cell disease and multiple viral respiratory pathogens including SARS-COV-2
Reason for review: Indicated child protection investigation within one year of child's death
Action taken: Pending systemic issue report

Narrative: Twenty-one-month-old was found unresponsive by her mother. The toddler had sickle cell anemia. The mother stated the toddler had a fever, and she gave the toddler ibuprofen and Tylenol (acetaminophen) one hour apart, but the toddler vomited up the second dose of medication. The mother stated the fever reduced, and she planned to take the toddler to the hospital in the morning. She reported the toddler went to sleep around 2:00am and did not respond when she checked on her at 6:30am. The toddler was pronounced deceased at the hospital. DCFS did not investigate the toddler's death for abuse or neglect.

Reason for Review: Approximately seven months before the toddler's death, DCFS received a report that the toddler's 16-year-old brother got into an argument with other children at a park, and the toddler's mother arrived and shot her gun around the children. The reporter added the mother had eight children, and they did not have food. The CPI spoke with law enforcement, who reported the mother had an active warrant related to discharging a firearm at the park. The mother told the CPI that on the day of the incident, around 9:00pm, she went to the park with her other children to look for the toddler's 10-year-old, 13-year-old, and 16-year-old siblings because they had not yet come home. When she arrived, she saw the 16-year-old on the ground while other teens were kicking

him, so she screamed at them to stop, and when they did not stop, she loaded her gun and shot it in the air twice and the 16-year-old's assailants then ran away. The mother denied she pointed the gun at anyone. The CPI met with the toddler and five siblings ages 6 to 17 years old. The toddler's siblings reiterated the mother's report. The siblings also stated the mother kept her gun in the safe and they had never seen it unsecured in the home. The CPI observed three guns in a secure safe. The children also stated they had enough food, and the CPI noted the toddler appeared to be an appropriate size for her age. DCFS indicated the mother for substantial risk of physical injury/ environment injurious to health and welfare by abuse (#10) and by neglect (#60) but unfounded her for inadequate food (#76).

Child No. 153	**DOB: 08/2022**	**DOD: 02/2024**	**Natural**
Age at death:	18 months		
Cause of death:	Toxic megacolon due to sepsis due to norovirus		
Reason for review:	Indicated child protection investigation within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Eighteen-month-old died at the hospital. He had been born with multiple medical complexities, including a history of respiratory failure. DCFS did not investigate his death for abuse or neglect.

Reason for Review: Seven months before the toddler's death, DCFS received a report that the then 11-month-old toddler, who had a history of respiratory failure and remained in the hospital for several months after his birth, had been left at home in the care of his 16-year-old sister, who had not been trained in his care. The mother stated that on the day of the incident, she sent the children to get special water for the toddler, but they bought the wrong water which the toddler vomited, so she left to purchase the correct water and was gone for approximately 15 minutes. The toddler recently had surgery for breathing issues and continued to receive medical care at the hospital as well as in-home nursing care. The parents declined intact family services. The sister stated her mother taught her how to care for the toddler if needed and how to call 911 in case of an emergency. The toddler's adult brother reported the mother never left the children alone. While the investigation was open, the toddler was briefly hospitalized again for respiratory concerns. DCFS indicated the mother for inadequate supervision (#74).

Child No. 154	**DOB: 07/2008**	**DOD: 02/2024**	**Natural**
Age at death:	15 years		
Cause of death:	Bronchial asthma; significant contributing condition of novel coronavirus (COVID-19) infection		
Reason for review:	Youth in care		
Action taken:	Pending systemic issue report		

Narrative: Fifteen-year-old, medically compromised teen died at the hospital after she was brought there for trouble breathing. She had been at a roller rink with a health aide when she began wheezing, so the health aide took her home and administered the nebulizer treatment. After she did not improve, the health aide brought her to the hospital. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: The teen initially came into DCFS care when she was 6 years old. In the year prior to her death, she remained in the foster home where she had been placed for the last three years, and her foster parent was in the process of adopting her. The teen received specialized services in school and at home, including physical, occupational, and speech therapies, and home health aides. She had a history of asthma, including an asthma attack four years earlier that resulted in hypoxia and brain damage. The teen had compromised mobility, and compromised verbal and cognitive abilities, but her placement worker made regular visits and noted her mobility and verbal communications were improving.

Child No. 155	DOB: 03/2024	DOD: 03/2024	Natural
Age at death:	7 days		
Cause of death:	Disseminated herpes simplex virus (type I) infection		
Reason for review:	Unfounded child protection investigation within one year of child's death		
Action taken:	Investigatory review of records		

Narrative: Seven-day-old died in the hospital after his family brought him to the emergency room for respiratory distress. The newborn's parents noticed breathing problems and called the maternal grandmother for help. The newborn became unresponsive while at the hospital. Medical staff revived and stabilized him, and prepared to transfer him to a children's hospital, but he went into respiratory distress again and medical staff were unable to revive him again. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: Approximately nine months before the newborn's birth, DCFS received a report that the newborn's paternal grandfather threatened the newborn's teenage father and other family members. The father stated the grandfather found cannabis and assumed it belonged to the father. The paternal grandfather punched him and pushed him into a wall, damaging property. The police report stated the paternal grandfather slapped, pushed, and punched the father with a closed fist. Following the incident, the father left the home and went to his stepmother's home. Police did not document any visible injuries to the father, and neither he nor the stepmother wanted to press charges. The father denied he had any marks, and the CPI did not observe any injuries to the father. The father's stepmother obtained an order of protection against the paternal grandfather. The father denied any prior incidents with the paternal grandfather. The paternal grandfather stated he hit a pipe out of the father's hand but denied he touched him otherwise. The father's stepmother denied the paternal grandfather was a threat to the father's younger siblings. DCFS unfounded the newborn's paternal grandfather for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 156	DOB: 03/2024	DOD: 03/2024	Natural
Age at death:	2 weeks		
Cause of death:	Staphylococcus aureus pneumonia		
Reason for review:	Split custody at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Two-week-old was found unresponsive, on his back, swaddled, in his bassinet, when his parents awoke to feed him. His parents reported they fed the newborn every three hours. DCFS did not investigate the newborn's death for abuse or neglect.

Reason for Review: The newborn's father and his former paramour had two children who became youth in care three years before the newborn's birth. The newborn's father and his former paramour were non-compliant with services. The goal for the children was substitute care pending termination of parental rights. Three months before the newborn's birth, the court terminated the father's parental rights. The newborn's mother was not involved with DCFS in the year before the newborn's death.

Child No. 157	DOB: 01/2024	DOD: 03/2024	Natural
Age at death:	2 months		
Cause of death:	Sudden unexpected infant death		
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: Two-month-old was found unresponsive by her mother, who called 911, and she was pronounced deceased at the hospital. The mother reported that she fed the infant a few hours earlier, placed her in the car seat, and then fell asleep on the couch. The mother brought the infant to the hospital the night before for nasal

congestion, and the infant was diagnosed with a general cold and discharged around 1:00am. Hospital staff stated they discussed safe sleep with the mother, who stated the infant had a bassinet. The mother reported a friend picked them up at the hospital following the infant's discharge and they stayed with the friend that night. The infant slept in her car seat because she did not have the pack-and-play with her. 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: Eleven months before the infant's birth, DCFS received a report that the mother left the infant's then 11-month-old brother home alone and used illicit drugs while caring for the brother. The reporter later admitted to calling in a false report to initiate this investigation. DCFS unfounded the mother for inadequate supervision (#74) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Three months after the prior investigation opened, DCFS received a report that the mother left the infant's then 15-month-old brother in the care of a neighbor's 4-year-old and 8-year-old children, who left, and the door locked behind them. The fire department had to be called to let the mother back into her apartment. The mother denied the report, but the local fire department confirmed they responded to the home to open the door for the mother, whose child was left alone. DCFS indicated the mother for inadequate supervision (#74). Two months before the infant's birth, DCFS received a report that the infant's cousin arrived at school with scratches on his face, neck, and back, and stated his aunt, the infant's mother, injured him. The CPI interviewed the cousin and his siblings, who reported the infant's mother babysat them while their mother worked and denied the infant's mother hurt the cousin. The cousin and his siblings stated the scratches were from playing rough. The infant's mother denied she intentionally scratched the children. The aunt reported the infant's mother and then 18-month-old brother lived with her, and the CPI observed a crib for the brother in the home. DCFS unfounded the infant's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 158	**DOB: 08/2006**	**DOD: 04/2024**	**Natural**
Age at death:	17 years		
Cause of death:	Cardiac arrhythmia		
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 unresponsive and lying face down on the floor, between a mattress and a wall, with no apparent injuries. The teen was pronounced deceased at the scene. First responders noted the teen's bedroom was in disarray with a bottle of whiskey on the floor. The teen's mother stated she last saw the teen alive two days earlier, before she went to work. She stated the teen often stayed his room and smoked marijuana but denied he drank alcohol or used other substances. The mother told the CPI she knocked on the teen's door and texted him the day before he was found, but she did not receive responses and believed he was sleeping because he played video games late into the night. She stated she did not go into the teen's room because he liked his privacy. The mother and paramour tested positive for THC and cocaine. DCFS took protective custody of the surviving children. DCFS unfounded the mother for death by neglect (#51) but indicated her for environmental neglect (#82) and indicated both the mother and her paramour for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Reason for Review: Approximately four months before the teen's death DCFS received a report that the mother and her paramour, who was father to the teen's 16-month-old and 2-year-old siblings, had an argument, and the mother contacted six friends who ambushed the paramour, pointed a gun at him, and the mother failed to protect the children, who were screaming and crying. The reporter stated the paramour went to get a knife but gave up the knife and the six friends threw him out of the home. Police arrived at the home and were unable to locate any firearms. The mother told the CPI she allowed the paramour's relatives to live in the home for the prior two weeks without contributing to the household, and she made them leave. She denied she saw a gun or knife during the incident, and denied anyone was injured. The teen confirmed he witnessed the mother and paramour argue but denied he saw a gun. The teen's 11-year-old and 9-year-old siblings stated they were in a neighbor's home at the time of the incident. The CPI observed the teen's 16-month-old and 2-year-old siblings appeared clean and healthy.

Before the investigation closed, the children told the CPI they had not seen the paramour since the incident. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 159	**DOB: 06/2020**	**DOD: 04/2024**	**Natural**
Age at death:	3 years		
Cause of death:	Respiratory arrest due to epilepsy due to cerebral palsy; significant contributing condition of global developmental delay		
Reason for review:	Youth in care at time of child's death; two unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Three-year-old, medically complex toddler was found unresponsive by her foster parent, her maternal aunt. The toddler was pronounced deceased at the hospital. The toddler's medical history included epilepsy, failure to thrive, atrial septal defect, and hearing loss, and she required a g-tube. She had been born with one eye and corpus collosum agenesis, a brain birth defect. DCFS did not investigate her death for abuse or neglect.

Reason for Review: The toddler came into DCFS care at 2 years old due to concerns about medical neglect and failure to thrive. In the year prior to the toddler's death, she received early intervention services that included a feeding clinic and occupational, physical, speech, and developmental therapies. The toddler was placed with her maternal grandmother. One year before the toddler's death, DCFS received a report that the toddler's mother physically abused the toddler's 6-year-old sister and the family used substances. The family denied the allegations, the sister denied that her mother abused her, and the placement worker, who visited at least three times a month, reported no concerns. The worker reported that the sister began living with the grandmother because the mother lacked stable housing. The CPI assessed the toddler and sister as safe. While the investigation was pending, the grandmother was evicted from her home and the placement worker moved the toddler to the home of her maternal aunt. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and unfounded the mother and grandmother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60). Seven months before the death, DCFS received a report that the toddler's 13-year-old sister and aunt had an altercation. The family, including the sister, reported the aunt was trying to keep the sister safe. The placement worker denied concerns about the family. DCFS unfounded the aunt for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11). The toddler remained with the aunt and the toddler continued to grow and gain weight in the aunt's care. The placement worker was concentrating on finding a school that could accommodate the toddler's needs.

Child No. 160	**DOB: 07/2023**	**DOD: 04/2024**	**Natural**
Age at death:	9 months		
Cause of death:	Anoxic brain injury due to hypoxic ischemic encephalopathy		
Reason for review:	Two pending child protection investigations at time of child's death; closed intact family services case and two unfounded child protection investigations within one year of child's death		
Action taken:	Pending systemic issue report		

Narrative: Nine-month-old, medically complex infant, died. He and his twin had been born premature at 25 weeks gestation. His twin had previously been discharged home, but the infant remained in the hospital for most of his life until he was transferred to a care facility. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Five months before the infant's birth, DCFS received a report that the infant's mother threw a remote at the infant's then 10-year-old sister, which caused the bruise to the sister's face. The CPI found the home to be cluttered and unsafe. The sister and the 8-year-old brother said the mother threw the remote because the children were fighting. The mother agreed to an out-of-home safety plan until the home environment was

repaired. The mother agreed to intact family services. DCFS unfounded the infant's mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11) and environmental neglect (#82). During the intact family services case, the mother began a parenting program, received regular visits from a family support specialist and after school care was put in place for the older siblings. After the mother gave birth at 25 weeks, the intact worker observed the twins in the NICU. Following the birth, DCFS received a report about environmental concerns in the family's home. The CPI did not observe any environmental concerns. DCFS unfounded the mother for environmental neglect (#82). Hospital staff reported the infant's twin had been weaned off the ventilator, but the infant remained intubated. They noted the mother continued to visit regularly and was involved in their care. Five months before the infant's death, his twin sister was discharged home. The following month, the intact worker visited the infant at a new hospital, where the infant was transferred and remained on a ventilator. Hospital staff reported the infant may require additional surgeries, and he would need multiple trained providers upon discharge. The following month, the mother requested her intact case be closed. Approximately two months before the infant's death, the intact worker made a final visit to the hospital and the intact family services case closed. The following week, DCFS received a report that police found the infant's 3-year-old sister outside, alone. The mother told police she left the apartment for five minutes to do laundry in the basement. The CPI met with the family, and the infant's 9-year-old and 11-year-old siblings denied their mother ever left them home alone, and the mother obtained safety locks. The investigation remained pending at the time of the infant's death. DCFS later unfounded the mother for inadequate supervision (#74) and inadequate clothing (#78). Three weeks before the infant's death, DCFS received a report that the mother used substances and physically abused the infant's 9-year-old brother. The CPI determined the mother reprimanded the brother for being aggressive towards the 3-year-old and noted the children appeared free of injuries. The investigation remained pending at the time of the infant's death. DCFS later unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10).

Child No. 161	**DOB: 05/2010**	**DOD: 05/2024**	**Natural**

Age at death: 14 years
Cause of death: Acute cardiorespiratory arrest due to probable mucus plug-in trach tube/severe hypoxic ischemic encephalopathy due to cerebral palsy
Reason for review: Pending child protection investigation at time of child's death
Action taken: Pending systemic issue report

Narrative: Fourteen-year-old, medically complex teen went into respiratory distress at home. The teen was pronounced deceased at the hospital. The teen had a history of hypoxic ischemia that resulted in seizure disorder, quadriplegia, and cerebral palsy. He required oxygen, a g-tube, was non-verbal and used a wheelchair for mobility. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Three weeks before the teen's death, DCFS received a report that the teen missed nine appointments over the prior year, and he had last been seen over one month earlier. The reporter added concerns about the teen needing surgery, a sleep study and medication. The CPI spoke with the reporter, who stated the teen saw numerous specialists and the missed appointments constituted medical neglect as the teen obtained medical supplies through his appointments. The mother cited weather and transportation as reasons for missed appointments. The mother provided contacts for the family's DSCC worker and the teen's caregiver when she worked. The DSCC worker reported a problem with late medical shipments which included things the teen needed in order to leave the home and they needed more help than the transport company could provide. While the investigation was pending, the teen died. DCFS later indicated the teen's mother for medical neglect (#79) based on the opinion of the teen's doctor.

Child No. 162	DOB: 04/2006	DOD: 05/2024	Natural
Age at death:	18 years		
Cause of death:	Serratia pneumonia due to acute respiratory distress syndrome		
Reason for review:	Youth in care and pending child protection investigation at time of youth's death; unfounded child protection investigation within one year of youth's death		
Action taken:	Pending systemic issue report		

Narrative: Eighteen-year-old, medically complex youth in care died in a hospital where she had been a patient for over a month. The youth's diagnoses included Down's syndrome, autism, and pica. One month before her death, she had spinal fusion surgery, but her health deteriorated following surgery. She developed pneumonia and sepsis and was placed on a ventilator. She died shortly after she was removed from the ventilator. DCFS did not investigate the youth's death for abuse or neglect.

Reason for Review: The youth came into DCFS care when she was 9 years old and was placed in assisted living. She was non-verbal, had a history of self-inflicted injuries and aggressive behaviors, and had significant medical needs. The youth remained in assisted living facilities until her death. She attended specialized schooling. At the time of her death, her permanency goal was "cannot be provided for in home environment," and her placement worker submitted adult guardianship and placement paperwork. Eleven months before the youth's death, DCFS received a report that the assisted living facility was understaffed, resulting in neglect. The CPI found no evidence the facility was understaffed. DCFS unfounded the facility for neglect by agency (#86). Prior to the closure of the child protection investigation, the facility ended their contract with DCFS. The youth was moved to a residential home temporarily while the placement worker looked for an appropriate placement. Six months before the youth's death, DCFS received a report that the youth had a gash near the corner of her eye. The CPI observed the youth at the residential facility and documented she had a dark red/brown mark by her left eye and red marks on the right side of her neck. The CPI observed the youth pinching the right side of her neck, and facility staff redirected her. The CPI also observed her try to hit the side of her eye where she was bruised, and facility staff continued to redirect her. While the investigation was pending, the youth died. The child protection investigation was unfounded for cuts bruises welts abrasions and oral injuries by neglect (#61).

Child No. 163	DOB: 11/2023	DOD: 05/2024	Natural
Age at death:	6 months		
Cause of death:	Hypoplastic left heart syndrome due to diastolic heart failure due to lymphatic failure		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Investigatory review of records		

Narrative: Six-month-old had been born with a rare heart defect, had four surgeries, and remained in a children's hospital with poor prognosis. The infant's parents signed a DNR order, and he was later removed from life support. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: One week before the infant's death, DCFS received a report that police responded to the family home following a report of an argument between the parents and that the mother left with the infant's twin and tried to hurt the father. The father reported concern about the mother following the birth of the twins. The father added they had just signed the DNR order for the infant. The older siblings reported the parents fought more since the twins' birth but denied the arguments were physical. Police reported no other contact with the family. The investigation remained pending at the time of the infant's death. DCFS later unfounded the parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 164	DOB: 01/2024	DOD: 06/2024	Natural

Age at death: 4 months
Cause of death: Unexplained sudden death (intrinsic factors identified); significant contributing conditions of premature birth; low growth parameters
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 in his crib by his parents, who called 911 and began CPR. The infant was pronounced deceased at the hospital. The parents stated the mother fed the infant baby food and burped him before she laid him down. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Six months before the infant's birth, DCFS received a report that his parents had a physical altercation in the car, while the infant's then 4-year-old maternal half-sister was present. Police responded but did not make any arrests. The mother told the CPI she accidentally hit the father when she reached back to fix the sister's car seat, and the father called police. The CPI discussed safe sleep with the mother, who stated she was pregnant with the infant and would have appropriate sleeping arrangements for him. DCFS unfounded the mother for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 165	DOB: 05/2024	DOD: 06/2024	Natural

Age at death: 3 weeks
Cause of death: Respiratory failure due to septic shock due to intestinal perforation due to bilateral pneumothorax
Reason for review: Open child welfare services referral at time of child's death
Action taken: Investigatory review of records

Narrative: Three-week-old died in the hospital. He had been born premature, at 24 weeks gestation, and never left the hospital. DCFS did not investigate the infant's death for abuse or neglect.

Reason for Review: Two days after the newborn's birth, DCFS received a report that the mother disclosed prior history with DCFS while she was at the hospital for the birth. The reporter stated three of the newborn's siblings lived with their maternal grandmother, and the other children lived with the mother. The reporter noted no concerns of abuse or neglect. DCFS opened a child welfare services referral. The CWS worker made multiple attempts to meet with the family and completed diligent searches but did not make successful contact prior to the newborn's death.

Child No. 166	DOB: 04/2010	DOD: 06/2024	Natural

Age at death: 14 years
Cause of death: Cardiac arrest presumably due to seizure and hypoxia due to seizure disorder due to obstructive sleep apnea significant conditions contributing to death cerebral palsy, microcephaly, broncholiths/pneumonia
Reason for review: Pending child protection investigation at time of child's death; one unfounded child protection investigation within one year of child's death
Action taken: Pending systemic issue report

Narrative: Fourteen-year-old, medically complex teen was found unresponsive by her parents. The teen was pronounced deceased at the hospital. The teen's medical diagnoses included cerebral palsy, seizure disorder, microcephaly, chronic respiratory failure, and osteoporosis. DCFS did not investigate the teen's death for abuse or neglect.

Reason for Review: Three months before the teen's death, DCFS received a report that the family's home was cluttered and dirty. The teen had eight hours of nursing a day. The nurses reported no concerns and noted the

family had multiple stressors because of health concerns for the father and grandmother. The CPI noted the home appeared cluttered but did not observe safety hazards. The CPI noted the teen was non-verbal, but her 5-year-old sister reported she felt safe at home. Before the investigation closed, the CPI noted the teen's care needs had increased, but the family did not have an in-home nurse due to the nursing shortage. DCFS unfounded the teen's parents for environmental neglect (#82). Earlier on the same day the teen died, DCFS received a report that the teen's 6-year-old sister had bruises to her back, bottom, legs, and arms. The reporter stated the sister disclosed her father hurt her. The CPI met with the sister and family including the teen. The CPI observed the teen and noted no visible concerns. The next day, while the investigation remained pending, DCFS received a report of the teen's death. DCFS later unfounded the teen's mother and father for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11), environmental neglect (#82), and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60).

Child No. 167	**DOB: 06/2024**	**DOD: 06/2024**	**Natural**
Child No. 168	**DOB: 06/2024**	**DOD: 06/2024**	**Natural**

Age at death:	Child No. 167 - 8 days
Age at death:	Child No. 168 - 11 days
Cause of death:	Child No. 167 - Extreme prematurity due to intraventricular hemorrhage due to respiratory failure due to cerebellar hemorrhage, significant contributing factors of hypovolemic shock, pulmonary hypertension, lactic acidosis, nectrotizing enterocolitis, seizures, coagulopathy
Cause of death:	Child No. 168 - Prematurity due to respiratory distress of newborn
Reason for review:	Unfounded child protection investigation within one year of child's death
Action taken:	Investigatory review of records

Narrative: Newborn twins were born premature at 23 weeks gestation. They remained in the hospital following their births. One newborn died at 8 days old, and the other died at 11 days old; both of complications of prematurity. DCFS did not investigate the newborns' deaths for abuse or neglect.

Reason for Review: Six months before the twins' birth, DCFS received a report that the twins' then 6-year-old brother presented at the emergency room following concerns regarding a laceration on his head and concussion. The family all reported the injury was the result of a fall and the brother hitting his head. The mother said she cleaned the wound and sent him to school but took him to the doctor upon advice of the school nurse. DCFS unfounded the mother for cuts, bruises, welts, abrasions, and oral injuries by abuse (#11).

TWENTY-YEAR DEATH RETROSPECTIVE

FISCAL YEAR	2005-19		2020		2021		2022		2023		2024		2005 - 2024		
													TOTAL	AVERAGES	
CASE STATUS	#	%	#	%	#	%	#	%	#	%	#	%	#	#	%
Youth in Care	314	20%	21	21%	11	9%	26	15%	30	19%	31	18%	**433**	**22**	**19%**
Unfounded DCP	415	27%	29	28%	45	37%	53	31%	55	34%	53	32%	**650**	**30**	**29%**
Pending DCP	229	15%	11	11%	20	16%	34	20%	23	14%	25	15%	**342**	**16**	**15%**
Indicated DCP	112	7%	14	14%	14	11%	11	6%	14	9%	16	10%	**181**	**8**	**8%**
Child of Youth in Care	31	2%	1	1%	0	0%	1	1%	1	1%	1	1%	**35**	**2**	**2%**
Open Intact	198	13%	13	13%	14	11%	23	13%	19	12%	18	11%	**285**	**14**	**13%**
Closed Intact	60	4%	5	5%	6	5%	8	5%	8	5%	7	4%	**94**	**5**	**4%**
Open Placement/ Split Custody	72	5%	2	2%	9	7%	6	4%	6	4%	9	5%	**104**	**5**	**5%**
Closed Placement/ Return Home	24	2%	1	1%	3	2%	3	2%	0	0%	1	1%	**32**	**2**	**1%**
Others	88	6%	5	5%	0	0%	6	4%	4	3%	7	4%	**110**	**6**	**5%**
TOTAL	**1543**	**100%**	**102**	**100%**	**122**	**100%**	**171**	**100%**	**160**	**100%**	**168**	**100%**	**2266**	**110**	**100%**

FISCAL YEAR	05-18	19	20	21	22	23	24	Totals 05-24
Total Deaths	**1420**	**123**	**102**	**122**	**171**	**160**	**168**	**2266**
Youth in Care	**292**	**22**	**21**	**11**	**26**	**30**	**31**	**433**
Natural	145	9	7	5	9	9	15	199
Accident	42	5	4	2	3	8	8	72
Homicide	69	6	4	2	10	7	3	101
Suicide	18	0	3	1	1	1	1	25
Undetermined	18	2	3	1	3	5	4	36
Unfounded Investigation	**368**	**47**	**29**	**45**	**53**	**55**	**53**	**650**
Natural	107	8	11	21	23	22	13	205
Accident	131	16	13	8	11	15	11	205
Homicide	59	11	1	6	11	15	16	119
Suicide	15	3	1	3	3	1	4	30
Undetermined	56	9	3	7	5	2	9	91
Pending Investigation	**210**	**19**	**11**	**20**	**34**	**23**	**25**	**342**
Natural	59	4	7	7	12	8	7	104
Accident	58	7	3	7	9	4	7	95
Homicide	37	2	1	3	7	6	3	59
Suicide	5	2	0	0	1	1	4	13
Undetermined	51	4	0	3	5	4	4	71
Indicated Investigation	**103**	**9**	**14**	**14**	**11**	**14**	**16**	**181**
Natural	29	3	6	4	4	5	5	56
Accident	32	3	3	4	2	2	6	52
Homicide	19	1	2	2	4	2	2	32
Suicide	3	1	1	2	0	0	0	7
Undetermined	20	1	2	2	1	5	3	34
Child of a Youth in Care	**29**	**2**	**1**	**0**	**1**	**1**	**1**	**35**
Natural	12	2	0	0	0	0	0	14
Accident	4	0	1	0	1	0	0	6
Homicide	4	0	0	0	0	0	0	4
Suicide	0	0	0	0	0	0	0	0
Undetermined	9	0	0	0	0	1	1	11
Open Intact	**190**	**8**	**13**	**14**	**23**	**19**	**18**	**285**
Natural	84	2	4	5	11	8	8	122
Accident	48	0	5	3	5	3	4	68
Homicide	27	2	2	3	4	3	2	43
Suicide	2	1	0	0	0	0	0	3
Undetermined	29	3	2	3	3	5	4	49

FISCAL YEAR	05-18	19	20	21	22	23	24	Totals 05-24
Closed Intact	**53**	**7**	**5**	**6**	**8**	**8**	**7**	**94**
Natural	16	5	4	2	2	4	1	34
Accident	15	2	0	2	3	0	0	22
Homicide	10	0	0	0	1	1	1	13
Suicide	0	0	0	0	1	0	1	2
Undetermined	12	0	1	2	1	3	4	23
Open Placement/Split Custody	**68**	**4**	**2**	**9**	**6**	**6**	**9**	**104**
Natural	39	2	1	4	2	2	3	53
Accident	14	1	0	0	3	1	4	23
Homicide	7	1	0	1	1	2	0	12
Suicide	0	0	0	1	0	1	0	2
Undetermined	8	0	1	3	0	0	2	14
Adopted	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Former Youth in Care	**15**	**0**	**0**	**0**	**4**	**1**	**1**	**21**
Closed Placement/ Return Home	**22**	**2**	**1**	**3**	**3**	**0**	**1**	**32**
Interstate Compact	**1**	**0**	**0**	**0**	**0**	**0**	**0**	**1**
Preventive Services	**29**	**0**	**0**	**0**	**0**	**0**	**0**	**29**
Subsidized Guardianship	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Child of Former Youth in Care	**1**	**1**	**2**	**0**	**0**	**0**	**0**	**4**
Extended Family Support	**12**	**0**	**0**	**0**	**0**	**0**	**0**	**12**
Child Welfare Referral	**27**	**2**	**3**	**0**	**2**	**3**	**6**	**43**

PART III: GENERAL INVESTIGATIONS

General Investigation 1

COMPLAINT A Department employee used her position to create fictitious child daycares in the Department's Child Care Data System (CCDS), registered Department involved children as attending those fabricated daycares, and received kickbacks from the fictitious providers receiving daycare payments from the Department.

