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

Death and Serious Injury Investigations

OIG2024 Death Investigation #5

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

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

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

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

Four days later, the child protection investigator met with the paramour and observed the child, who could not tell the investigator how the burn occurred. The paramour reported cleaning the child's wound and showed the investigator the first aid products. The paramour also told the investigator that she or the child's father provided care for the child while the mother worked, although the father was no longer involved; however, the investigator did not obtain additional information about the father during the investigation. The investigator

documented no new injuries or signs of abuse to the child, but the child protection investigator told IG investigators that she did not observe the child undressed, did not complete a body chart, and her supervisor did not instruct her to complete those tasks. Both the child protection investigator and her supervisor reported to

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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