Department of Children and Family Services
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Office of the Inspector General

File No: 041895

Minors: [redacted] (DOB [redacted]; DOD [redacted]
[redacted] DOB [redacted]
[redacted]. (DOB [redacted]

Subject: Child death/Developmentally Disabled Parent/Split custody

Date: April 6, 2005

SUMMARY OF COMPLAINT

A twenty-six-year-old developmentally delayed, mentally ill mother gave birth to a baby in the toilet. The baby was born alive. The mother reportedly saw the baby kick her legs, but left her in the toilet. Paramedics found the baby with her head face up at the bottom of the bowl amid human waste and cigarettes. The mother has been charged with first-degree murder. She was found not fit to stand trial and is being held in a psychiatric facility.

The mother has two living children. At the time of death, the Department had custody of the older child, [redacted] Eight-year-old [redacted] had been in foster care since 1998 when his mother was indicated for cuts/welts/bruises to him and substance misuse. A second child, [redacted] born in 1999 remained at home with mother. After the death of the newborn, the then five-year-old [redacted] was taken into custody and placed in specialized foster care.

INVESTIGATION

Background

[redacted] (DOB [redacted]) gave birth to three children:[1] [redacted] (DOB [redacted]), [redacted] (DOB [redacted]) and the deceased child, [redacted] (DOB [redacted]). The three children reportedly have different fathers. [redacted] father was reported to be [redacted] unknown) who was never located by the Department. At the time of [redacted] birth, [redacted] named [redacted] (DOB [redacted]) as [redacted] father. Subsequently, [redacted] father was reported to be [redacted] (DOB unknown). Father of the deceased child, [redacted] was reported to be [redacted] (DOB [redacted])

The Department commenced involvement with [redacted] and her children in November 1998 when then three-year-old [redacted] was brought into care. Over the course of the next five years, up to the time of [redacted] death, the Department kept the case open, allowing the mother to keep in her care a child born three months after [redacted] placement, while [redacted] had a permanency goal of "return home- five months". The caseworker and the supervisor were involved with the family, often visiting the foster child and the mother, usually at the foster parents' home. A homemaker was put in place, having contact with the mother up to five days a week. The caseworker and the supervisor described the mother as resourceful despite her developmental delays and mental illness. The service plans noted that reunification had not occurred because of the mother's inability to locate stable housing. The case records indicated that the younger child was doing well in the mother's care with the support of the child's maternal grandmother. At the time of the death the supervisor and caseworker were exploring changing the goal for [redacted] from return home to termination of parental rights.

Sequence A

[redacted] family came to the attention of the Department of Children and Family Services after the hotline was contacted on October 30, 1998 with allegations of cuts, welts, and bruises and medical neglect. The reporter alleged that [redacted] then slung him against the television so that he bumped his head. It was also alleged that [redacted] punched [redacted] in the nose while at K-Mart, causing it to bleed. The reporter further alleged that [redacted] was giving [redacted] Benadryl when she did not want to be bothered with him (SCR 798854A). The reporter, [redacted] was a friend who had been allowing [redacted] and her child to reside with her.

Child Protection Investigator (CPI) Vicki Misloski went to Ms. [redacted] home, in Madison Illinois, to meet the mandate. The investigator first interviewed [redacted] who denied the allegations. She stated that she would whip [redacted] if he misbehaved and only gave [redacted] Benadryl for his sinuses as ordered by Dr. Ahmed. [redacted] reported that she was six months pregnant, and [redacted] was the father of the baby. She reported that she formerly lived with an aunt who assisted her after [redacted] was born, but [redacted] said her aunt would not want to be contacted. She went on to say that she had moved into a place in Madison County but the landlady wanted too much rent. [redacted] reported that she

[1] Ms. [redacted] has reported to service providers and law enforcement that she has had other miscarriages and lost those infants in the same manner as she did Vanessa. No one has been able to confirm these reports.

was living off of SSI Disability and Public Aid. She had plans to move in with a friend named [redacted] who told her she would just have to help with the utilities. [redacted] told the investigator that she was upset that Ms. [redacted] said she needed help because she was able to care for herself and her children.

Ms. [redacted] told CPI Misloski that [redacted] loved her child but she had concerns. Ms. [redacted] said that [redacted] hit [redacted] for misbehaving and he fell and bumped his head but [redacted] did not actually throw him into the television. She also felt that [redacted] gave [redacted] medication when he did not seem to need it and this coincided with [redacted] saying he was "wearing her out." She reported that about a month and a half prior, when [redacted]'s sister [redacted], who was also developmentally delayed, was staying at her house, Ms. [redacted] came home at 7:00 pm and found [redacted] asleep. Ms. [redacted] said that [redacted] was generally up at that time and she could hardly wake him. When she asked [redacted] and C[redacted] why he was sleeping so heavily [redacted] answered, "we doped him up" with Benadryl adding, "we do it all the time." Ms. [redacted] said she explained to them that the medication was not to be used that way. She felt that [redacted] needed help taking proper care of herself and her son because of her intellectual limitations. For example, Ms. [redacted] said [redacted] would sleep until noon if someone did not wake her. Ms. [redacted] had taken [redacted] and her son in when they got evicted approximately four months earlier.[2] Presently no relatives were available to help [redacted] Ms. [redacted] feared Mr. [redacted], who [redacted] planned on moving in with, would take advantage of her. Ms. [redacted] was reportedly in the process of trying to assume guardianship of two of her grandchildren and found that [redacted] needs were too complex for her. She did not, however, want [redacted] to leave her home without help in place. The investigator also spoke with Ms. [redacted]'s adult daughter, C[redacted] [redacted] who corroborated her mother's description of [redacted] disabilities and reiterated concerns for [redacted]

CPI Sharon Miller was assigned to complete the investigation. On November 6, 1998, Ms. [redacted] told CPI Miller that she could not continue to let [redacted] stay in her home but [redacted] needed help taking care of [redacted] Ms. [redacted] further reported that she was afraid that [redacted] would hurt [redacted] She stated that whenever she [redacted]) got on [redacted] would take it out on [redacted] Ms. [redacted] reiterated the incidents that she had reported to the hotline. CPI Miller also attempted to interview [redacted] on this date. [redacted] stated that, "she did not want to talk about these things."

On November 6, 1998, protective custody (PC) was taken of [redacted] following an incident in which [redacted] refused to cooperate with the investigation and attempted to leave Ms. [redacted] home with [redacted] During a meeting, CPI Miller proposed that [redacted] stay with Ms. [redacted] until services could be put in place, as Ms. [redacted] had agreed to this. [redacted] refused and was advised that she had to agree or the investigator would have to take protective custody of [redacted] Reportedly, "[redacted] up, charged at the worker with her fists clenched intent upon striking the worker, stopped, then began jumping up and down and tearing her hair out. She then got down on all fours and banged her head against the television set deliberately." Following this incident, CPI Miller went out to her car and called police to request assistance with taking protective custody. While she was calling for assistance, [redacted] left with S[redacted] CPI Miller followed her down the block and was able to stop her

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[2] There is little information as to whether [redacted] was caring for S[redacted] independently prior to getting evicted, as reportedly she had never lived alone and [redacted] is an unreliable historian.

until the police arrived. [redacted] was advised that the case would be indicated and protective custody would be taken of [redacted]

The case was indicated for cuts, welts, and bruises and for substance misuse, based on the reports of [redacted] and her adult daughte[redacted] and [redacted] refusal to comment on them. It was unfounded for medical neglect, as it was determined that "substance misuse" was a more appropriate indication.

The Family Assessment Factor Worksheet[3] contained critical information regarding this family and the potential direction of this case. The investigator noted that [redacted] had been staying with strangers and was currently homeless. She had no family support, as her mother and sister were reportedly mentally retarded and her father was dead. [redacted] maternal grandmother raised her because of her mother's mental limitations. [redacted] received SSI but her last check was stolen. The investigator noted that this case was considered high risk as it involved an "impulsive, mentally retarded mother from a background of her own of child abuse/neglect with a three-year-old child." While [redacted] was strongly bonded to her child, she lacked adequate parenting skills and life management skills and was in need of an assisted living situation. The investigator recommended that the Department locate a responsible person to live with [redacted] and her child to monitor both of them, act as her payee for SSI (so that men in the community did not exploit her and steal her money) and who could have guardianship of her child(ren).

Follow-up case

cheri McCottrell-Wade

A follow-up case was opened to a unit specializing in reunification. Although [redacted] lived in the Granite City Field Office area, she was referred to the reunification program based out of the East St. Louis Office. [redacted] was the assigned caseworker and remained so until January 2005. Lorene Floyd was her supervisor throughout the case.

Cheri McCottrell-Wade and Lorene Floyd explained to OIG investigators that the reunification program, which was eliminated in December 2001, provided intensive services to families that were thought to be able to be reunified quickly. Ms. McCottrell Wade related that as part of the reunification program she was in contact with the family three to five times per week. If the family was not reunified within five to six months, an extension could be granted. The first and only extension found documented in the Ingram case record occurred in May 1999. A case entry dated May 20, 1999 by Lorene Floyd, noted: "Supervisor and worker discussed Ms. [redacted] case. Ms. [redacted] 6-month reunification date is up therefore supervisor is extending the case for an additional 6 months. Thus far Ms. [redacted] has maintained the child at home satisfactory with no indication of abuse or neglect. Continues to maintain contact with child in care but reunification is not recommended at this time." Reasons cited for the need for Department involvement included: [redacted] need for hands on training with parenting tasks and her need for assistance with housing. Further, [redacted] appeared to be mentally challenged and might be in need of further assistance.

[redacted]

[3] The Department is no longer using this form.

[redacted] was immediately placed in the foster home of [redacted] and remains with Mrs [redacted] who is now considering adoption. [redacted] visits with [redacted] took place in the foster parents home, and often times the homemaker accompanied her. The caseworker said she conducted most of her with [redacted] at the foster parents home. In addition because the foster parents home was so close to the places the family stayed, [redacted] would come by on a regular basis and considered the foster parent a support. In fact [redacted] listed Mrs. [redacted] as an emergency contact when she was hospitalized. Mrs. [redacted] told OIG investigators that the maternal grandmother and other family members would regularly stop by her home to visit [redacted] as well.

Educational Needs

Upon [redacted] entry into the foster care system he appeared to have some developmental delays. In the 1999 spring school quarter [redacted] was placed in a pre-kindergarten program with special education resource services. In September of the following year (2000) four-year-old [redacted] was found eligible for special education services and classified as Educable Mentally Handicapped (EMH) with speech and language impairment.[4] His special education teacher noted that [redacted] had very little self-control. He was impulsive and had autistic tendencies. He was described as oppositional and defiant as he refused to follow directions. On March 17, 2003 a school conference was held because [redacted], now six-years-old, continued to have behavior problems in school.[5] [redacted] had been suspended several times (1 full day and two ½ days). A week after the school staffing, Ms. McCottrell Wade noted (3/28/03) that she accompanied [redacted] for an appointment with a doctor affiliated with the Koch clinic who opined that it was not conclusive that [redacted] had ADHD, and he did not recommend any medication, but suggested that a management plan be written at school where behavior problems were noted.[6]

Parenting of [redacted]

[redacted] delivered [redacted]. on [redacted] as released from the hospital, however, they would not release the baby to [redacted] until they heard from DCFS, as they were aware that DCFS was involved and were unsure whether to release the baby. [redacted] contacted the caseworker on January 11, 1999 requesting that she contact the hospital. According to the records, the caseworker spoke to hospital staff that day and told them that DCFS had "no legal responsibility to the new born child and unless the hospital had some concerns, that we could not retain the child."

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[4] Participants in the Multidisciplinary Conference (10/25/00) included: the school psychologist; [redacted] teacher; the education coordinator; the speech and language pathologist; foster parent [redacted] caseworker [redacted]. The caseworker and foster parent were noted to have attended IEP conferences on a regular basis and [redacted] had excellent attendance.

