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File No: **2016-2602**
Subject: **Homicides of Wards**
Date: **April 15, 2016**

INTRODUCTION

The murder of Laquan M has become a catalyst for reform within the Chicago Police Department and the Cook County States Attorney's Office. His death should also cause pause for the Department of Children and Family Services and be a catalyst for change within the child welfare and juvenile justice systems. Laquan was one of 11 youth who were in the Department's care when they were murdered in FY2014 and 2015. With the exception of Laquan, the youth in this cohort were the victims of peer street violence. The Office of the Inspector General conducted a cohort investigation on these killings. Most of the youth lived and came from severely economically disadvantaged neighborhoods. The structural and environmental factors in these neighborhoods create and reproduce urban poverty. Most of the youth struggled in school with poor reading and math scores that were identified early on without meaningful interventions. The families in their neighborhoods face the toxic stress of guns and gang violence. The inequities inherent in these neighborhoods include failing schools, lack of economic opportunities, and paucity of recreational and other supportive social institutions. While the city of Chicago acknowledged that a safe passage was necessary to get children to and from schools, no one assured that safe passage was arranged for children to engage in recreational or supportive educational programs. While there are resources in these communities, such as The Boys and Girls Clubs of Chicago, these agencies receive no public funds to provide safe transportation despite the daily sounds of gunfire. The Department is well aware that as early as the third or fourth grade, if its children cannot read or keep up with math abilities of their classmates, the likelihood of the child dropping out of school increases exponentially. Gangs become an attractive avenue when a youth faces school failure. While Title XIX (Medicaid) funding can provide some support for interventions, it will not support either prosocial recreational programs or safe passage, and so is an insufficient remedy to the lure of gangs and guns in disenfranchised communities. Four of the youth in this cohort who lived in these high-risk neighborhoods came back into the Department's care after disrupted adoptions or guardianships. Sadly, three of the relative caregivers requested the youth's removal when the family became frightened by the youth's gang involvement and access to guns. The fourth relative caregiver passed away. While two of the families requested adoption/guardianship service assistance, the interventions neither addressed the child's academic vulnerabilities nor the lure of the gangs**.**

Many of the youth in the cohort had access to guns and as one explained, when he had his gun on him, "I get respect." With the exception of Laquan who used hard drugs (PCP), and the very youngest of the cohort who had no substance abuse problems, all of the youth used marijuana almost daily. Marijuana and alcohol can deaden the humiliation from school failure while contributing to further academic failure. It can soften the toxic effects of an environment besieged with violence while putting the individual in harm's way. Two youth who had completed substance abuse treatment voiced realistic concerns about relapse if returned to their previous placements. Neither was given the opportunity for young adult substance abuse transitional living programs.

The Chicago Reporter recently described the high rate of unemployment in many of these neighborhoods as a product of a perfect storm of issues including disinvestment, poor public schools, and high incarceration rates.[1] The majority (9) of the youth in this cohort were 18 and older, entering young adulthood with no employment skills. Only two had held jobs, and even then, they were only for a few weeks. The majority had been involved with the juvenile justice system, with some moving to the criminal justice system, thus heading towards lessening employment opportunities. The Department does not contract with existing resources such as the Isaac Ray Center and the Safer Foundation for mental health and employment resources, despite their expertise with this population.

The Office of the Inspector General previously recommended violence prevention programs and interventions for violent youth offenders to the Department. Many Department of Juvenile Justice agencies have implemented aggression replacement and moral reasoning programs to enhance the concept of restorative justice. The Office of the Inspector General has issued numerous Investigative Reports on violence. Following the murder of a female ward by another female ward, the Office of the Inspector General recommended that the Department determine the size and scope of its violent youth population and those youth at high risk for violence in order to intervene effectively while assuring the safety of the community. Tragically, the single female in this FY2014-15 cohort mirrored the previous Inspector General's investigation. She was violent, mentally ill, abused substances, was involved with adult criminal court, and so threatened other youth in her living site that orders of protection were filed. She was murdered while she was violently attacking a citizen.

As late as June 2015, the Office of the Inspector General repeated its recommendation that the Department needs to consider not only the safety and accountability of its young adults but also the safety of the community:

> The Department should develop a violence-free stabilizing center for the older youth (over 17) involved with the criminal court system or dually involved with adult and juvenile courts. The programming of the shelter should model a Safer Foundation approach. The staff should work with Cook County Sheriff, Criminal Court personnel and Probation. The stabilizing shelter should clearly define a no violence contract with each youth who enter the program. If the terms of the shelter's non- violence contract are violated the Department should immediately

[1] Lynch, L.R. (2016, March 29). On Chicago's West Side, no rebound from the recession. *The Chicago Reporter*. Retrieved from http://chicagoreporter.com/on-chicagos-west-side-no-rebound-from-the-recession/

inform the Juvenile Court and Adult probation of the violation and the intention of the Department to request termination of the youth's wardship.

EXECUTIVE SUMMARY

This report examines the homicide deaths of 11 DCFS wards killed during FY 2014 and 2015. A brief synopsis of each youth's case is provided with an appendix of more detailed reports on each youth. Following the synopses are an analysis and recommendations.

RO

In the early evening of January 25, 2015, 14-year-old RO was murdered at 7:26 p.m. in Riverdale, a southern suburb of Chicago where he lived in a specialized foster home. A short time after RO's death, two suspects, ages 19 and 20, were arrested and charged with his murder. They are currently awaiting trial in the Cook County Jail. RO had been scheduled to transfer to a new foster home the week after his death because his foster parent at that time was in the process of moving out of state.

