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

Death and Serious Injury Investigations

OIG2024 Death Investigation #9: OIG2023 #59

DEATH

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

INVESTIGATION

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

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

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

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

According to the reporter, the mother had diagnosed mental health issues and reported substance use during her pregnancy. In the second related information report, the reporter again requested a discharge plan for the mother and infant sibling. The reporter stated the mother tested positive for cocaine at a prenatal visit two months prior to the twins' birth. The mother reported housing issues following the death of the maternal grandmother two

months earlier. The hotline worker coded the call as action needed, which required the child protection investigator and supervisor to review the report within 60 minutes to determine the necessary action and establish a time frame for action according to DCFS Procedures 300.30.f. Reports of Child Abuse and Neglect: Content of Child Abuse and Neglect Reports, Report Response Codes. However, child protection staff never documented responding to the action needed report. The child protection supervisor told IG investigators that due to her flex schedule, she did not see the emails regarding the hotline calls for discharge planning in a timely manner. During the pending investigation, the child protection investigator also did not obtain information nor request documentation regarding the mother's mental health diagnosis. The child protection supervisor did not ensure that the child protection investigator issued subpoenas or obtained consents for the release of the mother's mental health records also required in DCFS procedures, as the information was essential to determine service provision.

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

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

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

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

her with a second crib to ensure both infants had safe sleep arrangements. The after-hours investigator observed formula, diapers, and clothing for the infants, and she discussed safe sleep practices with the aunt, explaining the infants must sleep in their own crib and not co-sleep with her in the bed. The after-hours investigator entered the unsafe Child Endangerment Risk Assessment Protocol (CERAP), which the primary supervisor approved.

According to DCFS Procedures 300. Appendix G. Requirements for Use of the Child Endangerment Risk Assessment Protocol, the child protection investigator is responsible for providing the responsible caregivers with their rights and responsibilities of the care plan, including how to obtain medical care. However, child protection staff never provided the aunt with information on how to obtain medical care for the infants.

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

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

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

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

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

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

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

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

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

RECOMMENDATIONS

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

The Department agrees. The employee was discharged.

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

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

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

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

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

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

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

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

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

6. Expanding on a prior OIG recommendation (from January 2022 Annual Report, Death and Serious Injury Investigation 4. See also: Department Update on Prior Systemic Recommendations), the Intact Family Recovery coordinator should conduct ongoing training for the region's child protection investigation supervisors and area administrators to ensure the field is educated about the Intact Family Recovery program and the referral process. If the program regularly has openings, the coordinator should, through email or an announcement, inform supervisors of the openings.

The Department agrees. The current Intact Family Recovery (IFR) manager completed a training with child protection staff and other stakeholders on the referral process for IFR. The IFR manager will also conduct training on the referral process for child protection investigators, supervisors and area administrators on a quarterly basis. In addition, the Intact Family Recovery brochure was updated and will be posted on the D-net.

OIG 2023 Child #59

Child No. 59	DOB: 01/2022	DOD: 04/2022	Undetermined
Age at death:	2 months		
Cause of death:	Undetermined		
Reason for review:	Pending child protection investigation at time of child's death		
Action taken:	Full investigation pending		

Narrative: Two-month-old was found unresponsive after co-sleeping with a maternal aunt and twin sister. The aunt called 911 and began CPR. The infant was transported by ambulance to the hospital, where he was pronounced deceased. DCFS investigated the infant's death and indicated the maternal aunt for death by neglect and substantial risk of physical injury/environment injurious to health and welfare by neglect.

Reason for Review: In January 2022, upon the birth of the infant and his twin sister, DCFS received three reports on three subsequent days. The reports alleged the mother used cocaine and marijuana during her pregnancy, had been staying in homeless shelters and was in an abusive relationship. The mother reportedly had a mental health diagnosis, and she had a young daughter who lived out of state. The mother and twins tested negative for substances at the time of delivery. The day of the first report, the CPI met with the mother at the hospital, who denied using any drugs during her pregnancy and stated she could stay with the infant's maternal aunt following her release from the hospital. The twins were observed to be healthy, awake, and safe with the mother at the hospital. The family member confirmed the mother could stay with her until she found her own home, and denied the mother used drugs during the pregnancy. In February 2022, DCFS received a report that the mother and twins lacked stable housing and the mother was a sex worker. The CPI spoke with a second maternal aunt, who stated she had taken the mother to a substance use treatment center in November 2021, but the mother left the facility after three days. The CPI made in-person contact with the mother and twins, and noted the twins appeared clean and lacked visible signs of maltreatment but were sleeping in a car seat and did not have cribs. The mother agreed to a safety plan with a third maternal aunt. The maternal aunt reported she had one crib in her home. The CPI provided a portable crib, discussed safe sleep with the aunt, and monitored the safety plan regularly. At the time of the infant's death, the intact family services case had not yet opened, the child protection investigation remained pending, and the infant and his twin remained in the care of the third maternal aunt. DCFS later indicated the mother for substance misuse by neglect, inadequate shelter, and substantial risk of physical injury/environment injurious to health and welfare by neglect.