[5] A conference was held on 3/17/03 about [redacted] behavior problems. The following people participated: Director of Special Education; Bessie Peabody, DCFS Education Advisor; foster parent [redacted] Wade, DCFS caseworker; the school principal; and [redacted] teacher, Ms. Luffy. A 4/1/03 case note stated that the worker met with school administration for the purpose of reiterating her concern about [redacted] being put out of school on several occasions, according to foster parent without documentation of the reason, nor the school contacting DCFS. (Both foster parent and homemaker were also present.) Teacher expressed frustration with [redacted] behavior.

[6] The doctor's report was not in the file. There was no evidence that a behavior management plan was developed.

When questioned about whether she had any concerns about [redacted]bility to parent [redacted]alone, especially considering that her three-year-old child was recently taken into custody, Ms. McCottrell Wade told OIG investigators that while she did have concerns about J[redacted] ability to parent alone, she believed that [redacted] was capable of parenting with a support system.

At the time of [redacted] birth, [redacted] was living with [redacted] purported paternal grandmother. According to case notes, the occupants of the residence included Ms. [redacted]nd a four-year-old granddaughter, [redacted] The caseworker's contacts show that the purported biological father was present in the home during at least one of her visits.[7] Ms. [redacted] told OIG investigators that she had contact with Ms. [redacted] prior to [redacted] release from the hospital to confirm that [redacted] and [redacted] would live with her and that Ms. [redacted] would assist [redacted] with [redacted]s care. The caseworker's notes reflect that on January 12, 1999, the caseworker along with the homemaker visited J[redacted] her residence. The caseworker asked to see [redacted] was told that he was upstairs. Only moments later, Ms. [redacted] four-year-old granddaughter was seen standing on the steps with J[redacted] in her arms. The caseworker expressed concern because neither Ms. [redacted] or J[redacted] appeared concerned about the infant's safety with the four-year-old. The caseworker and the homemaker showed [redacted] how to hold the baby, making sure his head was supported. While [redacted] reported that she was scared to hold the baby because he was so small, she was observed feeding and burping him, as well as changing his diaper[8]. The caseworker noted that when living with Ms. [redacted] would not tend to [redacted] slept in the same room as Ms. [redacted] because [redacted] would not wake up to care for the infant. According to a case note dated January 20, 1999, the homemaker told the caseworker that J[redacted] needed constant supervision with the baby. The homemaker further reported that during a visit on this date, she told [redacted] to put a blanket ove[redacted] because the home was chilly. [redacted] was sitting in a "punkin seat" and [redacted] put the blanket over the whole "punkin seat" covering [redacted] head. The homemaker instructed [redacted] to take the blanket off [redacted] head and showed her how to put the blanket on him properly.

During March, problems arose between [redacted]d Ms. [redacted] and [redacted]eft the home. The baby [redacted] remained with Ms. [redacted] for approximately two weeks. [redacted] told her caseworker that Ms. [redacted] would not give her the baby. Ms. [redacted] stated that J[redacted] left and never came back to get the baby. According to the case record, [redacted] attempted to get her baby by contacting the police, who contacted the caseworker. The police were advised that the Department had no legal involvement with [redacted]. A case entry dated March 15, 1999 noted that Ms. [redacted] called the caseworker stating that [redacted] left over the weekend and had not returned. She reported that [redacted] went to her mother's house. Ms. Ivy expressed frustration because she had to take the baby to the emergency room on Saturday because of a high fever and [redacted] would not answer the door (respond). Ms[redacted] had the baby and wanted custody of him. On March 29, 1999 Ms. [redacted] heard from [redacted] regarding her whereabouts and arranged a meeting. In April the caseworker took [redacted] to retrieve[redacted] after Ms. [redacted] agreed to give [redacted] to [redacted] Shortly thereafter [redacted] named someone else as [redacted] father. The homemaker's notes during this period reflect neither transitions nor the whereabouts of [redacted] and [redacted]

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[7] [redacted]. had a criminal history that included drug charges.

[8] In August 1999, Dr. Collins wrote that Jaki reported she did not know how to change [redacted] diaper, often putting it on backwards.

Ms. [redacted] expressed concern about [redacted] parenting skills on more than one occasion. An Administrative Case Review (ACR) was held at the field office on February 4, 1999. [redacted] was not there. However, after the review [redacted] and [redacted] Sr. showed up. The worker told them that she was unable to discuss services or progress with them without [redacted] consent.[9] They expressed concern for [redacted] and [redacted] Nine months later, after Ms. [redacted] was no longer residing with her, Ms. [redacted] wrote a letter to the Department dated November 8, 1999. In the letter Ms. [redacted] expressed concern that [redacted] was residing with her mother and her mother's boyfriend, who had sexually assaulted [redacted]'s sister [redacted] She also wrote that she believed that [redacted] was in need of a mental health program and a new caseworker.

In regard to having [redacted] remain with [redacted] the supervisor related to OIG investigators that they viewed the incident that brought [redacted] into care as a one-time incident. [redacted] told the supervisor and caseworker that she had hit [redacted] because Ms. [redacted] with whom they were living, had told her that [redacted] was too noisy and needed to be physically disciplined, and she did not want to upset Ms. [redacted] Ms. Floyd also pointed out that at the time this case was opened, [redacted] was three years old, [redacted] had been the primary caretaker for [redacted] and this was the first time she had come to the attention of the Department.[10]

Ms. Floyd and M[redacted]e told OIG investigators that after [redacted] and [redacted] left Ms. [redacted] home, the maternal grandmother was [redacted] primary caretaker. They did not think that [redacted] was capable of parenting him independently. According to Ms. Floyd, the maternal grandmother, [redacted] functioned at a higher level than [redacted] The caseworker saw the maternal grandmother as supportive of [redacted] allowing the Department into her home once [redacted] and [redacted] were residing with her. There was no record of a CANTS/LEADS check on the grandmother (or the boyfriend), and [redacted] history with the Department was never assessed to determine whether she was an appropriate caretaker for [redacted] Ms. [redacted]e and Ms. Floyd reported that in addition to maternal grandmother, [redacted] foster parent and the homemaker, Ms. Sykes, provided additional support for [redacted]

Department database checks show a case opened for neglect on [redacted] and her sisters, [redacted] and [redacted] from August 1979 to August 1980, perhaps explaining why a relative mainly raised [redacted] even though the placement screen indicates that she and her sisters were with their mother. As adults her sisters were not able to offer support and her mother's ability was unknown. In the social history dated November 20, 1998 Ms. McCottrell Wade noted that [redacted] was mentally challenged and displayed mental health issues. She wrote that [redacted] mother and sisters were also mentally retarded. [redacted]id not report on the extent of the family's problems or on their history of abuse. [redacted] reported to the caseworker that her family had drinking problems and described her mother as drinking everyday. [redacted]'s oldest sister, [redacted] lost custody of her eight children to the Department. [redacted] like [redacted] has developmental delays and has shown that she is unable to parent her children. She has been indicated for failure to thrive, medical neglect, inadequate supervision, environmental neglect, inadequate food and risk of harm. Though not indicated, [redacted]

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[9] The case record contains a signed release of information for Ms. [redacted]

[10] The Department does not know with any level of certainty that [redacted] was the primary caretaker for [redacted] before DCFS involvement except based o[redacted] reports.

was listed as an adult member of the household for many of the investigations and was not considered to be a viable relative placement. In 1995, [redacted] sister [redacted] was indicated for sexual penetration of [redacted] daughter as she admitted to digitally penetrating her niece while babysitting. [redacted] has since had four children removed from her care.

Both Ms. [redacted] and Ms. Floyd told OIG investigators that while they had observed [redacted], it was not on a regular basis. Ms. [redacted] reported seeing [redacted] in Ms. [redacted] home, where he and his mother were living for the first few months of his life. She also reported seeing him in [redacted]'s foster home during visits. She did not see [redacted] as much as she saw [redacted]. Ms. [redacted] told OIG investigators that she did not know the date that she last saw [redacted] prior to [redacted]'s death. Ms. [redacted] seldom noted [redacted] development.

When five-year-old [redacted] was taken into custody he was severely delayed.[11] He was not toilet trained or talking. The Department was aware of some delays with [redacted] At eighteen months, [redacted] was not walking and the homemaker took [redacted] and [redacted] to a doctor appointment concerning this. While both Ms. [redacted] and Ms. Floyd stated that they had concerns about delays with [redacted] they both expressed surprise at the severity and/or extent of [redacted] delays when he was taken into custody. Ms. Floyd reported that after observing [redacted] during a family meeting, in which he did not talk and only played with sticks, she told the caseworker to make a referral for [redacted]. There is a case note dated October 7, 2003, in which Ms. McCottrell Wade wrote that [redacted] (now four years old) may be delayed in speech and should be evaluated. No actual referral was found in the case record. Ms. [redacted] reported that the maternal grandmother initiated an assessment on her own. Neither Ms. [redacted] nor Ms. Floyd was able to provide any details including where and when an assessment was completed or what the recommendations were. Both believed that [redacted] was on a waiting list for services as reported by maternal grandmother. Ms. [redacted] told OIG investigators that maternal grandmother had shown her documentation of a completed assessment.

In May 2002 the Madison County Special Education District completed an assessment of [redacted].[12] The grandmother, listed as his guardian, accompanied [redacted] When asked what was the biggest concern for the child the grandmother replied that she had no concerns. The evaluation noted that [redacted] and his grandmother were homeless and were staying with a family that included 2-3 adults and 8-10 other children. Their daytime activities were listed as riding the bus all day. The evaluation noted that [redacted] attended one of the sessions and reported that [redacted] could say a limited number of words. The grandmother reported that he could say certain words though the evaluators were unable to discern any intelligible verbalizations. [redacted] reported that [redacted] had his hearing tested previously and was supposed to use hearing aids but did not have them yet. A referral for an audiological exam was completed as part of the evaluation. The evaluator indicated that [redacted] demonstrated noncompliant and destructive behavior throughout the evaluation. During the process

[11] Since coming into care, [redacted] was evaluated for early childhood and special education. According to the November 2004 service plan, the following characteristics were identified by the local school district in determining his eligibility for special education programs and services: speech and/or language impairment; autism; and developmental delay. In November 2004, [redacted] was enrolled in an early childhood center.

[12] The Department never obtained the assessment. The OIG obtained the assessment directly from the Madison County Special Education District.

the evaluator and the grandmother could not redirect [redacted]. The professionals noted that [redacted] behavior was that of a much younger child. The behaviors together with [redacted] speech and language delays prevented the use of standardized measures.

By January 2003 the Special Education District determined that four-year-old E[redacted] was eligible for special education services. [redacted] was assigned to a classroom but did not attend. In September 2003 the grandmother contacted Madison County, explained they had moved out of the county for a while, and were now seeking services. [redacted] was re-enrolled and attended one day. By November 26, 2003 Emmit, now close to five years old, was dropped from the program for non-attendance after missing 38 consecutive school days.[13] In addition, [redacted] was not in compliance with the medical requirements.

Once [redacted] moved in with her mother, the few case entries that mentioned [redacted] outside of confirming that [redacted] was current with his immunizations, were cursory. There were sparse descriptions of [redacted] interactions with [redacted] and no descriptions of the grandmother or her paramour's interactions with the child. The homemaker, charged with teaching [redacted] parenting skills, provided no baseline observations of the mother's parenting skills with [redacted] nor were the skills plotted to measure progress. Instead, there were vague entries, repetitive descriptions of instructions and general platitudes such as "we discussed your child's life is important learn all you can and become the best parent you can be". The homemaker repeated instructions, but gave no description of whether the mother applied the instructions or generalized the skills to her daily care of the child. There was no shaping or modeling of behaviors except for tasks related to grocery shopping and trips to the laundromat.