INVESTIGATION The Department placed the employee on administrative leave and notified the OIG after learning of the Department employee's alleged theft of state funds intended for childcare services. The OIG referred the case to the Illinois State Police, Division of Internal Investigation (ISP DII), which led to a joint investigation between the Federal Bureau of Investigations (FBI), OIG, and ISP DII.

The OIG found the Department employee held responsibility for approving daycare eligibility for foster parents, intact cases, reunification, and teen parents who need childcare for employment or enrollment in educational/vocational courses. The Department employee also held responsibility for adding selected daycares that were not current Department providers to the daycare payment system and assigning a provider ID to the daycare, which the Department utilized to pay the provider. The IG investigation found that the CCDS lacked internal controls and accountability measures to prevent fraudulent activities.

The joint investigation found that the Department employee created 19 fictitious daycare provider accounts in the Department's daycare payment system and recruited at least 14 family members and friends to serve as the fictitious providers. The Department employee then enrolled DCFS involved children into the fictitious daycares, even though the children were already enrolled in legitimate daycares receiving Department funds. The Department employee issued billing forms to the fictitious providers, who then fraudulently documented providing childcare. The Department employee filed the fabricated billings for payment to the fictitious providers. The fictitious providers then paid the Department employee roughly 50% of the money received from the Illinois Comptroller for the fictitious daycare services.

The joint investigation determined that the Department employee orchestrated the theft of at least $3.2 million from the state of Illinois, and the Department employee received approximately $1.6 million in kickbacks. The joint investigation resulted in a 41-count indictment against the Department employee and 14 co-defendants, whose charges are pending for Honest Services Wire Fraud.

RECOMMENDATIONS **1. The Department should ensure that the fraudulent providers identified are no longer utilized or reimbursed by the Department.**

The provider identification numbers for the involved fictitious daycare providers were deactivated in the DCFS Child Care Data System. The Department has also notified the DCFS Deputy Director of Licensing to ensure the daycare providers are no longer utilized or reimbursed by the Department.

2. The Department should implement internal controls that verify the accuracy of daycare billing invoices and identify potential fraud and suspicious billing patterns in the DCFS Child Care Data System (CCDS). The Department should consider including the following internal controls: automated requests for approvals when new providers are developed; automated rate assignment based on licensing status and location; automated requests for approvals when the licensing status or rates are changed manually; and verification when a child is entered as having multiple daycare providers in the system at a given time.

To ensure proper separation of duties, the two Office of Contract Administration (OCA) daycare billing employees who processed daycare payments from providers in the involved county have been moved from the OCA Daycare

Unit to the business unit to ensure separation of duties and proper verification of daycare billing invoices in an effort to identify potential fraud and suspicious billing.

Additionally, the Office of Contract Administration conducted a comprehensive review of all daycare billing employees who have access to the DCFS Child Care Data System (CCDS) to identify by employee which screens for each employee were essential to their position. All irregularities and requests for screen revocations for specific employees were submitted to the Department of Information and Technology (DoIT) in August 2024.

Lastly, the OCA Daycare Unit is working to implement a process whereby in the case of multiple providers for an individual youth, it must be approved by the supervisor and a comment entered on the CC-90 screen of the DCFS Child Care Data System (CCDS). Cases for youth who have multiple providers will also be reviewed on a quarterly basis.

3. While the above permanent changes are being made to the DCFS Child Care Data System, the Department should take immediate steps to develop an interim plan to protect against daycare billing fraud and at a minimum, ensure verification when a child is entered as having multiple daycare providers in the system at a given time as well as periodic verification of the child's attendance to the Licensed Day Care Home; Licensed Group Day Care Home; License Exempt Day Care Home; Non-relative daycare home; or Relative daycare home.

To ensure proper separation of duties, the two Office of Contract Administration (OCA) daycare billing employees who processed daycare payments from providers in the involved county have been moved from the OCA Daycare Unit to the business unit to ensure separation of duties and proper verification of daycare billing invoices in an effort to identify potential fraud and suspicious billing.

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4. This report should be shared with the Department of Human Services to consider appropriate action with respect to the fraudulent providers identified.

The Director of DCFS shared and discussed the report with the Department of Human Services.

5. This report should be shared with the Director of the Department of Early Childhood.

The Director of DCFS shared and discussed the report with the Department of Early Childhood.

General Investigation 2

COMPLAINT The Department approved a foster parent to utilize a supplemental day care provider when the foster parent worked beyond the primary day care's business hours. The complainant alleged that the supplemental provider overbilled the Department for at least 16 months, resulting in overpayments of almost $10,000.

INVESTIGATION The foster parent utilized day care services from two providers to accommodate their work schedule as the primary licensed day care provider did not operate on weekends or after 6:00pm on

weekdays. The foster parent told IG investigators that she utilized the supplemental day care provider when she worked on weekends and on occasional weeknights. IG investigators obtained the foster parent's timesheets from her employers from 2017 to 2021. The timesheets supported the foster parent's statement, and IG investigators substantiated that the foster parent likely used the supplemental day care provider a total of 373 days over the period reviewed, which averaged to 6.7 days per month. However, for that same period, the supplemental day care provider billed the Department for providing care to the foster parent's children for 865 days, which averaged to 17.7 days per month. The OIG estimated that the supplemental day care provider may have overbilled the Department and received a total overpayment of approximately $18,200 from 2017 to 2021.

During the OIG investigation, the Department put a hold on payments to the supplemental day care provider and the OIG referred the matter to the Illinois State Police for criminal investigation of theft of day care funds.

DCFS Procedures 302.330, Subpart C. *Services Delivered by the Department: Day Care Services* required the Department to provide childcare services for foster parents to accommodate work, employment training, and educational programs. To receive day care services, foster parents work with their caseworker to complete an application that includes proof that they work or attend school and are eligible for day care.

Department regional day care staff held responsibility for approving and processing day care requests and payments, and the Child Care Data System generates the Child Care Monthly Enrollment form that providers submit for payments. Multiple staff members in the day care billing office told IG investigators the billing system used by the Department did not provide any means to identify potential over-billing. The day care providers completed the Child Care Monthly Enrollment form with self-reports of the number of days they provided day care services for each child. The Department did not require day care providers to list specific dates of care on the form or foster parent signatures. The Department's child care billing staff told IG investigators that the current system did not have a mechanism in place for foster parents to verify the number of days billed by the day care providers. The staff also reported that their office processed a large number of payments each month and the only way billing errors were identified would be if staff entered the invoices in the system. However, the staff stated the Department was in the process of redesigning the program to prevent fraud, reduce the use of both full-time and part-time day care providers, and ensure foster children did not spend more time in day care than in their foster homes.

RECOMMENDATIONS

1. The Department should ensure that the supplemental daycare provider is no longer utilized or reimbursed by the Department.

The provider identification number for the involved daycare provider was deactivated in the DCFS Child Care Data System. The provider will no longer be utilized.

2. The Department should implement internal controls that verify the accuracy of daycare billing invoices and identify potential fraud and suspicious billing patterns in the DCFS Child Care Data System (CCDS). The Department should consider including the following in the internal controls: automated requests for approvals when new providers are developed; automated rate assignment based on licensing status and location; automated requests for approvals when the licensing status or rates are changed manually; and verification when a child is entered as having multiple daycare providers in the system at a given time.

To ensure proper separation of duties, the two Office of Contract Administration (OCA) daycare billing employees who processed daycare payments from providers in the involved county have been moved from the OCA Daycare Unit to the business unit to ensure separation of duties and proper verification of daycare billing invoices in an effort to identify potential fraud and suspicious billing.

Additionally, the Office of Contract Administration conducted a comprehensive review of all daycare billing employees who have access to the DCFS Child Care Data System (CCDS) to identify by employee which screens for each employee were essential to their position. All irregularities and requests for screen revocations for specific employees were submitted to the Department of Information and Technology (DoIT) in August 2024.

Lastly, the OCA Daycare Unit is working to implement a process whereby in the case of multiple providers for an individual youth, it must be approved by the supervisor and a comment entered on the CC-90 screen of the DCFS Child Care Data System (CCDS). Cases for youth who have multiple providers will also be reviewed on a quarterly basis.

3. While the above permanent changes are being made to the DCFS Child Care Data System, the Department should take immediate steps to develop an interim plan to protect against daycare billing fraud and at a minimum, ensure verification when a child is entered as having multiple daycare providers in the system at a given time as well as periodic verification of the child's attendance to the Licensed Day Care Home; Licensed Group Day Care Home; License Exempt Day Care Home; Non-relative daycare home; or Relative daycare home.

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4. The Department should share this report with the Chief Financial Officer and Office of Budget & Finance to explore the feasibility of recouping overpaid funds from the supplemental day care provider.

The report was shared with the Chief Financial Officer and Office of Budget & Finance.

5. This report should be shared with the Director of the Department of Early Childhood.

The Director shared a copy of the report with the Director of the Department of Early Childhood.

General Investigation 3

COMPLAINT The OIG received a complaint that a 16-year-old youth in care was being human sex trafficked when she was taken to work at an adult entertainment venue and forced to have sex. The complaint alleged that these concerns were reported to SCR but taken as Information Only. Additionally, the complainant alleged that the investigator and supervisor of a subsequent child protection investigation were aware of the sex trafficking allegation but did not address the concerns. It was alleged that the inaction resulted in a significant delay in a forensic interview and failure to assess human trafficking allegations.

INVESTIGATION The youth in care had significant prior history with the Department beginning at the age of 3 years old. The Department conducted 15 total child protection investigations involving the youth both in the care of the mother and other caregivers. At the age of 12, the department was granted custody of the youth after indicating a maternal relative for sexual penetration (#19) to the youth. Between age 13 and 14 the youth experienced multiple placement disruptions and a psychiatric hospitalization prior to her eloping to an unauthorized placement with a maternal aunt at age 14. In 2020, the Department placed the then 15-year-old with fictive kin after indicating the aunt for neglect. While placed with the fictive kin, the Department unfounded

three child protection investigations involving allegations of inadequate shelter (#77), substance misuse (#15), substantial risk of environment injurious to health and welfare by neglect (#60), sexual exploitation (#20), sexual penetration (#19) and human trafficking (#40) to the youth. In the summer of 2021, the youth eloped from the fictive kin placement, and began living in an unauthorized placement.

Almost one year after the youth began living in the unauthorized placement, law enforcement responded to a disturbance between the then 16-year-old youth and a then 18-year-old, who was also a youth in care. The youth alleged to the officer that she had been sex trafficked, reporting that she was recruited and provided with a fake identification card so that she could work at the club. The youth also told the officer that she engaged in sexual acts at the club and consumed drugs. The 18-year-old admitted to the officers that she recruited the youth so she would make more money.

Two online reports were made to the hotline as a result of the incident. The first report came from an anonymous source, who reported the youth was forced to use drugs but did not include information that she was working in an adult entertainment venue. A mandated reporter submitted the second online report, noting that the youth provided a fake identification card to the adult entertainment club but did not mention sex trafficking. SCR took both reports as "Information Only" (IO) determining that no eligible perpetrator was identified in either report.

The IO reports were forwarded to the youth's worker and supervisor, who failed to ascertain details about the alleged incident or adequately address the incident with the youth. When the Department receives any reports alleging that youths in care are involved with adult entertainment venues, the Department should gather additional information to determine eligibility for an investigation due to the correlation between these venues and sex trafficking. IG investigators found that the Department did not provide guidance for case workers regarding information only reports involving a youth. The Deputy Director of Permanency confirmed for IG investigators that there are no procedures that specifically address caseworkers' responsibilities after receiving an IO report.

In June 2022, a month after the incident with law enforcement, the Department initiated an investigation for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and substance misuse by neglect (#65) to the 16-year-old after receiving an anonymous report that both the 16-year-old and her mother used drugs. The assigned CPI for this investigation did not address the alleged sex trafficking from the IO reports as she was not aware of the allegations. In an interview with IG investigators, the child protection investigator reported reviewing the youth's Department history, requesting the mother's police reports, and checking police activity at the address listed on the hotline report. However, the child protection investigator did not check for police reports under the youth's name and did not know how to access IO reports from one month prior. At the close of the investigation, the GAL refused to sign off on the investigation until the sex trafficking allegation was investigated. As a result, five months after the alleged trafficking, another child protection investigation was opened to investigate the sex trafficking allegations. The youth participated in a forensic interview as part of the investigation, but noted she had difficulty recalling details of the incident because of the time lapse and because she was under the influence on the night of the incident. The youth confirmed that she worked at the adult entertainment venue and that the 18-year-old friend provided a fake ID. The Department closed the investigation indicating the mother and the 18-year-old youth in care for human trafficking (#40). The rationale included that the mother transported the youth to the adult entertainment venue in exchange for money.

Youth in care are at high risk for human trafficking, especially youths with unstable housing or in unauthorized placements. According to the National Human Trafficking Hotline, individuals with unstable living situations, prior sexual abuse, histories of domestic violence, run away behaviors, involvement with juvenile justice or child welfare system, and issues with drugs are more vulnerable to trafficking. Traffickers seek victims in a variety of settings such as adult entertainment venues, truck stops, and motels. The OIG found that the youth in this report had several risk factors that made her vulnerable to human trafficking including a significant history with the Department, a victim of sexual abuse, unstable housing, and drug use.

IG investigators found that there is only one DCFS Human Trafficking Prevention Program Manager for the state. The Manager attempts to link the workers and youth in care to appropriate services. However, this program is

understaffed, and therefore, the program is unable to provide adequate clinical support on the complicated issue of human trafficking.

The OIG also determined that child welfare workers need guidance on working with human trafficking victims or even suspected victims. Human trafficking often intersects with use of illegal substances and housing instability, allowing a trafficker to provide those things, which in turn may make it more difficult for a victim to make an outcry or report. The OIG found that the Department had no policies nor procedures that provide guidance as to when a caseworker should complete a referral to the Human Trafficking Prevention Manager.

RECOMMENDATIONS

1. The Department should amend Procedures to provide guidance to placement staff on what action should be taken by a placement worker in response to an Information Only report from SCR staff, such as contacting mandated reporters. The placement worker should be required to follow-up with the information and contact the hotline if abuse or neglect is discovered. In the interim, the email sent by SCR staff alerting placement workers that a report was taken as Information Only should instruct placement workers to follow-up with the information and contact the hotline if abuse or neglect is discovered.

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

2. Department Procedures should require placement staff to contact the placement clearance desk for a background check (i.e., CANTS/LEADS) when a child has self-selected an unauthorized placement.

In response to the OIG's recommendation, a multi-divisional workgroup was formed to review the identified concerns regarding unauthorized placements. The workgroup reviewed the placement clearance desk process, licensed home capacity issues and 906 codes. As a result, the workgroup recommended numerous programmatic and policy changes as it relates to unauthorized placements. Additional recommendations were made and approved by the Chief Deputy Director of Permanency. The Executive Summary and next steps are currently under review by the Director.

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

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4. This report should be shared with the Department's multi-disciplinary workgroup tasked with addressing current practice issues and barriers related to unauthorized placements.

The Department agrees. The report was shared with the workgroup.

5. The Department should consider expanding the Human Trafficking Prevention Program through the creation of additional staff positions. The additional staff should be available to child protection staff to provide consultation when there are allegations of Human Trafficking of Children by Abuse (#40) or Human Trafficking of Children by Neglect (#90).

The Department is preparing to expand the Department's Human Trafficking division to include a Human Trafficking Coordinator in each region. The Department is also working to contract with an agency who specializes in this work to create a certification training that would be used to train staff within DCFS and in Child Welfare Contributing Agency's facilities.

General Investigation 4

COMPLAINT An employee was alleged to hold concurrent employment at the Department and a child welfare contributing agency (CWCA).

INVESTIGATION The employee began employment at a child welfare contributing agency (CWCA) in August 2022. The OIG determined that at approximately the same time, the employee applied for employment with the Department and subsequently began employment with the Department in May 2023, without disclosing her current employment with the CWCA to the Department or informing the CWCA of her employment with the Department. Shortly after beginning Department employment, the employee contacted the Department's Conflict of Interest Committee (COIC) to report her secondary employment and was issued a COIC determination, copied to the Department's Office of Employee Services and the Area Administrator, that the secondary employment created an actual conflict of interest. The Area Administrator forwarded the determination to the employee's direct supervisor who acknowledged receipt of the email. IG investigators found that as a practice, notification of a conflict determination was issued only to Department personnel and not to the CWCA.

The employee told IG investigators that after receiving the COIC determination, she misunderstood the email and believed the Department sanctioned the secondary employment with the CWCA. The employee told IG investigators that she informed the CWCA Director of her employment with the Department. The employee stated that the CWCA job schedule was flexible and did not conflict with the Department schedule. The employee also informed IG investigators that she was concurrently enrolled in graduate school.

In an interview with the OIG, the CWCA Director stated that the employee did not report her employment with the Department until October 2023, approximately four months after the employee's actual start of employment with the Department and reported that the secondary employment had been approved by the Department. Upon learning of the secondary employment, and believing it had been approved by the Department, the CWCA Director planned to transfer the employee to part time status. Around this same time, the CWCA Director's request for licensing credentials for the employee from the Department's monitoring division was denied because of the conflict of interest created by the dual employment. The monitoring division employee then provided the CWCA Director the COIC determination that had been issued over three months earlier. The CWCA Director told IG investigators that upon learning that the secondary employment had not been approved, he informed the employee to choose between the CWCA and the Department as the employee could not work at both agencies. The CWCA Director said the employee reported a plan to resign from the Department with a two-week notice. IG investigators found however, the employee did not resign from the Department and continued dual employment for the next several months and provided false information to the CWCA Director. Upon learning about the continued dual employment, the CWCA Director requested and received the employee's resignation.

According to the employee's Department supervisor, the employee's attendance was an on-going issue during this time including unaccounted time in the field, a lack of responsiveness, and not adhering to their scheduled in-office days. The CWCA Director also stated that during this time, the Director had difficulty reaching the employee during work hours, the employee struggled to complete tasks, and that the employee did not consistently follow-up with clients.

The OIG found that the employee worked over 136 days at both places of employment with overlapping schedules over an eight-month period, violated the COIC determination, and continually provided false information to both employers.

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

The employee was discharged from the Department.

2. For cases in which the Conflict of Interest Committee has determined an actual conflict of interest exists involving secondary employment of a DCFS employee with a contracted Child Welfare Contributing Agency (CWCA), the COIC should notify the involved CWCA.

In such cases, the Conflict of Interest Committee will communicate the conflict determination to the direct supervisor at the CWCA (and any others in the chain of command up to the Director of the CWCA), and designated Agency Performance Monitoring and Execution (APME) staff, to ensure applicable individuals are notified to resolve the conflict.

3. The Conflict of Interest Committee should consider notification to the Area Administrator in cases of a determination of an actual conflict of interest involving secondary employment of a DCFS employee and a contracted child welfare contributing agency.

In this case the Conflict of Interest Committee notified both the area administrator and the supervisor of the conflict, which is the general practice of the Conflict of Interest Committee, via notification from the Committee Chair (DCFS Ethics Officer).

General Investigation 5

COMPLAINT A Department placement supervisor, who was also a licensed foster parent, solicited placement of a relative's four children, ages 5, 7, 9, and 11, after the Department took the children into protective custody and placed them in a fictive kin home. The complainant alleged that the placement supervisor coached and manipulated the children's mother and the 11-year-old child to lie about the conditions in the fictive kin home, so that the Child Welfare Contracted Agency (CWCA) placement staff would move the children to the placement supervisor's home.

INVESTIGATION During a child protection investigation, the Department took protective custody of the four children in response to the parents' history of domestic violence and placed the four children with a maternal aunt. The placement supervisor, who was related to the children, requested the children be placed in her home, but her foster home license had a 20-day hold for an unrelated unfounded child protection investigation. However, one day after placement with the maternal aunt, the child protection supervisor learned that the placement supervisor was violating the 20-day hold by having the four children live with her. The child protection supervisor then moved the four children to a fictive kin home after the request for a waiver of the 20-day hold on the placement supervisor's home was denied.

To avoid any potential conflict of interest, the children's family placement case was assigned to a different CWCA from the one that licensed the placement supervisor as a foster parent. During the handoff meeting, child protection staff informed the CWCA staff of the family's background, that the placement supervisor requested to have the children placed with her after the 20-day hold expired, and that the fictive kin reported being willing to keep the children as long as needed.

The OIG found that after the CWCA decided that the children would remain with the fictive kin, the placement supervisor began encouraging the mother to request for the CWCA to place the children with the placement

supervisor, promising the mother that as a Department employee she could allow more frequent visits with the mother and have the children returned to the mother's care sooner.

Shortly after placement with the fictive kin, the Department initiated an investigation for inadequate supervision by the fictive kin foster parents after an online report alleging that the fictive kin's 15-year-old biological child had a history of sexually inappropriate behavior, and the reporter expressed concern for the female children placed in the home. That same day, the mother also reported to the DCFS hotline that the fictive kin did not properly care for the children and wanted the Department to place the children with the placement supervisor. The mother told IG investigators that she was with the placement supervisor when she contacted the DCFS hotline, and that the placement supervisor encouraged her to make the hotline report. Additionally, the placement supervisor dialed the number for her and coached her through making the report, including encouraging her to exaggerate concerns. The Department took the report as related information, and within the following three weeks, the Department received six additional related information reports regarding the children in the fictive kin's home.

During the child protection investigation, the placement supervisor emailed the children's GAL from her Department email account to inquire about the children. The placement supervisor did not mention her relationship with the children, and the email included signature lines with her Department permanency supervisor role and her office phone number. In an interview with IG investigators, the placement supervisor confirmed that the email was not related to Department business but denied trying to obtain information in her professional capacity, but to report the mother's concerns to the GAL.

The OIG obtained text messages in which the placement supervisor texted the mother with messages intended to be shown to the 11-year-old child at the mother's visit with the children. In the text messages, the placement supervisor instructed the 11-year-old to misbehave at the fictive kin home and to encourage the siblings to do the same. The mother told IG investigators that the placement supervisor instructed the mother to show the message to the 11-year-old, which she confirmed doing. According to the mother, the placement supervisor told her that the CWCA would move the children to the placement supervisor's home sooner if the fictive kin requested their removal.

In a separate interview, the placement supervisor confirmed to IG investigators that she sent the text to the mother to show the message to the 11-year-old. The placement supervisor stated that she had concerns for the children's safety at the fictive kin home based on the mother's statements and that she wanted the children in a safe home.

All four children participated in CAC interviews, and except for the 11-year-old, the children reported no concerns, denying all allegations of abuse or neglect. The 11-year-old told the CAC interviewer that the fictive kin foster father occasionally hit her; however, the CAC interviewer noted that the 11-year-old's statement regarding the physical abuse contained inconsistencies. The 11-year-old also stated that the placement supervisor had been contacting her via the 11-year-old's school computer saying that if the children came to the placement supervisor's home, they could see their mother more.

Three days prior to the children's move to the placement supervisor's home, the case worker documented that the 11-year-old reported that the mother instructed her to lie about the fictive kin. The following month, the Department closed the investigation, unfounded the fictive kin foster parents, and marked the investigation as harassment.

The OIG concluded that the placement supervisor exhibited egregious behavior and crossed professional boundaries on multiple fronts for the purpose of having her relative's children placed with her. Her actions disregarded the children's needs and the pressures being exerted on them. The placement supervisor's efforts came at a cost of both emotional harm to the children and to the fictive kin family after numerous false allegations were reported against them. Her actions greatly inhibited the ability of the CWCA to act in the children's best interest.