RO first came to the attention of DCFS in 2010, when he was 10 years old. He, his parents, and five younger siblings were found to be living in unsafe conditions in an abandoned house in Maywood. All of the children, including RO, were placed in protective custody. A subsequent medical examination revealed that RO and his siblings had been subjected to significant physical abuse. The parents were later found to be depressed and the mother had an IQ of 65. The children were all placed in foster care at SOS Villages. RO's case was subsequently transferred to a private specialized foster care agency for case management after he was placed in specialized foster placement.

RO had a history of psychiatric diagnosis and medical issues. Prior to DCFS involvement, he was also diagnosed with Lead Poisoning in 2006 and was diagnosed with Type II Diabetes in October 2009. The DHFS records available to the Department do not indicate how these were treated and if follow-up testing was done.

An IEP completed in 2010 indicated that RO had a full scale IQ of 89, with a significant differential between his verbal score of 96 and his performance score of 83. His achievement test scores at that time were very low: 1.1 in Reading and 2.6 in Math. It was intimated that he had not attended school for the year leading up to his entry into DCFS custody. RO received special education services, with a primary disability of Emotional Disorder, and had an IEP at school. The caseworker attended IEP meetings and noted that RO was going to be meeting with a teacher after school for extra help. In December 2013, test scores indicated that his Reading level had risen to 4.4 but his Math score had declined to 1.3. The school district decided to hold him back in 8th grade against the school social worker's recommendation.

According to law enforcement, RO was a casualty of a dispute between two breakaway factions of the Gangster Disciples street gang, who were operating in Riverdale. Law enforcement questioned whether RO was gang involved. However, a lieutenant of the Riverdale PD, knew RO through his off-duty work as a security guard at RO's middle school. The lieutenant identified RO's body at Christ Medical Center. The lieutenant stated that while RO might have been involved in some ill-advised activity on social media, he was not involved in any gang

activity, nor was he prone to aggressive behavior. The lieutenant stated that RO was visiting a friend at a housing complex where rivals of the suspects charged with RO's murder are known to live. RO is the youngest of the victims in this report, and it appears that of this group, his personal behavior contributed the least to his being at risk for this type of violence; his victimization was more related to the community factors where he resided. He was doing well in foster placement at the time of his death. Statistically, African-American youths in RO's community are equally at risk for this type of street violence.

MP

Seventeen-year-old MP was shot to death on June 30, 2014, one block from the home of his godparent. The police reports described him as having been engaged in conversation with several unknown assailants who were in a black van. A second victim, the son of the godparent, was wounded but survived.

The family came to the attention of DCFS in July 2007 when the mother was indicated for inadequate supervision. The mother had left the children with their father, who was unable to care for them. A second report came in on January 16, 2008, when a hospital social worker notified DCFS that the mother was not providing medical care for MP's younger sister. The mother was indicated for medical neglect. An Intact Family Services case was opened and closed within months, on March 27, 2008. The mother was again indicated for medical neglect in November 2011. A second Intact Family Services case remained open until April 25, 2012; that same day the hotline received a report that the mother had abandoned the children. Fifteen-year-old MP and three younger siblings came into the care of DCFS on April 25, 2012. The mother was indicated for inadequate supervision and temporary custody was granted on April 30, 2012. MP's parents were declared unfit at a neglect hearing in DuPage County on November 20, 2012. His mother remained homeless and she died in June 2013.

MP's case was assigned to a private child welfare agency. He was placed in the relative foster homes of his aunt and grandmother, but did poorly in both homes, with behavior problems and runaways. On June 15, 2012, the grandmother refused to allow him back into her home. Although he had moved MP regularly visited his grandmother's house where his siblings lived. He was moved to the home of his godmother, an unlicensed placement. He stayed there intermittently until his death. Ms. H's son, Ramone H had been on probation in the DuPage County. A Social Investigation completed by DuPage County Juvenile Probation Department indicated that Ms. H had a continuing alcohol problem including a conviction for a DUI. She also had been on Court supervision for a battery charge.

For a brief period, the godparent moved to Indiana and MP was placed in Glendale Heights in the home of his aunt and her husband, an unlicensed relative placement. MP had a difficult time adhering to rules and expectations in his aunt's home. His aunt stated he could be seen on Facebook flashing gang signs. Once Ms. H relocated back to Chicago, on the southeast side, both MP and his godmother requested his placement back with the godmother. MP began visiting the godmother's home on weekends.

MP involvement with Juvenile Justice began when 16 year-old MP was charged with misdemeanor Battery and had to appear in Court in DuPage County. He was charged with attempted robbery later that same year.

In February 2014, 17-year-old MP returned to his godparent's home. The caseworker continued to have concerns. During a visit on March 5, 2014, she smelled marijuana and suspected MP was high. At a status hearing on April 29, 2014, the Court Appointed Special Advocate expressed concerns about MP's gang involvement and the area of Chicago in which he was living.

MP continued to attend a therapeutic day school, an off-campus site of High School while living in Chicago. He was in an off-campus program because he had been previously expelled from High School for possession of marijuana. For a few weeks, MP also had a part time job at a restaurant. The agency provided transportation to and from school. MP graduated from High School in June 2014, shortly before he was murdered. Ms. H's son, Ramone was with MP when he was killed. Ramone left the scene of the murder and was found with a gunshot wound by the police and transported to the hospital.

