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

**Death and Serious Injury Investigations**

**OIG2024 Death Investigation #6**

**DEATH**

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

**INVESTIGATION**

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

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

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

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

by abuse (#11) to the child. The children continued to reside with their grandmother.

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

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

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

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

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

During the child protection investigation, staff from the originating county state's attorney informed the investigator that, according to records, the juvenile court terminated wardship and granted guardianship to the paternal grandmother. The supervisor documented consultation with the child protection investigator in SACWIS and waived daily attempts to see the children. The supervisor told IG investigators that the child protection investigator reported that the juvenile court found the parents fit, but the supervisor did not know

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

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

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

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

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

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

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

The child protection investigator interviewed the child in his bedroom and documented he appeared clean but sickly and thin. The investigator observed multiple snacks on the child's shelves, and the child stated he ate all the time but did not gain weight. The child denied anyone hurt him and stated he felt safe in the home. However,

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

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

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

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

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

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

## RECOMMENDATIONS

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

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

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

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

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

The Department agrees. The employee was issued a counseling.

**The child protection investigator and supervisor in the February 2022 investigation should participate in the Medical Aspects of Child Abuse training. After training completion, the DCFS Medical Director or designee should facilitate a discussion with them about applying knowledge learned to child abuse and neglect investigations.**

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

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

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

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

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

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

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

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

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