The OIG determined that the placement supervisor misused Department resources by contacting the children's GAL and failed to acknowledge the personal nature of the email. Additionally, the placement supervisor used her professional relationship with the GAL to gain influence. Though the GAL did not recall weighing in on the children's placement, the OIG found evidence to counter this statement through documentation in SACWIS

and interviews. The OIG also found that pressure from the placement supervisor, the mother, the GAL, and the increasing severity of allegations to the DCFS hotline, led to the CWCA's decision to move the children to the placement supervisor's home.

RECOMMENDATIONS **1. The placement supervisor should be disciplined up to and including discharge. If discharged, a do not rehire should be placed in the personnel file and entered into the Central Management Services' personnel database.**

The employee was discharged from the Department. The employee does not have reinstatement rights to return. A notation was made in the system to not rehire.

2. The OIG will share a redacted copy of this report with the CWCA that licensed the placement supervisor as a foster parent and submit a licensing complaint to the CWCA licensing team for investigation of the placement supervisor's foster home license.

The OIG shared the report with the foster care licensing team and made a referral for a licensing complaint investigation against the placement supervisor's foster home license.

3. The Department should consider a placement hold on future placements in the placement supervisor's foster home.

A Director placement hold was placed on future placements in the placement supervisor's foster home.

4. This report should be shared with DCFS Clinical to review and make a determination as to whether it is in the best interest of the children to remain in the placement supervisor's home.

DCFS Clinical conducted a best interest clinical staffing to review whether the youth in care should remain in the placement supervisor's home.

5. A redacted copy of this report should be shared with the children's Guardian *ad Litem.*

A redacted copy of the report was shared with the children's Guardian *ad Litem*.

6. The OIG will share a redacted copy of this report with the CWCA to provide placement staff full information for case planning purposes regarding the children named in the report.

A redacted copy of the report was shared with the placement team.

General Investigation 6

COMPLAINT A child protection investigator engaged in a personal relationship with a father, who was an alleged perpetrator in a child protection investigation the child protection investigator was assigned.

INVESTIGATION The family first came to the Department's attention in November 2021 after the mother reported to emergency services that she smothered her then 1-month-old infant. Emergency services found the infant in the father's care, and assessed that the infant had no visible injuries, marks, or signs of trauma. The father reported to the emergency personnel that the mother had mental health issues, did not take her medication, had not slept for two days, and was hallucinating. Emergency services transported the mother to the hospital for a psychiatric admission. The Department closed the child protection investigation and unfounded the mother for substantial risk of physical injury by neglect (#60), as the infant was unharmed, and the mother accepted mental health treatment.

Approximately seven months after closing the first investigation, the Department initiated a second child protection investigation after law enforcement responded to the home for a domestic disturbance. When law enforcement attempted to separate the couple, the mother pushed the father after he tried to take the 7-month-old infant. Law enforcement arrested the mother for domestic battery. The Department closed the investigation and indicated the mother for substantial risk of physical injury by neglect (#60). The mother also pleaded guilty to domestic battery/physical contact and resisting a peace officer, and the court gave her conditional discharge for one year.

Less than a year later, the Department initiated a third child protection investigation after the mother called 911, reporting that the father attacked her and attempted to strangle her. Upon arrival, law enforcement observed the mother had injuries on her neck and body and that the then 23-month-old child had a small cut on her foot from stepping on broken glass. Law enforcement arrested the father, documenting that he appeared intoxicated and uncooperative.

The child protection investigator named in the complaint interviewed the mother at the family's home, who reported that she returned home from work on the previous evening and found the father intoxicated. The mother stated that they began to argue, and that she called the police after the fight turned physical. The child protection investigator documented that the mother tested negative for all substances. The child protection investigator documented that she observed the puncture wound on the bottom of the child's foot, and the mother agreed to take her to the doctor. However, the child protection investigator did not note any injuries to the mother nor any information regarding the physical altercation between the parents. The following day, the child protection investigator met again with the mother after learning about the family's prior Department history. The mother stated that she had not taken the child to the doctor because she experienced issues related to her mental health. The child protection investigator implemented a safety plan and placed the child with the paternal grandparents, who agreed to supervise any interaction between the parents and the child. Conditions to terminate the safety plan included that the father would complete a substance abuse assessment and that the mother would see her primary care physician and attend counseling.

That same day, the child protection investigator spoke with law enforcement and obtained the police report. In the police report, law enforcement documented the mother's injuries and noted that the father was aggressive and uncooperative throughout the entire encounter; however, later in the investigation, the child protection investigator entered a note into SACWIS, writing that the officer stated the father cooperated. The child protection investigator told IG investigators that the police officer stated that he saw marks and bruises on the mother's arm, but the child protection investigator stated that she did not observe any marks on the mother during the initial interview. The OIG investigation found that the child protection investigator falsely reported that the father obtained an order of protection against the mother, failed to document the father's substance abuse assessment or the mother's mental health treatment as required for safety plan termination, failed to ensure the father completed a substance abuse assessment, and failed to refer the family for intact family services as instructed by her supervisor.

IG investigators found that two months into the pending child protection investigation, the court convicted the father of a criminal felony of aggravated domestic battery and sentenced him to 36 months' probation, drug treatment, mental health treatment, a fine of $2,975, and 180-days jail time. Child protection staff did not document the father's conviction in SACWIS.

The Department closed the investigation and indicated both parents for substantial risk of physical injury/environment injurious to health and welfare by abuse (#10) and the father for cuts, bruises, welts, abrasions, and oral injuries by neglect (#61), citing the broken glass that cut the child's foot. The Department closed the investigation without child protection staff conducting substance abuse or domestic violence screenings with the father.

Six days after the Department closed the investigation, the child protection investigator sent a text message to the father from her personal cell phone. IG investigators reviewed the child protection investigator's personal cell phone records and found 34 phone calls and 2,960 text messages between the child protection investigator and father for a 7-week period after the initial text message. IG investigators also observed that the child protection investigator's public-facing social media page listed her in a relationship with the father and that the profile picture was a photograph of them together.

The child protection investigator told IG investigators that she and the father began to casually talk over the phone weeks after the investigation closed and that the conversations progressed into a romantic relationship. The child protection investigator stated they first met for personal reasons approximately three weeks after the investigation closed. The child protection investigator reported to IG investigators that she was currently in a romantic relationship with the father and that they resided together. The child protection investigator denied that any non-professional relationship occurred prior to the close of the investigation and stated that she did not have any concerns about having a romantic relationship with the father after the investigation because she did not discuss her work at home. The child protection investigator stated she was not aware of any DCFS policy or ethics violations related to relationships with current or former clients and did not intentionally violate the policy. IG investigators found that upon the child protection investigator's hire with the Department, the child protection investigator signed a form indicating they were aware of Department policy and the ethics guide that included specific language against relationships with current and former clients.

The Code of Ethics for Child Welfare Professionals in the DCFS Employee Handbook states: "Child welfare professionals should not engage in sexual activities with former clients who were adults during the professional intervention for a period of at least two years after the termination of the professional intervention…" The Code of Ethics also provides that child welfare employees should consider the "potential harm" that non-professional relationships with clients could have on their professional judgment, and that employees should "avoid any conduct that would lead a reasonable person to conclude that the child welfare professional might be biased or motivated by personal interest in the performance of duties."

The OIG concluded that the ethical principle underlying the policy prohibiting relationships between child welfare employees and their clients is central to the authority granted to the Department and to the social contract between the Department and the public it serves. Objectivity is one of the tenets of critical thinking; inappropriate close relationships with clients can lead to errors in decision making. In addition, the power dynamic of a child protection investigator having the ability to indicate or unfound a caretaker, and the profound impact that may have on a family, dictates that Department employees must behave in a manner that reflects such a level of public trust, not only for the individual employee, but for the Department as a whole.

The OIG found indications of bias throughout the child protection investigation as the child protection investigator amplified the mother's history of mental health issues and minimized the father's violence. There is a danger in ignoring or minimizing an incident of domestic violence, especially by discrediting the victim when there is evidence to the contrary, such as the police report which was obtained by the investigator.

RECOMMENDATIONS **1. The Department should pursue disciplinary action of the child protection investigator, up to and including discharge, for engaging in an intimate relationship with a former client in violation of the Code of Ethics for Child Welfare Professionals.**

The employee was discharged from the Department.

General Investigation 7

COMPLAINT A Department contracted residential treatment facility entered into a verbal agreement with the Department to allow the use of the agency's vacant facility to temporarily house and supervise youth. It was alleged that over two years later, DCFS Agencies & Institutions Licensing inappropriately cited the agency for violations of licensing standards related to the verbal agreement with the Department.

INVESTIGATION IG investigators found that in November of 2020, DCFS solicited and entered into verbal agreements with multiple residential facilities to use open beds at their facilities as "Welcome Centers." The program was intended to circumvent the need for youth, who were difficult to place and required a higher level of care, to stay in offices or shelters by providing temporary placements in residential facilities. Though the

Welcome Centers were intended to be solely supervised by Department staff with the residential staff managing the medication and providing meals, the generalized agreements failed to establish detailed programmatic plans for medication management, staffing issues, and crisis management for youth who needed de-escalation. During the establishment of the Welcome Centers, the Department operations administration failed to consult the divisions of Contract Administration or Agencies and Institutions Licensing.

IG investigators found that the Department's agreement put the residential agency in a compromising position in multiple ways. The Department's agreement encouraged the residential staff to manage and distribute medication to the youth that were not part of the agencies' residential program. Despite the agreement the Department would supervise all youth in the Welcome Center, residential staff were frequently forced to supervise youth due to Department staff's lack of attendance or their need for breaks. Department supervision staff were not trained in de-escalation techniques and the residential agency had no on-site security. Facility administrators told IG investigators that youth placed at a Welcome Center displayed behaviors that put the staff, youths, and facility at risk for assault, elopement, aggression, property damage, and fire setting. Additionally, while facility staff had specific de-escalation and crisis training, the Department's sit staff lacked appropriate training for crisis situations and the responsibility to prevent harm essentially fell to the facility staff who were trained in crisis management.

IG investigators found that in April 2023, two and a half years after the Welcome Center agreement, DCFS Licensing initiated a licensing investigation and cited the residential agency for providing services to youth who were not enrolled in the agency's residential treatment program. The OIG determined that the facility named in the complaint bore the brunt of the Department's lack of planning and detail when establishing the Welcome Centers. The facility had a reasonable expectation that the Department vetted its proposed program amongst the various divisions.

The OIG found that the Department solicited various facility providers to implement Welcome Centers but failed to consult the divisions of Contract Administration or Department licensing. The Department entered into generalized verbal agreements with residential facilities without establishing programmatic plans for medication management, staffing issues, and crisis management for youth who needed de-escalation. Though the Department intended to manage the Welcome Center program, inadequate planning left the residential facilities to fill in the real time gaps in service and failed to protect facilities from unforeseen licensing violations.

The OIG found that while the Department was proactive and well-intentioned in responding to a crisis of placement shortages for youth, the implementation of the Welcome Centers violated those duties and responsibilities. The Department has a fiduciary duty to the youth we serve. The Department also has a professional and ethical responsibility to Child Welfare Contributing Agencies. The lack of internal Department communication and collaboration and the lack of written contracts resulted in a program that provided inadequate supports and safeguards for youth and positioned valuable community partners in an untenable situation.

RECOMMENDATIONS

1. The Department should facilitate a discussion with the residential facility named in the complaint in an effort to repair the professional relationship with this valuable community partner. In addition, the Department should rescind the April 2023 Confirmation of Substantiated Violations and Corrective Action Plan, and acknowledge the untenable position that the residential facility was placed in.

DCFS Clinical and other divisions are in conversations with the residential facility and discussing relationship building. The Division of Licensing has rescinded the Confirmation of Substantiated Violations and Corrective Action Plan dated April 2023, as recommended. In addition, the Department no longer utilizes Welcome Centers.

The DCFS Director personally reached out to the Executive Director of the residential facility to apologize and mend fences. Additionally, the Director has held several discussions in DCFS leadership meetings to continue the conversations about de-siloing and collaboration between divisions.

2. In the event that the Department seeks an addition or modification to the facility, service or program of a Child Welfare Contributing Agency, the Department must amend the contract to reflect the change.

Per program and contractual expectations, any changes to a facility and/or program will be reflected in the program plan and contractual amendment or a new contract.

3. Department senior leadership along with Department Deputies should use this Report to facilitate a discussion addressing improving internal communication and collaboration and the professional and ethical duties owed to community partners.

There has been a series of conversations around program performance including relationships within the various Divisions within DCFS as well as other stakeholders. Conversations have been productive and continue to assure a mutual understanding of all expectations. Additionally, the Director has held several discussions in DCFS leadership meetings to continue the conversations about de-siloing and collaboration between divisions.

4. The Inspector General will share a copy of this report with the residential facility named in the complaint.

The OIG shared a copy of the report with the involved residential facility.

5. This report should be shared with the Department's Medical Director, Director of Nursing and Director of Residential Monitoring to further explore the need for written policy and training for Department staff responsible for medication management and distribution when a child is brought in for an emergency shelter placement.

The report will be shared with the identified staff to explore the need for written policy and training to address the recommendation.

General Investigation 8

COMPLAINT The OIG received a complaint with concerns about the Department's handling of a child protection investigation involving a 1-year-old child's presence during a domestic altercation between the parents. The allegations of the complaint were not substantiated. However, during the IG's preliminary investigation, IG investigators found that the Department failed to open intact family services prior to closing the most recent child protection investigation, despite the family agreeing to services.

INVESTIGATION The mother's first involvement with the Department as a parent occurred in 2015, following the birth of her first child, who tested positive for marijuana. The report was not taken for investigation.

In 2018, the mother was indicated for substantial risk of physical injury (#10) to her second born child, then 7 weeks old, after a domestic violence altercation between the mother and the infant's father. The family was referred to intact family services. The intact case was open for four months and closed when the parents agreed to give guardianship of the infant to his paternal grandmother.

Seven months after the intact family services case closed, the Department initiated separate investigations for cuts, bruises, welts, abrasions, and oral injuries (#11) by mother to her oldest child and for medical neglect (#79) to the child by his father after a hotline report that the then three-year-old child had injuries and had not been taken to the doctor. The oldest child was primarily living with his father at the time. The father agreed to take the child to the emergency department and told child protection staff that the child's finger was accidentally smashed in a car door while with his mother. The treating physician reported no concerns and reported that the injuries appeared consistent with accidental injuries. The Department closed and unfounded the investigations.

In 2021, shortly after the birth of the mother's third child, the Department initiated a child protection investigation after the oldest child, then 6 years old, reported the mother hit him with a belt. While the investigation was pending, the Department opened a second investigation after the mother reported wanting to drop the 6-year-old off at the

police station because she could no longer care for him. The Department unfounded and closed both investigations and opened a second intact family services case for the family.

While the intact family case was open, there were two additional unfounded child protection investigations involving the family. The intact case remained open for sixteen months and closed successfully in March 2023 after the parents completed their services, including substance abuse treatment, and mental health services, and received assistance with housing.

Three months after the intact family services case closed, the Department initiated a child protection investigation after law enforcement arrested the father of the youngest child for domestic battery, after he allegedly struck the mother in the presence of their then 1-year-old daughter. That same day, the child protection investigator interviewed the mother, who reported that the domestic dispute started after she discovered the father's drugs and disposed of them. The mother stated he pushed her out the door and punched her in the back. The mother reported that she stayed at a shelter and planned to obtain an order of protection against the father. Several days later, the mother moved out of state.

The child protection investigator met with the father, who denied the allegations and reported he left the residence during the verbal argument, and when he returned, the mother told him that the neighbors called the police and that she reported that he punched her. One month prior to the child protection investigation closing, the father agreed to participate in intact family services that would include a substance abuse assessment, parenting classes, counseling, and a 0-3 assessment for the child. However, the Department closed the investigation, indicating the father for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), without opening an intact family services case.

DCFS Procedures 300.130c. *Reports of Child Abuse and Neglect: Referral for Services, Processing the IFS Referral* requires child protection investigators to complete intact family services referrals within 48 hours of the family's agreement to services and the supervisor's approval of the services.

During the three-month investigation, four different child protection supervisors entered notes into SACWIS for the investigation. One supervisor met with the child protection investigator to close the investigation, noting the father agreed to participate in intact services; and the day after the investigation closed, the investigator emailed a referral to a different child protection supervisor. According to Department issued emails, the supervisor did not send a reply to the investigator nor did the supervisor send the referral to the area administrator for approval, as procedurally required.

In separate interviews, both supervisors told IG investigators that the referral process for intact services consisted of the child protection investigator emailing their supervisor the intact referral for approval. After reviewing the referral, the supervisor emails the referral to the area administrator for approval. After the area administrator approves the referral, the supervisor then emails the referral to the intact assignment unit.

The failure to refer families for intact family services in a timely manner was not unique to this child protection investigation. In the last three years, the OIG issued four reports to address issues of untimely referrals resulting in families no longer wanting services or a breakdown in the referral process. The OIG acknowledges the difficulty Department staff face when confronted with staffing shortages. However, timely intact family services referrals must be a core principle reinforced with frontline child protection staff because delays in referring families to intact services may result in missed opportunities to engage with families.

RECOMMENDATIONS

1. This report should be shared with the child protection investigator and both child protection supervisors and used as a teaching tool.

The report was shared with the child protection investigator and both child protection supervisors and used as a teaching tool.

2. The OIG reiterates the following prior OIG recommendation, "The Department should ensure that the intact referral process is incorporated into the Department's new data information system to allow for tracking, follow-up, and initiation of services."

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

3. While awaiting implementation of recommendation 2, the Department should develop interim measures to provide better checks and balances within the current intact family services referral process. These interim measures should include a requirement that the child protection investigator document in a SACWIS case note the date and time the CFS 2040, Intact Family Services Case Referral and Assignment Form was emailed to their supervisor.

The Department of Child Protection agrees to requiring the child protection investigator document in a SACWIS case note the date and time the CFS 2040, Intact Family Services Case Referral and Assignment Form was emailed to their supervisor as an interim measure until the full development and transition to IllinoisConnect. Also, the Deputy Director of Child Protection and Deputy Director of Intact Family Services will continue their standing monthly meeting to review data regarding potential delays of intact case opening, intact refusal data, and referral documentation.

General Investigation 9

COMPLAINT A Department employee was arrested and charged with violating an order of protection. The Department placed the child protection investigator on desk duty pending the OIG investigation.

INVESTIGATION A former paramour filed for an order of protection against the child protection investigator, alleging that the employee posted false allegations online and emailed similar allegations to two professional organizations affiliated with the paramour. The paramour also reported that the Department employee damaged the paramour's property and broke into their home. Approximately one year after the order of protection was issued, a complaint was filed that the Department employee had violated the order of protection by sending a text message to the paramour on two separate occasions. Law enforcement arrested and charged the Department employee with violation of the order of protection. The next day, the court released the employee on the condition of compliance with the requirements of the order.

The OIG found that the Department does not currently require incidents of an arrest, criminal charge or criminal conviction to be reported to the Office of Employee Services, Division of Labor Relations. The DCFS Employee Handbook (Chapter 5.7) requires Department employees to file an unusual incident report with their supervisor if they were arrested, charged with or convicted of a crime and Department Procedure 331.140, *Significant Events Involving Personnel, Caregivers and Facilities*, also requires for unusual incidents to be entered into SACWIS. However, the lack of directive for the incidents to be reported to the Division of Labor Relations may lead to inconsistencies in the evaluation of employees' conduct and monitoring of the status of such incidents. While an arrest, in and of itself, may not impact a person's suitability for employment, a nexus of the conduct to job responsibilities may warrant action by Department administration and the Department's Office of Employee Services.

RECOMMENDATIONS **1. The Department should require notification to the Division of Labor Relations of Significant Events (Unusual Incidents) involving the arrest, charge, or conviction of an employee to allow for consistent evaluation and monitoring. The Employee Handbook and Department Rules and Procedures should be amended accordingly.**

The Department has obtained the protocol used by another state agency which will be used to build a protocol involving the arrest, charge, or conviction of an employee.

2. The Office of Employee Services, Division of Labor Relations should develop a written protocol detailing the process for evaluating an employee's arrest, charge, or conviction and also determining an appropriate work status in conjunction with the assigned supervisor or administrator.

The Department has obtained the protocol used by another state agency which will be used to build a protocol involving the arrest, charge, or conviction of an employee.

General Investigation 10

COMPLAINT The Department was alleged to have mishandled child protection investigations involving two adolescent siblings with law enforcement involvement. Law enforcement received a significant number of calls regarding the youth running from their terminally ill caregiver and the Department failed to intervene. During the pending OIG investigation, the Department received report of the death of one of the older adolescent siblings.

INVESTIGATION At the beginning of 2022 the guardian, also the paternal grandmother, reported wanting to relinquish guardianship of the adolescents citing issues managing their behaviors and the guardian's terminal illness. The guardian petitioned the probate court for discharge of guardianship while living in a county outside the county that originally granted the initial guardianship eight years earlier. Over the next 14 months, the family had contact with local law enforcement, DCFS and the community agency charged with serving youth who ran from their homes. OIG review of law enforcement records found that the local police department received 38 calls involving the family with 63% related to the guardian reporting the adolescents as missing from the home. The local police department also arrested both adolescents during this time on charges related to battery, theft, and drug possession. During this time, the Department received 21 reports to the hotline in the same 14-month period. Child Welfare Service Referrals accounted for 12 of the reports and four reports resulted in child protection investigations all of which were unfounded. The remaining reports to the hotline did not meet criteria for intervention. OIG review found that DCFS child protection investigations as well as Child Welfare Service Referrals were closed often noting that no abuse/neglect was alleged, and that the guardianship issue would be addressed in probate court. However, the probate court matter continued for over a year which left the children in the home of their terminally ill guardian with no support. The Department did not adequately assess the family's need for intervention. The OIG assessed that the frequency of calls regarding the family in a relatively short period of time indicated a substantial need for intervention.

One of the child protection investigations the Department conducted during the 14-month period for allegations of substantial risk of physical injury/environment injurious to health and welfare (#10) involved a community agency that provided crisis response services to youth aged 11 to 17 at risk of involvement with the child welfare or juvenile justice systems. The community agency received funding for services through the Illinois Department of Human Services. The OIG identified that both law enforcement and DCFS identified the community agency as the appropriate agency for managing runaway youth, yet the agency failed to open a case for services citing no records of the family and referring to the children as habitual runaways. During that same investigation, child protection staff never went to the guardian's home, never interviewed one of the siblings, and never confirmed information about the pending petition to discharge guardianship. The failure to complete investigative tasks further hindered the Department's ability to adequately gain information about the family.

In the spring of 2023, the probate court granted the guardian's petition and the adolescents' adult sibling became their short-term guardian for a period of one year. At the court hearing, attended by DCFS legal, the probate judge ordered DCFS to provide the adult sibling and the adolescents with intact family services and then closed the probate court case.

At the time of intact family case opening both adolescents had delinquency court involvement and their cases transferred to the county where the adult sibling lived. One of the adolescents had been in juvenile detention for two months stemming from multiple juvenile delinquency petitions for charges of disorderly conduct, aggravated

battery, resisting a peace officer, criminal damage to property, unlawful possession of a controlled substance and unlawful possession of a controlled substance with intent to deliver. Conditions of the adolescent's probation included not violating any laws, not using substances, and participating in a substance abuse assessment. However, over the next year, the adolescent continued to engage in negative behaviors including drug use and additional criminal activity that resulted in additional arrests. The adult sibling and the intact worker attempted to work with the probation officer in securing substance abuse services for the adolescent, but the probation officer cited a lack of positive drug tests and "hearsay" as insufficient for court intervention. When the delinquency court did enter an order for drug treatment the family met significant barriers to treatment such as a lack of beds, insurance issues and programs that did not accept youth with aggressive behaviors.

OIG review of intact family records found that throughout the intact case, both adolescents demonstrated significant behavioral and mental health issues. The older adolescent continued delinquency involvement and was arrested for vehicular carjacking during the intact case in addition to continued reports of substance abuse and running from the home. The younger adolescent had issues with aggression at school and required psychiatric hospitalization during the intact case. The Department also conducted three child abuse and neglect investigations during the year of intact services for allegations related to inadequate supervision (#74), inadequate food (#76), and substantial risk of physical injury/environment injurious by neglect (#60). While all investigations were unfounded, the continued reports to DCFS suggested continued crisis in the home of the adult sibling. Additionally, the adult sibling resisted obtaining permanent guardianship of the siblings citing concerns about their behaviors and their resistance to services and interventions. The intact family staff assessed a need for a higher level of services and separately contacted both the DCFS Office of Legal Services and the Assistant State's Attorney for assistance in obtaining court intervention. Office of Legal Services staff cited that the adult sibling's failure to obtain permanent legal guardianship through probate court did not require juvenile court intervention. The Assistant State's Attorney noted that the adult sibling's continued willingness to care for the children did not rise to the level of a dependency petition failing to recognize that the adult sibling, despite willingness, needed greater support in caring for the siblings. Failure to consider dependency for the adolescents allowed them to remain in a home with limited support and resources to address the difficult issues of substance abuse, non-compliance, and mental health.

One year after opening the intact family case and during a pending child protection investigation for allegations of inadequate supervision, the Department received notification of the death of the older adolescent who had been shot and killed in the community. The Department added the report to the pending investigation which remained open at the time of the OIG report. The adolescent had been reported missing by the adult sibling approximately three months earlier. The delinquency court judge issued a juvenile arrest warrant for the missing adolescent who did not return to his home prior to his death. The intact worker attempted to locate the missing adolescent and had one contact with the adolescent two weeks prior to the death. The younger sibling arranged for the adolescent to meet with the intact worker in the community and the adolescent reported staying with friends but would not provide the intact worker with any further information. One month later the intact family case was closed at the request of the adult sibling. The intact family worker assisted the family with funeral arrangements and provided linkage to community referrals for service provision.