Laquan M

A Chicago Police Officer shot and killed 17-year-old Laquan M at approximately 9:58 p.m. on October 20, 2014, near 41st and Pulaski in the city of Chicago's 8th Police District. The officer who shot Laquan has been charged with First Degree Murder.

Laquan's mother, a DCFS ward at the time, was 15 years old when she gave birth to him on September 25, 1997. The mother and her siblings became DCFS wards less than a year earlier when their mother gave birth to a substance-exposed infant. The maternal grandmother had a long history of drug abuse and an extensive criminal record and gave birth to her first child at 13 years old. Laquan's mother spent some time in foster homes, including the home of her maternal grandmother. The teen parent received services through Lawrence Hall when Laquan was born. She gave birth to his sister three years later, in March 2000.

Seven months later, the mother left Laquan and his infant sister home alone. Laquan's sister severely burned her leg on a radiator. The mother was indicated for inadequate supervision and Laquan and his sister were taken into care. They were placed in several foster homes, including the relative foster homes of the paternal great-grandmother and that of the maternal great-grandmother. The court returned both children to their mother in May 2002.

Thirteen months later, in June 2003, the Department indicated the mother for physical abuse after she and her boyfriend beat Laquan in front of staff at his daycare center. Protective custody was taken of Laquan and his sister on June 10, 2003. They were placed in a traditional foster home. A month later, they were moved to the relative foster home of their great-grandmother, Goldie H, after Laquan reported that he had been sexually abused in the foster home.

On June 24, 2003, DCFS vacated guardianship of Laquan's mother when she turned 21. She continued to receive services as a parent. Laquan and his sister remained in the home of their great-grandmother. The mother struggled with homelessness and substance abuse and did not

visit consistently. On September 12, 2006, a permanency goal of subsidized guardianship was established for Laquan and his sister.

On January 28, 2008, guardianship was established with their 74 year old great-grandmother. She received $422 a month. The great-grandmother's daughter, Laquan's great-aunt, was established in court as the backup caregiver.

After DCFS involvement ended, Laquan continued to have behavioral issues in school and home. Laquan had consistent problems in school with truancy, behavioral issues and poor academic achievement. He finished elementary school at Montefiore, a school designed for children with academic and behavioral problems. He did poorly in high school. He was assigned to an alternative school for ninth grade. Laquan had suspensions and expulsions. He received special education services when present at school. He began using substances by the age of 12 when he reported beginning daily use of marijuana. He also used PCP.

Laquan was first arrested at age 13 for drug possession. On September 3, 2012, he was placed on 18 months of probation on a juvenile petition for Possession of a Controlled Substance. Two petitions for violation of probation were filed, one of which resulted in Laquan being sentenced to an additional year of Intensive Probation on August 8, 2013. The second violation recommitted him to probation on September 23, 2014, 27 days before his death. While he was involved with the Delinquency Court, Laquan had several warrants issued for his arrest. He also spent a significant amount time in the Juvenile Detention Center.

In August 2013, 15 year old Laquan's great-grandmother passed away. Laquan was released from the Juvenile Detention Center to see her before her death and to attend the funeral. Immediately after, he cut off his electronic monitoring bracelet and went on run. When he was apprehended, he was once again placed in the Juvenile Detention Center. According to an integrated assessment, Laquan's mother reported to the Department that the great-grandmother had died and she was requesting that the subsidy be transferred to her as Laquan was now staying with her. In October 2013, the mother petitioned the court to have him returned to her custody. Despite having been named in 2008 as the back-up caregiver, the great aunt told OIG investigators that the Department did not contact her regarding Laquan and his sister being placed with her. The court date was continued and in January 2014, the court found the mother unable and returned Laquan and his sister to the custody of DCFS.

From January to May 2014, Laquan remained in detention. His sister was placed in the relative foster home of their 26-year-old maternal uncle. Laquan joined her there after he was released from detention. Laquan was referred to the Regenerations Program of Lutheran Child and Family Services. In September 2014, he was enrolled at Sullivan House, an alternative high school. Between his enrollment date of September 1, 2014 and his death on October 20, 2014, he was suspended twice. Laquan continued his involvement with Bobby Wright Clinic for services but was inconsistent after he moved to his foster home. Two weeks before his death, his caseworker took him to an intake appointment for services. He was scheduled to begin twice-weekly services, but had not started before his death.

The uncle's home remained Laquan's official placement until the time of his death. He was also spending a significant amount of time with his mother. Laquan's younger sister was returned to the mother's custody approximately one year after Laquan's death.

JS

Eighteen-year-old JS was murdered at approximately 7:30 a.m. on August 6, 2014. He was shot 12 times in front of the home of his grandmother and aunt on the southwest side of Chicago. His murder remains unsolved, but police believe it may be gang related. Police reports indicated that he was a member of the Brick City faction of the Black Disciples street gang.

Between December 2011 and April 2012, the Department initiated four child protection investigations on his mother. Two were indicated and two were unfounded and have been expunged. In April 2012, while JS and his older sister were at school, their mother moved with the two youngest children to a new home and did not inform the older children. During the investigations, his mother reported that JS vandalized the apartment and she was facing eviction. She also reported he was refusing to take medications. Prior to DCFS involvement, JS was psychiatrically hospitalized in 2008 for aggressive behavior at both home and school. He was hospitalized again in 2011 and diagnosed with Mood Disorder NOS and Impulse Control Disorder. According to the integrated assessment, JS had been treated for lead exposure as an infant. All the children were screened into court.