One of [redacted] parental deficits was her misuse of medication with her three-year-old son. However, neither the homemaker nor caseworker targeted this as a potential problem in the care of [redacted] While the homemaker repeated generalized instructions for [redacted] to read all labels on medications, the homemaker never practiced or asked [redacted] to demonstrate this skill or noted if [redacted] ever was on medications. Public Aid records show that [redacted] was on several medications including amoxicillan and topical antifungal when he was a month old. He was prescribed amoxicillan and albuterol syrup at three months old as well as topical antifungal. In April 1999 he was prescribed antibiotics for his ears. On May 14, 1999 Emmit was taken to the emergency room for diarrhea. Yet, Ms. [redacted] [redacted]'s May 14, 1999 note described the baby as looking healthy, gaining weight and smiling a lot. Although [redacted] was not home on the morning of May 14, 1999 (the caseworker had picked up [redacted] at 8am and returned her after Dr. Collin's evaluation session) the homemaker noted she provided services to [redacted] from 8am to 10am: "we discussed caring for yourself and practice good health habits". Neither the caseworker nor homemaker noted any problems with the infant who was ill. On August 17, 1999 [redacted] returned to the emergency room for an ear infection. It appears by this time he was taking albuterol on a regular basis. The homemaker and caseworker's records are silent on [redacted] health problem. There is very little on the mother or grandmother's functioning in following doctor's orders, assuring they understood dosage amounts and schedule. In November

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[13] The School district sent a letter to the parents of [redacted] informing them that he was being dropped for non-attendance. The letter urged that they contact the teacher if they needed assistance and wanted [redacted] to remain in the program.

1999 [redacted] was prescribed an antihistamine, the same type of medication [redacted] had misused to make [redacted] quiet. [redacted] was also at this time on and off of pediatric electrolyte. The doctor visits note continuing ear infections. The homemaker never noted that [redacted] was crying or uncomfortable, a common reaction to ear infections. On February 2, 2001 public aid paid for a taxi to take [redacted] to Cardinal Glennon Children's Hospital in St. Louis. He was being seen for lack of development. The homemaker reported that on February 2, 2001 she took [redacted] to the laundromat; there are no notes about [redacted] Two weeks later, the precipitating event to [redacted] February 16, 2001 psychiatric admission was [redacted] angry and aggressive outburst following requests during the child's hearing exams to give [redacted] his antibiotics.

Early Intervention

The worker never referred [redacted], who was at high risk having a developmentally delayed mother and sibling, to a Zero to Three program. Ms. [redacted] told OIG investigators that she could recall only referring one child to a Zero to Three program in her time as a caseworker. The child was referred because Ms. McCottrell Wade noted he needed socialization skills. When asked about [redacted] socialization skills the worker stated that she observed him socializing with his brother at the foster parents home and he did fine. However, [redacted] foster parent Mrs. [redacted], when contacted by hospital staff following the death of [redacted] described [redacted] has having developmental issues and out of control behavior.[14]

Early intervention services are readily available to children in Illinois[15] who show any lack of cognitive, physical or psychosocial development. In addition children diagnosed with a physical,[16] or mental condition with a high probability of resulting in developmental delays or with certain family circumstances that put them at risk of substantial delays are also eligible.[17] Regional Child and Family Connections agencies, one of which is located in Madison County, provide evaluations and assessments for children under three. These assessments are done at no cost to the family. Families with eligible children receive an Individualized Family Service Plan, which lists the services and supports that must be made available to the family.[18]

The Early Intervention Services System Act[19] was meant to assure that eligible children receive timely services targeted toward overcoming developmental problems. Health care providers, childcare providers, and other professionals who identify a child with a disability or possible developmental delay are to refer that child for services right away. The law states referrals must be made within two working days.

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[14] Hospital staff called Mrs. [redacted] the request o[redacted] who was psychiatrically hospitalized. [redacted] wanted Mrs. White to have custody of [redacted]

[15] Illinois has a statewide, family-centered service system to find and help children who are eligible for early intervention services as defined in Part C of the Federal Individuals with Disabilities Education Act.

[16] Physical delays include hearing, vision, language and speech

[17] According to the Illinois Pro Bono Training and Tools for volunteer attorneys at Chicago Kent College of Law an example of an at risk condition includes having a parent with developmental delays or a severe emotional disturbance.

[18] Information is from the Illinois Department of Human Services Bureau of Early Intervention Child & Family Connections.

[19] 325 ILCS 20/1 Early Intervention Services System Act

DCFS Procedure 314.70 describes Early Intervention services as an array of services for children, birth to three years of age, who are experiencing a developmental delay or have a condition that has a high probability of resulting in developmental delay, including those children at risk because of environmental risk factors. The procedure dictates that caseworkers for DCFS wards should immediately refer a child exhibiting eligible conditions to the nearest early intervention program. The referral is to be documented in the child's case record.

The caseworker did not get [redacted] medical records that documented his developmental delays. In addition [redacted] outpatient treatment noted developmental delays. The Child & Family Connections that serve the Madison County area had received a referral from St. Elizabeth's hospital after an audiological assessment was completed March 15, 2001. There was no follow-up by [redacted] or the extended family.[20]

Homemaker

A referral for homemaker services was completed on November 20, 1998. The referral indicated that duties expected of the homemaker were, "To assist parent to upgrade parenting skills, work on budgeting, assist with looking for adequate housing, help monitor visits between mother and child." In her interview with the OIG, Ms. McCottrell Wade stated that a homemaker was put in place to help with parenting skills because it was believed that [redacted] would be unable to comprehend a parenting class. The homemaker was to help with budgeting, shopping, and assisting [redacted] with appointments. Ms. McCottrell Wade also helped with these tasks. Ms. McCottrell Wade stated that [redacted] was never "resistant to try to learn" however, she was dependent on others.

Ms. Sykes reported that she has worked as a homemaker for over twenty years. She was J[redacted] assigned homemaker for approximately four years; the majority of the time she provided services in the morning, four days a week. At the time of the referral, [redacted] was pregnant with [redacted], Ms. Sykes stated that she believed DCFS was looking for housing for [redacted], not for [redacted] and her mother. The homemaker accompanied [redacted] to the [redacted]s foster home for visits with [redacted] She told OIG investigators that she spoke with the caseworker at least three times a week or more as needed to inform the caseworker of interactions between herself and [redacted]

According to Ms. Sykes, [redacted] was "slow" and ambivalent about accepting homemaker services. Ms. Sykes related that [redacted] could take direction but you never knew if she would retain what she had been taught. [redacted] could be unreliable in providing information. [redacted] often talked about being pregnant even when she was not.[21] [redacted] did not want help managing her money, refusing to disclose any information about her spending habits or amount of money available to her. Ms. Sykes said that

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[20] The Early Intervention program includes several services including: Family training; Social work, including counseling and home visits; Special instruction; Speech, language pathology and audiology services; Occupational or physical therapy; Psychological services; Service coordination services; Medical services for diagnostic and evaluation purposes; Health services that are needed to enable the child to benefit from other early intervention services; Vision services; Transportation; Assistive technology devices and services.

[21] Hospital records indicate that in 199[redacted] went to the emergency room complaining of vaginal cramping and spotting stating she thought she was pregnant. When staff tried to give her a pregnancy test she refused and signed out against medical advice. In 2001 [redacted] told outpatient mental health treatment staff that she was pregnant although she was not.

budgeting was one area that was never addressed.

According to Ms. Sykes, [redacted] was the primary caretaker for [redacted]. There were times when [redacted] would stay somewhere other than with her mother but [redacted] would stay with his grandmother. Ms. Sykes noticed speech delays with [redacted] and discussed this with the mother, grandmother and the caseworker. [redacted] told her [redacted] was "just lazy" and other family members had late development. Ms. Sykes reported that she thought the family was in denial. Ms. Sykes believed that [redacted] living with his mother and grandmother was appropriate, as [redacted] was not able to parent alone. Because the homemaker services ended abruptly in May 2003,[22] Ms. Sykes was unable to prepare [redacted] or her mother for the termination of services. In the service plans all tasks related to [redacted] cooperation with the homemaker were rated as satisfactory. The narrative in the service plans remained unchanged for the four years [redacted] was "upgrading her parenting skills". No specific examples or explanations of the progress in parenting or self-sufficiency skills were cited. Reportedly homemaker services were terminated because after four years, the case was going to legal screening.

Validity of Homemaker Notes

There are additions to the discrepancies between the homemaker and caseworker's notes on services provided to [redacted] on the morning of May 14, 1999. During 2000 the homemaker failed to note scalp and facial burns on [redacted] In 2001 the homemaker billed for services while [redacted] was psychiatrically hospitalized.

In the late evening of January 12, 2000 [redacted] was brought to the emergency room by emergency medical services. [redacted] had first and second degree burns to her forehead, scalp, top of her ears and back of her neck. [redacted] told staff that her hair was on fire and her mother had put it out with water. [redacted] was crying and upset. She pulled a dressing off and refused to have it replaced saying, "I don't care." An attending doctor was paged and instructed that [redacted] be admitted. Following admission [redacted] was given an IV that she pulled out yelling, "I don't want it" and stated her desire to leave. [redacted] refused to sign the AMA papers and left the hospital with a friend. The next morning the homemaker noted: "It is important to learn physical and emotional needs. learn (sic) all you can." Ms. Sykes told OIG investigators she thought [redacted] burned her arm or her leg with grease.

[redacted] was in an inpatient psychiatric unit from February 16, 2001 through February 21, 2001 and March 8 through March 13, 2001. While [redacted] was in the hospital, the homemaker, Ms. Sykes, billed and recorded homemaker services to [redacted] from 8am to 10am. There were no early morning visiting hours at the hospital and [redacted] had no passes to leave.

Ms. Sykes records describe: February 19, 2001, "I take [redacted] to WIC." On February 19 hospital professionals described [redacted] as being irritable, depressed and isolated; February 20, 2001, the homemaker noted "I talk to [redacted] about caring for herself and her child. Take and give him a bath every day. Put clean clothes on give him three meals per day and a snack." On February 20, 2001 hospital records described [redacted] as psychotic-still hearing voices and depressed; February 21, 2001,

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[22] Per note dated May 27, 2003, to Central Baptist, from [redacted], "Please be advised that as of May 18, 2003 it is requested that services be termination (sic) for the above client due to services being complete." There was no transition period after four years of almost daily contact with homemaker.

Ms. Sykes recorded "I take [redacted] to the laundry mat (sic) and stop by the store to get a few items." The hospital reported [redacted] was discharged late afternoon on February 21. There is no reference in any of the homemaker's notes that [redacted] was hospitalized, prescribed psychotropic medication, had difficulty getting up in the morning, heard dead people speaking[23] to her or was in need of mental health services.

On March 8, 2001 [redacted] was readmitted to the in-patient unit. She was discharged March 13, 2001. Again, the homemaker recorded uninterrupted homemaker services to [redacted] during the period [redacted] was in the psychiatric unit. The homemaker recorded:

3/8/01 I taken (sic) [redacted] to Aldi to pick up grocery & pampers
3/9/01 We discuss housekeeping things you need to do everyday wash dishes sweep & mop floor take out the trash what ever you see that need to be done make sure your home a clean place to live.
3/12/01 office visit
3/13/01 [redacted] visit her caseworker at public aid to discuss her check

Following her discharge from the hospital the homemaker made no references to Jaki's mental health:
3/14/01 Visit son at school
3/15/01 Dr. visit
3/16/01 [redacted] & I discuss discipline. I told her it's an ongoing process it begins early in the child's life. It's a part of your job as a parent.

Similarly, all of the homemaker's notes belie the reality that [redacted] and her mother's situation was chaotic. There is no reference to the effects of their instability on [redacted] According to the homemaker's notes, she continuously provided [redacted] daily-uninterrupted services from 8am to 10 am. There are no references to the family's eviction in 2001 or the fact that [redacted] at some point lives in another city with [redacted] and that prior to staying with her sister, [redacted] was constantly moving from place to place after the 2001 eviction. The homemaker's notes never reflect that [redacted] is the primary caretaker of [redacted] and her housing situation is also unstable.