In the two years leading up to the adolescent's death, the family had concurrent involvement with multiple agencies/systems including DCFS, law enforcement, delinquency court, probate court, and community providers. OIG review found a disconnect between entities with little to no coordination or communication. When multiple agencies serve families, collaboration and information sharing is critical to successful intervention. No one system serving the needs of children and families can work effectively in isolation and will certainly not work when information is siloed. The sharing of information and collaboration regarding youth involved in multiple systems can help achieve success on both the systemic and case specific levels. At the systems level, sharing information on youth that touch multiple systems helps to understand trends and patterns that support system reform. On the case level, sharing information can support better case planning, reduce duplicative services, and increase understanding of overall functioning and wellbeing. The ability to address information sharing issues is critical to cross-system collaboration efforts and remains essential to meaningful intervention with vulnerable populations.

RECOMMENDATIONS

1. The Department should use this report as a resource for strengthening internal practice and communication. Given that a siloed approach to service provision fails to fully recognize or adequately respond to the complex and multi-faceted issues confronting families, this report highlights the dangers inherent in a system in which a lack of coordination and limited sharing of information hinders the ability to effectively and meaningfully provide for children and families involved with the Department.

Intact Family Services, Child Protection and Permanency leadership met to review this case. The Department agrees to use this report as a resource for strengthening internal practice and communication.

2. The Department should identify community partners that provide services to youth involved with delinquency and child welfare services, including Child Protection and Intact Family services, to explore avenues for improved barriers to obtaining vital services for this vulnerable population. The Department should convene the involved community partners using this case as a guide for discussion among the community partners.

Through the Children's Behavioral Health Initiative, the Department is connecting with other agencies and community partners to collaborate and communicate to obtain vital services for children and families. These discussions occur weekly. Also, Intact and Quality Assurance launched the statewide use of the QUEST tool in July 2024. This tool measures quality of services provided to families, as well as service provider and community support engagement in the case planning process. The Department has set up standing meetings to review this data quarterly at the statewide level, CWCA level and regional level. The Department will develop trackable action plans and goals around the results of the data. The first of these meetings will begin in October of 2024 once the first quarter of data has been reviewed. In addition, Beacon has gone live for Childrens Behavioral Health Support. Beacon is the state's new online portal designed to help Illinois families connect to behavioral health resources. In addition, this report will be shared and used as a guide for discussion among community partners.

3. The Department should develop a mechanism for identifying youth during child protection investigations and intact family services cases that also have delinquency involvement. The Department should ensure the sharing of information with appropriate court, probation, and community providers to better support case planning, reduce duplication of services, and increase the understanding of a youth's overall functioning and well-being.

Through the Children's Behavioral Health Initiative, the Department is connecting with other agencies and community partners to collaborate and communicate to obtain vital services for children and families. These discussions occur weekly which lead to avoidance of duplication of services and improved communication. Additionally, Intact Family Services is currently working with Deloitte to build a legal section related to each child in an intact case where intact workers and child protection staff can record all legal involvement.

4. This report should be shared with the Children's Behavioral Health Initiative and used to inform outreach and education on the importance of sharing information between multiple systems for those youth who are dually involved but not youth in care.

The Department agrees. The report was shared with the Children's Behavioral Health Initiative to inform outreach and education.

5. The OIG will share this report with the IL Department of Human Services to address issues identified in this report involving, Comprehensive Community Based Youth Services (CCBYS) provider.

The report was shared with the Illinois Department of Human Services.

6. The OIG will share this report with the Director of the involved County's Juvenile Probation and Court Services Division.

The report was shared with the Director of the involved county's Juvenile Probation and Court Services.

PART IV: ERROR REDUCTION TRAINING

In FY 2024, the Office of the Inspector General continued implementation of its error reduction initiative building on efforts that began in 2008, with the enactment of legislation requiring the Office of the Inspector General to remedy patterns of errors or problematic practices identified in Inspector General investigations and by Child Death Review Teams. (20 ILCS 505/35.7)

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. Recognizing that weaknesses in organizational processes can contribute to negative outcomes for children and families, the Office of the Inspector General implements both a systems perspective and root cause analysis to identify errors, craft recommendations and develop trainings that strengthen the Illinois child welfare system. Informed by investigative findings, the Inspector General's error reduction initiative works to support both administration and front-line staff through promotion of critical thinking and evidence-based decision-making.

In May 2023, the Inspector General submitted an Error Reduction Implementation Plan addressing the assessment and decision-making process when crucial and documented family histories directly related to risk factors were not sufficiently considered or shared across disciplines concurrently working with the family. The overarching goal for all Error Reduction Training deliveries is to encourage and support the use of critical thinking, resulting in drawing logical conclusions based upon available information thus reinforcing the practice of readjusting assessments as new evidence/information becomes available.

Training objectives for the error reduction plan included implementing tools and strategies to use information from a family's history; sharing a series of exercises to establish methods to identify errors that promote an introspective environment able to admit the occurrence of errors; recognizing near misses to learn from them and developing effective prevention strategies to improve practice. The training design focused on assisting the field in limiting errors by working to improve supervision, increase understanding of procedures, and use supportive tools and resources to effectively address practice challenges. The training agenda included a review of available support tools; discussions of regionally specific practice issues; recognizing internal and external challenges; common missteps, and biases inherent to the complexities of child welfare; understanding and navigating guardianship; error management strategies; assessment of lengthy and complex family histories; and the introduction of Problem Based Learning (PBL) as a tool to support best practices with front-line staff through critical thinking.

In consideration of the crisis in staffing, record high caseloads and the number of trainings now required of DCFS staff, this iteration of Error Reduction Training was delivered regionally in small venues to approximately 300 staff in all five regions of the state from September of 2023 through May of 2024. The Department's Office of Legal Services provided training support with regional counsel at each of the trainings. The target audience included DCFS and CWCA direct service supervisors, Area Administrators and Regional Administrators. The participants included staff from Child Protection, Intact and Permanency Placement within their region which allowed for the identification of regional issues and allowed for discussion around systemic issues and regionally specific practices that impact children's safety.

DEPARTMENT UPDATE ON PRIOR SYSTEMIC RECOMMENDATIONS

The Office of the Inspector General's systemic recommendations are designed to strengthen the child welfare system to better serve children and families. The OIG tracks and monitors the implementation of recommendations accepted by the Department. The 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 2023 **The Department should develop and require training for temporarily assigned supervisors who are currently employed as Child Protection Specialists and Child Protection Advanced Specialists (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2024 Department Update: A workgroup that consists of child protection supervisors, area administrators, and Office of Learning and Professional Development staff are in the process of developing a training for child protection investigators that are temporarily assigned as child protection supervisors.

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

2024 Department Update: The DCFS Chief of Nursing, in collaboration with the DCFS Medical Director completed the development of the training materials. The training materials are being finalized for release to the field.

FY 2023 **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 (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 6).**

2024 Department Update: The report was shared with the Office of Legal Services. The Deputy General Counsel and Assistant Deputy General Counsel provided in-person training to Child Protection Regional Administrators, Area Administrators and Supervisors, in the involved region, relating to guardianship, types of guardianship, and how guardianship impacts a parent's rights. Also, in 2023 and 2024 the Office of Legal Services participated throughout the state in the OIG's Error Reduction Training, "Feedback to the Field". This training targeted supervisors and managers, and provided training and resources on guardianship, including a discussion of fitness.

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

2024 Department Update: The Division of Child Protection and Action 4 Child Protection will continue to collaborate as they develop ongoing training for the child protection division. The report has been shared to be used in training materials along with other identified closed cases.

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

2024 Department Update: Due to the drastic difference between the number of teams within the Department of Child Protection (DCP) and the number of child protection advanced specialists within DCP, there are feasibility concerns with meeting this request. The interim measure is to design a training for our temporarily assigned child protection supervisor's to better equip them for that temporary role which is inclusive of seeking out support on safety decisions from an area administrator. A workgroup is underway that consists of public service administrators-supervisors, area administrators, and Office of Learning and Professional Development staff that will design a training for child protection investigators that are temporarily assigned as child protection supervisors.

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

2024 Department Update: The Office of Child and Family Policy is working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The recommendation will be incorporated in these updates.

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

2024 Department Update: The recommendation will be incorporated into revisions to Procedures 300.50, Procedures 300.130 and Procedures 302.389. The revisions will include instruction on how to use short-term guardianship, including, when it might occur during an investigation where there is not present danger, due to abuse or neglect. These procedural changes will be part of the conversion to the SAFE Model. The Office of Child and Family Policy is also working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The system's implementation date is scheduled for Spring 2025. In addition, DCFS Legal facilitated a training discussion regarding temporary guardianship. DCFS Legal will prioritize developing training materials regarding this topic for future trainings.

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

2024 Department Update: The recommendation will be incorporated into the Department's conversion to the SAFE Model. In addition, the Office of Child and Family Policy is working on procedural revisions that will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The system's implementation date is scheduled for Spring 2025.

FY 2022 **The Department should develop procedures for notifying the local Illinois Department of Human Services (DHS) Child Care Assistance Program when a protection plan is implemented, and a daycare is temporarily voluntarily closed. The Department should also immediately notify DHS 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).

2024 Department Update: The recommendation was incorporated into the revision of Procedures 383.45(b)(7), *Protective Plans in All Other Circumstances* and issued to the field on January 9, 2024.

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).**

2024 Department Update: The CFS-531, *Regional Nurse Referral Form*, was revised and issued to the field on July 20, 2024. The form is available on the Department's templates drive. In addition, the nursing division has been providing in-service training to child protection staff throughout the state on the role of DCFS nurses and the use of the CFS-531 form.

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).**

2024 Department Update: The recommendation was incorporated into revisions to the CFS 2040, *Division of Child Protection- Intact Family Services Case Referral and Assignment Form* and CFS 2040WR, *Intact Family Services Weekly Report*. The revised forms were released via 2023.13 Informational Transmittal which was sent out as an announcement and an email to staff on December 29, 2023. The revised forms can be found on the Department's templates drive. In addition, the workflow capabilities of IllinoisConnect will support automated notifications to the referring person.

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

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

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).**

2024 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. The scheduled implementation date within the Division of Child Protection is in the fall of 2025.

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).**

2024 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 which is scheduled to be implemented within the Division of Child Protection in the fall of 2025.

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).**

2024 Department Update: The recommendation was addressed in a Practice Memo dated November 16, 2022, that was shared with Child Protection staff, the Office of Learning and Professional Development staff, regional administrators and area administrators with the direction to share at the team and worker level. Additionally, the Department is in the process of revising Procedures 300 which will address the consistent application of the definition of "blatant disregard." The revisions will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the Allegation system. The procedural revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The 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).**

2024 Department Update: The Department is conducting an overall revision of Procedures 300, including Section 300.80, *Child Protection Supervisor/Area Administrator Waivers* which will address the steps investigators must take when an alleged child victim is inaccessible or otherwise unable to be seen in the proper time period. This rewrite will encompass the Department's new safety decision tool titled Safe Assessment and Family Evaluation (SAFE) which will include revisions to the child protection protocols. The procedural revisions will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect. The system's implementation date is scheduled for Spring 2025.

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).**

2024 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, which is scheduled for implementation in fall 2025.

Intact Family Services

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

2024 Department Update: The Intact Family Recovery Manager has begun conducting training on the Intact Family Recovery referral process for Child Protection investigators, supervisors and area administrators on a quarterly basis. In addition, the Intact Family Recovery brochure was revised September 2023 and reposted recently on the D-Net on April 4, 2024. The Intact Family Recovery Manager also posts referral instructions on the D-Net on a quarterly basis as well as sending monthly emails to DCP teams informing them of openings in the Intact Family Recovery program. In addition, the Department is in the process of updating the FY 26 program plan for the Intact Family Recovery program. Following integration of the SAFE Model and IllinoisConnect, the Intact Family Recovery Program will be incorporated into procedures.

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

2024 Department Update: Intact Leadership is working with IllinoisConnect to incorporate the recommendation into the new system.

FY 2023 **Expanding on a prior OIG recommendation (from January 2022 Annual Report, Death and Serious Injury Investigation 4), 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 (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 9).**

2024 Department Update: The Intact Family Recovery Manager has begun conducting training on the Intact Family Recovery referral process for area Child Protection investigators, supervisors and area administrators on a quarterly basis. In addition, the Intact Family Recovery brochure was revised September 2023 and reposted recently on the D-Net on April 4, 2024. The Intact Family Recovery Manager also posts referral instructions on the D-Net on a quarterly basis as well as sending monthly emails to DCP teams informing them of openings in the Intact Family Recovery program. The involved intact regional administrator also brings referral information to the involved quarterly regional administrator meetings. Additionally, all intact referrals are reviewed by the intact family services referral mailbox. If a referral meets the requirements of the Intact Family Recovery Program, the Management Operations Analysts will inform the referring team that the referral will be sent to the Intact Family Recovery Program.

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).**

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

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).

2024 Department Update: The Office of Intact Family Services is offering training with our nursing program to review services offered to Intact families. The first training was held on July 25, 2024, and was offered statewide to both DCFS and CWCA providers. This training will be offered twice a year along with refreshers on the medically complex practice memo for intact cases. Additionally, the Office of Intact Family Services will work to develop a system at intake in which referrals will be flagged when a medically complex child is identified. This system will be in place by fiscal year 2025. Once a case is flagged as medically complex, it will be put into a rotating review system which will result in quarterly reviews of these flagged cases. If during this review concerns are raised regarding the case, this will trigger a meeting with the assigned agency team, Management Operations Analysts, Agency Performance Monitoring and Execution (APME) staff, and the Deputy Director of Intact. In addition, the Office of Intact Family Services will develop a training series around common medical complexity issues to be delivered to the field in fiscal year 2025, as well as develop a best practice guide for medically complex cases to be implemented into the current revisions to procedures. The overall intent is to increase consultation with DCFS Nursing Staff.

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

2024 Department Update: Procedures 302.388, Intact Family Services, is in the process of being revised. DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors continue to utilize the October 20, 2023 practice memo which specifically addresses consents to be signed by the parents at the transitional visit with the child protection investigator. The procedural revisions to 302.388, *Intact Family Services* will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect and the SAFE Model. The system's implementation date is scheduled for Fall of 2025.

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).**

2024 Department Update: Procedures 302.388, Intact Family Services is in the process of being revised. DCFS and Child Welfare Contributing Agency Intact caseworkers and supervisors continue to utilize the October 20, 2023 practice memo which requires a 30-day staffing with all health care professionals. The procedural revisions to 302.388, *Intact Family Services* will take place in conjunction with the Department's conversion to its new comprehensive child welfare information system, IllinoisConnect and the SAFE Model. The system's implementation date is scheduled for Fall of 2025.

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).**

2024 Department Update: A contract was finalized in June 2024, expanding the Child Welfare Training Academy Simulation program for intact family services staff. DCFS has developed three intact simulations that will be piloted in the second quarter of fiscal year 2025. The simulation scenarios will be presented as Intact Family Services in-service workshops with an emphasis on the application of Motivational Interviewing within the Child and Family Team setting.

Personnel

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

2024 Department Update: The Department is currently in negotiations with the AFSCME labor union regarding finalizing an agency protocol related to restrictive duty status.

FY 2021 **The Office of Employee Services and the Child Welfare Employee Licensure (CWEL) 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).**

2024 Department Update: The Office of Employee Services has added additional criteria to the background check form. The candidate will now have to identify if they have ever worked for a Child Welfare Agency in which the position required them to have a CWEL license. The candidate will also need to indicate if the CWEL license was issued. If the CWEL license was issued they will need to contact the CWEL mailbox and get a letter stating that the license is in good standing. A copy of the license will not satisfy the requirement. The background check will not be completed without the letter of good standing. If the candidate states that the license is not in good standing, the Office of Employee Services is requesting a detailed explanation for the reason.

Services

FY 2023 **When a case is closed in court prior to the completion of the six months of required after care services in violation of Illinois law, the assigned caseworker and supervisor should contact the Office of Legal Services for assistance. OLS is encouraged to request the court to keep the case open during the six months of after care services. This recommendation should be incorporated in Procedures 315.250 and the Department should provide education to the field regarding this issue (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2024 Department Update: Requests to incorporate the recommendation into Procedures 315.250, and to communicate the forthcoming policy change to the field, are pending with the Office of Child and Family Policy (OCFP) and are being prioritized for completion. The Department anticipates communicating these changes by way of an Action Transmittal which is being drafted by OCFP.

FY 2023 **The Department should collaborate with the Administrative Office of Illinois Courts (AOIC) to provide training and education on the procedural and statutory requirements of after care services to court personnel statewide. A redacted copy of this report should be shared with the AOIC and Office of Legal Services to assist with the training (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2024 Department Update: The Office of Legal Services shared the report with the AOIC and met with the Director of the AOIC's Courts, Children and Families Division about educating Juvenile Court judges and court personnel on the requirements of aftercare services. OLS and Permanency have developed a fact sheet for judges and other court stakeholders about the requirements for after care services, including illustrative case examples. AOIC and DCFS will distribute the fact sheet to juvenile court judges, state's attorneys, and guardians *ad litem* throughout the state, and thereafter co-host lunchtime virtual information sessions for judges to highlight key aspects of after care and provide a forum for discussion on the topic. These sessions are anticipated for early 2025.

FY 2023 **The Office of Legal Services should convene meetings with local State's Attorneys to discuss the procedural and statutory requirements of after care services (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 7).**

2024 Department Update: The Office of Legal Services and the Permanency Division have developed a fact sheet for judges, State's Attorneys, and other court stakeholders about the requirements for after care services, including illustrative case examples. The AOIC and DCFS will distribute the fact sheet to state's attorneys and will encourage juvenile court judges to share the resource with Assistant State's Attorneys assigned to their courtrooms. The Department is exploring additional avenues to engage with States' Attorneys for educational and training purposes.

FY 2023 **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 (CIPP), 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 (from Fiscal Year 2023 OIG Annual Report, General Investigation 7).**

2024 Department Update: The report was shared with the identified staff and a discussion was facilitated that included the topic of accessing information when deciding placement of young children with complicated histories.

FY 2023 **A redacted copy of the report should be shared with the Department and incorporated in outreach and education regarding ethical decision making for supervisors and managers (from Fiscal Year 2023 OIG Annual Report, General Investigation 9).**

2024 Department Update: The Department agrees that it is important to address ethics in the workplace with staff as it relates to supervision and daily interactions with other staff. In fiscal year 2025, the Ethics Officer plans to work with the Office of Employee Services to recommend adding information to the Employee Handbook, highlighting important aspects of ethics in our professional relationships, as well as considering ethics in interacting with the families we serve. The Ethics Officer also plans to develop information for the D-Net identifying key components of ethics in the workplace. Finally, the Department is exploring the possibility of incorporating this education into Foundations Training, in order to establish the framework for an ethical culture within DCFS from our earliest interactions with new employees. The Ethics Officer will consider how best to incorporate this report in implementing this recommendation.

FY 2023 **The Department should develop a policy addressing toxicology results detailing guidelines for accepted providers, inconclusive results and testing timeframes to be used by frontline staff (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 8).**

2024 Department Update: The Department's drug testing protocol has been revised and will be issued to the field. Tip sheets regarding drug testing were announced and posted on the D-Net under the Clinical Division's tab.

FY 2023 **The Department should review and evaluate its compliance with Procedures 302, Appendix L, Services for Deaf and Hard of Hearing Clients (from Fiscal Year 2023 OIG Annual Report, General Investigation 4).**

2024 Department Update: Procedure 302, Appendix L was updated, approved, and a policy transmittal was sent out via email and posted to the D-Net on October 18, 2024.

FY 2023 **The Department must establish a process addressing requests by private agencies for cases to be returned to the Department when specialized services are required (from Fiscal Year 2023 OIG Annual Report, General Investigation 4).**

2024 Department Update: The Department's Specialty Clinical Services Unit within the Clinical Division provides support to all CWCA agencies and DCFS around the following specialties: Domestic Violence, LGBTQ, Deaf/Blind, HIV, Sexually Problematic Behavior, Developmental Disabilities or Substance Abuse. Per the contract, the CWCA (Child Welfare Contributing Agencies) are required to identify and provide appropriate services to

families, including specialty services. All Department specialty services and consultations are available to CWCA agencies and should be accessed to provide support and guidance related to service needs and linkage to appropriate services. If an agency is having challenges or is not able to provide the level of service necessary to adequately address the family's needs, the CWCA shall request a Clinical Staffing to determine the appropriate services and frequency needed for the family. The respective Specialist from the Clinical Unit shall participate in the staffing to assist in the determination of needs and level of services. If the agency is requesting a transfer based on the need of the family and the agency's inability to meet that need is outside of the program plan; a review of the request to transfer will occur. Agency Performance Monitoring and Execution (APME) staff will review the clinical recommendation related to services and the case and a determination will be made if these can be accessed and shall be provided by the CWCA agency through the existing program plan and if not, it will be reviewed for transfer to the Department. If determined a transfer is needed, the case transfer process will be initiated with final approval from APME Deputy. In addition, AP9 is being amended with the above changes. In the interim, a Practice Memo will be sent to all CWCA's by December 1, 2024, informing them of the new process.

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).**

2024 Department Update: A multi-divisional workgroup was formed as a result of the OIG recommendation to review the identified concern regarding unauthorized placements. The workgroup identified areas involving placement clearance, licensed home capacity issues and 906 codes. The workgroup has approved the policy changes and recommendations. Additional review and recommendations were made by the Chief Deputy Director of Permanency. The policy and programmatic changes are currently under review by the Director.

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).**

2024 Department Update: A multi-divisional workgroup was formed as a result of the OIG recommendation to review the identified concern regarding unauthorized placements. The workgroup identified areas involving placement clearance, licensed home capacity issues and 906 codes. The workgroup has approved the policy changes and recommendations. Additional review and recommendations were made by the Chief Deputy Director of Permanency. The policy and programmatic changes are currently under review by the Director.

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).**

2024 Department Update: A multi-divisional workgroup was formed to review issues 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. The workgroup identified areas involving placement clearance, licensed home capacity issues and 906 codes. The workgroup has approved the policy changes and recommendations. Additional review and recommendations were made by the Chief Deputy Director of Permanency. The policy and programmatic changes are currently under review by the Director.

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).**

2024 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 and

recovery program staff developed several documents in their training components called the 440 series. These tools were developed for workers and others to use in talking with clients to determine their level of substance use. The Behavioral Health Unit is currently working with an assigned policy analyst to update the CFS 440 forms related to client substance abuse. In addition, educational tip sheets outlining how to recognize signs of client substance misuse were announced and posted on the D-net. The tip sheets can be found on the Clinical Division's page on the D-net.

FY 2022 **This report should be shared with the Division of Clinical Practice Behavioral Health/Substance Use group. The group should develop guidelines around assessment of marijuana use and its impact on parenting (from January 2023 OIG Annual Report, Death and Serious Injury Investigation 1).**

2024 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. These tools were developed for workers and others to use in talking with clients to determine their level of substance use. The Behavioral Health Unit is currently working with an assigned policy analyst to update the CFS 440 forms related to client substance abuse. In addition, educational tip sheets outlining how to recognize signs of client substance misuse were announced and posted on the D-net. The tip sheets can be found on the Clinical Division's page on the D-net.

FY 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 (ICWA) (from January 2022 OIG Annual Report, General Investigation 5).**

2024 Department Update: The Division of Diversity, Equity and Inclusion formed a workgroup consisting of ICWA Specialists and policy writers from the Office of Child and Family Policy. Procedure 307 has been updated to reflect the federal definition of "Active Efforts" along with examples. ICWA Specialists have been advocating within the Department to ensure compliance with all 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 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).**

2024 Department Update: A workgroup that was formed in response to the recommendation determined that the Department should continue the current practice for the self-designation of Spanish speaking by the foster home applicant. In the event that the Spanish speaking licensing representative finds that the applicant was not able to communicate effectively using conversational Spanish, the licensing representative would cross the Spanish speaking designation off of the Individual License Summary and follow the general licensing practices of completion of an Individual License Summary.

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).**

2024 Department Update: A workgroup concluded that 105 ILCS 85/ Student Online Personal Protection Act, as amended on July 1, 2021, provides guidance on who holds the authority to access student online educational portals and that authority for youth in care is given to the DCFS Guardianship Administrator. The workgroup drafted an

Information Transmittal which will be sent to all DCFS and CWCA staff providing guidance on the process to request approval of access to student online educational portals. Additionally, the workgroup drafted a letter that is co-signed by the Guardianship Administrator and the Deputy Director of Education and Transition Services that will be sent to the Illinois State Board of Education for dissemination to all public school district superintendents and/or Foster Care Liaisons.

Technology

FY 2023 The Department must secure a mobile application for child protection and other DCFS and private agency staff to use for on-demand video for American Sign Language interpretation services (from Fiscal Year 2023 OIG Annual Report, General Investigation 4).

2024 Department Update: The developers of the ASK app are exploring the feasibility of an application that allows staff to use on-demand video for American Sign Language interpretation.

FY 2023 The Department should explore technology that provides real time information for better oversight and coordination for child protection supervisors to ensure children are being seen in a timely manner. This data should allow for a distinction between when a child is physically seen and when a good faith attempt was made but the child was not seen (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 2).

2024 Department Update: 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.

FY 2023 The Department's new data system, IllinoisConnect, should include prompts for required investigative contacts that cannot be waived and prompts when a waiver is required (from Fiscal Year 2023 OIG Annual Report, Death and Serious Injury Investigation 1).

2024 Department Update: The Department will include required investigative contacts that cannot be waived and prompting when a waiver is required, in ongoing discussions in the development of the Department's new data system, IllinoisConnect.

FY 2023 The Department should develop and implement a means to maintain electronic records of all consents approved by the DCFS Guardian in a youth in care's person management file in the Department's new data system, IllinoisConnect or SACWIS (from Fiscal Year 2023 OIG Annual Report, General Investigation 5).

2024 Department Update: Staff from the Office of the Guardian met with the IllinoisConnect development team and requested that the new data system allow for all consents to be transported to youth in care's electronic casefiles.

FY 2022 The Department's new data information system should include a mechanism for direct notification to licensing of a child protection investigation involving a facility (from January 2023 OIG Annual Report, General Investigation 6).

2024 Department Update: In FY 2022, at Child Protection statewide meetings for supervisors and area administrators, the need for child protection to notify licensing at the onset of any facility report, licensed or unlicensed, was emphasized. In addition, automation of notifications, including to licensing, will be a part of ongoing discussions and requests as the Department moves forward with the development of Release 8 of IllinoisConnect. The targeted implementation date is FY 2026.

