Office of the Inspector General Report to the Governor and General Assembly (Jan. 2024)

Death and Serious Injury Investigations

OIG2024 Death Investigation #1

DEATH

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

INVESTIGATION

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

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

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

that everyone in the home helped take care of the youth.

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

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

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

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

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

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

RECOMMENDATIONS

1. The OIG reiterates the following recommendation (from January 2022 OIG Annual Report, Death and Serious Injury Investigation 6. See also: Department Update on Prior Systemic Recommendations) should be incorporated in Procedures 300: In the absence of the Public Service Administrator, only a Child Protection Advanced Specialist or Area Administrator should be allowed to approve a Child Endangerment Risk Assessment Protocol and/or provide a Final Supervisory Decision.

The Department agrees. The Office of Child and Family Policy will incorporate the following procedural requirement in Procedures 300, "In the absence of the Public Service Administrator, only a Child Protection Advanced Specialist or Area Administrator can approve a Child Endangerment Risk Assessment Protocol, approve a critical decision regarding protective custody and provide a Final Supervisory Decision."

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

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

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

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

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

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

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

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

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

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