Ms. Sykes told OIG investigators that even though the time sheets would indicate that she was with [redacted] from 8:00 am to 10:00 am she would be there at different times because she had flexible hours. Ms. Sykes stated that the practice began several years ago when she was hired and was serving the reunification program. In addition Ms. Sykes said that she had visited [redacted] in the hospital, even accompanying the caseworker. While [redacted] was in the hospital Ms. Sykes said she would continue to visit the home and help the grandmother. At times Ms. Sykes said she would go to WIC herself with [redacted] ID when [redacted] could or would not go to use the WIC coupon for [redacted] and [redacted] before it expired. She would use [redacted] name in the case note because the case was in [redacted] name. Ms. Sykes stated she had gotten approval from the caseworker. The caseworker said she was aware of Ms. Sykes doing things for the grandmother when [redacted] was not there. Ms. Floyd told investigators that Ms. Sykes would call the office and ask permission to take [redacted] WIC or the laundromat or go without [redacted] but she did not know it was documented as taking [redacted] in the notes. Ms. Floyd said

[23] See mental health section on page 14

she rarely read the homemaker notes, the caseworker read the notes.

Housing[24]

For the term of the case, housing was an issue for this family. Though J[redacted] main residence was with her mother, whose housing situation was tenuous, [redacted] would live with friends or other family members for days or weeks at a time. There is documentation in the case record that the caseworker tried to assist [redacted] in obtaining her own housing (private or public). Homemaker notes reflect that the homemaker took [redacted] to see various apartments. Early on the caseworker took J[redacted] to Madison County Housing Authority to apply for public housing. J[redacted] was placed on a waiting list. Her name came up on the waiting list in 1999, but J[redacted] was unable to occupy the unit because of an outstanding utility bill from Illinois-Power for $2400.[25] The Department tried to work with J[redacted]on developing a budget and to assist her in paying off her outstanding utility bill. At one point, J[redacted] ecured a job. However, after a period of approximately two weeks, [redacted] was terminated from the job.[26] At the time of [redacted] death, nothing had been paid on the outstanding bill.

For approximately three months, from early December 1998[27] to March 1999, [redacted] lived with Ms. [redacted] until disagreements arose and [redacted] left. [redacted] then moved in with her mother who was living with her boyfriend. The apartment was within walking distance of [redacted] foster home. In August 2001, a family meeting was held, as the family had been evicted.[28] Present for the meeting were the caseworker, supervisor, homemaker, foster parent, mother and maternal grandmother. Since the eviction, they were staying with another family in the housing complex.

In August 2002, cash assistance was requested to secure housing. The form indicated that [redacted] paid $500 as part of the deposit. It was later documented that the landlord later rented to someone else. It was documented that in 2002 and early 2003, [redacted] was living with her godmother in the Madison area, with her sister [redacted] in Pontoon Beach and then with her boyfriend at some point. [redacted] was with his grandmother living with a family in a nearby housing complex.

Around October 2003, [redacted] and [redacted] moved to 218 Kerr St, which was [redacted]s brother's home. At the time of [redacted] death, [redacted] told law enforcement that they had been residing at that address for approximately seven months.[29] Ms. McCottrell Wade told OIG investigators that she visited the family at that address. Ms. McCottrell Wade told OIG investigators that she last saw the home between February and March 2004 prior to going on medical leave, and she did not see any problems.

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[24] Housing was also addressed by a community agency. That involvement is further explained in the Outpatient Mental Health section below.

[25] [redacted] told mental health providers that the reason she had a large utility bill was that her uncle put utilities in her name.

[26] In 2001 [redacted] told mental health providers that she sometimes worked temporary jobs through a firm called Labor Ready.

[27] There is a case note indicating that the caseworker and the homemaker picked J[redacted] up from a shelter in Alton on December 1, 1998 to transport her to R[redacted] home in Venice. According to the case note, the occupants of the residence included [redacted] and her granddaughter, [redacted]

[28] According to a note in the service plan the family was evicted for illegal use of utilities.

[29] [redacted] boyfriend Larron lived with them.

Mental Health

Psychological Evaluation

[redacted] participated in a psychological evaluation at the request of the Department following the birth of E[redacted] in order to determine [redacted] ability to parent. Dr. Bernice Collins completed the psychological in August 1999.[30] Dr. Collins noted that [redacted] was unreliable as an historian as [redacted] was inconsistent in her accounts but not in an attempt to be deceitful. [redacted] was unaware of her many limitations and deficits which clouded her accounts and the information she presented did not likely reflect her actual experiences. [redacted] told Dr. Collins that she did not know how to do many of the tasks associated with childcare. For example, [redacted] often put her youngest son's diaper on backwards. [redacted] relied on her mother and stepfather to provide most of the care for her children.

During the evaluation, [redacted] made reference to her mental health problems. [redacted] told Dr. Collins that she was seeing a psychiatrist[31] for "bad nerve problems" in which she shook and feared holding her baby, afraid she would drop him. She described a suicide attempt two months before the testing period. [redacted] said she planned to "cut herself all over" but her mother took the knife away before she could harm herself. She also described trying to break her arm as an adolescent. [redacted] reported that she began drinking at 16, and presently smoked 'weed" occasionally, when someone would bring her some. Dr. Collins noted that [redacted] was easily frustrated and related that she responded to frustration with verbal and physical aggression. Her behavior was often childlike. [redacted] lacked the practical skills to care for herself. Dr. Collins concluded that [redacted] lacked problem solving skills, had poor anger management and poor judgment.

The testing indicated that [redacted] was functioning in an extremely low range of intellectual abilities with a Full Scale IQ of 58. Dr. Collins noted that "...it is doubtful that increased exposure to enlightening or educational experiences will result in an increase in achievement related to cognition for this client." In regard to behavioral limitations Dr. Collins wrote, "Ms. [redacted] narrative about her typical daily living schedule suggests that she has insufficient skills to provide for herself independent of the added complications of caring for children." She went on to note that, "The results of intelligence, personality, and emotional testing strongly suggest that this young mother does not have minimal skills necessary to provide adequate parenting and that her social and emotional functioning is sufficiently inadequate to disallow a possible offset of other weaknesses."

Dr. Collins recommended: 1) Ms. [redacted] should consider the use of contraception as she participates in indiscriminate sexual relationships and is unable to engage in acceptable parenting; 2) Given Ms. [redacted] poor problem solving skills, history of depression and prior attempts to harm self she should be monitored for suicidal ideation and self-harming behaviors; 3) Ms. [redacted] should participate in psychiatric and psychological treatment for depression, anger management, and problem-solving strategies; and 4) Ms. [redacted] should be monitored in the presence of her children since, by her own admission, she was unable to perform some of the requirements (e.g. diapering,

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[30] Case notes indicate that the caseworker transported [redacted] to the psychological [redacted] was not at home on one of the scheduled dates.

[31] The name of the psychiatrist was not included in the evaluation or in the DCFS case notes. Later in the case [redacted] was seeing Dr. Habib but never on a consistent basis.

cooking, etc.) of parenting. She had limited understanding of childhood development and might benefit from participation in a parenting class designed to teach her some of the typical expectations of children.

Dr. Collins' recommendations were never incorporated into [redacted] service plan. Ms. McCottrell Wade and Ms. Floyd told OIG investigators that they were aware of Dr. Collins' assessment but that [redacted] was pursuing mental health services on her own. Throughout the case they accepted by way of [redacted] self report that she was complying with mental health services. Even after [redacted] was psychiatrically hospitalized, Ms. McCottrell Wade did not monitor her treatment for depression and anger management. Both Ms. McCottrell Wade and Ms. Floyd appeared assured that [redacted] visits with [redacted] were supervised, but never considered that Dr. Collins' had been operating under the assumption that [redacted] was a ward and as such was supervised, not under the unsupervised care of [redacted] and her family. A dependency petition as to [redacted] who was still in [redacted] care, was never considered.

Ms. McCottrell Wade told OIG investigators that she knew [redacted] had been psychiatrically hospitalized, had been prescribed psychotropic medication and had periodic involvement with an outpatient mental health clinic. Ms. McCottrell Wade said she called the clinic but only got general information about [redacted] cooperation with treatment. There were no consents or notes documenting contacts in the case record. Ms. McCottrell Wade said she could not recall if she had asked [redacted] to sign consents for release of information.

Inpatient Psychiatric Hospitalization

When [redacted] was two-years-old [redacted] was psychiatrically hospitalized twice at Gateway Regional Medical Center. In February 2001 [redacted] was admitted to the psychiatric unit following an incident where she became enraged at a clinic in Belleville where [redacted] was supposed to have a hearing test. [redacted] became infuriated, pulling out her hair and yelling that she wanted to kill herself. [redacted] related that the staff had prescribed ampicillin for [redacted] even though she had told them that [redacted] was allergic to the medication. At the hospital she reported that she felt very depressed especially in the last few months. She stated that she had not been eating or sleeping, and had been crying and isolative. She expressed thoughts about hurting herself although she had no specific plan. She reported hearing voices telling her to hurt herself. She reported she had one previous suicide attempt when she tried to strangle herself, though she was not specific about the time frame. The examiner noted paranoia and guardedness with poor judgment and limited insight. Her diagnosis was major depression with psychotic features, rule out schizoaffective disorder, rule out schizophrenia paranoid type. According to medical records [redacted] refused to participate in treatment or assessment for her first two days on the unit. [redacted] had poor boundaries and needed redirection to prevent relationships with male peers. [redacted] spoke with the staff and [redacted] by phone. [redacted] told the staff that [redacted] was not sick and that she was supposed to be admitted for only one day after she became angry at the clinic. [redacted] signed a release of information for DCFS[32] and it was noted that patient treatment and monitoring was discussed with DCFS including a referral to Chestnut Health Services for follow-up services. By February 21, 2001 she was sleeping and eating and denied feeling hopeless or helpless. She was discharged and referred to outpatient treatment.

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32 [redacted] signed the hospital's release of information allowing hospital staff to share information with DCFS. The release was not initiated by the caseworker.

On March 8, 2001, [redacted] presented to the hospital with complaints of depression, suicidal ideation and hearing voices of deceased relatives.[33] She reported that she was living with her mother and two children. Records noted that she had been discharged during the prior month with prescriptions for Celexa, an anti-depressant, and Risperidal, an anti-psychotic drug. [redacted] reported that she had not taken the Celexa. She came to the hospital on the advice of the psychiatric nurse who saw [redacted] on an outpatient basis. [redacted] boyfriend was in the hospital and staff suspected she wanted to be admitted to be with him, which was confirmed when [redacted] became upset upon being admitted to a different unit. Her five-axis diagnosis was:

Axis I: Major depression with psychotic features
Axis II: Borderline intellectual functioning
Axis III: None
Axis IV: Inadequate social support system
Axis V: Current global assessment of functioning 20

During the hospitalization [redacted] displayed depression, often not caring about hygiene and refusing medication. She was pleasant but would become easily agitated when redirected and was noted to have poor insight and poor impulse control. She tearfully discussed her children and not knowing her own mother until she was ten years old. On March 8, 2001 [redacted] told the social worker that she did not know where her sons were, stating she was involved with DCFS. [redacted] provided the phone number for Ms. [redacted]. The social worker documented that she left a message for Ms. [redacted]. There is no notation of Ms. [redacted] or Ms. Floyd calling back for more information. [redacted] told the social worker that she planned to take her youngest son and move in with her boyfriend. The hospital social worker documented a conversation with a social worker, from an unidentified agency, who was involved with [redacted] on an outpatient basis. The social worker expressed concern because [redacted] son was two years old, not walking and needed a hearing test. The social worker had attempted to set up a hearing test in Belleville on February 16, 2001, but [redacted] became agitated pulling out her hair and taking pictures off the wall resulting in the first hospitalization. The social worker noted that [redacted] might not be able to care for her needs or her son's needs. Ms. [redacted] told OIG investigators that she was aware of [redacted] hospitalizations. She believed that [redacted] was resourceful enough to take herself to the hospital when she needed help. Following the hospitalization, Ms. [redacted] and Ms. Floyd did not evaluate [redacted] and her ability to parent in light of the apparent mental health issues.