Prior to his involvement with DCFS, JS had juvenile arrests. Juvenile Court placed JS on Probation, the result of his having been found guilty of Attempted Residential Burglary and Criminal Damage to Property. Prior to DCFS custody, the delinquency judge had appointed a maternal aunt as a temporary guardian. JS's sister was also living there. Protective custody was taken of 16 year-old JS and his sister in June 2012. At that time, their aunt indicated that she was unable to be a long-term caregiver. She complained of JS's aggressive behavior, marijuana use, and refusal to attend school. The 18-year-old sister refused services and made her own living arrangements with relatives. She complained to investigators that the mother had abandoned them in this fashion before and that she had beaten them with extension cords and belts. She eventually entered the Youth in College Program.

In July 2012, JS was placed in the detention center. Eight days later, he transferred from the Juvenile Detention Center to the Saura Center, a detention alternative program. In September 2012, was placed in a residential drug treatment program. He remained in that program until January 14, 2013, when he was successfully discharged. JS transitioned to his grandmother's home against his caseworker's recommendation. JS relapsed soon after returning to the grandmother's home. He also began exhibiting other problematic behaviors. He was moved to his aunt's home, but she soon requested his removal.

On March 4, 2013, JS was placed in the shelter in Nachusa. He remained there until August 7, 2013, when he was placed in residential treatment at Allendale in Lake Villa. He did well at Allendale but consistently reported that he wanted to leave the program when he turned 18 in December. His juvenile probation was terminated while he was at Allendale. His mother picked him up from the facility on his 18th birthday and took him to her home, against his caseworker's recommendations.

JS remained in unauthorized placement at various relatives' homes between December 20, 2013 and his death on August 6, 2014. He briefly attended school from January to March 2014, but had dropped out by April following his arrest for Possession of a Controlled Substance and Trespassing. He was briefly in Cook County Jail. The caseworker maintained contact with JS and his mother. Case notes from July 2014 indicate that JS agreed to be placed in a Transitional Living Program (TLP) and to enter the shelter system to facilitate that move. On July 21, 2014, he refused to accompany the caseworker to the shelter despite having previously agreed to do so.

On August 5, 2014 the worker received a call from Aunt Martha's shelter staff stating JS and his mother had come to the shelter requesting services but there was a delay with the authorization process. A second shift worker at the shelter had found an open bed at Nellum, but JS and his mother had left and the case manager could not reach JS, and his caseworker was still working on authorization. They planned to continue the process the next day.

The mother reported that the caseworker told her to take JS to the shelter, not necessarily on that date but when the opportunity presented itself. She stated that she and JS were at the shelter for several hours but the intake worker reported they could not get authorization to place him. The intake worker said she told JS and his mother to return the next day. The mother took JS to her mother and sister's home on her way to work. It was in front of this home where JS was murdered the following morning. Before the caseworker was notified of his death, he had been seeking approval for JS's placement that morning.

Since JS's death, the Department has re-issued the directive that it is not necessary to contact the caseworker to place wards who have walked into the shelter. It states that Aunt Martha's will receive all the necessary documentation to place the ward from the Child Intake and Recovery Unit and that unit will notify the caseworker.

RW

At 1 a.m. on May 22, 2014, 18-year-old ward RW was murdered outside Geneva Foundation, a DCFS-funded facility on the west side of Chicago. RW had multiple gunshot wounds to his head, chest, and arms. Police found 9 mm shells at the scene. RW had moved into Geneva Transitional Living Shelter two weeks earlier, on May 8, from an Aunt Martha's group home in Park Forest. The Chicago Police Department homicide case incident report listed him as a member of the Black P Stones gang.

In June 2011, three years before his homicide, a dependency petition was filed and the court granted DCFS temporary custody of the soon-to-be 16-year-old. RW's grandmother, his adoptive parent, could no longer care for him because of his anti-social behaviors, gang affiliations, and her increasingly failing health. The grandmother had a prior history of aortic dissection and had recently been diagnosed with heart failure. The grandmother had contacted the Department in August 2010, approximately one year earlier, requesting assistance with RW. The grandmother told DCFS that RW had severe behavior problems, had been suspended five times, and had stolen her car.

RW, who had been born substance exposed, had previously entered foster care at 3 years old when his mother abandoned him in a drug house. After a temporary foster placement, he was placed with an uncle, where he joined his 7-year-old brother. RW's maternal grandmother also moved into the home. She adopted him in 2007. While living with his maternal grandmother, RW received special education services to address emotional and learning disabilities. In sixth grade, he read at a second grade level. A full neurological evaluation determined that he had a complex developmental encephalopathy, most likely secondary to apparent multiple intrauterine drug exposures. He was later prescribed medication for ADHD.

In June 2011, after RW's adoption disrupted, DCFS placed him in a traditional foster home. Within three weeks of the placement, the family requested his removal. The foster mother required emergency surgery and RW had brought a gun into the home. RW admitted to the caseworker that he had a gun, but that it had been taken from him. RW was moved to the Nellum Shelter on July 15, 2011. RW admitted to having a gun at a clinical staffing 11 days later, and stated he was involved with the Four Corner Street Hustlers gang on the west side of Chicago. There had been several deadly gang outbursts and he felt he needed the gun for protection. Despite RW's admission of gun possession, child welfare staff did not follow DCFS Procedure 18 that addresses how to handle wards in possession of guns, including notification of local authorities. During this time, RW also reported daily marijuana and alcohol use. He remained in placement at the Nellum Shelter from July to October 2011, but he was reported absent regularly. The Chicago Police Department arrested him three times between July 29 and August 6, 2011 and brought him to a holding facility on charges of battery, possession of cannabis, assault, and criminal damage to property. RW choked a peer in September 2011, during his last month at Nellum.