FY 2021 **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).**

2024 Department Update: The Department has received a very clear response from the Department of Information and Technology (DoIT) that there will not be any capability built into the new system for any Illinois state employees at any state agency to have social media access within their Illinois.gov accounts.

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).**

2024 Department Update: The IllinoisConnect project began July 1, 2022. Notification through several channels (email, screen popups, text messages, Microsoft Teams messages, etc.) are a base capability of IllinoisConnect. IllinoisConnect also contains workflows as a base capability which will be used to trigger the required review by an Area Administrator. IllinoisConnect is currently targeting implementation with this functionality in 2025. In the meantime, the Area Administrators get a weekly report of child protection investigations involving children under the age of 3 and are required, per procedure, to document their assessment at the time of the safety decision.

FY 2020 **DCFS should ensure that the new data information system (IllinoisConnect) has an indicator to alert SCR staff when a subject in a Hotline report has had their parental rights terminated. (from January 2021 OIG Annual Report, General Investigation 2).**

2024 Department Update: The Department will ensure there is an indicator to alert State Central Register staff when a subject in a Hotline report has had their parental rights terminated. 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).**

2024 Department Update: The IllinoisConnect project 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).**

2024 Department Update: The recommendation will be incorporated in the IllinoisConnect project. The Illinois-Connect project began July 1, 2022. The Intake module, used by the state central register, 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).**

2024 Department Update: The recommendation will be incorporated in the IllinoisConnect project. The Illinois-Connect 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 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).**

2024 Department Update: The Department has explored and received a very clear response from DoIt that there will not be any capability built into the current or new system for any state employees at any state agency to have social media access within their Illinois.gov accounts.

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).**

2024 Department Update: The Department's Office of Health Services met with Healthworks in October and November of 2023 and reviewed the expectations related to obtaining the results of the genetic metabolic screens on all children regardless of age, upon entering the Department's care, and how to obtain the results when they are unavailable and where to document the results. Information was provided to ensure the screen is completed during the comprehensive exam. Resources were provided as well as information from the DCFS Medical Director. YouthCare has revised the HealthWorks Manual which included directions on obtaining the results of the newborn genetic metabolic screens.

CHILD WELFARE EMPLOYEE LICENSURE

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

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

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

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

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

Department Rule 412.40 provides that a licensee may voluntarily relinquish his or her license at any time during a pending licensure or disciplinary investigation, administrative proceeding, or subsequent court action. Department Rule 412.100 allows a former licensee to request the reinstatement of his or her revoked, suspended, or relinquished license no earlier than 30 business days after receipt of the written notice of license revocation, suspension, or relinquishment. The OIG is notified within 10 days after receipt of a request for reinstatement of a license and may file a written objection to the request within 30 days after receipt of the notice.

In FY 2024, the ELRT referred 58 CWEL Complaints to the OIG for investigation and/or monitoring of an alleged Rule 412.50 violation.

FY 2024 CWEL Investigation Referrals and Dispositions	
Pending CWEL Investigation	8
Closed CWEL Investigation, No Licensure Action	4
Pending Monitoring of an SCR Report	7
Closed Monitoring of an SCR Report	30
Pending Pre-Licensing Investigation	2
Closed Pre-Licensing Investigation	3
Closed, CWEL Voluntarily Relinquished	2
Pending AHU Decision	1
Pending CWEL Board Final Decision	1
FY 2024 CWEL Investigation Referrals Received	**58**

OIG Prosecution of FY 2024 CWEL Referrals

Of the 58 CWEL complaints referred to the OIG, four complaints were simultaneously referred to the CWEL Board for preliminary suspension pursuant to Rule 412.90. Of the four preliminary suspensions imposed by the Board, two licensees requested a post-preliminary suspension hearing that was prosecuted by an IG attorney.

In one of the 58 CWEL complaints referred to the OIG, an OIG attorney filed administrative charges seeking revocation of an individual's CWEL.

Licensure Action of FY 2024 CWEL Referrals

The following cases represent action taken against Child Welfare Employee Licenses (CWEL) in FY 2024.

License Relinquishments (2)

In the following two cases, a licensee relinquished their CWEL during a pending OIG investigation.

- A licensee allegedly falsified his job application and resume to omit prior employment. The licensee also altered his dates of employment at a second place of employment to prevent disclosure that he resigned prior to a disciplinary hearing due to his not showing up for work.
- A licensee allegedly falsified case notes documenting in person home visits that foster parent reported did not occur.

Pending Administrative Hearing Recommendation (1)

The Office of the Inspector General issued charges based on an indicated finding of child abuse/neglect against licensee. The CWEL matter was pending administrative hearing.

Pending CWEL Board Final Decision (1)

The Office of the Inspector General issued charges based on egregious acts against licensee. Licensee failed to appear at the scheduled pre-hearing. Administrative Law Judge sent Recommendation of Abandonment to the CWEL Board, and the matter is pending CWEL Board Final Order.

FY 2024 Disposition of CWEL Referrals Pending from Prior Fiscal Years

There were 36 additional CWEL referrals opened in prior fiscal years that were pending at the beginning of FY 2024. Of these 36 cases, 27 were closed in FY 2024 and nine remain pending.

FY 2024 Disposition and Status of CWEL Referrals Opened in Prior Fiscal Years	
Closed, CWEL Revoked by Board	3
Closed CWEL Investigation, No Licensure Action	5
Closed, CWEL Voluntarily Relinquished	10
Closed Monitoring of an SCR Report	9
Closed	**27**
Pending CWEL Investigation	3
Pending AHU Decision	3
Pending CWEL Board Final Decision	3
Pending	**9**
Total	**36**

FY 2024 OIG Prosecution of CWEL Referrals Pending from Prior Fiscal Years

In FY 2024, an OIG attorney serving as Department Representative filed administrative charges to revoke the CWEL of seven individuals.

In FY 2024, the CWEL Board issued one preliminary suspension of an individual CWEL complaint pending from a prior fiscal year.

In FY 2024, an OIG attorney serving as Department Representative prosecuted four post-preliminary suspension hearings.

CRIMINAL BACKGROUND AND LAW ENFORCEMENT COORDINATION

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

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

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

OIG has seven LEADS operators, five primary operators and two secondary operators. In FY 2024, OIG LEADS operator conducted 7,852 queries, an increase of more than 500 from the prior year.

Law Enforcement Liaison

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

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

In FY 2024, the OIG engaged in seven instances of cooperation with law enforcement. In five cases, the OIG made a referral to ISP for investigation of possible criminal activity by a DCFS employee. In two other cases, federal enforcement agencies reached out to the OIG for assistance with an investigation.

GLOSSARY

AHU: Administrative Hearings Unit
ANCRA: Abused and Neglected Child Reporting Act
AOIC: Administrative Office of Illinois Courts
APME: Agency Performance Monitoring and Execution
ASA: Assistant State's Attorney
C-section: Cesarean section birth
CAC: Children's Advocacy Center
CANTS: Child Abuse and Neglect Tracking System
CCDS: DCFS Child Care Data System
CDRT: Child Death Review Team
CERAP: Child Endangerment Risk Assessment Protocol
CILA: Community Integrated Living Arrangement
CIPP: Clinical Intervention for Preservation of Placement
COIC: Conflict of Interest Committee
CPR: Cardiopulmonary resuscitation
CPI: Child protection investigator
CWCA: Child Welfare Contributing Agency
CWEL: Child Welfare Employee Licensure
CWS: Child Welfare Services, or Child Welfare Specialist
DCP: Department of Child Protection
DHS: Illinois Department of Human Services
DNR: Do not resuscitate
DoIT: Department of Innovation and Technology
DSCC: Division of Specialized Care for Children
ELRT: Emergency Licensure Review Team
EMS: Emergency medical services
ERT: Error Reduction Training
FBI: Federal Bureau of Investigation
G-tube: gastrostomy tube or feeding tube
GAL: Guardian *ad Litem*
OCA: Office of Contract Administration
ICWA: Indian Child Welfare Act
IEP: Individualized education program
IO: Information Only
ISP DII: Illinois State Police, Division of Internal Investigation
LEADS: Law Enforcement Agencies Data Systems
MRI: Magnetic resonance imaging
NICU: Neonatal intensive care unit
OCWEL: Office of Child Welfare Employee Licensure
OEIG: Office of the Executive Inspector General
OIG: Office of the Inspector General for DCFS
OLS: Office of Legal Services
PSA: Public service administrator, or supervisor
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 Registry
SSCP: Social Services Community Planner
TAS: Transition to Adult Services
WIC: Special Supplemental Nutrition Program for Women, Infants, and Children

APPENDIX

Daycare Fraud A-1

Amy Zinn, Sex Trafficking B-1

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.

Subject: Daycare Fraud

I. SUMMARY OF COMPLAINT

The OIG received a complaint alleging that a DCFS employee used their position as a Social Services Community Planner (SSCP) to create fictitious daycares in the DCFS Child Care Data System (CCDS); listed DCFS youth in care as attending those fictitious daycares; and received kickbacks from the providers receiving daycare payments from DCFS for children who had not been in their care.

The matter was referred to the Illinois State Police and the Federal Bureau of Investigations for criminal investigation. A joint investigation was initiated by the FBI, DCFS OIG, and the Illinois State Police Division of Internal Investigations. As a result of the investigation, the DCFS employee and 14 others were charged with honest services wire fraud.

This OIG investigative report identifies and addresses the systemic issues related to the lack of accountability and internal controls within the CCDS.

II. FINDINGS

The DCFS employee used their position as Social Services Community Planner (SSCP) to create 19 fictitious provider accounts in the CCDS associated to their friends and family. The subject of this investigation then enrolled DCFS involved children into the fictitious daycares, even though the children were already enrolled in other legitimate daycares that received DCFS funds. After creating the fictitious provider accounts, the subject issued billing forms to these fictitious providers via the state email system on which the providers fraudulently documented providing childcare. The subject then filed the fictitious billings for payment to these fictitious providers who were friends and family members. Once the friends and family received the money from the state of Illinois, the friends and family gave the subject roughly 50% of the money received. Through this scheme, approximately $3.2 million in daycare money was fraudulently obtained from the state of Illinois. The subject received roughly $1.6 million of the total amount over a span of six years (2016 - 2022).

OIG investigators found that the subject was able to create the fictitious providers in the CCDS without any accountability. The subject was able to enter the new providers into the system, enroll DCFS involved children into multiple daycares, set the pay rates and set the licensing status of the fictitious providers, all without knowledge of co-workers or approval of supervisors, in the CCDS. The caretakers of the children were unaware that the fraudulent daycares received state funds for the childcare and in some instances, the legitimate daycare providers were denied payment as a result of the fraudulent daycare payments.

III. INVESTIGATION

A. Background

1. *Department Employment History*

The subject of this investigation was promoted to the position of Social Services Community Planner (SSCP) in 2015. In August 2022, DCFS placed the employee on administrative leave. In July 2023, after being criminally charged with honest services wire fraud, the Department placed the employee on suspension pending judicial verdict status.

2. *Social Services Community Planner Duties*

According to the subject's supervisor, the subject's role as a Social Services Community Planner (SSCP) was to approve daycare eligibility for foster parents, intact cases, reunification, and teen parents (henceforth known as "caretakers").[1] A caretaker who needs daycare for hours of employment or enrollment in educational/vocational courses is eligible for the services. The supervisor told IG investigators that once a caretaker has been determined eligible, the caretaker identifies a daycare provider[2] and completes a Day Care Services Application (CFS 2000) which requires the caretaker include information about and proof of their employment/educational/vocational services, the hours attended and information about the child in need of daycare services. The child's caseworker is responsible for conducting a CANTS and LEADS background checks on any unlicensed providers and signing off on the caretaker's choice of daycare. Once approved by the caseworker, the SSCP opens a daycare services case in the CCDS. If the selected daycare has not previously been a DCFS provider, the SSCP would be responsible for creating a new provider profile, including assignment of a provider ID number in the CCDS, which allows the daycare to be paid by the Department.[3] According to the supervisor, the SSCP duties also include processing Day Care Services-Eligibility Redetermination Applications (CFS 2000-R) every six months.[4] The redetermination process requires caretakers to confirm a continued need for daycare services in order to remain eligible for continued DCFS payment to daycare providers.[5]

B. Suspected Daycare Fraud

1. *Discovery of Irregularities in Daycare Documentation*

The subject's supervisor informed IG investigators that in the involved county office there are two Social Services Community Planners (SSCP), including the subject. The two SSCP's split the workload by alphabet using the first letter of the foster parent's last name for assignment. The other SSCP stated to IG investigators that in July 2022 they found a daycare billing form[6] on the office printer for a daycare provider which had been assigned a licensed exempt institution rate. The other SSCP stated that they had never heard of that daycare provider and found the daycare's roster in the CCDS unusual because at least one of the children were with foster parents assigned to their own caseload and they had not completed approvals for that daycare. After doing further research, the other SSCP found that the daycare provider in question did not qualify for the licensed exempt institution rate they were receiving; rather the daycare should have been paid at an unlicensed daycare home rate, a difference of roughly $19 per child per day. Additionally, the daycare roster in the CCDS showed more children than allowed

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1 As of October 2023, daycare eligibility for teen parents has been transferred to DHS.

2 The Department can assist in identifying a daycare provider, should the caretaker request such assistance.

3 In addition, the supervisor told IG investigators that to be paid, the new daycare fills out a W9 form that is sent to the budget and finance division. The supervisor reported that the Office of Budget and Finance then checks the social security number to make sure that it is not an entity that is already being used by the state for another purpose.

4 The Day Care Services-Eligibility Redetermination Applications (CFS 2000-R) are not reviewed by the caseworker.

5 Caretakers are required to provide proof of employment/educational services at each redetermination.

6 A DCFS form submitted by providers for reimbursement for child care.

in a non-licensed daycare.[7] When the other SSCP began calling foster parents of the children listed on the daycare provider's roster, the foster parents reported having never heard of the daycare provider and all the foster parents reported that the children attended other daycares.

The subject's supervisor told IG investigators that after the other SSCP brought the issue to their attention, they identified that the subject entered the rate information as well as the roster of children for the daycare provider in question into the CCDS. Initially believing it was a mistake, the supervisor asked the subject to calculate the amount of overpayment and submit it to the account technician to pursue recouping the money. The supervisor told IG investigators that after a month, they learned that the subject had not submitted the information to the account technician. The supervisor explained that since each foster parent has a file of applications and redeterminations for daycares, they decided to review the files. The supervisor said they asked the subject to bring the foster parent files associated with the children on the roster. The subject initially told the supervisor they couldn't find the files so the supervisor sent an Office Associate to retrieve them. The supervisor said that when the Office Associate went to the file room and began retrieving the files, the subject walked in, took the files out of the associate's hand and ran out of the room. The supervisor said the subject was then found altering and attempting to shred the files. When the supervisor had an employee go out to the address listed in the system for the daycare provider in question, the employee found that the address belonged to a beauty shop and that there was no daycare.

2. *Joint Criminal Investigation*

In August 2022, after learning of the allegations, the OIG referred the matter to the Illinois State Police, Division of Internal Investigation (ISP DII). The ISP DII subsequently referred the matter to the Federal Bureau of Investigations (FBI) who accepted the case. A Joint investigation was initiated by the FBI, DCFS OIG and ISP DII.

During the Joint investigation, as noted in the U.S. Attorney's Office press release, Northern District of Illinois and unsealed complaint to the United States District Court, Northern District of Illinois Eastern Division, investigators found that between 2016 and 2022 the subject of the investigation recruited at least 14 family members and friends to serve as fictitious daycare providers. The fictitious providers received more than $3.2 million in daycare services money. The investigation found that the subject entered in the CCDS, fictitious daycares registered to the friends and family that were recruited. Upon those friends and family receiving the money from the Illinois Comptroller for the fictitious daycare services, they paid the subject roughly 50% of the revenue. The FBI found that the subject received in excess of $1.6 million in state money paid out for daycare. As a result of the investigation, the subject and 14 others were charged with honest services wire fraud.

C. Establishing and Maintaining Fictitious Providers in the Child Care Data System

The supervisor told IG investigators that in some cases a caretaker may legitimately need two different daycare providers in cases where the caretaker's employment or educational/vocational courses are outside the hours of a single daycare provider. For example, some caretakers take classes by day and work at night or are first responders or medical providers who work shifts during both the day and night. In those cases, the SSCP can approve a second part-time or full-time daycare provider that can accommodate the hours needed. The supervisor stated that, in practice, the SSCP should seek supervisory approval to add a second daycare; however, nothing in the CCDS requires entry of supervisory approval when adding a second daycare. Additionally, the supervisor noted that nothing in the current system would prevent or flag two different providers being paid for the same child during the same times, as the CCDS does not require the SSCP to enter dates and times of daycare services. The system only requires the classification of full or part time services.

The supervisor told IG investigators that after finding the documentation related to the initial daycare provider in question, they reviewed the subject's assigned cases. The supervisor stated that they found in the CCDS that the subject set up fictitious providers in the CCDS and then assigned foster children already receiving daycare services from legitimate providers onto the rosters of the fictitious providers. The supervisor said that as a result,

7 A Department administrator told IG investigators that one shortfall of the current CCDS is that the system allows children to be enrolled with providers that may be over licensed or unlicensed capacity.

the children enrolled in daycare with the fictitious providers had two different daycares in the CCDS: the fictitious and the legitimate. IG investigators found that for one of the fraudulent providers, there were four different daycares associated with the provider. IG investigators found that the subject was transmitting the billing for four different fictitious daycares to this provider, who then signed the fraudulent billings and returned the billings to the subject to be submitted for payment.

The supervisor explained that in the involved county, the only possible check on multiple providers occurs when the account technician processes the billings and happens to notice two providers for the same child. However, as the account technicians process hundreds of billings per month, they may only catch a fraction of errors. The supervisor stated that when staff reviewed the names of the children that the subject had entered for multiple daycares they found that the subject regularly deactivated payments to the legitimate provider and activated the payments to the fictitious provider, alternating back and forth in intervals of several months so both would get paid within those intervals. The supervisor speculated to IG investigators that the subject did this to avoid the account technician noticing a child with two providers. The supervisor added that historically, providers would often complain that they were not being paid but it was assumed that the state was slow to pay because of budgetary reasons. However, the supervisor told IG investigators that prior to the discovery of the fictitious providers, they had noticed that providers on the subject's caseload complained about payment or filed for court of claims at a rate of nearly twice that of the other SSCP in the office. The supervisor said that they regularly met with the subject about the issue and the subject would offer the explanation that they must have accidentally deactivated the payments to the provider.

D. Inflated Daycare Rates for Fictitious Providers

The supervisor told IG investigators that once a daycare provider has been established in the CCDS, the SSCP has the responsibility and authority to manually set into the CCDS the pay rates, as determined by the Illinois Department of Human Services, to allow for payment to the daycare provider. According to the Child Care Payment Rates for Child Care Providers publication (December 2022), Illinois Department of Human Services calculates the rates based on the region of the daycare and licensing status: Licensed Daycare Center, Licensed Exempt Daycare Center, Licensed Daycare Home or License Exempt Daycare Home. The following table illustrates the most recent rate schedule as of the time of this report:

Licensed Daycare Center	
Full Day	Between $67 and $43 (age dependent)
Part Day	Between $34 and $23 (age dependent)
Licensed-Exempt Daycare Center	
Full Day	$41
Part Day	$21
Licensed Daycare Home or Licensed Group Daycare Home	
Full day	Between $48 and $41 (age dependent)
Part Day	Between $24 and $20 (age dependent)
License Exempt Daycare Home, Non-relative or Relative	
Full Day	$22
Part Day	$11

The supervisor told IG investigators that during a review of the subject's assigned cases, they found that the subject inappropriately assigned the fictitious providers Licensed Daycare or Exempt License Daycare center rates.

E. Handling of Fraudulent Billings

The supervisor explained to IG investigators that daycare providers seek payment through submission of a DCFS Child Care Monthly Enrollment Form (billings). The DCFS Budget and Finance Office automatically mails the billings to providers each month. The billings are pre-populated with the name of each approved child attending

that daycare, as well as the pay rates. Daycare providers, both licensed and unlicensed, complete the form by self-reporting the number of days they cared for a child that month and signing it. The form does not require the providers to enter specific dates or times of service and the billings are not verified by the caretaker or caseworker. The supervisor reported that in the involved county the billings are sent directly to the account technician via email, fax or regular mail. The account technician reviews the billing, approves for payment and transmits the billings to the comptroller's office.

IG investigators obtained the subject's Department emails between 2016 and 2022. IG investigators found that the subject regularly emailed the billings directly to friends and family members associated to the fictitious providers. Emails indicate that the subject requested that the fictitious providers send the billings back directly to them. The supervisor told IG investigators that SSCP's emailing the bills to and from the provider is an unusual practice and for legitimate purposes it would only be needed in the rare occasion when there is a billing mistake in the system. The supervisor told IG investigators that since the subject appeared to be doing this monthly, they believed the subject did this to review the completed billings to ensure that they would not raise suspicion when the account technician reviewed them for payment.

A Department administrator told IG investigators that following the discovery of the subject's fraud, the Department began to address the deficiencies with the CCDS. According to the Department administrator, the Department contracted with a consulting agency to engineer a new billing system. The new system's automation and built-in required approvals would limit the amount of autonomy a SSCP has with the current CCDS. According to the Department administrator, completion of the project will be a lengthy process. The Department administrator and subject noted that they are currently implementing interim measures to address accountability deficiencies in the CCDS. The current practice includes the Illinois Department of Innovation and Technology (DoIT) running monthly reports for the supervisor to detail changes made by the SSCP in the CCDS, regular communication with the field, better coordination with licensing, and requiring a higher level of approval for extraordinary requests.

F. Report of the Auditor General for the State of Illinois

Separate and apart from the OIG investigation, on September 26, 2023, the Auditor General for the State of Illinois issued an auditing report regarding DCFS operations for "the two years ended June 30, 2022." According to the report, auditors found that the Department "failed to maintain proper segregation of duties over daycare providers licensing information, childcare information and billing system." Specifically, auditors found that some users had rights to enter, modify and delete daycare providers' information, child information and billing information. Auditors recommended that the "Department implement proper segregation of duties and ensure no one individual has the rights to enter, modify, and delete daycare providers' information, child information and billing information." Additionally, auditors recommended the Department complete monthly user access reviews.

IV. ANALYSIS

According to the U.S. Attorney's Office, Northern District of Illinois, the subject of this investigation orchestrated the theft of at least $3.2 million that was to go to childcare providers to assist caretakers who have children involved in DCFS services. Of the $3.2 million, the subject received roughly half, $1.6 million in bribes and kickbacks.

The OIG found that the subject was able to defraud DCFS due to a significant lack of internal controls within the CCDS. The OIG identified the following deficiencies within the CCDS:

- An SSCP can autonomously establish a new provider within the CCDS without approvals or involvement of other Department personnel, including being able to set up overlapping providers for the same child. Though the SSCP is expected to obtain permission from the supervisor to add a second provider, nothing prevents the SSCP within the CCDS from doing so. Automated supervisory approvals would decrease the ability to establish fraudulent providers.
- An SSCP can set provider rates and licensing status manually without approvals, despite rates being regulated by the Illinois Department of Human Services. CCDS automated rates based on the licensing status and location would reduce under or over payments.

- Dates of attendance and verification of attendance are not required for providers' billings. Providers are only required to record the number of days that the child attended the daycare in the month. Verification of attendance from the caretakers would significantly decrease fraudulent submissions.

V. RECOMMENDATIONS

1. The Department should ensure that the fraudulent providers identified are no longer utilized or reimbursed by the Department.

2. The Department should implement internal controls that verify the accuracy of daycare billing invoices and identify potential fraud and suspicious billing patterns in the DCFS Child Care Data System (CCDS). The Department should consider including the following in the internal controls: automated requests for approvals when new providers are developed; automated rate assignment based on licensing status and location; automated requests for approvals when the licensing status or rates are changed manually; and verification when a child is entered as having multiple daycare providers in the system at a given time.

3. While the above permanent changes are being made to the DCFS Child Care Data System, the Department should take immediate steps to develop an interim plan to protect against daycare billing fraud and at a minimum, ensure verification when a child is entered as having multiple daycare providers in the system at a given time as well as periodic verification of the child's attendance to the Licensed Day Care Home; Licensed Group Day Care Home; License Exempt Day Care Home; Non-relative daycare home; or Relative daycare home.

4. This report should be shared with the Department of Human Services to consider appropriate action with respect to the fraudulent providers identified.

5. This report should be shared with the Director of the Department of Early Childhood.

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): Amy Zinn (DOB 08/2005)
Subject: Sex Trafficking

I. SUMMARY OF COMPLAINT

The OIG received a complaint alleging that 16-year-old youth in care, Amy Zinn, was being human sex trafficked by two women when she was taken to work at an adult entertainment venue and forced to have sex. The complaint alleged that in May 2022, these concerns were reported to SCR but taken as an Information Only report. The complaint alleged that the case notes do not indicate that the Information Only report was addressed with the minor. Additionally, the complainant alleged that the investigator and the supervisor of a subsequent child protection investigation, SCR 1111B, were aware of the related police reports for the sex trafficking allegations but did not address the concerns during the investigation. It was alleged that the inaction resulted in a significant delay in a forensic interview for Amy and failure to assess human trafficking allegations.

In 2021, the Office of the Inspector General completed two investigations involving Amy Zinn. The first OIG investigation involved failures by caseworkers to obtain background information from Amy's unauthorized placement with her aunt and making minimal efforts to remove Amy from the placement. IG investigators found that the aunt was living in a drug house, had previously lost custody of her own children to DCFS and had spent six years in prison for manslaughter after injecting a man with a lethal dose of heroin. The caseworker was unaware of this history for the unauthorized placement. The second OIG investigation found that the DCFS child protection investigator inadequately investigated an allegation that the adult son in Amy's foster home sexually molested Amy and sent pictures of his genitals to then 14-year-old Amy via private social media messaging. IG investigators found that the CPI and local law enforcement ignored text messages from the adult son that confirmed the incidents happened and that he would pay Amy not to disclose the incidents.