Outpatient Mental Health Services

Following each hospitalization [redacted] was referred to Chestnut Health Systems for outpatient care. Chestnut records indicated that [redacted] sporadically participated in her treatment. After her first hospitalization, Chestnut staff developed a mental health treatment plan with [redacted] Her presenting problem was described as "[redacted] has anxiety and depression which manifests itself in anger and inability to function in everyday situations." Stressors included unemployment, lack of direction, homeless, one child with DCFS involvement and another child with medical problems[34]. She had

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[33] [redacted] later reported that she had been hearing voices of deceased relatives since the age of ten years.

[34] [redacted] was having medical problems that were not being noted by the caseworker or homemaker.

problems adjusting to adult responsibilities. The diagnosis at Chestnut in February 2001 was adjustment disorder with mixed anxiety and depressed mood. Chestnut recommended intensive case management for [redacted] to assist in locating housing, taking care of her outstanding utility bill, encouraging her to stay on her medications, and seeing Dr. Habib regularly.

[redacted] contact with case managers was sporadic. Chestnut case managers had contact with [redacted] anywhere from twice a month, to three times a week, from March through June 2001 depending on [redacted] needs and whereabouts. When case managers conducted visits to [redacted] her home they described the home environment as dirty and unorganized. The number of people in the apartment made it difficult to have a private conversation with [redacted] also approached Chestnut staff in the street, as the office was near to [redacted] residence.

In March 2001, following her second hospitalization, much of the interaction between [redacted] and Chestnut focused on getting her medications after she lost her prescriptions. Chestnut staff gave [redacted] samples until her doctor's appointment near the end of the month. Housing options were discussed with [redacted] but in April 2001 [redacted] told case managers she was thinking of moving in with her boyfriend so she did not need to pursue housing. [redacted] thought she could be pregnant so the case manager set a doctor's appointment for her. By mid-April [redacted] had learned she was not pregnant and again requested assistance with housing. Chestnut provided her with a list of landlords the agency had worked with before.

At the end of April 2001 [redacted] told the case managers that she was not taking her medication and no longer wanted case management. Case managers encouraged [redacted] to continue with medication and referred her to Dr. Habib for medication management. Chestnut planned to terminate services once she was linked with Dr. Habib. The case manager went to [redacted] and [redacted] residence to inform [redacted] about an appointment with Dr. Habib on May 11, 2001. [redacted] was not home so the case manager gave the information to [redacted] and asked her to assure that [redacted] got the message. On May 14, the case manager returned to the home. [redacted] said she did not go because she had not received the message. [redacted] overheard the conversation and told the case manager that [redacted] had been given the message. [redacted] admitted that her mother told her, but she forgot. The case managers made a final home visit on June 29, 2001 to attempt to engage [redacted] in treatment. [redacted] said she was not interested in seeing a psychiatrist or taking medications. [redacted] told the case manager that she was working temporary jobs for a company called Labor Ready and knew community resources.

In early October 2001, Chestnut staff made a visit to [redacted] as a "periodic check". [redacted] told the case manager she was not taking medication but had made an appointment with a psychiatrist. [redacted] said her youngest son was learning to walk and she was visiting her oldest son twice a week. In late October, [redacted] approached the case manager on the street. The case manager noted that [redacted] looked disheveled. [redacted] said she moved in with a boyfriend. [redacted] said she was worried about her older son because he was having seizures.[35] [redacted] said she did not have any medication left. The case manager urged [redacted] to make an appointment with the psychiatrist. The case manager noted that [redacted] youngest son was showing delays, as he was just learning to walk at age three. She planned to assist [redacted] with accessing community resources.

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[35] There was nothing in the case record to indicate that [redacted] had seizures

There was no further contact with [redacted] until December 17, 2001, when [redacted] asked the case manager for assistance with housing. [redacted] said she was living with her boyfriend but wanted to explore other options. Two days later the case manager contacted [redacted] foster home, as [redacted] had left several messages. [redacted] wanted the number for Dr. Habib. The case manager provided the number but [redacted] became upset when the case manager would not provide [redacted] with medication until the appointment. The case manager reminded [redacted] that she needed to see Dr. Habib for the prescription. On January 17, 2002, the case manager again contacted [redacted] her boyfriend's home in Alton, as [redacted] had left several messages. [redacted] wanted the case manager to come to Alton, pick her up and take her to Madison. The case manager said she could not do that. [redacted] told the case manager that she was hearing voices of dead relatives telling her to take her medications. The case manager noted that Chestnut would assist [redacted] in accessing community resources as appropriate. There was no further contact between [redacted] and Chestnut until after the death of [redacted] told OIG investigators that she had contact with Chestnut and knew of [redacted] inconsistency with treatment.

Extended Family and Household Composition

Three months after [redacted]'s birth Ms. [redacted] allowed [redacted] to remove [redacted] from the care of the paternal grandmother to live with [redacted] and her mother. Once [redacted] and [redacted] went to live with the maternal grandmother neither Ms. [redacted] nor the homemaker documented or evaluated who lived or stayed in the maternal grandmother's household.

On May 20, 1999 in the Assessment report accompanying the service plan Ms. McCottrell Wade stated:

> [redacted] Jr. progresses well in the home with [redacted] with no indication of abuse or neglect.... Currently she is living with her mother at her mother's boyfriend's public housing unit. It is a one-bedroom apartment. [redacted] and her baby sleep in the bedroom and [redacted] mother and boyfriend sleep in the living room. There is no other extended family involvement with [redacted] other than the mother that this worker is aware of.

A CANTS check on the grandmother would have indicated that [redacted] was a member of the household when [redacted] was investigated by DCP. When [redacted]'s oldest children were adopted the Children's Summary described the problems present at the time of custody:

> [redacted] allowed her children to urinate and defecate on the floor, and she and other family members cleaned it up only when being prompted by others. (The children) were put at environmental risk due to unsanitary conditions...bottles were found frequently unwashed and the children were found to be walking or crawling in feces. [redacted] and other family members where (sic) found frequently asleep during the day, and this left the children unsupervised.

Ms. McCottrell Wade noted the grandmother lived with her boyfriend but only his first name, [redacted] was listed in the records. A criminal background check was not completed on him.

Presence of [redacted]

Throughout the case there are references to the presence of [redacted]'s sister, [redacted] As noted earlier,

[redacted] sisters, [redacted] and [redacted] had all of their children removed from them. The Department indicated [redacted] in 1995 for the sexual abuse of her 2, 3 and 4 year-old nieces. [redacted] was convicted of attempted criminal sexual assault and sentenced to the Department of Corrections. She was released in 1998 and at the time of the A sequence investigation (involving [redacted]) was a registered sex offender. [redacted] had recently given birth to her first child, which DCFS took custody of a few weeks prior to the hotline call on [redacted]. Over the next several years Camille gave birth to three more children who were immediately taken into custody. [redacted] sequence investigation and the mental health records indicated that [redacted] sister [redacted] had lived with [redacted]. Case notes indicate that Ms. [redacted] was aware that [redacted] frequented the maternal grandmother's home. On March 23, 1999 [redacted]'s foster mother reported that she saw [redacted] and [redacted] with her mother and sister. Two months later on May 7, 1999 at 8:30 am when Ms. [redacted] went to pick up [redacted] for Dr. Collin's assessment Ms. [redacted] documented that [redacted] sister" answered the door and told her that [redacted] had spent the night at a friend's house. Ms. [redacted] [redacted] saw the baby. On the same day, May 7, 1999, the homemaker's case entry purports she was in the home from 8 am to 10 am and that she talked to [redacted] (see validity of homemaker's notes on page 13) "about her appearance and whether she was pregnant."

In October 1999 when Ms. [redacted] wrote a letter to DCFS outlining her concerns about [redacted] he also wrote of her concerns that [redacted], who had sexually abused a child, was living with [redacted] and [redacted] and that [redacted] had been raped by her mother's boyfriend. She reported that [redacted] mother and the mother's boyfriend were using [redacted] for her money as they were abusing drugs. During the same month Ms. [redacted] reported, "there are no issues of sexual abuse."

In January 2000 Dr. Collins conducted a psychological evaluation on [redacted] reported that her stepfather's brother sexually abused she and her sisters as children. [redacted] said she informed her mother of the abuse but [redacted] made no effort to protect them. She also reported that her mother's boyfriend sexually assaulted her in June 1999. By her account he placed a knife to her neck and threatened to kill her if she told anyone.[36]

On July 24, 2002, during a family meeting, Ms. [redacted] noted in her case record that [redacted] moved frequently from one place to another and that currently she was living with her sister [redacted] The caseworker noted that the maternal grandmother and her paramour were evicted (in 2001) and living elsewhere. [redacted] was supposedly living with them, though no specific address or names of people in the household were noted. The homemaker's notes during this time do not indicate anything about the eviction (in 2001) nor [redacted] or [redacted] whereabouts.

Boyfriend in the Home

In her (8/20/99) Psychological evaluation of [redacted] Dr. Collins[37] noted that [redacted] reported dating a man, [redacted], who stayed at her mother's home with her. Dr. Collins, describing examples of [redacted] verbal aggressions, quoted [redacted] as saying: "I curse my momma and stepfather out if they wake me up…I slam the door and cry…I say get out of my fucking room, [redacted]"

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[36] In the Madison Police report [redacted] did not mention a knife. [redacted] was questioned and given a polygraph which he passed. The States Attorney declined to prosecute.

[37] [redacted] initial appointment with Dr. Collins was on 4/30/99.

[redacted]lso reported to the psychologist that [redacted]drank heavily and encouraged her to drink. The psychologist concluded that because of the current substance abuse of her relatives and friends and their encouragement of [redacted]o drink alcohol, they are a "risk factor for Mrs. [redacted]and her children *if they are returned to her care"* (emphasis added). At the time of the assessment Dr. Collins was unaware that DCFS had left [redacted] infant in the care of [redacted]and her family.

On July 24, 2002 the caseworker noted that [redacted]and her boyfriend, [redacted]were planning to get a place. The record contains no CANTS or LEADS on him but an application for an apartment with [redacted]and [redacted]as applicant and co-applicant was in the DCFS file. The OIG conducted a LEADS check and found that [redacted]has an extensive criminal background including convictions for assault, larceny, robbery, burglary, and invasion of privacy charges and charges for homicide and weapons offenses. His last arrest was in December 2004 for driving on a suspended license. Ms. Sykes told OIG investigators that [redacted]was usually at the home and she often saw him drinking beer in the morning.

The Maternal Grandmother also stated that she and her paramour were going to get a place. Both [redacted]and maternal grandmother stated that they wanted [redacted]to live with them. [redacted]and the grandmother were instructed by Ms. [redacted] that whatever they intended to do they needed to do it now. There was no evaluation of the effect that this chaos had on [redacted]

Observations of Household Members by Mental Health Providers

In February 2001 following [redacted] psychiatric hospitalization, [redacted]nd her mother accompanied [redacted]or an intake interview. During the next four months mental health workers conducted regular home visits. They described the home as being dirty and disorganized with several people present (3/9/01) and having difficulty providing medication education discussions with [redacted]ecause of the large amount of people in the home (3/29/01). An April 2001 entry also noted "several people coming in and out. In March the record noted persons answering the door did not know when [redacted] was returning. In April [redacted]reported that she was spending the nights with her boyfriend ([redacted], who she met while hospitalized. At the end of April, the outreach worker described [redacted]s being inappropriately dressed for the weather (4/30/01). In May (5/14/01) she was described as looking disheveled.

Though Ms. Sykes did not document it in her notes, she told OIG investigators the home was often dirty. She described dirty dishes, food left out overnight, dirty floors and trash left out. Ms. Sykes said several people were in and out of the home and when she arrived they were sleeping in the clothes they had worn the day before. Ms. Sykes said there was never any improvement in the housekeeping. Ms. [redacted] described the home as marginal.