In October 2011, RW moved into Aunt Martha's group home in Park Forest. RW was enrolled at Rich High School with special education services. He did well during the first six weeks of school, but demonstrated anti-social behavior across the school and group home settings by December 2011. He was arrested for aggravated assaults in December 2011 and February 2012. In December 2011, RW was hospitalized for anti-social behaviors, including aggression towards Aunt Martha's staff and peers, regular marijuana use, and elopement. The assessment tool for hospitalization noted that RW reportedly had a weapon and was gang involved. Following discharge, he resisted treatment and failed to take his medication consistently. He had his first court date on aggravated assault and assault on December 28, 2012. The case manager had pressed charges against RW in February 2012 after he pulled out a lighter and lit it two inches from his case manager's face while threatening to set her on fire. SASS authorized admission to a facility where he remained for 14 days. He received one year of supervision with a probation officer for the assault charge.

After discharge, RW refused court-ordered anger management classes and substance abuse treatment. In November 2012, he violated his supervision for failing to meet his probation officer, and the judge ordered him to the evening reporting center. He continued to be reported for school infractions, including aggression to peers, disrespect to teachers, disrupting classes, and displaying gang signals. His juvenile supervision ended in June 2013. In October 2013, RW was arrested and charged as an adult with Domestic Battery. He received 12 months of court supervision and was again ordered to anger management classes. The Court issued an Order of

Protection against RW because he physically abused, intimidated, and stalked a 16-year-old who resided in the same group home. By the spring term, High School transferred him to Ombudsman alternative school but he refused to attend. He was the oldest resident at the Aunt Martha's group home. RW entered a Transitional Living Facility in Chicago on May 8, 2014. He was murdered less than two weeks later. In his last contact with staff, he said he was going to make some money.

DZ

On December 27, 2014, Chicago Police Department Detectives notified Thresholds staff that 18-year-old DZ had been found shot to death in an alley. Officers found three .40-caliber shell casings at the scene. During a canvass of the neighborhood, police learned that several people heard multiple gunshots earlier that morning, between 1 and 1:30 a.m. The medical examiner pronounced DZ dead at the scene and ruled the death a homicide.

DZ came to the attention of the DCFS at 16 years old, in September 2012, when the hotline received a report that the US Embassy had arranged for DZ's return to the United States after his mother left him in a foreign country. His mother refused to allow him to return to her home, citing his aggressive behaviors and saying she feared for the safety of her 2-year-old son, DZ's half-brother. DZ later reported instances of abuse at the hands of relatives in the foreign country, including sexual abuse. The Department indicated the mother for Lock Out and placed DZ in a traditional foster home. The foster father agreed to be a temporary placement for the teenager, but preferred a younger child.

Three months after placement, the foster father requested DZ's removal after he had allegedly taken a weapon to school and the foster father reported being afraid of the teenager. DZ was placed at Aunt Martha's shelter until a foster placement could be located. During the Integrated Assessment, DZ reported weekly marijuana use beginning at age 14. The clinical screener summarized that DZ appeared to have experienced multiple traumatic experiences throughout his childhood that impacted his emotional and interpersonal functioning.

DZ remained at the Aunt Martha's shelter for just over 30 days, until a clinical staffing approved him for group home placement. The agency could not locate a foster home, even though DZ reported wanting to remain in a foster home in the suburbs. DZ moved to Larkin on November 21, 2012 and attended High School as a sophomore. He often skipped class, received failing grades, went on run daily, and smoked marijuana. Within the first three months, DZ required hospitalization for aggressive behaviors. He was non-compliant with medication. Police arrested DZ twice for theft, commencing his involvement with County Juvenile Services. DZ received one year of supervision. One month later, he had a third arrest for Possession of Alcohol by a minor and retail theft.

Between June and September 2013, DZ was arrested four more times. Three were juvenile arrests for criminal trespass to a motor vehicle, disorderly conduct, and failure to appear at court. Police picked him up on a warrant and he served two days in County Jail. On the fourth arrest, DZ was charged as an adult for Disorderly Conduct-False 911 call, a class 4 felony. Police had concerns that staff could not control DZ. He had been reported as runaway 84 times between

November 2012 and September 2013. DZ attended court in the County at the end of May and agreed to treatment; instead he was stepped up to a residential placement.

In December 2013, DZ was placed at Maryville, where he remained until October 2014. Staff enrolled him in High School as a sophomore. DZ had two additional arrests shortly after his placement at Maryville. In one of these arrests he was charged with battery. In April 2014, 18 year old DZ went on run for approximately three weeks. During that time, Elgin police arrested him for criminal sexual abuse, later reduced to battery, for which he received 24 months adult probation.

DZ moved to Thresholds Young Adult Program in October 2014 and continued to exhibit impulsivity, an inability to handle emotions, and poor insight and judgment. He used alcohol and marijuana. He transferred from High School to an alternative school placement because of behavior difficulties, but did not regularly attend school. DZ was considered absent without leave seven times, including the day before he was murdered.