II. FINDINGS

IG investigators found that in May 2022, Amy Zinn became involved with another youth in care, Bree Cain, who was believed to be a sex worker and known to work at an adult entertainment venue. During this time 16-year-old Amy was recruited by 19-year-old Bree to work at the adult entertainment venue where Amy used drugs and engaged in sexual acts.

In May 2022, Law Enforcement A responded to a disturbance at Bree's home involving Amy, Bree, and another person. Amy alleged to the officer that she had been sex trafficked, reporting that she was recruited and provided with a fake identification card so that she could work at the club. Amy also told the officer that she engaged in sexual acts at the club and consumed drugs. Bree admitted to the officers that she recruited Amy so she would make more money.

Two online reports were made to the hotline as a result of the incident. The first report was from an anonymous source, reporting that Amy was forced to use drugs but did not include information that Amy was working in an adult entertainment venue. A law enforcement official made the second report, reporting that Amy provided a fake identification card to the adult entertainment venue but did not mention sex trafficking. SCR took both reports as "Information Only" (IO) determining that there was no established eligible perpetrator. IG investigators found that the call floor worker did not follow up with the law enforcement officer to obtain further details on the incident or the involvement of an eligible perpetrator. SCR forwarded the IO reports to Amy's caseworker, Diana Duke, and the supervisor, Eva Eaton. IG investigators found that Amy's worker, Diana Duke, failed to ascertain details about the alleged incident from law enforcement or others involved.

IG investigators found that in June 2022, approximately one month after the IO reports to the hotline, another call was made to the hotline which was opened for investigation (B-sequence). The hotline call alleged that Amy's mother, Fiona Zinn, allowed Amy to smoke marijuana while Fiona used intravenous drugs in the home. The assigned CPI for the investigation did not address the alleged sex trafficking from the IO reports as she was not aware of the allegations. At the close of the investigation, Amy's guardian *ad litem* (GAL) refused to sign off on the investigation until the sex trafficking allegation was investigated. As a result, five months after the alleged sex trafficking, another child protection investigation (C-sequence) was opened to investigate the sex trafficking allegations. Amy participated in a forensic interview as part of the C-sequence child protection investigation, but noted she had difficulty recalling details of the incident because of the time lapse.

Additionally, IG investigators found that Amy lived in an unauthorized placement for two years with an adult who refused to provide her information for a background check.

III. INVESTIGATION

A. Family Composition

Amy Zinn (DOB 8/2005) was born to Fiona and George Zinn. The couple had two other children together, Harper Zinn (DOB 11/2007) and Isaac Zinn (DOB 10/2014).

B. Summary of Amy Zinn's Department History 2009 – 2021

As detailed in a prior OIG investigation involving Amy Zinn, in 2021, the OIG received a complaint that 14-year-old Amy Zinn had been living in an unauthorized placement with her aunt, Jewel Farley, for approximately a year when a hotline call came in against Ms. Farley alleging medical neglect of Amy. It was also alleged that Ms. Farley used drugs and had tested positive for amphetamines/methamphetamines. Additional problems included Amy not attending school and having a sexual relationship with an adult. The Inspector General's Office issued a report to the Department that addressed those complaints. The investigative report included a comprehensive review of Amy's involvement with the Department from 2009 – 2021. This current OIG report addresses allegations of incidents occurring after the prior OIG report was issued. Given that a comprehensive understanding of Amy's history is critical to understanding the issues raised in this report, the following is a summary of Amy's Department involvement as contained in the prior investigative report.

Amy has been an alleged child victim in eleven child protection investigations involving allegations of environmental neglect (#82), inadequate supervision (#74), medical neglect (#79), substance misuse by neglect (#65), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), sexual penetration (#19), sexual exploitation (#20), inadequate shelter (#77), substance misuse (#15), and human trafficking of children (#40). Amy's mother, Fiona Zinn, was indicated in four allegations for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), inadequate supervision (#74), substance misuse by neglect (#65) and medical neglect (#79) to Amy and/or her sibling. Amy's father, George Zinn, was the alleged perpetrator in four child protection investigations of which all were unfounded.

In May 2009 the Department indicated Amy's parents for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and environmental neglect (#82) after it was alleged that the parents used

methamphetamine in front of 3-year-old Amy and 19-month-old Harper. Amy and Harper were taken into custody and placed in foster care from May 2009 until July 2011 at which time Amy was returned home to her mother. Between November 2015 and January 2018, Amy alternated between living with her mother and two different aunts: Ms. Farley and Kara Gabel. Amy's mother, father and aunt, Ms. Farley, were using drugs and in and out of prison during that time.

In January 2018, Amy's mother gave guardianship of Amy to her uncle, Larry Hanks. In April 2018, Amy reported that while living with Mr. Hanks, Mr. Hanks had been forcing himself on her and threatened to kill her if she told anyone. Mr. Hanks was indicated for sexual penetration (#19) and substantial risk of physical injury/environment injurious to health and welfare (#10) to Amy and substantial risk of sexual abuse - sex offender has access (#22) to his own children. Amy was taken back into DCFS custody and placed with fictive kin in April 2018.[1]

In July 2018, Amy was psychiatrically hospitalized after the fictive kin gave notice that Amy could no longer stay there due to Amy's behavior difficulties. The same month, Amy was placed in a specialized foster home. The household included the foster parents' 23-year-old son. Over the next year, according to SACWIS records, 13-year-old Amy's behaviors became increasingly difficult. In June 2019, the foster parents gave notice to have Amy removed. Amy was subsequently placed in another specialized foster home where she disclosed to her caseworker that the 23-year-old son of the prior placement had sent pictures of his penis to her via social media app. It was also alleged that he texted Amy to "please do not tell anyone" and "I can pay you money not to tell." Amy also disclosed to her caseworker that "there was some physical contact too, but it was consensual." During the child protection investigation, Amy declined to complete a victim sensitive interview at the Children's Advocacy Center (CAC), explaining that she participated in a CAC interview two years prior [during the sex abuse investigation of her uncle] and did not want to go through that again. Law enforcement B declined to charge. In December 2019, the child protection investigation was unfounded for substantial risk of sexual abuse (#22b), due to insufficient credible evidence.[2]

In late September 2019, 14-year-old Amy eloped from her new specialized placement and began staying with her aunt, Jewel Farley in an unauthorized placement. While there, Amy was inconsistent with taking her medications, seeing her therapist and psychiatrist, used marijuana, was not attending school regularly, refused to come home or follow house rules.

A year later, in September 2020, Alpha Hospital Emergency Department reported that 15-year-old Amy arrived at the ED via ambulance with complaints of abdominal pain. It was alleged that her aunt, Ms. Farley, who accompanied Amy, was under the influence of substances (SCR 2222A). According to SACWIS, Amy was participating in sexually risky behavior and was diagnosed with Pelvic Inflammatory Disease and Chlamydia. Ms. Farley tested positive for amphetamines and methamphetamines and was indicated for substantial risk of physical injury/environment injurious to health and welfare by neglect to Amy (#60). The Department then placed Amy with fictive kin Margot Ibarra. In September 2020, the court ordered CWCA A be removed as the agency assigned the case due to mismanagement and Amy's case was transferred back to DCFS.

As detailed in a prior OIG investigation, IG investigators found that Ms. Farley had lost custody of her own children in 2012. Ms. Farley had a substantial history of methamphetamine abuse and, at the time of placement (September 2019), had just been paroled from a six-year prison term after being convicted of manslaughter for injecting a man with a lethal dose of heroin. Amy's placement worker at the time did not obtain basic background information from the aunt and did not contact the Placement Clearance Desk to determine why the foster mother had been in prison. IG investigators also found that Department procedures do not include guidance regarding background checks for unauthorized placements.

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1 According to a clinical staffing report, Mr. Hanks stalked Amy in attempts to intimidate her.

2 The OIG conducted a separate investigation concerning the deficiencies of the child protection and police investigations.

C. Amy Zinn's Department Involvement January 2021 – May 2022

While in placement with Margot Ibarra, the Department unfounded five child protection investigations related to Amy Zinn between January and May 2021. The investigations all had similar allegations that Amy, her mother, boyfriend and others were living in a shed,[3] and the occupants of the shed were using and selling drugs. There were also multiple allegations of sex abuse to Amy.

1. *SCR 2222B Jewel Farley (Unfounded)*

In January 2021, an anonymous caller reported to the hotline that 15-year-old Amy was living in a small shed with her 15-year-old boyfriend, Nate Hensley, her mother and her mother's boyfriend.[4] The reporter stated the mother sold methamphetamines and it was believed that Amy sold methamphetamines for her aunt, Jewel Farley. The reporter said the family might have weapons as they witnessed Amy chase her boyfriend with a knife a few weeks prior. During the child protection investigation Amy denied all allegations, was seen at Ms. Ibarra's home twice and tested negative for all substances. Ms. Farley was unfounded for substantial risk of physical injury/environment injurious to health and welfare by neglect to Amy (#60).

2. *SCR 3333F Fiona Zinn (Unfounded)*

On that same day in January 2021, an anonymous reporter,[5] reported to the hotline that Amy's mother, Fiona Zinn, was selling meth out of the residence. It was alleged that 15-year-old Amy was staying with her mother instead of with Ms. Ibarra, the mother was giving Amy drugs (marijuana and ecstasy) to use and sell, Amy was dating 19-year-old Nate and living in the shed on her mother's property. A child protection investigation was opened against Ms. Zinn.

Three weeks later, in February 2021, the hotline took a related information report from an anonymous caller who stated:

> Amy (age 15) is residing in a shed along with her mother, her mother's boyfriend, and Amy's boyfriend, Nate. The shed is in the yard of an uncle whom Amy is having sex with. Amy's mother will encourage her to have sex with older men and then blackmail them into giving them money. Amy has been sending the uncle text messages saying that she will send him pictures of her "boobs and other things" for money. Reporter has some of the text messages. The mom's boyfriend does METH all the time around Amy. Reporter is aware of current DCFS involvement and states that Amy is supposed to be residing elsewhere but isn't. Caller described the shed being "freezing" cold.

Per SACWIS both Ms. Zinn and Amy denied all the allegations. Amy's fictive kin foster placement Margot Ibarra confirmed that Amy lives with her, not in a shed, and Amy's mother lived with Amy's grandmother who Amy frequently visits so she sees her mother then.

According to SACWIS, two weeks later, Amy was involved in an auto accident. The worker noted that Amy was riding in the back of a pick-up truck. Amy was hospitalized at Alpha Hospital where she was treated for a fractured pelvis, shoulder, spine (L5) and face. Amy tested positive for THC. Amy was released from the hospital with a walker.

According to SACWIS, four days later, Amy eloped again. Over the next two months her caseworker, Child Welfare Specialist (CWS) Ophelia Greene,[6] made multiple attempts to find Amy. While Amy would respond to

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3 There were no descriptions or observations of the "shed" so it was unclear what specific type of structure this was and if it had utilities or not.

4 Nate was 19, not 15, at the time of this hotline report.

5 The CPI documented an attempt to reach the reporter, however noted in SACWIS in 02/2021 that the woman who answered the phone stated she didn't know who that was and when asked if she had made a DCFS hotline report the phone disconnected.

6 CWS Greene was assigned to Amy's case from 1/2021 to 05/2021.

text messages from her worker, she refused to provide her location. In April 2021, CWS Greene, filed a missing person's report with Law Enforcement A.

In March 2021, the Department unfounded Ms. Zinn for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), substance misuse (#15), sexual penetration (#19), sexual exploitation (#20), inadequate shelter (#77), and human trafficking (#40) to Amy. At the time that the child protection investigation closed, Amy's whereabouts were unknown.

In May 2021 Amy's placement case was transferred to CWS Natasha Jarvis. According to SACWIS, in July 2021, Amy began living in the unauthorized home of Pearl Kaiser. Amy's boyfriend, Ronald Kaiser, also lived in the home.

3. *SCR 3333H Fiona Zinn (Unfounded)*

In May 2021, two months after the close of the previous child protection investigations, the hotline received another anonymous call. The hotline report noted:

> …this is an ongoing issue that has not stopped. Reporter stated that Amy (15) is living in a home in unsanitary conditions in a shed in a back yard and the home should be condemned. Amy is residing in the home with Fiona (mother), Fiona's paramour, Nate (Amy's boyfriend) and recently a minor showed up last week to move in as well. There is constant drug use and activity in the home. The children openly drink alcohol with Fiona, Fiona's paramour and other adults while they all fight each other. Reporter stated that Amy has an open case with Fiona and supposed to be in foster care. Amy is being subjected to prostitution in exchange for drugs and money. A source stated that Amy is supposed to be residing with fictive kin. The fictive kin is also unfit to provide for Amy and is known for drug abuse. Amy was in a serious accident in February and hurt "bad" and has not received follow up medical care. Reporter stated that they were informed that Amy's caseworker messages her on Facebook to let her know when a hotline call is made and to leave the location she is at. Reporter stated that, "If something is not done about this situation, I will be contacting the state's attorney, local news sources and anyone else who will listen. The system so far, has failed Amy.

Fifteen days later, the hotline received another anonymous report stating that Amy lives in a shed in the backyard and that her mother, Fiona, is a known drug addict and is forcing Amy to have sex with men for money.

During the H-sequence investigation, according to SACWIS, the assigned CPI and CWS Jarvis,[7] met with Amy outside of her unauthorized placement at the Kaiser home where her boyfriend lived. Amy denied living in the shed behind her mother's residence saying she had not lived there since before her car accident in February. Amy denied drinking or using drugs or that she had ever been asked or forced to have sex with anyone for drug money. Amy reported she does not see or speak with her mother because her mother continues to use drugs and she did not want to be around those things. Ms. Zinn confirmed to the CPI that she had been living in the shed but said Amy had not. Ms. Zinn denied anyone forced Amy to have sex for money. In August 2021, the Department again unfounded Ms. Zinn for substance misuse (#15), substantial risk of physical injury/environment injurious to health and welfare by neglect (#60), medical neglect (#79), and human trafficking of children (#40).

D. Permanency Goal Changed to Independence

According to SACWIS, Amy's permanency goal changed to Independence in August 2021. In January 2022, Amy's placement case was assigned to DCFS CWS Diana Duke who was supervised by Public Service Administrator, Eva Eaton. At the time of the assignment, Amy, age 16, had been living with her boyfriend in the unauthorized home of Pearl Kaiser since July 2021. (See Lack of Background Checks of Unauthorized Placements, below.) CWS Duke was Amy's worker for approximately 11 months, until November 2022.

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7 CWS Jarvis was the assigned worker from May 2021 to January 2022.

SACWIS notes show that between January and October 2022, CWS Duke documented monthly, in-person visits with Amy at the Kaiser home. CWS Duke documented discussing Amy's progress toward obtaining her GED, attending doctor appointments, and her contact with her family. CWS Duke's SACWIS notes reflect that Amy struggled with completing her GED, maintaining employment, and meeting other goals such as attending dental exams, life skills classes, and a mental health juvenile justice program. CWS Duke also documented talking with Amy about enrolling in school. CWS Duke noted that she arranged to have DCFS pay a balance owed to school to assist in Amy being able to enroll. CWS Duke did not document any safety concerns during the ten months she was assigned to the case.

CWS Duke told IG investigators that she felt Amy operated on her own, like she was older, often taking care of things herself, such as setting up her own appointments. CWS Duke said that most of her communication with Amy was at the Kaiser home, though Ms. Kaiser was never there. CWS Duke said that as a result, she treated Amy and managed the case as if Amy was an adult. CWS Duke said Amy's biggest challenges were that, "She didn't have the resources to get everything she needed. Not being in school, not having structured foster parents." She added that DCFS not providing adequate care and support for her was, "a barrier to her whole life." CWS Duke told IG investigators that she recalled Amy's only progress while CWS Duke had the case was Amy wanting to go back to school, because she realized she was falling behind.

E. Reported Sex Trafficking, May 2022

In May 2022, Law Enforcement A officers responded to a disturbance at a residence belonging to Amy's friend Bree Cain.

1. *Background Information of Youth in Care Bree Cain*

According to SACWIS, Bree Cain, who was the alleged victim of eight child protection investigations[8], was taken into custody in 2013, at the age of 9 years, after her mother neglected to pick up the youngest child from the sitter the day prior. The mother left Bree and a sister in the care of their incarcerated father's paramour the month prior to coming into care. The mother had a history of mental health issues, domestic violence, criminal behavior, drug use and employment as an exotic dancer. During Bree's permanency case, she moved between placements including homes of relatives, fictive kin, psychiatric hospitals, detention and independent living. Bree began using drugs at 12 years, progressed to cocaine and Xanax (alprazolam) by age 16, and required hospitalization for overdoses. Bree made outcries of sexual abuse to her mother before coming into care, but her mother believed she was lying. Bree had multiple psychiatric hospitalizations, prompted by self-injurious behaviors, episodes of depressions, and suicide attempts. Bree's diagnoses include bipolar disorder, major depressive disorder, oppositional defiant disorder and post-traumatic stress disorder. Bree had a history of volatile and violent relationships. Bree's worker documented that he verified Bree was a dancer at two different adult entertainment venues, she was dating one of the club's owner's brothers, he suspected that she was engaging in sex work. Bree had been criminally charged with receiving/possessing stolen vehicles, criminal damage to property, contributing to the delinquency of a minor, leaving the scene of an accident, possession of methamphetamine, and possession of a controlled substance.

In April 2019, Bree reported to her caseworker that she was pregnant. Bree gave birth to a baby in January 2020. Bree was investigated for substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to the baby after she overdosed on LSD. The allegation was unfounded as the baby was not in her care at the time of the overdose. A second investigation began in February 2021, after Bree refused to pick up the baby and due to being under the influence. The reporter stated that the baby was dirty, had lice, no socks, no coat and looked as if he had been in the same clothing for days. The assigned CPI documented meeting with Bree and observing no safety concerns for the baby. In March 2021, Bree's placement worker contacted the CPI to report drug use and concerning behavior while caring for the baby. The CPI took protective custody that same day. According to

8 Allegations #19 sexual penetration, #21 sexual molestation, #60 substantial risk of physical injury/environment injurious to health and welfare by neglect, #82 environmental neglect, #11 cuts, bruises, welts, abrasions and oral injuries, and #74 inadequate supervision.

SACWIS, Bree surrendered her parental rights to her son in December 2022, and the baby was adopted by his foster parents.

2. *Police Reports and Video of the May 2022 Incident*

IG investigators obtained the Law Enforcement A Report of the May 2022 incident. According to the police report, written by Officer Santiago Lopez, police were called to the residence at 2:29 pm in May 2022. Officer Lopez noted that 16-year-old Amy said she had an argument with Bree Cain, age 18, about money and clothing belonging to Amy that had gone missing. Amy stated that the night prior to the disturbance, her mother, Fiona Zinn, allowed Bree Cain and Amy to borrow Amy's grandfather's van. Amy said they used the van to go to Adult Entertainment Venue A. Amy said that when they arrived, Bree Cain told the staff at Adult Entertainment Venue A that Amy was 22 years old and provided a fake ID to the person in charge. Amy reported that she was working at the club as an exotic dancer for cash and had been doing so for approximately one week. Officer Lopez noted that Amy had bruising on the right side of her neck that appeared to be a hickey, as well as bruising that suggested squeezing or choking. Officer Lopez noted during the conversation with Amy that a family friend, Tiffany Mack, who was on scene, instructed Amy not to admit where she was the night prior or where she works.

IG investigators obtained a copy of the police in-car video and audio recording from Law Enforcement A. On the video, Amy can be heard telling Officer Lopez, *"I'd rather talk to you one on one. All I can say is it's like sex trafficking."* [Italics added by OIG.] Amy can be heard speaking to an unidentified person saying, "Bree texted me and she was like come work with me for a couple days. They took me. They didn't ask for my ID or anything." When Officer Lopez asked Amy if Vanessa [referring to the person who runs Adult Entertainment Venue A] knew if Amy was underage, Amy stated "I didn't have to talk to Vanessa at all. Bree went up to her and said this is my friend, showed her my fake ID and she said I was good to go." Amy told Officer Lopez that she had been working at the club for "maybe a week."

In the police car video recording, Amy told Officer Lopez, "I did a line of coke too," and "she [Bree] gave me two triple bars [Xanax]", and "last night was my first night ever doing a line." Officer Lopez noted in his written report that Amy stated that Bree Cain provided her with Xanax and cocaine.

According to the written police report, Bree Cain told Officer Lopez that she recruited Amy and Whitney Nash to work at the club because she believed Amy would attract more clients and that would increase Bree's income. Bree stated that she drove Amy and Ms. Nash to an unknown place where Amy bought the Xanax and cocaine from Amy's friend. Officer Lopez noted that both Bree Cain and Ms. Nash admitted to knowing Amy was underage. Both Bree Cain and Ms. Nash were arrested for contributing to the delinquency of a minor.

According to the police report, Officer Lopez spoke with Fiona Zinn when she arrived at the scene. Ms. Zinn told Officer Lopez that Amy contacted her to obtain the spare keys for the vehicle that Amy and Bree had borrowed from Amy's grandfather. Ms. Zinn told Officer Lopez that she allowed Amy and Bree Cain to borrow the van to go grocery shopping, they had not returned the vehicle and she did not follow up with them. Ms. Zinn denied being aware that Amy or Bree Cain went to the adult entertainment venue or that Amy worked at the adult entertainment venue.

Officer Lopez documented that when he met with Amy on scene, she was having abdominal pains, was feeling sick and vomited in the vehicle. He noted that she was transported to Beta Hospital.

Officer Lopez documented that he contacted Pearl Kaiser, where Amy was living in an unauthorized placement. Ms. Kaiser stated that she last saw Amy the day before, when she left with Bree Cain. Officer Lopez noted that Ms. Kaiser stated that she was told Amy would be sleeping at Bree Cain's house.

The detective noted in the supplemental interview report that he interviewed Whitney Nash in May 2022. During this interview, Ms. Nash stated that Amy's mother, Fiona, knew that Amy was working at the adult entertainment venue and that Fiona had driven Amy to the club, spoke to the bouncer and told club employees that Amy was 21 years old.

3. *Amy Zinn's Medical Records for May 2022*

IG investigators obtained records from the involved emergency medical services (EMS) for the treatment and transport of Amy to Beta Hospital as well as records from the Beta Hospital.

According to the EMS notes, Amy told EMS personnel that she had been assaulted by multiple females, kicked and punched multiple times, and cut by a knife. The notes document that Amy had a small laceration on her chin and abdominal pain. Amy stated she was up all-night using cocaine and ecstasy. EMS also noted that a police officer told EMS that Amy worked at an adult entertainment venue and that the officer believed that Amy may have been sexually assaulted.

Beta Hospital Emergency Department records indicate that Amy arrived at 4:13pm and was discharged at 6:35pm. The registered nurse noted in Amy's file that Amy reported she felt fine and wanted to leave. The hospital social worker documented that Amy refused a rape kit. The hospital social worker noted the concerns law enforcement had about sex trafficking and reported that she made an online report to the human trafficking hotline and a referral.

4. *May 2022 Hotline Reports*

On the day of the incident in May 2022, there were two online reports to the hotline that documented the incident that occurred with Amy.

The first online report[9] was submitted anonymously at 4:27 pm and indicated that Whitney Nash, Tiffany Mack and Bree Cain were other persons with information. The hotline report noted:

> Whitney Nash and Bree Cain gave Amy triple bars, Xanax, cocaine, alcohol and then jumped her while she was supposed to be staying with them. Reporter also said they forced drugs down Amy's throat. Bree and Whitney are ineligible perpetrators at this time. It is unknown if they were in a caretaking role during the incident. It's unknown if Amy ever stayed over, or if any adult caretaker was involved with this incident. This information is not able to be gained due to an anonymous reporter with no contact information.

The second online report[10] was submitted one hour later at 5:24 pm by the assisting officer who was on scene, but who did not interview Amy or complete the police report. Officer Pate provided his mailing address, work phone number, and email address. Other persons with information were noted to be Whitney Nash, Officer Santiago Lopez [the officer who interviewed Amy] and Bree Cain. The intake narrative processed by a different call floor worker[11] noted:

> At approximately 1500 hours, the reporter and OPWI 2 [Officer Lopez] were dispatched to a disturbance. The reporter arrived and made contact with Amy Zinn (youth in care- age 16). Amy advised she and Bree Cain had an argument inside of Bree's apartment and was being prevented from gathering her items located inside of the apartment. Amy stated she had car keys as well as other clothing items inside of the apartment.
>
> Officer Lopez and the reporter made contact with Amy Zinn. Amy advised OPWI 1 [Whitney Nash] and OPWI 3 [Bree Cain] were together the previous night. Amy advised that she, OPWI 1 [Whitney], and OPWI 3 [Bree] got together at 2000 hours and received permission from Bree's[12] grandpa to retrieve his vehicle and take it to the grocery store. Amy advised she did not go to the Grocery store with Whitney and Bree and instead went to Adult Entertainment Venue A. Amy advised she told Adult Entertainment Venue A's staff she was 22 and provided a fake I.D. and was allowed to work at the club. Amy advised

9 IO 4444

10 IO 5555

11 According to SACWIS, both call floor workers that took the IO reports had the same supervisor.

12 The van belongs to Amy's grandfather, not Bree Cain.

working included being on stage and stripping her clothes off. Amy advised she engaged in sexual acts with males while she was at the club.

Amy advised she worked until the midnight hours. Amy advised she bought Xanax and cocaine from a male at the club. Amy advised she, Whitney and Bree returned to Bree's apartment and consumed various amounts of cocaine and Xanax. Amy advised the three continued to consume drugs and alcohol until the morning hours. Amy provided a birthdate of 08/2005, making her a juvenile at 16 years of age. Amy advised she was currently in the foster care system and advised of Pearl Kaiser as her legal Guardian.

Amy was taken into protective custody and escorted to the rear of Officer Lopez's squad car. While speaking to Amy, the reporter observed what appeared to be hickeys and red marks on each side of her neck. While in the rear of OPWI 2[Officer Lopez]'s squad car Amy began to vomit and EMS was called to transport Amy to the emergency department.