Permanency

This case was no closer to permanency in 2004 than it was in 1998. For five years, the recommended goal remained "Return Home within five months." But as early as October 26, 1999, the worker discussed with [redacted]e possibility of [redacted]residing with Ms. [redacted]on a permanent

basis. [redacted] became defensive. A few days later on October 28, 1999, the caseworker discussed permanency with the foster parent, who stated that she was not interested in keeping [redacted] on a permanent basis. By the following Spring (March 6, 2002), the caseworker noted: "[redacted] has become so much a part of the foster home that he states he doesn't want to go home." On March 27, 2002, the supervisor, homemaker and caseworker discussed case progress, which was described as slow to non-existent. All present agreed that unless progress was made in the next six months, an alternate goal for the family would have to be explored. In September 2002, after years of seemingly little progress Ms. [redacted] voiced her fear that [redacted] was getting lost in the system. She did not think [redacted] was going to be returned to his mother and she did not want to be considered an adoptive resource. Nothing additional was done to move this case towards permanency. In April 2003 the caseworker noted that [redacted] did not appear interested in visiting with [redacted] On May 27, 2003 the caseworker met with the foster parents to discuss adoption and subsidized guardianship. Mr. and Mrs. [redacted] again stated that they were not interested in either option. The following day the supervisor called the foster parents, they reiterated that they understood what subsidized guardianship was but felt that they could not give [redacted] what he needed because of their age. Ms. [redacted] stated that she hated for [redacted] to leave but it would be for the best. The supervisor stated that the worker would be looking for another home and would give Ms [redacted] notice when a home was found.

There were at least twelve ACR feedbacks (7 chronics, 1 critical, and 4 monthly) issued in this case prior to [redacted] death, with the same issues being repeated over and over (See Attachment A). [redacted] is, the East St. Louis site administrator and Lorene Floyd's supervisor, was copied on at least four (chronic 5/2/02; chronic 5/2/03; critical 11/12/03; monthly 12/17/03) of these reports prior to the death of [redacted] She was also copied on two reports following [redacted] death.

The first chronic in this case was issued in May 1999. At that time the chronic issue referred to a lack of documentation of a current physical and immunizations for [redacted] The next chronic was issued in November 2000. The chronic issue according to the reviewer had to do with lack of permanency for then five-year-old [redacted] The reviewer noted that [redacted] had been in foster care since November 1998 and continued to have a goal of return home. Mother was mentally retarded; lacked independent housing and the ability to obtain public housing due to an outstanding utility bill; and lacked the ability to parent effectively on her own. A psychological evaluation recommended parenting classes and counseling, but the worker felt that mother was too intellectually limited to benefit from either. In the meantime, the case remained Norman certified. Recommendations made by the reviewer included conducting a CANTS/LEADS check on mother's boyfriend because [redacted] kept talking about the possibility of living with him, and obtaining the psychiatric report completed on mother.

Six months later, in May 2001, another chronic was issued. The chronic issues were identified as the need to obtain psychiatric reports on mother and an Individual Education Plan (IEP) on [redacted] and to complete a CERAP. In November 2001, yet another chronic was issued. The chronic issue was again identified as an issue of permanency. The reviewer noted that [redacted] was being denied permanency as he had been in foster care since November 1998 with a continuous goal of return home. It was again noted that mother was mentally retarded, lacked independent housing and lacked

the ability to parent effectively on her own. Past plans for maternal grandmother to obtain Section 8 housing and for everyone to live with her did not materialize. The reviewer described the current plan, for mother's boyfriend to obtain housing in his name, as shaky at best. Mother was still unable to obtain housing because of the outstanding utility bill. The second chronic issue discussed by the reviewer had to do with the continuing need for previous feedback issues to be addressed including obtaining psychiatric reports on mother from her two previous hospitalizations, conducting a CANTS and LEADS on the boyfriend (who reportedly has some criminal involvement). It was recommended that the case be scheduled for legal screening.

In May 2002, a chronic was issued regarding the permanency issue and the continuous need to address previous feedback issues. Recommendations made by the reviewer included addressing the chronic issues and changing the permanency goal in compliance with a court order. In November 2002 another chronic was issued noting the same two chronic issues as discussed in the prior chronics. The reviewer again noted that the first chronic issue had to do with a lack of permanency for then seven-year-old [redacted] who had been in foster care since November 1998. Legal screening had finally been scheduled for 12/8/02. The second chronic issue had to do with the continuing need to address previous feedback recommendations including conducting a CANTS/LEADS check on mother's boyfriend, and obtaining past psychiatric reports on mother. In May 2003 a new reviewer issued a chronic in this case.[38] The reviewer noted:

> PERMANENCY ISSUES: CHRONIC FEEDBACK FOR UNMET SERVICE NEEDS PER LAST TWO CHRONIC FEEDBACKS OF 11/14/02 AND 05/02/02. INVOLVED WARD IN CARE FOR MORE THAN FOUR YEARS. LEGAL SCREENING NOT DONE AND LACK OF DOCUMENTATION EXISTS TO GET CASE APPROVED ONCE LEGAL SCREENING IS HELD. OBJECTIVE AND TASKS NEEDED FOR FATHER. VISITATION PLAN NEEDED FOR FATHER. DILIGENT SEARCH NEEDED FOR FATHER. MOTHER HAS BEEN WITHOUT HOUSING FOR FOUR YEARS AND RESIDES WITH FAMILY AND FRIENDS. MOTHER HAS CHILD HMP UNDER THE AGE OF 4 YEARS AND MOTHERS CARETAKER ABILITY IS SUSPECT. MOTHER RECEIVES APPROXIMATELY $700.00 PER MONTH BUT IS WITHOUT HOUSING. UNKNOWN HOW MOTHER WHO

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[38] In response to a May 2003 chronic feedback, Ms. M[redacted]e wrote to Lorene Floyd:

> In regards to the Chronic Feedback regarding [redacted]D #8503-99-02 dated 5/8/03 please be advised of the following: Permanency Issues: At the time of the administrative case review the [redacted] case had been previously scheduled for a legal screening but was requested by the persons in legal screening to be rescheduled due to a conflict in their availability to do the screening at the time that was set. As far as there being a lack of documentation to get the case approved, I believe that would be on the part of the legal department to decide once submitted. Therefore this worker nor the person that conducted the case review has any indication that information already obtained is insufficient for legal screening. Nevertheless, due to the fact that there is no father legally established in this case, nor has any person came forward to this worker nor the court advising of paternity, a diligent search was discussed. A diligent search is in the record from the time of case opening. However, no father is listed on the child's birth certificate and the child's mother has given a name of a[redacted]who she says lives out of state with no known address: 1) No one has established paternity; 2) where about of the name given is unknown to Department, and 3) there is no knowledge of any person who can verify any information in regards to the paternity of this child.

REPORTEDLY IS MENTALLY CHALLENGED USES MONTHLY FUNDS. RECOMMENDATIONS FROM PSYCHOLOGICAL EVALUATION AS DATED 8/20/99 NEEDS TO BE INCORPORATED IN CLIENT SERVICE PLAN, I.E., PSYCHIATRIC AND PSYCHOLOGICAL TREATMENT FOR DEPRESSION, ANGER MANAGEMENT, PROBLEM SOLVING, ALCOHOL ASSESSMENT, ETC. MOTHER REPORTEDLY VISITS WITH MINOR AT FHB'S HOME AND FHB NOT INTERESTED IN BECOMING ADOPTIVE RESOURCE. PERMANENCY COMMITMENT FORM NEEDS TO BE SIGNED BY FHB BEFORE LEGAL SCREENING IS HELD. MOTHER NOT MOTIVATED TO WORK CLIENT SERVICE PLAN AS SHE VISITS CHILD AT WILL AT FHB. WORKER REPORTS IN-PERSON CONTACT WITH MOTHER AT FHB. LEGAL SCREENING WAS TO BE HELD 12/02 AND WAS NOT HELD. INVOLVED WARD LOCKED IN FOSTER DRIFT WITH NO REAL PERMANENCY IN SIGHT.

The reviewer goes on to note:

SAFETY ISSUES: CERAP DONE AND LISTS CHILD AT HMP AS BEING "SAFE". CRUCIAL PARENTING ISSUES REMAIN UNRESOLVED. DOCUMENTATION OF MOTHER'S MENTAL STATUS NOT AVAILABLE. DOCUMENTATION VERIFYING CHILD IS SAFE AT HMP NEEDED SINCE MOTHER IS WITHOUT HOUSING AND LIVES FROM PLACE TO PLACE.

Several people were forwarded copies of this chronic, including [redacted]is, site administrator. [redacted]s confirmed that she had received a 2003 ACR feedback, though she did not specify chronic or critical.[39] She told OIG investigators that she became concerned. She met with the supervisor Lorene Floyd who told her that the ongoing issues discussed in the feedback were being addressed. [redacted]s told OIG investigators that she did not look into the matter any further because she took the word of the supervisor. [redacted] also told the OIG investigators that following a chronic issued on this case, she called a staffing with the caseworker, the supervisor, and the field educator. Ms. Dennis reported that the caseworker could not answer her questions, became upset and left the staffing. The caseworker subsequently went on medical leave. [redacted]told the supervisor to reassign this case. There was no further follow up.

A critical report about the lack of permanency for [redacted]was issued in November 2003. The 11/03 critical report warned:

CRITICAL ISSUES: PERMANENCY ISSUES: CLIENT SERVICE PLAN NOT PREPARED FOR ADMINISTRATIVE CASE REVIEW. PERMANENCY STAFFING (LEGAL SCREENING) NOT HELD. LACK OF PERMANENCY STAFFING HAS BEEN THE SUBJECT OF THE LAST TWO CHRONIC FEEDBACKS DATED 05/02/03 AND 11/14/02. [redacted]N CARE FOR FIVE YEARS AND IS NO CLOSER TO RETURN HOME NOW THAN FIVE YEARS AGO. DILIGENT SEARCH NEEDED FOR PARENTS. CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL NOT AVAILABLE (BUT REQUIRED IN THAT RETURN HOME GOAL IN EFFECT ON OPEN FAMILY CASE AND MOTHER HAS A FOUR YEAR OLD AT HOME). UNSURE HOW MINOR AT HOME IS DOING. MOTHER HAS MENTAL HEALTH ISSUES. MOTHER AT ADMINISTRATIVE CASE REVIEW AND MADE VERBAL THREATS TO STAFF. MOTHER EMOTIONALLY CHARGED AT ADMINISTRATIVE CASE REVIEW REFUSING TO TALK TO ADMINISTRATIVE CASE REVIEW STAFF OR DCFS STAFF. MOTHER APPEARED TO BE PREGNANT. CURRENT FOSTER PARENT NOT WILLING TO ADOPT IF MINOR IS EVER

[39] An ACR chronic feedback was issued in May 2003. In November 2003 a critical report was issued.

FREED FOR ADOPTION. FOSTER PARENT REPORTS MOTHER VISITS WITH CHILD WEEKLY AT FOSTER HOME. LEGAL SCREENING NEEDED ASAP. INTERIM ADMINISTRATIVE CASE REVIEW TO BE SCHEDULED.

SAFETY ISSUES: UNCLEAR WHERE MOTHER RESIDES. UNCLEAR WHO IS PROVIDING CHILDCARE TO MINOR AT HOME. CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL NOT COMPLETED. MOTHER OVERLY THREATENING AT ADMINISTRATIVE CASE REVIEW. CAUTION RECOMMENDED WHEN ADDRESSING SAFETY OF MINOR AT HOME DUE TO VERBAL THREATS MADE BY MOTHER AND MOTHER'S APPARENT MENTAL HEALTH ISSUES. ADMINISTRATIVE CASE REVIEW INTERIM TO BE SCHEDULED.

WELL-BEING ISSUES: FOSTER PARENT REPORTS PHYSICAL, EYE, DENTAL EXAMS CURRENT BUT NO DOCUMENTATION OF SAME. NO DOCUMENTATION AVAILABLE REGARDING IMMUNIZATIONS. FOSTER PARENT REPORTS WARD HAS HAD PERFECT SCHOOL ATTENDANCE FOR FOUR YEARS. DOCUMENTATION NEEDED FOR PHYSICAL, EYE AND DENTAL.