DJ

On April 21, 2014 at 12:46 p.m., 18-year-old DJ was shot multiple times outside of the home of his girlfriend's sister. Police found a semi-automatic pistol at the scene. A ballistic test showed the semi-automatic pistol had not been fired. Before he died, DJ gave police the name of the shooter. DJ had a total of eight gunshot wounds: three in his abdomen, two in his lower right back, and three that shattered his right arm. He died during surgery. On May 31, 2014 law enforcement arrested and charged 17-year-old Antwone L with first-degree murder. Antwone was acquitted, testifying he fired in an act of self-defense. Antwone testified that DJ pulled the gun out while Antwone was in the car and he fired his gun believing DJ was going to fire at him.

The Department has a long history with the J family starting from 1990, when child protection indicated the mother for inadequate supervision and physical abuse to an older sibling. The mother had a history of substance abuse beginning at age 14. She participated in inpatient and outpatient substance abuse treatment. She relapsed in 2002 and in 2005. In 2004, the mother reported having diagnoses of depression and borderline personality disorder. She received mental health services from a community agency. DJ became involved with the Juvenile Justice System in 2005, at age 9, after he shot a peer with a bb gun. He was placed in foster care in December 2006, after a violent episode where he threatened his sister with a knife. During his first six months in foster care, DJ had three failed foster home placements.

In July 2007, the Department placed 11-year-old DJ at the Baby Fold Residential Treatment Center. His mother visited him consistently during his stay at Baby Fold. DJ adjusted to school and his behaviors improved over time. At the end of December 2009, 14-year-old DJ moved to a specialized foster home. Four months later, he went on run during a family visit. Police picked him up 10 days later on a Delinquency Petition, alleging Possession of Cannabis and Cocaine with the intent to deliver. DJ admitted a previous history of selling heroin, marijuana, and cocaine when he was 11 years old. He explained he had been a member of the WACO street gang and at times had been in possession of multiple guns. DJ was committed to Illinois Youth Corrections (IYC), where he remained for six months.

Upon his discharge from IYC on November 15, 2010, soon to be 15 year old DJ was placed at Lawrence Hall, where he received bi-weekly individual sessions and attended CPS High School. While at Lawrence Hall, staff completed 15 UIRs, including a school suspension for fighting. His placement lasted less than four months. DJ eloped in late December and was missing for three weeks before he returned in January 2011. He continued to run from the facility. DJ was placed in detention on March 9, 2011 and transferred to IYC in Harrisburg five days later. Sixteen-year-old DJ had 10 adjudicated offenses and five violations of Probation. While at IYC in the southern region, his DCFS case was transferred to the Harrisburg Field Office. His mother remained in contact with DJ, but distance made it difficult for her to visit. While incarcerated, DJ cooperated with services and did well in GED classes.

DJ was released on February 22, 2012 and placed at One Hope United group home, where he stayed for two months before running. His whereabouts were unknown for over eight months, from April 9, 2012 to January 23, 2013. During this time, DJ regularly called his mother and sister. Police picked DJ up on a warrant and he was transferred from the county detention center to IYC. He was then transferred to Harrisburg IYC. DJ attended GED classes while in IYC. At 17 ½ years old, DJ was discharged from Harrisburg on May 31, 2013 and went to live with his older sister. DJ wanted to attend college and was provided with information about the Youth in College program. However, his case assignment remained in southern Illinois. He enrolled in four classes at College in August 2013. The college dropped him for non-payment.[2] Bureaucratic delays were caused by lack of coordination between the case management agency and Department middle management resulting in failure to provide him with community college tuition payment forms until the following year. DJ continued to meet with his parole officer and cooperate with the conditions of parole. He met with his case manager, who provided him with payment information for community college, on April 18, 2014. DJ was killed three days later.

DD

At 10:51 p.m. on November 21, 2014, DD was shot multiple times behind a TLP. DD had been living at the TLP for six months at the time of his death. Police officers arrested and charged 20 year old James S, also a DCFS ward, with DD's murder.

DD first came to the attention of DCFS when he was an infant. SACWIS records indicate that a family case was opened on November 15, 1995 to July 18, 1997, after DD was born testing positive for cocaine. The family had no further involvement with the Department for the next 14 years.

On September 23, 2011, a hotline caller reported that DD's mother refused to pick him up at the police station. He had been arrested for a robbery, allegedly committed at his high school. DD reported that his mother had kicked him out of her house a few weeks prior to his arrest saying he had struck his grandmother. DCFS was granted custody of DD on September 29, 2011. He was placed on 18 months of probation on October 20, 2011.

For the following 15 months, DD was either missing or in shelter care. One of his runs lasted for 10 months. He was the subject of several juvenile arrest warrants. He was placed at the Saura

[2] The Community College Payment Program allows youth under DCFS Guardianship enrolling in an Illinois community college the opportunity to have their tuition, fees, required books, and supplies paid for by DCFS.

Center, a detention alternatives program of the Juvenile Court, on December 30, 2012. From there, he was placed at a group home, on the southeast side of Chicago, on January 11, 2013.

DD's initial stay at the group home was characterized by behavioral issues, school problems, and substance abuse. On June 25, 2013, the delinquency judge ordered DD to be held in custody after his probation officer showed the court pictures the youth had posted on social media depicting him holding a handgun. He tested positive for high levels of THC indicating heavy use of marijuana. He was released from custody on July 9, 2013 and ordered to cooperate with treatment. He was placed in the Evening Reporting Center Program and returned to the group home.