The reporter made contact with Whitney and Bree inside of the apartment. Bree advised Amy, Whitney and herself went to a club to work but refused to state the name of the adult entertainment venue. Bree advised while at the club Amy purchased Xanax and cocaine from a male. Bree advised it was only her and Amy that were working at the time. Bree advised the three returned to her apartment and continued to party. Bree advised she did not consume any cocaine and only smoked marijuana and drank alcohol. Bree advised the party continued into the morning hours. The three went to sleep and two hours later Amy awoke and began to throw things about in her apartment causing a disturbance. The reporter spoke with Whitney and she advised of the incident occurring the same way as Bree described it.

Officer Lopez and the reporter advised Whitney and Bree that Amy was 16. Whitney and Bree advised Amy always told them she was 22 and they never questioned it. Whitney and Bree were advised they were under arrest for contributing to the delinquency of a Minor. Officer Lopez placed Bree in properly fit, double-locked handcuffs and placed her in the rear of the reporter's squad car. The reporter advised Whitney she was under arrest and placed her into properly fit, double-locked handcuffs and escorted to the rear of the reporter's squad car.

Whitney and Bree were transported to Law Enforcement A Department where they were processed, fingerprinted, booked, and housed.

Though the officers noted in the Law Enforcement A reports that Whitney Nash indicated that Amy's mother was aware that Amy was going to perform at an adult entertainment venue, the officer who called the hotline made no mention of that detail in the narrative. The officer who completed the online hotline report also did not include Amy's statement that she was being sex trafficked.

Both reports were taken by the hotline as "Information Only" (IO). Both IO reports were forwarded to Amy's case worker, CWS Diana Duke and supervisor, PSA Eva Eaton.

5. *Classification of Reports as Information Only*

The Deputy Director of the State Central Register told IG investigators that both hotline reports came in via the web-based reporting system and did not identify an eligible perpetrator as a household member or in a caretaker role, and that a caretaking relationship could not be established in either report. The Deputy Director stated the first online report, IO 4444, came from an anonymous source and therefore the call floor operator was unable to contact the reporter for more information. Regarding the second report, IO 5555, the Deputy Director reiterated that the report was not taken for investigation as they did not have anyone in the report that was an eligible perpetrator. The Deputy Director added that according to the report, Amy gave the adult entertainment venue a fake ID and that no one forced her. She said that the report did not indicate that a caregiver did this to her and Amy was known to be

staying in an unauthorized placement. The Deputy Director stated that it was “hard to call it human trafficking” as there appeared to be no evidence based on the hotline report that Amy was coerced to work at the venue.[13]

The Deputy Director told IG investigators that the online reporting system is designed to elicit as much information as possible. In the case that a report lacks clarity, the call floor worker handling the report makes the decision to call a reporter back for more information. She said that anytime an intake is classified as a “no report taken” or “information only,” the decision is reviewed by a supervisor.[14] The Deputy Director reviewed the police report with IG investigators and stated that if SCR had the full police report, they may have taken the report for investigation as the report adds more detail that refers to the possibility of sex trafficking. The Deputy Director stated that because the call floor workers did not have enough information from the online report to make that determination, it was the responsibility of the permanency worker to obtain more information and call the hotline if they believed it warranted an investigation.

In an OIG review of Department procedures, IG investigators found no guidance for what steps a caseworker should take upon receiving an IO report involving their client. The Deputy Director of Permanency confirmed for IG investigators that there are no procedures that specifically address caseworker responsibility after receiving an IO report.[15]

6. *Public Act 102-056, Changes to “Person Responsible for the Child’s Welfare”*

On January 1, 2022, Public Act 102-0567 amended the Illinois Abuse and Neglect Child Reporting Act definition of “Person responsible for the child’s welfare” expanding who could be included as an eligible perpetrator in instances of alleging involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons for forced labor or services. The following details the changes to the definition:

> “Person responsible for the child’s welfare” means the child’s parent; guardian; foster parent; relative caregiver; any person responsible for the child’s welfare in a public or private residential agency or institution; any person responsible for the child’s welfare within a public or private profit or not for profit child care facility; or any other person responsible for the child’s welfare at the time of the alleged abuse or neglect, including any person who commits or allows to be committed~~, that is the custodian of a child under 18 years of age who commits or allows to be committed,~~ against the child, the offense of involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons for forced labor or services, as provided in Section 10-9 of the Criminal Code of 2012, including but not limited to the custodian of the minor, or any person who came to know the child through an official capacity or position of trust, including but not limited to health care professionals, educational personnel, recreational supervisors, members of the clergy, and volunteers or support personnel in any setting where children may be subject to abuse or neglect.

According to an official who led a taskforce that drafted Public Act 102-0567, the change was made to address the hotline’s inability to investigate allegations of involuntary servitude, involuntary sexual servitude, or trafficking in persons for forced labor or services due to the perpetrator being ineligible because they were not a parent or guardian to the youth. The official explained to IG investigators that the Act amended the definition to adjust “person responsible for the child’s welfare,” removing language that requires the perpetrator to be a custodian. The official stated the Act now more broadly defines “person responsible for the child’s welfare” as anyone who

13 The Deputy Director stated that typically SCR would refer a report like that to the police, however this one came from the police, so it was not necessary.

14 Both IO reports were reviewed by the same supervisor.

15 The Deputy Director of Permanency stated that ongoing assessment is part of procedural requirements as covered in procedure sections 315.95 through 315.100. According to IL DCFS procedure, section 315.95 (d), after the initial and integrated assessments, caseworkers are responsible for providing ongoing assessments which makes note of critical parenting issue requiring immediate action. The procedure states that when a permanency worker is made aware of a critical parenting issue during a clinical consultation, the permanency worker shall immediately consult with the permanency supervisor and determine a plan of action on how to address the risk and safety issues.

is responsible for the involuntary servitude, involuntary sexual servitude of a minor, or trafficking in persons for forced labor or services.

In response to Public Act 102-0567 effective on January 1, 2022, the DCFS Executive Deputy Director issued a memo to SCR staff on December 31, 2021, informing staff of the changes to the definition and how that correlates to the allegation of harm #40/90 human trafficking of children.[16] The memo, in part, directs:

> … If the CWS on the call floor hears information that sounds *concerning for one of the below 3 offenses*, but the caregiver does ***not*** appear to be custodial in any way, the new consideration requires looking to identify how the perpetrator may have committed or allowed to be committed:
>
> *1. Involuntary servitude*
>
> *A person commits **involuntary servitude** when he or she knowingly subjects, attempts to subject, or engages in a conspiracy to subject another person to labor or services obtained or maintained through any of the following means, or any combination of these means:*

- *causes or threatens to cause physical harm to any person;*
- *physically restrains or threatens to physically restrain another person;*
- *abuses or threatens to abuse the law or legal process;*
- *knowingly destroys, conceals, removes, confiscates, or possesses any actual or purported passport or other immigration document, or any other actual or purported government identification document, of another person;*
- *uses intimidation, or exerts financial control over any person; or*
- *uses any scheme, plan, or pattern intended to cause the person to believe that, if the person did not perform the labor or services, that person or another person would suffer serious harm or physical restraint.*

> *2. Involuntary sexual servitude of a minor*
>
> *A person commits **involuntary sexual servitude of a minor** when he or she knowingly recruits, entices, harbors, transports, provides, or obtains by any means, or attempts to recruit, entice, harbor, provide, or obtain by any means, another person under 18 years of age, knowing that the minor will engage in commercial sexual activity, a sexually-explicit performance, or the production of pornography, or causes or attempts to cause a minor to engage in one or more of those activities and:*

- *there is no overt force or threat and the minor is between the ages of 17 and 18 years;*
- *there is no overt force or threat and the minor is under the age of 17 years; or*
- *there is overt force or threat.*

> *3. Trafficking in persons for forced labor or services*
>
> *A person commits **trafficking in persons** when he or she knowingly:*

- *recruits, entices, harbors, transports, provides, or obtains by any means, or attempts to recruit, entice, harbor, transport, provide, or obtain by any means, another person, intending or knowing that the person will be subjected to involuntary servitude; or*
- *benefits, financially or by receiving anything of value, from participation in a venture that has engaged in an act of involuntary servitude or involuntary sexual servitude of a minor. A company commits trafficking in persons when the company knowingly benefits, financially or by receiving anything of value, from participation in a venture that has engaged in an act of involuntary servitude or involuntary sexual servitude of a minor.*

16 The Deputy Director of the State Central Register told IG investigators that SCR workers take the mandatory training on Sex Trafficking called *Providing Care for Trafficked Children: A Comprehensive Approach.* The training is located on the Illinois Connect DCFS Training site.

If information heard by the call floor involves an adult non-custodian who appears to have committed one of the above three offenses, these intakes now meet criteria for investigation for human trafficking.

7. *Diana Duke and Supervisor Eaton Response to the IO Reports*

IG investigators obtained and reviewed CWS Duke's Department emails. According to the emails, CWS Duke and Supervisor Eaton received the IO reports the same day as the incident in May 2022, with the narrative included.[17]

Following the receipt of the reports, according to SACWIS, between May 2022 and when the case was reassigned in November 2022, CWS Duke made a total of five monthly visits that took place in the Kaiser home. However, there is no documentation from CPI Duke of the IO reports or relevant subject matter such as conversations with Amy. According to SACWIS, Supervisor Eaton documented in a quarterly supervision note written in June 2022:

> Worker reports concerns with the behaviors Amy has displayed last month. Amy was hospitalized with a possible overdose on 5/22. Youth is in a self-selected unapproved placement. Report came in that Amy reported she was in a club stripping. Worker went to the home to speak to Amy about the incident. Worker reports Amy denied knowing of any report that she was stripping. Worker reported Amy stated she got into a fight with someone she thought was her friend. Amy admitted to using illegal substances with this friend prior to the fight. Amy reported to the worker that she knew what she was doing when she took the illegal substance but was trying to fit in with the friends.

During the OIG interview with CWS Duke, CWS Duke recalled the IO reports regarding Amy stating that Amy had "gotten into it with some girls" and "she threw up in a police car" and that they had to take her to the hospital. CWS Duke stated when she spoke to Amy, Amy claimed she didn't remember anything from that night. CWS Duke commented that "Amy was just trying to make it seem like she was the victim, that her friends had turned on her". CWS Duke stated that Amy said that her friends made her use the drugs, but she had used some of the drugs on her own[18]. CWS Duke stated that she couldn't remember what Amy and her friends argued over, however it was over something small, and Amy claimed that the girl had hit her. CWS Duke said she didn't remember if they had any conversation about the adult entertainment venue. CWS Duke told IG investigators that she did not contact the hotline reporter, explaining that, as a caseworker, she would not contact the reporter because it was not an investigation.

Supervisor Eaton told IG investigators that she staffed the IO report with CWS Duke and instructed her to go out and speak to Amy. Supervisor Eaton stated that it was her understanding that Amy denied the report. Supervisor Eaton stated she spoke with Amy herself and Amy reported that she got into a fight with some girls who she thought were her friends. Supervisor Eaton said that it would have been her expectation that CWS Duke would reach out to the reporter; however, she was not aware of whether that happened. Neither Supervisor Eaton nor CWS Duke were aware of any Department policy regarding what should be done in response to an Information Only report.

8. *Placement Worker Response to Information Only (IO) Regarding Bree Cain*

In May 2022, the IO report involving Bree's recruitment of Amy to Adult Entertainment Venue A was called into the hotline by Law Enforcement A. Bree's placement worker, CWS Ben Aguirre, documented that Bree was arrested again and noted that he suspected that Bree was a sex worker. In June 2022, CWS Aguirre[19] documented finding that Bree had been arrested twice in the prior month.[20] CWS Aguirre documented multiple attempts to contact

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17 According to the Deputy Director of the State Central Register, the first IO report, 4444, automatically generated an email at 5:49pm and was sent to CWS Duke and Supervisor Eaton. The second IO report, 5555, automatically generated an email at 6:45pm and was sent to CWS Duke and Supervisor Eaton. OIG retrieved emails from CWS Duke and Supervisor Eaton's email accounts and found that the emails were received that same day from the call floor workers of the SCR.

18 According to the Law Enforcement A Report from May 2022, Amy told Officer Lopez that she used Xanax, cocaine and alcohol.

19 CWS Specialist Aguirre with CWCA B from 05/2022 to 11/2022.

20 According to County B Court records, Bree had a criminal damage to property charge in May 2022.

Bree. In August 2022, CWS Aguirre documented attempting to find Bree at two neighboring adult entertainment venues, Adult Entertainment Venue A and Adult Entertainment Venue B, documenting that he verified Bree's employment with the manager of Adult Entertainment Venue B and Bree herself. The manager stated that Bree was dating his brother. There are no SACWIS notes that documented the outcome of the worker's suspicion that Bree was a sex worker, nor that the IO report was addressed. CWS Aguirre documented Bree's continued struggle with consistency in keeping appointments, staying sober and maintaining stability. CWS Cameron Ball[21] took over Bree's case in November 2022. CWS Ball continued to document Bree's instability, drug use, failed drug and alcohol treatment attempts, and mental health issues. CWS Ball did not document concerns regarding Bree's work at the adult entertainment venues.

CWS Ball documented that Bree went to drug and alcohol treatment in November 2023, but was discharged from the program in December 2023, for threatening violence against another client. Bree has moved between her grandmother's home, drug and alcohol treatment, her aunt's home and eventually began living with a person Bree identified as a friend of her music producer. CWS Ball documented that Bree may be living in an environment that is exploitive and that these concerns were expressed to Bree, however Bree denied that she was being asked to do anything sexually or financially.[22] Per CWS Ball's documentation, Bree continues to struggle with her son's adoption and maintains that she is going to buy him back for $1,000,000 when her music career takes off. Bree told her worker that plans were being made for her to go on tour with her music. CWS Ball documented that Bree was not compliant with her medication and struggled with manic episodes.

F. SCR 1111B Zinn, Fiona (06/2022 -11/2022)

Unfounded: substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to Amy by mother, Fiona Zinn; unfounded: substance misuse by neglect (#65) to Amy by mother, Fiona Zinn

In June 2022, approximately a month after the IO reports, a child protection investigation was opened against Fiona Zinn. The anonymous hotline caller stated:

> …Fiona (mother) was allowing her 16-year-old daughter Amy to smoke weed and Fiona shoots up drugs in the home. Fiona and Amy lives [sic] in the home with [Tiffany Mack]; according to the reporter, [Ms. Mack] was also allowing her 13-year-old daughter to smoke weed; according to reporter [Ms. Mack] smokes weed with her daughter. The most recent incident was a week ago. Reporter said that Darian (father) does METH in the house. There are also Ms. Mack's 12 and 10-year-old children in the home. Reporter said that Darian says to people that he was wanted by the police; Darian carries a around knife with him. Reporter said that there is also Edgar in the home; Darian's girlfriend is always present in the home but reporter did not know if she lives in the home.

The investigation was initiated for allegations of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and substance misuse by neglect (#65) to Amy. The investigation was assigned to Child Protection Investigator, Natasha Jarvis and supervised by Public Service Administrator Emily Chung. A concurrent companion investigation was opened for Ms. Mack and was later unfounded for allegations of substance misuse (#15) to her oldest daughter and substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) to Ms. Mack's three children. At the time, Ms. Mack had an open intensive intact family services case for neglect to her three children.

CPI Jarvis told IG investigators that when she received the B-sequence investigation for Amy she reviewed Amy's Department history. CPI Jarvis stated that she requested police reports under Fiona Zinn from Law Enforcement A and also checked police activity at the address listed on the hotline report. However, she did not check for reports under Amy's name. When IG investigators asked CPI Jarvis if she looked up the Information Only reports concerning Amy, she stated that she didn't know how to look those up and it was not until after being notified of the police report from the GAL that she saw the IO reports. (See below for more information regarding the GAL.)

21 CWS Specialist Ball with CWCA B from 11/2022 to current.

22 First noted in SACWIS in 02/24.

According to SACWIS notes, CPI Jarvis contacted Tiffany Mack in July 2022. Ms. Mack confirmed knowing Amy, a friend of her oldest daughter. Ms. Mack told CPI Jarvis that she saw Amy the day prior with her daughter but denied seeing Amy with Ms. Zinn, stating that Amy and Ms. Zinn do not get along. Ms. Mack told CPI Jarvis that Amy stays with her boyfriend and his mother.

According to SACWIS, CPI Jarvis documented that she and CWS Duke met with Amy in July 2022, at the Kaiser home. Amy denied using any drugs other than smoking the vape and she agreed to a toxicology test. Amy admitted to marijuana use, however denied smoking with her mother. CPI Jarvis noted that Amy stated she had not seen her mother since the month prior when Amy was in the hospital. CPI Jarvis documented, "Ms. Duke reported she was aware of the incident." CPI documented no further details regarding the hospital incident that resulted from the night at the adult entertainment venue.

In the OIG interview, CPI Jarvis stated that Amy confirmed being at her friend's mother's [Tiffany Mack] house, however she denied using drugs and said she had never seen anyone at the house use drugs. CPI Jarvis said Amy's oral toxicology test was negative and had scheduled her for a urine toxicology test, however due to it being on a Friday and a holiday weekend they were unable to get Amy in promptly.[23] Regarding the hospital incident, CPI Jarvis stated that CWS Duke told her that a month prior, CWS Duke received a report that Amy was at some type of club and the police were involved. CPI Jarvis stated that CWS Duke told her that Amy denied the allegation but said CWS Duke did not provide much more detail. CPI Jarvis stated that no one told her why Amy was in the hospital and that she did not find out further details of the incident until after the GAL brought it to her attention. CPI Jarvis stated that CWS Duke told her she had no concerns for Amy.

According to SACWIS, 45 days later, in August 2022, CPI Jarvis documented that she called and spoke with CWS Duke who reported that Amy was doing well in her unauthorized placement, that she was working and was re-enrolled in night school. No concerns were noted. That same day, DCP Supervisor Chung documented a supervisory consultation with CPI Jarvis in which CPI Jarvis reported insufficient evidence to support abuse and the alleged child victims reported no incidents.

In September 2022, according to SACWIS, Supervisor Eaton noted that CWS Duke reported that Amy was doing well in her placement; there were no health or safety concerns; Amy was up to date on all her medical, dental and eye exams; and she was attending school and working part time. There was no mention of the ongoing B-sequence child protection investigation in Supervisor Eaton's note.

CPI Jarvis contacted the GAL in September 2022 to check on the status of the B-sequence investigation that was submitted for review. The GAL informed the CPI that she had heard some concerning information about Amy, however, was unable to discuss at that time. According to Department emails obtained by IG investigators, at 2:52pm that same day, a Department official emailed CWS Duke and Supervisor Eaton asking, "Are you aware that Amy is making reports to Law Enforcement A that she is being sex trafficked? An ASA just contacted me about it. I do not see a hotline that was made." CWS Duke replied at 2:53 pm: "No, I was not aware." The Department official replied back and requested someone follow up with Amy. CWS Duke emailed back, "I just called Amy, she said she did not make any reports to the PD regarding sex trafficking…" CWS Duke told IG investigators she did not follow up with Law Enforcement A.

According to Department emails, three weeks later, the GAL reviewed the B-sequence investigation then sent an email to CPI Jarvis noting that she could not sign off on the investigation as being unfounded.[24] The GAL wrote that she had possession of a police report with information contrary to that contained in the investigation, with direct statements of drug usage with Ms. Zinn, usage of her vehicle and her being an accessory to Amy and another youth in care working under age at an adult entertainment venue.

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23 Per SACWIS on July 15, 2022, CPI Jarvis documented that she reached out to Amy to have her complete a urine toxicology screen. According to SACWIS, Amy called and confirmed taking her toxicology test at a substance abuse provider.

24 There is no documentation in SACWIS reflecting when this investigation was sent to the GAL for initial review.

CPI Jarvis followed up with the GAL asking for the police reports. CPI Jarvis told IG investigators that though she requested the police reports, the GAL never sent them, so she requested the report directly from Law Enforcement A under Amy's name. Law Enforcement A sent the police report directly to CPI Jarvis in October 2022, via email. CPI Jarvis reiterated that when she originally requested police reports from Law Enforcement A, at the start of the investigation, she was unaware of the incident with Amy and only requested reports related to Fiona Zinn's name, not Amy's name and therefore she did not receive the May 2022 report.[25]

G. Decision to Open the Information Only (IO) Report as an Investigation

According to the B-sequence investigation file, DCP Supervisor Emily Chung emailed "SCR"[26] three weeks later, in October 2022, requesting a review of IO 5555 for conversion to a report due to concerns raised by the GAL regarding possible human trafficking.[27] According to Department emails, the following week, DCP Supervisor Chung received an email from the SCR Manager that both her and the SCR Deputy Director had looked at the intake and questioned how Amy knew the individuals and what led up to her agreeing to strip with them at the club. The SCR Manager cited the definition for involuntary sexual servitude of a minor as detailed in the Illinois Complied Statutes 720 5/10-9 (c) and included in the memo sent out to SCR on December 31, 2021, in response to the law change. The SCR Manager wrote "they could go either way as they seem to be lacking information, however, can see why they would want this investigated further for human trafficking." The SCR Manager noted that they could convert this intake to a report if it was felt strongly that it should be converted. DCP Supervisor Chung responded, "Yes, we have a GAL who [is] requesting that we investigate." A new investigation was initiated the next day. (See SCR 1111C, 6666E and 7777A, below.)

In November 2022, allegations of substantial risk of physical injury/environment injurious to health and welfare by neglect (#60) and substance misuse by neglect (#65) were unfounded against Mrs. Zinn due to insufficient evidence to support the allegations as Amy resides in an unauthorized placement, she denied using drugs, she denied being in the presence of her mother and her oral toxicology screen was negative.

In an OIG interview, DCP Supervisor Chung stated that she unfounded the B-sequence despite the information in the police report due to the original allegation from the B-sequence being a different set of circumstances. DCP Supervisor Chung confirmed that they did drug test Amy, and it was negative. DCP Supervisor Chung stated that after learning of the alleged sex trafficking, her plan was to keep the B-sequence open and had SCR decided to not take on the investigation, she would have added the allegations onto the B-sequence and continued the investigation.

1. *Companion reports*
SCR 1111C Zinn, Fiona (10/2022- 12/2022) Indicated
SCR 6666E Cain, Bree (10/2022- 12/2022) Indicated
SCR 7777A Nash, Whitney (10/2022- 12/2022) Unfounded

In October 2022, a day following the email exchange between DCP Supervisor Chung and the SCR Manager, SCR opened three companion investigations, SCR 1111C (Fiona Zinn), SCR 6666E (Bree Cain), and SCR 7777A (Whitney Nash) for allegations of Human Trafficking (#40) to Amy Zinn. The allegation narrative for all three reports was a copy of the IO 5555 from Law Enforcement A Department. The investigations were assigned to DCP Investigator Georgia Elliott and supervised by DCP Public Service Administrator Katarina Fernandez.

Per SACWIS, CPI Elliott contacted Law Enforcement A where she spoke with the assigned detective, who said he was surprised that the investigation had taken so long to initiate, five months after the original officers reported the information to the hotline. During the investigation, CPI Elliott initially documented that Amy would not be

25 Per Department emails, CPI Jarvis received the police report from the records office of the Law Enforcement A department the following week. The email records do show that the GAL forwarded CPI Jarvis the same police report two days after that.

26 The email is a general email box that does not have a specific person specified as the recipient.

27 IO 5555, submitted by the Law Enforcement A Officer in May 2022.

interviewed by the CAC due to the length of time that had passed, however the GAL requested a forensic interview to provide one valid interview so everyone could see and hear the same narrative, instead of Amy telling different people different things. CPI Elliott documented in SACWIS that Amy agreed to participate in the CAC interview.

CPI Elliott documented in SACWIS meeting with Amy the next day. Amy told the CPI that she worked one day at Adult Entertainment Venue A after the car she borrowed from her grandfather was impounded. Amy told CPI Elliott that Bree told her she should work and get money to get the car out of impound. Amy reported doing a stage dance, however denied any private dances or engagement with the club patrons. Amy told CPI Elliott that she was under the influence and doesn't remember talking to the police that night. On this same day, CPI Elliott documented speaking with the Assistant State's Attorney, who stated that Bree Cain was currently in County B jail awaiting trial on a criminal felony charge related to car theft from September 2022 and that it was suspected that Bree Cain had been driving the vehicles stolen by her pimp.

In November 2022, during the child protection investigation, a new placement worker, CWS Lilith Garrison, was assigned to Amy's case. CWS Garrison noted in SACWIS meeting with Amy, in her unapproved placement in November 2022. CWS Garrison documented that 17-year-old Amy reported she did not have a bedroom. Amy stated her boyfriend slept in the basement; however, she doesn't like to be in the basement and preferred sleeping on the couch.

A week later, CWS Garrison documented that she saw Amy's unapproved placement and again noted the lack of a bedroom. The note documented that Amy said she was distancing herself from the girls that assaulted her after going to the adult entertainment venue and they discussed the plan for moving forward with monthly visits and that they could meet more often if Amy wished to do so. Per SACWIS, this meeting happened before CWS Garrison transported her to the CAC interview.

2. *Children's Advocacy Center (CAC) Interview*

In November 2022, a little over five months after the May 2022 incident, Amy participated in the CAC interview. CPI Elliott wrote in SACWIS on this same date that she observed the interview and that Amy showed poor recall due to the amount of time that passed, and that Amy said she feels as if the system failed her by not addressing the incident sooner. CPI Elliott noted that Amy said she was provided an ID by Bree Cain and that she was then propositioned at the adult entertainment venue, however, denies engaging in sexual acts. Amy stated that she did inform her mother about what she was doing and that her mother told her, "You're better than this."

IG investigators reviewed the CAC interview video recording. In the recording, Amy initially stated that she didn't remember anything that she said on the police report and that she didn't want to get in trouble for lying or mixing up the story. She told the interviewer, "I was on two substances… It was so far back, I feel like if it was maybe a month after it had happened my memory would be more fresh." Amy reported that she had been taking Bree to work every day and the only reason she went to work in the club was because her grandpa's van had been impounded and she needed to earn money to get the van out of impound. Amy said that Bree had a photo of her friend's ID and Bree messaged the friend and said Amy was going to use the ID and was making sure she was okay with it. Amy said:

> When they [Vanessa][28] asked me how old I was, I looked at Bree and then I looked at them and I was like 22. I had to remember what was on the ID. They said I didn't have to lie, even if you're under 21 I'll still serve you alcohol. I was like ok, I didn't want to get caught in a lie, so I said I was 22, I lied about my age."