REVIEWER: WILLIS H. JENKINS

CC: WILLIAM PEYTON, RA
CRETORA BARNETT, ACR
MICHELEEN CORA, ACR
MARILYN ARNOLD, ACR
IRVIN WILLIAMSON, ATTORNEY
VENDETTA DENNIS, SITE ADMINISTRATOR

From February 1999 until present, DCFS Policy Guide 98.15 has dictated procedure to be used in order to assure follow-up, resolution, and tracking of critical and chronic issues identified in ACR feedback reports. According to Policy, a response is not required for monthly feedback. However, when a chronic or critical feedback is issued, the supervisor is to review the critical or chronic issue report with the assigned caseworker and develop a corrective action plan that incorporates a response to the feedback. The corrective action plan is to be completed and forwarded to the Field Service Manager within fourteen days after receipt of a critical feedback and thirty days after receipt of a chronic feedback. Field Service Managers are responsible for monitoring critical and chronic issue reports for follow-up with those caseworkers or supervisors who do not respond with a corrective action plan within the designated time frames. The Field Service Managers are to forward copies of corrective action plans to the appointed designee of the Deputy Director of Administrative Case Review upon receipt. Regional Administrators are to provide the Deputy Director of Program Operations with monthly aggregate data reports and corrective action plans for teams with recurring critical or chronic issues. Regional Administrators are also to have monthly discussions with the Deputy Director of Program Operations concerning the status of corrective action plans and disposition of critical and chronic issues. Unfortunately, reportedly, statewide there is only a 25% response to this Policy guide.

For the first time, in the November 2003 plan, the worker indicated that the case would be referred for legal screening. The case record indicates that the first attempt to take this case to screening occurred in 2003, five years after the case was initially opened.[40] Legal Screening was initially

[40] On October 24, 2002, there is a court order indicating that the goal is return home within five months, however, mother had not made reasonable progress and DCFS was to take the case to legal screening scheduled for November 13, 2002 in an attempt to terminate parental rights. There is nothing in the case record that indicates that this occurred.

scheduled in May 2003; however, the caseworker was contacted by DCFS Legal and informed that the case had to be rescheduled, as Madison County cases were only heard on certain days. A Legal screening form prepared by Cherri McCottrell Wade dated November 12,2003 was found in the case record. The first actual screening date was December 30, 2003.[41] Participants at the staffing were Cherri McCottrell Wade, DCFS; Ali Tolliver, ASA Madison County; Bernice Bell, Adoption Coordinator; Debra Moore and Irvin Williamson, Regional Counsel. The Permanency Staffing Committee determined that this case was not approved for filing a petition to terminate parental rights at that time because a clinical staffing was recommended, and the service plan did not address issues identified in the 1999 psychological evaluation. A month later the reviewer issued a monthly report noting that [redacted] had been in care for five years and legal screening was to be held 12/17/03 but was cancelled for the third time. A case staffing to address case deficiencies and foster care drift was recommended.

When questioned by OIG investigators about why it was so difficult to move this case, Ms. McCottrell Wade stated that because she was a reunification worker she was not familiar with the legal screening process and was only in front of the Judge one time. This case was one of the few that she took to legal screening. She told OIG investigators that in preparation for screening, she gathered all of the documents that she had been told by others, were necessary.

Ms. Floyd told OIG investigators that she was not providing close supervision to her follow-up cases, as she generally would have. She felt that poor supervision might have played a role in the outcome of this case. She related that the East St. Louis office started the paired team model in December 2001 after the Reunification program was eliminated. Prior to that Lorene Floyd was supervisor for follow-up cases only. Ms. Floyd stated that supervising investigators consumed a lot of her time; they had strict deadlines and often needed more immediate supervision. In addition she had to learn Rule and Procedure 300 and very few people in the office were familiar with DCP investigations. Ms. Floyd stated that her passion was in follow-up and she preferred working only on follow-up cases.

The supervisor and the caseworker told OIG investigators that part of the reason for not being able to change the goal from reunification was that they had difficulties navigating the Madison County court system. Being from the East St. Louis office they were more familiar with the St. Clair County Court system. Because [redacted] resided in Madison County at the commencement of the case, it was heard in the Madison County court. The caseworker and supervisor said they were rarely in front of the judge and the case was always continued. The OIG contacted the Madison County States Attorney but the State's Attorney was unable to confirm that the problems with changing the goal in the case were connected to continuances or scheduling of the case.

Ms. Floyd told OIG investigators that when the Reunification program was eliminated in 2001, they wanted to transfer this case to the Granite City field office. However, she claimed she could not

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[41] A screening packet prepared by Cherri McCottrell Wade, dated May 28, 2003 was found in the case record. However, there is no indication that a Permanency Staffing was held prior to the December 30, 2003 date. In the May 28, 2003 screening packet, the caseworker wrote that she did not believe termination of this mother's parental rights was in the best interest of this child. Her reasons were: "This is a mother who is parenting a child that is in her custody, (independent DCFS), and has maintained a strong bond with the child who is in DCFS care."

because of policy in the region, which prohibited transfer of a case with ongoing court involvement. Ms. Floyd stated that she did not push for transfer as hard as she could have as their office staff had established rapport with this family. Ms. Floyd stated that [redacted] did not trust the Department and was particularly fearful that the "white caseworkers" were trying to take her children. Ms. Floyd stated that if this case were transferred to the Granite City field office, [redacted] would most likely have a white worker, and she feared that this would have a negative impact on progression of the case. Ms. Floyd had developed a relationship with [redacted] would often call Ms. Floyd directly for clothes and other needs.[42] Ms. Floyd's presence was needed to get [redacted] to sign service plans after an ACR because [redacted] did not trust the Department ACR reviewers.

Sequence B/Death of [redacted]

On April 28, 2004 at approximately 8:20 p.m. [redacted] was complaining of abdominal pain. Her mother, [redacted], reportedly went to a neighbor's to call 911 and when she returned to the residence she found [redacted] on the couch saying that she had lost the baby while in the bathroom. [redacted] reported that she went into the bathroom to find the infant but was unable to locate her because there were no lights. Paramedics arrived and found the infant in the toilet and unresponsive. According to the police report, the paramedic, with a flashlight, could see the baby's knees, labia, and buttocks inside the toilet and could feel that the baby's head was totally submerged and face up at the bottom of the bowl. The infant was transported by ambulance to the hospital where she was pronounced dead. [redacted] told numerous people that she was five months pregnant. The infant to whom she gave birth was full-term. [redacted] (DOB [redacted]) died [redacted] from Postpartum Neglect with Positional Asphyxia following vaginal delivery into a toilet. Following [redacted] death, [redacted] was hospitalized at Gateway Regional Hospital Kettler Center after she became belligerent and uncooperative with the OB/GYN, Dr. Wasserman.

[redacted] death was taken as a B sequence report. CPI Jennifer Kitzmiller was the assigned investigator from the Granite City Field Office. Police were called to the home to investigate a child death. Law enforcement described the home in their report as "the house was cluttered and in disarray and had a filthy appearance." It was reported that the residence had a strong odor of a combination of bleach, feces and urine throughout. The water had been turned off to the residence and the toilet was full of urine and feces. There were no light bulbs in the receptacles as it was reported that there was a short in the electrical and the lights would cause the house to burn down. The police officer stated that the home was in "horrendous" living condition and he felt it was an unsafe environment. The police observed the environment and took photographs. The crime scene investigator documented that "The kitchen and bathroom were in a state of despair. (sic)" Maternal grandmother reported to law enforcement that the landlord of the residence had told her that there was an electrical short in the wiring and the use of lights had the potential to cause a fire. According to [redacted] she would turn the water on from the water main, fill milk jugs with water, and then turn

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[42] There were periods during the case when the caseworker was on medical leave. The caseworker was on medical leave for several weeks during the summer of 2003. Caseworker Cathy Lang visited Ms. [redacted]'s foster home August 11, 2003. Ms. McCottrell Wade again went on medical leave after she was involved in a serious car accident in March 2004. She was on leave at the time of [redacted] death.

the water off at the main so the bill wouldn't be high. [redacted] boyfriend, told law enforcement that because the water was not on, they would take gallon milk jugs to neighbor's houses and fill them up. They would dump the water into a "Chitlin" pot and use that to flush the toilet. The gas to the stove had been turned off. They would use a kerosene heater when it was cold.[43]

Protective custody was taken of [redacted] on April 29, 2004. An Illinois State Police officer described Emmit as being "underdeveloped." The officer reported that this five-year-old was still in diapers and spoke no words. He did not believe that the child was safe and felt that he should be removed from the home. Illinois State Police assumed investigative responsibility for the case after a request by the Venice Police Chief.

Illinois Mentor supervisor Andrea Schickedanz told OIG investigators that they have had responsibility for [redacted] since he came into the system in April 2004, however, they did not get the full case record, including a request for a copy of the investigation that brought [redacted] into care, from the Department until mid-January 2005, and only after getting Agency Performance Team (APT) involved. They also assumed responsibility for [redacted]'s case. Initially, Illinois Mentor was given just basic information, including a social history written before the birth of E[redacted] with no updates. [redacted] was not part of the case record. It was as if he did not exist. Ms. Schickedanz told OIG investigators that the DCFS supervisor, Lorene Floyd, told them that there was no relationship between [redacted] and [redacted] therefore, not to worry about visitation, and [redacted] foster mother would not approve. Ms. Schickendanz further informed the OIG investigators that DCFS took the case to legal screening in November, however, it did not pass because DCFS again failed to incorporate recommendations from the 1999 psychological, specifically [redacted] inability to parent, and did not include [redacted] in the screening packet. DCFS told the Illinois Mentor caseworker that there was a new screening date of February 1, which had never been scheduled. Illinois Mentor plans to schedule a legal screening date for both boys.

In the DCP investigation Ms [redacted] was indicated for environmental neglect, inadequate shelter, and death by neglect. The rationale for not indicating [redacted] for environmental neglect and inadequate shelter was that "[redacted] was the caregiver of [redacted]" "[redacted] is being unfounded because she was not in the caregiver role. Therefore, [redacted] is an ineligible perpetrator." PSA Ann Dingwell agreed with this finding. On April 30 2004 there was a discussion between the supervisor and the CPI that [redacted] must be removed from the unsafe environment. An investigation note dated April 30, 2004 stated: "This family is well known by DCFS and extended family will not be able to provide safe placement for this child. Supervisor instructed Ms. Kitzmiller to go to the home with the police. [redacted] cannot stay in the custody of [redacted] or [redacted] because of the seriousness of what the police found in the home." At the time of [redacted] death and at the time that [redacted] came into care, Ms. [redacted] was on medical leave..

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[43] This residence was the one that had been seen by the caseworker in February or March 2004 about a month prior to the death. Also, in a case note dated October 14, 2003, Ms. McCottrell Wade describes the house as "a shot-gun type house (straight through). It is an enclosed porch, living room, and what appears to be a dining room converted into a bedroom, kitchen, bath." The worker goes on to note in the 10/03 entry that all utilities were operable during this visit and that [redacted] reported that her brother owned the house.

Standards in the Training of at Risk Developmentally Disabled Parents.

Literature in the 1980's (Seagull and Scheurer, 1986) described increased risks to parents with retardation when their family background was chaotic and abusive. Studies in the 1990's supported a relationship between risk and support systems. Tymchuck (1993) found that an IQ below 60 could be a predictor of neglect, especially, if there is an absence of suitable societal or familial supports. Feldman (1998) expressed the opinion that concerns about the parenting of persons with mental retardation center on physical and psychological neglect more than abuse. More specifically, literature[44] reports that there is increased risk of neglect when there is a combination of risk categories: lack of reading skills that make parents incapable of consulting printed material for directions or help, for example being unable to read medication labels; concrete thinking that may limit the parent's repertoire of skills or techniques, for example playing games that the parent enjoys that are too far above or below the child's ability; a lack of knowledge, problem solving and adaptability for health care, safety and emergency situation-for example insisting on a certain course of action that is not relevant or that may be harmful to the child; and lack of stimulation that leads to lack of knowledge and cognitive development of their children.