After he returned to the group home, he was soon charged with two new delinquent offenses. The first was for robbery and assault of a staff member at the group home, the second was for retail theft. He pleaded guilty to retail theft; the assault and battery charges were dismissed when the staff member did not come to court. The court ordered DD into residential substance abuse treatment on October 23, 2013. He was placed at a treatment facility and remained there for 63 days. He successfully completed treatment and returned to the group home despite the fact that this move was contraindicated for maintaining his sobriety. He told his caseworker he felt anxious about returning to the group home. He feared he would relapse if returned to the group home. He was referred to outpatient treatment as a follow-up to residential treatment. However, his attendance was inconsistent and he soon lapsed back into marijuana abuse and other problematic behaviors.

DD's mother has a documented history of drug and alcohol abuse. Reports allege that he suffered from fetal alcohol syndrome. Early health records do not definitively support this diagnosis, but the clinician at the group home indicated that some of his learning problems could be attributed to fetal alcohol exposure. He was never evaluated for special education services while in the care of DCFS.

On February 23, 2014, 18 year old DD was recommended for a step down to a TLP. He was placed in a TLP on May 23, 2014. His adjustment to the setting at the TLP was reasonably successful. Nevertheless, he still struggled with his substance abuse issues and did not attend classes at an alternative high school.

DD continued to struggle with his substance abuse issues and was in the process of being referred to a program when he was killed. He seemed to respond to some of the staff. He was referred by the staff to the Teen Parenting Service Network as he had a 3-year-old daughter whom he was not seeing because he was estranged from the mother. His wanting to visit his daughter motivated him to attend school regularly again. He also was named as a possible father for another child but a paternity test proved he was not the father. He had a phone interview with TPSN on November 13, 2014, eight days before he was killed.

AB

Eighteen year old AB was murdered on April 3, 2015. His body was found behind a building on the south side of Chicago. According to witness accounts, AB was shot by two young males who were following him in a vehicle. The driver of the vehicle exited and fired a number of shots.

The passenger also got out of the car, walked with the driver to where AB lay prone on the ground, and shot him again. Reports from the Chicago Police Department indicate the shooting may be part of an ongoing feud between a breakaway faction of the Gangster Disciples, known as Brick Squad, and a similar faction of the Black Disciples referred to as Lamron.

AB's initial involvement with DCFS came when he was 2 months old and his biological mother abandoned him. The mother was reported to have severe addiction problems and had similarly abandoned AB's older brother in May 1995. This older sibling also came under DCFS guardianship and was adopted by a relative. AB was placed with his maternal great aunt in August 1997. AB's adoptive mother reported that he had been drug exposed in utero. The adoption was completed in July 2000. The adoptive mother was provided a monthly stipend of $326 per month.

In June 2014, 17 year old AB was arrested for Aggravated Unlawful Use of a Weapon. Two months later, AB pleaded guilty and was sentenced to 18 months probation. The court also ordered the Probation Department to complete a Social Investigation for the sentencing hearing scheduled for October 1, 2014 in Cook County Juvenile Court. While conducting the Social Investigation, the hotline received a report that AB's adoptive mother had expressed thoughts of killing AB. She stated he was breaking her heart because of his involvement with the streets and the gangs. She was later indicated for risk of harm. On October 1, 2014, the Delinquency Judge committed him to DCFS. At that time, AB was placed at the Saura Center, a staff-secure facility used as an alternative placement to the Juvenile Detention Center. On October 15, 2014 he was transferred to the a Shelter. He remained in that placement until his death on April 3, 2015.

AB attended High School. He had poor attendance, and exhibited aggressive behavior when he was there. He never advanced beyond ninth grade. Psychological testing completed in 2014 indicated that he had a full scale IQ of 79. AB admitted daily use of marijuana, but he did not participate in substance abuse treatment.

While at the Shelter, AB was uncooperative with efforts to secure a more permanent placement for him. According to records from the Child Intake Recovery Unit, AB was reported absent a total of 51 times between November 27, 2014 and March 19, 2015. Of these incidents, 18 were for two days or more. There is no indication of AB's whereabouts between March 19, 2015 and the date of his death on April 3, 2015. Nellum staff indicated that the youth returned to their program on March 24, 2015 but there was not a bed available for him. AB refused their offer of transportation to Aunt Martha's shelter. A juvenile warrant was issued for him that same day when he failed to appear for a hearing on his delinquent case. He appeared later in the day and the warrant was recalled. The case notes indicate that the caseworker attempted to place AB in a Transitional Living Program, but two programs rejected him and AB refused to consider a third.

KB

On June 21, 2015, the body of 20-year-old KB was found on Chicago's far south side. Police reports described the body as "burned beyond recognition." KB's girlfriend identified him three days later based on remnants of clothing. She had reported KB missing to the Police. The Medical Examiner listed the cause of death as undetermined and the manner of death homicide.

KB's mother had a long history of involvement with DCFS. In December 1995, KB's older brother was treated for a spiral fracture of his leg. He had suffered second-degree burns 11 months earlier, the result of a skillet falling off the stove. After the second incident, 9 month old KB and his older brother were placed in the relative foster home of their aunt. When she requested their removal, they were placed with another aunt, their mother's adoptive sister. Subsequently, four younger siblings would be removed from the mother's care and placed with relatives.

In 2002, aunt obtained subsidized guardianship of seven year old KB and received $384 a month. In 2007, when KB was 12, the guardian reported that KB began having behavioral problems. According to reports, KB had a brief intervention in 2008 that consisted of participation in an outpatient program. He was admitted on February 20, 2008 and was discharged on March 13, 2008. However, his guardian refused the medication upon recommendation of KB's pediatrician.