Amy stated she was told by the boss, "Vanessa", that she could just be a stage dancer, that she didn't have to participate in the VIP rooms. Amy said she had never pole or stage danced before but learned via social media and another dancer. Amy reported that at the adult entertainment venue she was offered alcohol, Xanax, cocaine, and

28 The manager at the adult entertainment venue.

money for sexual favors. Amy denied using any drugs while in the club, however admitted to having one mixed drink. Amy described her experience of working at the adult entertainment venue, stating:

> My first day working there I was really nervous. My social anxiety is really bad. This guy walked up to me and asked me how much I charged for head and pussy. I don't do all that. My friend Bree took him to the VIP room. I asked her what she did. She gave him head for $1000. I have been taken advantage of before…

Amy stated that she, Bree and a friend were paid $100 dollars each to give each other hickeys. Lastly, Amy discussed the disappointment that she faced from her mother and her foster mother for her actions at the adult entertainment venue. Amy identified her foster mother and boyfriend as her support system. She declined a counseling referral.

3. *Closing the Companion Report Investigations*

CPI Elliott documented attempts to reach the alleged perpetrators in each of the investigations, but never located Ms. Zinn or Ms. Nash. CPI Elliott documented speaking with Bree Cain, however Bree Cain stated that her GAL[29] advised her not to make a statement.

In December 2022, PSA Fernandez conducted supervisory consultations with CPI Elliott for the three companion investigations. For SCR 1111C (Fiona Zinn), PSA Fernandez documented that Ms. Zinn was involved in Amy being allowed to strip at the club, knowing she was underage. PSA Fernandez noted that Ms. Zinn was involved in extorting money from Amy for the acts and she was involved and contributed to the human trafficking as she provided the transportation and was to gain money from the reported incident. Ms. Zinn was indicated for human trafficking (#40) to Amy as she allowed Amy and Bree Cain to borrow the vehicle with the expectation that they would pay her with the cash they made from tips at the adult entertainment venue. For SCR 6666E (Bree Cain)[30] PSA Fernandez documented that Bree Cain was directly involved in Amy being allowed to strip, supplying a fake ID, and knowing that Amy was underage. PSA Fernandez noted that Bree Cain showed Amy the "ropes", helped her feel comfortable at the adult entertainment venue, know what to do at the club, and agreed to pay Amy's mother, Ms. Zinn, for transportation to the adult entertainment venue. Bree Cain was indicated for human trafficking (#40) to Amy as she facilitated Amy's recruitment, harboring, transportation and soliciting of a commercial sex act. For SCR 7777A (Whitney Nash),[31] PSA Fernandez documented that while Ms. Nash was with Amy at the adult entertainment venue in May 2022, she did not contribute to the human trafficking as she did not provide any materials to Amy to participate in any illegal activity as documented by Amy's statement. Ms. Nash was unfounded for human trafficking (#40).

H. Lack of Background Checks of Unauthorized Placements for Amy Zinn

At the time the prior OIG report was issued, IG investigators noted that Amy had been living in the unauthorized home of a Pearl Kaiser since July 2021 and that no information was known about this person. Placement clearance had not been called and IG investigators found no information in public databases about this person. Following the OIG's prior report being issued the first name of Ms. Kaiser was changed to Pearl in the SACWIS placement screens; the address remained the same.

According to SACWIS in August 2021, Supervisor Eaton documented in supervisory note that CWS Duke met with Amy and Ms. Kaiser at her residence and documented that Ms. Kaiser did not want to give her information for a background check. In September 2021, then CWS Jarvis documented in SACWIS that Ronald Kaiser gave her his information to complete CANTS and LEADS on him, however IG investigators found no evidence in SACWIS that a LEADS search was completed. A Placement Clearance Desk supervisor informed IG investigators that the Placement Clearance Desk was not called for Pearl Kaiser, Ronald Kaiser or the address where Amy was living.

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29 Bree Cain who is also a youth in care had the same GAL as Amy.

30 Bree Cain was charged with contributing to the delinquency of a minor with a finding of Nolle Prosequi.

31 Whitney Nash was charged with contributing to the delinquency of a minor with a finding of Nolle Prosequi.

In the OIG interviews with CPI Jarvis, CWS Duke and Supervisor Eaton, IG investigators addressed the continued lack of background checks of Amy's unauthorized placement. CPI Jarvis stated that when she was Amy's case worker (from May 2021 to January 2022), she attempted to obtain information from Ms. Kaiser so she could call Placement Clearance; however, Ms. Kaiser did not want to provide her information, saying that Ms. Kaiser didn't care about being paid.

CWS Duke, in her OIG interview, said that she was not aware of any other resources available to her as a placement worker when background information is refused. Supervisor Eaton told IG investigators that this was the first time a placement refused to provide their information despite multiple attempts to do so.

Regarding placement in an approved home or facility, CPI Jarvis told IG investigators that she broached this subject multiple times and Amy said she would just run back to Ms. Kaiser's home. Both CWS Duke and Supervisor Eaton reiterated what CPI Jarvis relayed, stating that they were afraid that Amy would go on run status again if they tried to move her.

I. Amy Zinn's Current Status

CPI Georgia Elliott documented, in November 2022, during Fiona Zinn's C-sequence child protection investigation, discussing a referral to CWCA B's program for youth in care at high risk for trafficking to be made by then CWS [Lilith Garrison]. There were no further notations in SACWIS addressing Amy's participation in CWCA B's program. Supervisor Eaton told IG investigators that she did not know if Amy ever participated in CWCA B's program. Both CPI Jarvis and Supervisor Eaton stated in their OIG interviews that Amy would waver on her decision to go into a residential program. According to the SACWIS placement screen, Amy never attended CWCA B's residential program.

CWS Garrison met with Amy 11 times between November 2022, and May 2023, ten of which took place in the Kaiser home and one that took place at a restaurant. CWS Garrison noted in SACWIS that at the end of November she took Amy to a store to buy over the counter cold and flu remedies as she was ill and she did not have a formal caregiver.[32] CWS Garrison noted in SACWIS that Amy informed her that she might be pregnant, so she accompanied Amy to a prenatal appointment. CWS Garrison continued to meet with Amy and work with her toward her permanency goal of independence. At Amy's request, she assisted Amy in looking for alternative placements in maternity homes.

In Novemeber 2022, Supervisor Eaton documented recommending that CWS Garrison work with Amy on family planning, attending school, and life skills. Per CWS Garrison's SACWIS notes, Amy had dropped out of school after finding out that she was pregnant and had not re-enrolled in the GED program.

Around this time, Amy became more amenable to other placement options. In December 2022, CWS Garrison documented meeting with Amy privately outside the Kaiser home "due to being aware that her current placement was resistant to the youth speaking honestly with DCFS." CWS Garrison noted they discussed options about future placements. Amy reported concerns about cocaine use in the home and said she was open to other placement options. CWS Garrison noted that Amy agreed to cooperate with a Clinical Intervention for Placement Preservation (CIPP) to discuss a new placement option.

According to SACWIS a Clinical Intervention for Placement Preservation (CIPP) was conducted in January 2023, by a clinical services coordinator. In the CIPP report, the clinical services coordinator noted:

> …Amy is not involved in any service, but she is 3 months pregnant and due in August. She is reported to be attending her doctor appointments for prenatal care. She states there are a few programs she is willing to attend for pregnant women and another program for parenting education. This is a home visiting program. They will stay with Amy until the child goes to kindergarten. She will also do the Hospital Classes for the pregnancy…It is recommended Amy be accepted into Program A to assist her in finding

32 CWS Duke stated in her OIG interview that Amy was allowed to operate on her own and was responsible for making all of her own appointments.

her own place, stabilizing in this place, maintaining employment, and establishing an environment to provide for the safety, well-being, and permanency of her soon to be born child.

The clinical services coordinator documented strengths for Amy such as a strong desire to live independently, intelligent, resourceful, open to treatment and has the skills necessary to maintain a clean home and cook for herself. She also noted the concerns of the pregnancy, lack of school credits after dropping out and continued marijuana use, which Amy reported she could not stop using even though she is pregnant.[33]

In March 2023, CWS Garrison documented that Amy reported she enrolled in parenting classes. CWS Garrison noted that Amy had not signed up for WIC, GED classes or counseling, the latter because Amy stated that she couldn't reach her counselor. There was no documentation about Amy's later participation in individual counseling.

According to SACWIS, CWS Garrison continued to meet with Amy monthly and discuss Amy's goals, her placement and needs. Over the next six months Amy fluctuated between wanting to stay in DCFS care and wanting to be discharged after her 18th birthday as well as the type of placement she wanted. CWS Garrison documented that in May 2023, she assisted Amy with her application for WIC and advised her of an opening at a maternity home, though Amy stated she was safe and had friends to stay with if needed. Supervisor Eaton told IG investigators when they broached the topic of the CIPP placement recommendations with Amy she was not actually willing to move to a different place.

Amy's case was reassigned to CWS Meadow Harrington, supervised by PSA Rosalie Irwin, in June 2023.[34] At that time, Amy continued to live in the Kaiser home and had not re-enrolled in school or entered a GED program. Supervisor Irwin documented that Amy received a referral for counseling but had not yet participated. CWS Harrington documented multiple attempts to meet with Amy in June and July, prior to the birth of Amy's baby, but Amy rarely answered the phone or door and rescheduled any appointments she made. CWS Harrington reached Amy after the birth of her baby, and Amy reported that she, Ronald and the baby moved across the street. CWS Harrington documented in SACWIS in July 2023, that Amy reported she was scheduled for parenting classes in July, however her attendance was never documented.

According to SACWIS, CWS Harrington met with Amy in August and September and noted concerns about Amy not attending counseling or taking her prescribed medication. In September 2023, a hotline report, taken as an information only report, addressed public Facebook photos that showed Amy co-sleeping with the baby. According to SACWIS, CWS Harrington advised Amy of the dangers of co-sleeping. Between October and November 2023, CWS Harrington documented Amy's continued lack of progress with meeting her goals in education, counseling, making and keeping medical appointments and missing appointments with her caseworker. In November 2023, CWS Harrington documented Amy's desire for DCFS to assist her in finding alternative housing, but no documentation in SACWIS indicated further action. In November 2023, CWS Harrington documented that Amy moved to a different town to live with her father's former girlfriend. CWS Harrington attempted to get more information in order to complete backgrounds checks on the household, but Amy did not respond. Amy did not come to court in December 2023, despite reminders from the caseworker. The judge granted the release of custody and guardianship of Amy and DCFS closed her case.

J. DCFS Human Trafficking Prevention Program Manager

IG investigators met with the Statewide Human Trafficking Prevention Program Manager for DCFS under the Division of Child Services. Per the DCFS job description, this position oversees and implements planning and evaluation of activities concerning human trafficking prevention services; develops, formulates, and implements Department policies and procedures; and provides advice and consultations regarding program services and activities relative to human trafficking. The Program Manager is also involved in identifying, visiting, and vetting

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33 The clinical services coordinator documented a target completion date for counseling services to be scheduled by February 2023.

34 CWS Garrison was assigned from November 2022 to June 2023. CWS Harrington was assigned in June 2023, and is the most current CWS.

sex trafficking residential treatment programs in and out of the state of Illinois, and coordinating with these homes to stay abreast as to how they potentially help the youth that are placed there. The Program Manager works to ensure that a victim of sexual exploitation is matched with the most appropriate placement. The Program Manager is also responsible for identifying, facilitating, and monitoring contracts with the current providers who offer direct services to youth or congregate care staff. The position serves as the Chief Departmental liaison with law enforcement, the National Center for Missing and Exploited Children and other appropriate entities pertaining to human trafficking.

The Program Manager told IG Investigators that as part of her job, she consults with case managers to aid in finding treatment programs for youth who are victims of trafficking and exploitation. The Program Manager reports that involvement in a case starts when a referral is completed during the CIPP process or when someone directly contacts her via email. She stated not all referrals that are received are for services, that some are for educational materials or just general information about programs. The Program Manager only keeps record of the referrals that result in staffings. The SCR Deputy Director reported during her interview, that SCR does not make referrals to the DCFS Human Trafficking Prevention Program Manager, that those referrals would come from investigative staff or from the field.

The current Program Manager, the only Human Trafficking Prevention Program Manager in the state, reported that according to her data, collected from SCR, in FY 2022 there were 200 allegations[35] of human trafficking of children by abuse (#40) or human trafficking of children by neglect (#90). In FY 2023, there were 151 reports[36] of those allegations. The Program Manager states that in 2022, she participated in 212 sex trafficking consultations regarding youth in care, and in 2023, she participated in 135 such staffings. The Program Manager reported the amount of work does not allow time to address each allegation of sex trafficking. The Program Manager explained that the most common way she is informed of a youth in care being sex trafficked is through ACR alerts transmitted via email to her in an ACR Issues Feedback Critical Report. The Program Manager stated that when she receives these alerts, she reviews the information, paying particular attention to the child's age and will then reach out to the worker or review the case in SACWIS to see if there is any indication of sex trafficking. If she identifies a placement issue, she will contact clinical matching. The Program Manager told IG investigators that she received two ACR alerts regarding Amy Zinn, one in April 2021, and again in April 2023. She said she did not note contact with the workers following the alerts, most likely due to time constraints, however, did recall Amy being on run status and felt that she may have had a brief conversation with the worker to develop a plan for when Amy returned. She said to date, there is no policy or procedures in place that provide guidance as to when a referral should be made to her.

The Program Manager told IG investigators that she had no record of a referral, CIPP, or consult made for Bree Cain, however Bree's name did show up in an FY 2022 report that indicated she was missing from September 2019 to October 2019 for 27 days. The report did not describe a possible human trafficking allegation for Bree and the disposition was listed as client returned. SACWIS reflects that during this time Bree had left her foster care placement and was staying with her biological father in an unauthorized placement.

IV. ANALYSIS

Youth in care, especially those with unstable housing or in unauthorized placements are at high-risk for being a victim of sex-trafficking. The National Center for Missing & Exploited Children (NCMEC) reported that in 2022 the organization assisted in 21,494 cases where children were missing from care of social services. The NCMEC estimated that 18% of the children that were reported missing in 2022 from care were likely victims of child sex trafficking.[37]

In the United States, the Trafficking Victims Protection Act of 2000 (TVPA), as amended by the Justice for Victims of Trafficking Act of 2015 (JVTA), defines sex trafficking as "recruiting, harboring, transporting, providing, obtaining, patronizing, or soliciting of an individual through the means of force, fraud, or coercion for the purpose

35 Nine reports were unqualified for no eligible perpetrator.

36 Ten reports were unqualified for no eligible perpetrator.

37 Our Impact (missingkids.org).

of commercial sex" defined as "any sex act on account of which anything of value is given to or received by any person" (22 U.S.C. 7102). However, it is not necessary to demonstrate force, fraud, or coercion in sex trafficking cases involving children under the age of 18; initial consent is not relevant if the victim is a minor.

According to the National Human Trafficking Hotline[38] individuals may be more vulnerable to trafficking if they have unstable living situations, prior sexual abuse or domestic violence, have run away, been involved in the juvenile justice or child welfare system, have caregivers or family members with substance use disorders, or are addicted to drugs or alcohol themselves. Traffickers seeking out victims often provide for housing or other needs and use tactics such as threats, manipulation, and false promises. Traffickers may seek victims in a variety of settings such as adult entertainment venues, truck stops, and motels.

Amy Zinn had several risk factors leaving her vulnerable to being a victim of sex trafficking. Amy had been the alleged victim in eleven child protection investigations, seven with allegations of sexual abuse, one of which was indicated after her uncle allegedly raped 12-year-old Amy over a period of a year and threatened to kill her if she told anyone. In addition, between January and May 2021, the hotline received five reports that 15-year-old Amy lived with her mother and others who were using and selling drugs and Amy was having sex in exchange for drugs or money. Though all five of the investigations were unfounded, consistent multiple allegations may lead a reasonable person to have concerns about Amy's unauthorized placement and activities. In May 2021, Amy's mother admitted she was currently living in a shed but denied that Amy had been there. The numerous alleged instances of sexual abuse and unstable housing indicate the presence of risk factors for Amy to be a victim of human trafficking.

A. Missed Opportunity for a Timely Child Protection Investigation

On January 1, 2022, to comply with Public Act 102-056, the Department changed SCR policy, expanding the definition of eligible perpetrator in allegations of sex trafficking of children to include persons who do not meet the narrow definition of a "custodian" but committed or allowed sex trafficking.

SCR received a report of Amy working in an adult entertainment venue. The connection between adult entertainment venues and sex trafficking is well established. Dan O'Bryant, associate at the Weatherhead Center for International Affairs at Harvard University, and advocate for victims of sex trafficking, has noted the strong connection between adult entertainment venues and sex trafficking.[39] According to the Polaris Project which operates the US National Human Trafficking hotline, of the victims whose recruitment was known, 69% were recruited by a potential or current employer; specifically victims are frequently recruited to work in adult entertainment venues as hostesses, servers or dancers, but then are required to provide commercial sex to customers.[40]

The State Central Register missed an opportunity to initiate a timely investigation of sex trafficking allegations of Amy Zinn when, after receiving the May 2022 online report from Law Enforcement A, the call floor worker and supervisor did not seek to contact the police for more information and classified the report as "Information Only" to be shared with the caseworker and supervisor. The report included information that Amy was working in an adult entertainment venue where she was "…on stage and stripping her clothes off," and engaging in sexual acts with patrons of the club. The SCR Deputy Director noted the report did not identify an eligible perpetrator and there was no indication that Amy was forced or recruited to work at the adult entertainment venue, thus, it was determined to be an investigation for Law Enforcement A and information for the caseworker.

While it is debatable, in this case, as to whether the police officer's report to SCR, without clarification, contained enough information to meet the expanded definition of eligible perpetrators for sex trafficking, anytime a youth

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38 The National Human Trafficking Hotline is an online resource that connects victims and survivors of human trafficking to support and services. It supported by the Administration for Children and Families (ACF) of the United States Department of Health and Human Services and operated by Polaris.

39 O'Bryant, Dan (2017) "Inextricably Bound: Strip Clubs, Prostitution, and Sex Trafficking," Dignity: A Journal of Analysis of Exploitation and Violence: Vol. 2: Iss. 3, Article 9. https://doi.org/10.23860/ dignity.2017.02.03.09

40 https://polarisproject.org/2020-us-national-human-trafficking-hotline-statistics/ acceded on April 17, 2024.

in care is alleged to be working in an adult entertainment venue, forced or not, efforts should be made to gather more information to determine eligibility for an investigation. The police report detailed drug use, bruises on Amy, Amy's report that she was being sex trafficked and Bree Cain admitting to recruiting Amy and providing her with a fake ID so that Bree could make more money. The police report also listed another woman (Whitney Nash) who told police that Amy's mother knew she was working there. Law Enforcement A left contact information, which would have allowed SCR to call the reporter and explore what the officers knew at the time. The call floor worker likely would have learned key details that may have met the criteria for the expanded definition of the eligible perpetrator in cases of child sex trafficking. Given the expanded definition for eligible perpetrators in trafficking allegations, even if the call floor worker had been unable to contact the police officer, erroring on the side of taking it for investigation and allowing a CPI to gather more information would have been prudent.

In addition to the SCR not seeking further information, when the Information Only report was forwarded to Amy's permanency worker Diana Duke and supervisor Eva Eaton, CWS Duke made only minimal efforts to establish the facts. CWS Duke told IG investigators that when she questioned Amy about the incident, Amy could recall little about that night. The supervisor noted that Amy denied stripping in a club and both the caseworker and supervisor allowed Amy's self-report to suffice for addressing the incident. Seeking more information from police could have confirmed for the worker that Amy may not remember the details of the night because of extensive substance use requiring medical treatment. Also, given the nature of the allegations it is not surprising that Amy may have been less than forth coming. The SCR Deputy Director reported that workers are expected to follow-up with information only reports, and if a worker determines a child protection investigation is warranted, they should call the hotline. CWS Duke reported she did not know this was expected of her as a caseworker. IG investigators found no guidance in Department Procedures regarding what action a worker is expected to take in response to an IO report.

As a result of SCR not taking the reports for investigation and the caseworker not following up with the IO, the allegation was not investigated until five months later, and then at the insistence of Amy's GAL. Amy did not participate in a CAC forensic interview until six months after the incident. Her interview answers were then vague and inconsistent with prior police interviews. As a result of the untimely CAC interview, and the lack of prompt follow up with Law Enforcement A, details of what occurred could not be corroborated.

B. Strengthening the Department's Response to Human Trafficking

Despite the vulnerabilities of youth in care, sex trafficking has traditionally been viewed as an "extrafamilial" issue outside of the realm of child welfare.[41] Illinois is one of the few states that has tried to combat that risk when a caretaker or someone responsible for a minor's welfare is the perpetrator with the Human Trafficking allegations (#40/90). For youth in care the Statewide Human Trafficking Prevention Program Manager attempts to link them with appropriate services, if the worker knows to reach out. Yet, that may not address the issue fully or even partially.

The covert nature of human trafficking makes having definite proof without extensive investigation difficult and no one individual system, whether law enforcement, the legal system, healthcare, social services or child welfare, can alone effectively address the issue of human trafficking. The Department benefits by working with the other systems. The dilemma faced by the SCR call floor workers in taking of the Information Only reports exemplify the difficulty presented in determining the role of the Department worker. The information provided was concerning, a minor working at an adult entertainment venue, but without an identified perpetrator did not meet investigation criteria. Thus, the information goes to the caseworker who likely has little specialty information on addressing human trafficking. The Statewide Human Trafficking Prevention Program Manager, as the only person in this role statewide, is unable to provide adequate clinical support because of the volume of referrals. DCFS must coordinate with law enforcement when human trafficking is suspected. If there is not a DCP report taken because of the lack

41 Institute of Medicine; National Research Council. Confronting Commercial Sexual Exploitation and Sex Trafficking of Minors in the United States: A Guide for Providers of Victim and Support Services. Washington (DC): National Academies Press (US); 2014 Jun 20. 3, How Victim and Support Services Can Help. Available from: https://www.ncbi.nlm.nih.gov/books/NBK223977.

of an eligible perpetrator, the Department needs to develop clear guidelines to case workers on following up on the available information and working with law enforcement.

Workers also need clinical guidance on working with victims or even suspected victims. Sex trafficking often intersects with substance misuse and housing instability allowing traffickers to provide those things, which in turn may make it more difficult for a victim to make an outcry or even be willing to report. A harm reduction approach, or practices designed to mitigate some of the consequences of problematic behaviors may offer some guidance. Originally applied in treating substance use disorders, the principles of harm reduction are being applied across many social issues. A caseworker can approach a youth in a manner to "meet them where they are"[42] address their continued safety, going so far as discussing safe sex practices and medical exams, even if they will not share who is behind their trafficking or even that they have been trafficked. Other providers, such as healthcare workers, can reinforce this. Amy's caseworkers did continue trying to contact her and getting her into services. The services, except for the residential program for youth at high risk for trafficking, were generally not geared toward ameliorating the likelihood of her being trafficked or addressing the problems she had already faced.

C. Unauthorized Placement, Placement Clearance Background Checks

As noted in the prior OIG investigation involving Amy Zinn according to Procedure 301, Appendix E, "Placement clearance from the Placement Clearance Desk (PCD) is required before a child for whom the Department is legally responsible can be placed in a home." The PCD supervisor told IG investigators that placement clearance should be called even in situations when it is believed that the self-selected unauthorized placement will not pass placement clearance. Even in situations where a youth may refuse to leave a self-selected unauthorized placement there is great value in a placement clearance desk check as, placement clearance can provide a worker with CANTS and LEADS specific information that could better inform the caseworker with the knowledge that could help mitigate risk in the home. For instance, if a caseworker was to learn that there were arrests for sex trafficking, the worker could make a referral to the Department's Human Trafficking Prevention Program Manager for consultation.

In the prior OIG investigation, IG investigators found that the case worker, at the time, failed to call placement clearance. As a result, the worker was unaware that Amy's aunt in whose unauthorized home 14-year-old Amy was living, had been convicted of manslaughter after overdosing a man with heroin and had previously had her own parental rights terminated. Similarly in this IG investigation, Amy lived in the unauthorized home of Pearl Kaiser for roughly two years, between July 2021 and July 2023. Ms. Kaiser refused to provide the multiple assigned workers with enough information to obtain a placement clearance check. In both cases the workers were unaware of the specific concerns pertaining to Amy's placement to better mitigate risk. In the OIG interview of Amy's previous caseworkers, none of the workers had knowledge of any resources they could have sought out to obtain the information sufficient to complete a placement clearance check. In these circumstances efforts should be made to check with local law enforcement to obtain any information they may have including calls to the home. Additionally, the Department has other tools that could be utilized to obtain the necessary information such as the Integrated Eligibility System (formally known as the public aid search) and Lexis Nexis public database searches to be used to complete a Placement Clearance Desk check.

V. RECOMMENDATIONS

1. The Department should amend Procedures to provide guidance to placement staff on what action should be taken by a placement worker in response to an Information Only report from SCR staff, such as contacting mandated reporters. The placement worker should be required to follow-up with the information and contact the hotline if abuse or neglect is discovered. In the interim, the email sent by SCR staff alerting placement workers that a report was taken as Information Only should instruct placement workers to follow-up with the information and contact the hotline if abuse or neglect is discovered.

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42 Langton L, Planty MG, Banks D, Witwer AR, Woods D, Vermeer MJD, Jackson BA. Sex Trafficking and Substance Use: Identifying High-Priority Needs Within the Criminal Justice System. Rand Health Q. 2022 Aug 31;9(4):14. PMID: 36238009; PMCID: PMC9519098.

2. Department Procedures should require placement staff to contact the placement clearance desk for a background check (i.e., CANTS/LEADS) when a child has self-selected an unauthorized placement.

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

4. This report should be shared with the Department's multi-disciplinary workgroup tasked with addressing current practice issues and barriers related to unauthorized placements.

5. The Department should consider expanding the Human Trafficking Prevention Program through the creation of additional staff positions. The additional staff should be available to child protection staff to provide consultation when there are allegations of Human trafficking of Children by Abuse (#40) or Human Trafficking of Children by Neglect (#90).