Teaching parents with developmental disabilities minimally requires hands on training with demonstration, coaching, and modeling in incremental steps with reinforcements throughout. Skill development should be reliably measured. Typical observation measurements included baseline of whether the individual does (or could do) the task without help or supervision-adaptive behavior scales. Functional observations on daily life, personal living, community living, social and communication skills are usually rated on a four point scale i.e. never or rarely, does but not well-25% of the time-may need to be asked, does fairly well-75% of the time –may need to be asked and does very well, always or almost always-without being asked. Without initial measurements and ongoing measurements it cannot be ascertained whether the training is effective. These observations and measurements are considered to be part of the standard practice in interventions with the developmentally-delayed population.

Impounding & Allegations of Tampering

Shortly after the impound notice precipitated by the death, concerns were raised about possible tampering of the records. Specifically concerns focused on case note entries and the length of time it took the field office to send the original case record to the OIG. A case note with a contact date of February 11, 2004 states "Caseworker asked [redacted] whether she was pregnant" was created on May 2, 2004 after the death. Ms. McCottrell Wade told OIG that she could not recall asking [redacted] about her pregnancy but she may have because she would sometimes ask because [redacted] always looked pregnant.[45] Ms. McCottrell Wade said she did not enter that note into SACWIS because she was on leave at the time of the note's creation. She stated that she would write notes in a notebook and someone else may have entered it into the computer on the May date. Ms. Floyd told OIG

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[44] Llewellyn, 1997;Tymchuck, 1997; Rosenberg and Mc Tate, 1982; Kaatz,1992;Feldman, 1998; Llewellyn, 1995;
[45] The caseworker, the supervisor and the homemaker independently stated that [redacted] "always looked pregnant" during interviews with OIG investigators.

investigators that after the death she found a legal pad in Ms. McCottrell Wade's office with handwritten case notes regarding the [redacted]ase. Ms. Floyd stated that she gave the notebook to secretarial staff and instructed her to enter the notes in SACWIS. After the entries Ms. Floyd readied the case to be sent. The fact that there were entries after the death should have been noted on the Statement of File Integrity since the information added was from events before the death.

In return home cases CERAPS are required to be completed before the ACRs. At the time of the November 2003 ACR, a CERAP did not accompany the service plan. In the record there is a CERAP with a date of November 12, 2003 and an assessment date of April 24, 2003. On the signature page the date of May 2, 2003 has a line through it and the date of November 12, 2003 added. Neither Ms. McCottrell Wade nor Ms. Floyd could answer why the CERAP was not with the service plan. Ms. Floyd stated that sometimes if the CERAP did not change they would copy it and change the date. Ms. Floyd stated she did not add the CERAP after the death.

Finally there were concerns about the worker signing for the supervisor on service plans and case notes. The caseworker told OIG investigators that she has signed for her supervisor in the past with Ms. Floyd's permission or if she was the TA (Caseworker III). Ms. Floyd confirmed this noting that there was a period when she was out on medical leave.

Though not part of the concerns noted about the record, OIG investigators found that case entries between June 2000 and August 2001 were missing from the record. Both the supervisor and the caseworker stated that there were notes done during that time period and were surprised to learn that there were no notes for that time found in the case record. The caseworker did not know why they were not in the record. The supervisor explained that the clerical who did the filing for the team would remove duplicates from the file and shred them. In fact Ms. Floyd had seen the clerical shredding duplicates at one time and stopped her. Ms. Floyd kept boxes of papers. OIG investigators along with Ms. Floyd examined the boxes and while duplicates of service plans were found, the notes were not found. Ms. Floyd hypothesized that the notes had accidentally been labeled as duplicates and destroyed.

Because of the lack of notes there is no documentation as to the activities of Ms. McCottrell Wade during that time period, which included [redacted]sychiatric hospitalizations. Ms. McCottrell Wade told investigators that she visited [redacted]hile in the hospital and took signed releases of information to [redacted]outpatient mental health provider and left the releases. Copies of the releases are not contained in the legal section of the file. Hospital records do not note any visits made by the caseworker to the hospital during either of [redacted]hospitalizations.

ANALYSIS

The critical question posed in this case was could this mother who is developmentally delayed and mentally ill parent her children? The clinical answer was no. Despite Dr. Collins' well-articulated answer the supervisor and caseworker chose to ignore the response to this question. The impulsive young mother was neither monitored nor received needed mental health treatment. Her child at home was not afforded the early intervention desperately needed for his developmental delays.

[redacted]ingered in foster case for five years without any progress towards permanency.

While the ACR critical and chronic feedback reports portrayed a mother not cooperating in mental health services, the case notes depicted a mother living with a supportive family member trying to get housing, but otherwise caring adequately for a child at home. The documentation was vague and there was little attempt to corroborate self-reporting. The service plans were poorly written and did not address the real issues or problems facing the family. Vital information was never utilized such as that contained in the 1999 psychological evaluation, or even obtained, such as that in [redacted] special education assessment and information on J[redacted]s psychiatric hospitalizations. The case had inappropriate actions and failures to act, but was mainly plagued by the inactions. There are critical turning points in the case that should have prompted further action and changes in assessment. Those points include the birth of [redacted]nd [redacted]eaving [redacted]home; the psychological evaluation; the psychiatric hospitalizations and the eviction of [redacted]and [redacted] All the reasons for which [redacted]was taken into custody presented risk to a newborn. Additional information only added to the risk factors.

Since [redacted]was homeless when the case began the case was treated as though the primary issue was a need for permanent housing. Services provided to [redacted]were directed at her obtaining her own apartment or obtaining an apartment with her mother who had not proven any more proficient in maintaining stable housing. [redacted]efused to discuss budgeting with the homemaker although a large utility bill was a major barrier to [redacted]obtaining housing. A payee for [redacted]uch as Chestnut Health, was not considered. Chestnut was attempting to address [redacted]housing need but the agencies did not share information. Communications between DCFS and the mental health agencies would have been helpful.

The caseworker and supervisor described [redacted]as being cooperative and making progress. An assessment attached to a service plan stated that [redacted]was capable of doing most things for herself. Yet during the five years of case documentation, [redacted]showed that she could not manage her mental health care, finances, housing and, by DCFS' own admission, could not parent on her own. The caseworker's statement about [redacted]successful handling of her finances in the response to the November 2003 ACR critical review was based on [redacted]self report as the homemaker had been dismissed months earlier. The only task [redacted]effectively completed was visiting [redacted]in the foster home. When the inconsistencies were pointed out to the worker and supervisor, they agreed but could offer no explanation.

The Department failed [redacted] for the first five years of his life. The caseworker and supervisor did not deny that they had some responsibility toward [redacted]but the focus was on [redacted]Staff at the hospital where [redacted]was born three months after [redacted]was taken into custody contacted the caseworker. The worker told the hospital that if they did not have concerns the Department had no legal relationship with the infant. Despite the Department's having worked with the mother, seeing no improvement, and having information from the A sequence investigation, the caseworker left the assessment of [redacted]ability to parent [redacted]p to hospital personnel who had been involved with the mother for a couple of days. If the worker was not going to assess the situation herself, she should have directed the hospital to call the hotline or called the hotline herself.

RECOMMENDATIONS

1. Lorene Floyd should be disciplined for her failure to ensure the caseworker was appropriately assessing and servicing the case, and moving the case toward permanency.

Attachment A: Chart of ACR Feedbacks

ACR Date	Feedback	Reviewer	Issues*
2/4/99	Monthly (90 day ACR)		• Mother mentally retarded • Recently gave birth to another child • Mother is reportedly too limited to participate in regular parenting • Psychological evaluation is recommended to assess mother's parenting capabilities and current level of functioning
5/20/99	Chronic		• Mother mentally retarded • Mother is without housing • Lack of documentation of current physical and immunizations on [redacted]
11/8/99	Monthly		• Mother is without independent housing • Concerns regarding mother's ability to care for her children without support • Mother referred for public housing but not eligible due to outstanding utility bill in the amount of $2400.00 • Need diligent search on father
5/5/00	Monthly		• Mother is without independent housing • Continuing concerns regarding parenting skills • Mother mentally retarded

			• Obtain psychiatric information on mother from St. Elizabeth's Hospital • Verify whether additional school testing was done on Shaquille and if so obtain documentation • Need CANTS/LEADS check on mother's boyfriend • Need diligent search on father
11/9/00	Chronic	Jacqueline Huch	• Five year old in foster care since 11/98 lacks permanency, continues to have return home goal. • Mother mentally retarded • Mother lacks independent housing & lacks ability to parent effectively on own; mother can't obtain housing due to outstanding utility bill; plan for mother's boyfriend to obtain housing in his name is shaky at best. • Need CANTS/LEADS check on mother's boyfriend • Need mother's psychiatric reports • Need diligent search on father
5/11/01	Chronic		• Need mother's psychiatric reports • Need to obtain current IEP on [redacted] • Need to complete CERAP
11/15/01	Chronic	Jacqueline Huch	• Mother mentally retarded • Mother lacks independent housing & lacks ability to parent effectively on own • Need CANTS/LEADS check on mother's boyfriend (who reportedly has some criminal involvement) • Need mother's psychiatric reports (from 2 prior hospitalizations) • Need diligent search on father • Need [redacted]s school report • Need to schedule legal screening • Need current dental on [redacted]
5/2/02	Chronic	Jacqueline Huch	• This is ACR #8, [redacted]as been in foster care since 11/98 with a continuous return home goal • Mother mentally retarded • Mother lacks independent housing & lacks ability to parent effectively on own; past plans for MGM or BF to obtain housing did not materialize; mother cannot obtain housing on own due to outstanding utility bill ($2400). • Need CANTS/LEADS check on mother's boyfriend • Need mother's psychiatric reports • Need diligent search on father • Need [redacted] school report • Need current physical/dental/eye/hearing exam • Need to complete CERAP • Need to change permanency goal in compliance with current court order cc to various people including Vendetta Dennis
11/14/02	Chronic	Jacqueline	• Mother mentally retarded

		Huch	• Mother lacks independent housing & lacks ability to parent effectively on own • Need CANTS/LEADS check on mother's boyfriend • Need mother's psychiatric reports • Need diligent search on father • Need [redacted] school report • Need current dental/eye/hearing exam • Need to complete CERAP • Legal screening scheduled for 12/8/02
5/2/03	Chronic	Willis H. Jenkins	• Chronic feedback for unmet service needs per last two chronic feedbacks of 11/14/02 and 5/2/02 • [redacted] in care for more than 4 years • Legal screening not done and lack of documentation exists to get case approved once legal screening is held • Need diligent search on father • Mother without housing for 4 years, resides with family and friends • Mother has child home under the age of 4 years and mother's caretaker ability is suspect • Psychiatric evaluation records need to be incorporated in service plan, i.e., psychiatric and psychological treatment for depression, anger management, problem solving, alcohol assessment, etc. • Need [redacted] school report • Need current dental/eye/hearing exam • Crucial parenting issues remain unresolved. Documentation of mother's mental status not available. Need documentation verifying child is safe at home since mother is without housing and lives from place to place. cc to various people including Vendetta Dennis
11/12/03	Critical	Willis H. Jenkins	• Client service plan not prepared for ACR • Legal screening not held, needed ASAP • Lack of permanency staffing has been the subject of last 2 chronic feedbacks • Need diligent search for parents • CERAP not completed • Unsure how minor at home is doing • Mother has mental health issues • Mother at ACR, emotionally charged, made verbal threats to staff, caution recommended when addressing safety of minor at home • Unclear where mother resides or who is providing care to minor at home • No documentation re physical/eye/dental/

			immunizations • Interim ACR to be scheduled cc to various people including Vendetta Dennis
12/17/03	Monthly	Willis H. Jenkins	• [redacted] care for 5 years; legal screening to be held 12/17/03 but was canceled for the 3d time • No documentation that recommendations from psych evaluation of 8/20/99 have been pursued, mother's mental health basic reason child came into care • Case staffing recommended to address case deficiencies and foster care drift • Permanency review hearing needed asap • Unknown but suspected that MGM provides primary care to child at home cc to various people including Vendetta Dennis

* This chart contains repeat issues; not every concern addressed in the feedbacks is included in this chart.