In April 2008, the first of a series of arrests and referrals to Juvenile Court began. In April 2008, he was arrested for Criminal Trespass to Land. In September 2008, 13 year old KB was arrested for Aggravated Battery after he struck a girl in the head with a bat. He pleaded guilty to the reduced charge of battery. KB was placed on one year of Court Supervision in January 2009. After being found in violation of the Supervision Order on June 11, 2009, he was placed on one year of probation and ordered to enter residential drug treatment. While at Gateway, KB admitted smoking two marijuana blunts daily. He was discharged approximately three weeks later for aggressive behavior toward peers, and failed to complete the program. In January 2010, he was placed on three years of probation for Robbery.

KB had a long history of failure in school. He attended 10 different schools and failed to achieve in all of them. He was expelled from Chicago Public Schools in 2009 because of alleged gang activity. At the time of his death, he had failed to graduate from high school or earn a GED.

In 2010, his guardian petitioned the court to have her guardianship of KB vacated. Both Delinquency Court and DCFS provided services in an attempt to stabilize the placement. Multi-Systemic Therapy was ordered through Delinquency Court and DCFS arranged for Adoption Preservation Services. After a search warrant was executed on her home because the police believed that KB had hid a gun used in a murder, the guardian reported she was threatened with eviction and wanted to give up guardianship. On March 11, 2010, DCFS assumed guardianship of 15 year old KB.

Because of his dual involvement with the Child Protection and Delinquency Courts, KB was referred to the Regenerations Program of Lutheran Child and Family Services. KB was initially placed at the Shelter from which he frequently ran. He was placed in his first Regenerations specialized foster home in August 2010. He was required to take part in meetings at the LCFS offices and participate in the Youth Advocate Program for which he would receive a $300 monthly stipend.

KB's behavior while in the Regenerations Program ranged from noncompliant to aggressive. Multiple specialized foster parents requested his removal. A violation of probation was filed in

May 2011 alleging that KB had threatened his caseworker. Regenerations staff would at times withhold KB's stipend for failure to participate, but he would become combative and threatening and staff would acquiesce. On one occasion, he threatened his caseworker verbally in her office and then reiterated the threat in a text message when he was refused his stipend. There are references in the case notes to the caseworker meeting KB in the community and giving him the stipend despite his lack of participation. In January 2012, KB was sentenced to 30 days in the Juvenile Detention Center and his probation case was closed. This ended KB's involvement with the Delinquency Court.

Over the following years his pattern of non-compliance continued. He cycled in and out of various foster homes. KB became a father in 2012. He was offered services through the Teen Parent Service Network but refused to participate. In December 2014, he was arrested for Domestic Battery after he assaulted the mother of his child and spent time in Cook County Jail. KB pleaded guilty and was sentenced to Conditional Discharge and 30 days in Jail. There was also a protective order issued for the victim.

On June 10, 2015, when he was 20 years old, KB attended a clinical staffing with his caseworker. The case note from the meeting reported that KB, though officially placed in a non-relative foster home on the south side of Chicago, was not staying there regularly. It was reported that he often stayed with his girlfriend, the mother of his child, and a cousin. During the meeting KB agreed to enroll in a GED class and was once again informed of services available through the Teen Parent Service Network. A Youth Transition Plan was completed and KB was informed to appear at a permanency hearing on June 18, 2015. KB failed to attend the June 18 hearing despite the caseworker's reminder the day before. There was no further contact with KB before his body was discovered. The case note describing this hearing was the last entered in KB's case. KB's body was found on June 23, 2015.

AE

Twenty-year-old AE died after being stabbed during an altercation. According to Chicago Police Reports, AE accompanied two friends she knew to an alley in the neighborhood. The group had arranged to meet another peer there. One of AE's friends had been feuding with that peer on Facebook. Police reports state the trio cornered the man. AE punched him first and the two others followed, punching and kicking the man. The man being attacked removed a two-inch pocketknife from his boot, stabbed AE in the chest, and then stabbed the two men before escaping. He called 911 once on the train. One of AE's friends suffered multiple stab wounds to the arm, chest and back; the other suffered stab wounds to his face. The two friends were arrested and charged with felony murder.

AE's mother was 16 years old when she gave birth to her. The mother later reported that AE's father abused her and after having another child with him, left the marriage when AE was two years old. The Department has not had contact with the father and AE was inconsistent as to if she had contact with her father. AE was known to the Department since at least the age of five years. The mother reported to Cook County Special Services that AE has a history of sexual abuse beginning at age 3, when AE's babysitter watched pornography with her. The report did not provide further details and there does not seem to have been any DCFS involvement at this time. AE's stepfather was unfounded for sexual molestation in 2001 but had been indicated for

risk of harm. AE displayed sexualized behaviors and eventually an unknown perpetrator was indicated. She became a ward at age 9, when her mother was indicated for inadequate supervision and was not cooperating with services, including those for AE. Her siblings also came into care.

Between 2007 and 2014, AE was psychiatrically hospitalized over 30 times while moving between five different residential facilities. AE had a history of sexual abuse and trauma, severe mental illness, substance abuse and violent behavior.[3] AE's five siblings eventually obtained permanency, four returned to the parents and one to a subsidized guardian, AE's behavioral and mental health problems kept her in the system. The family case closed in September 2011 and a goal of independence was entered for AE in March 2012. One of the facilities in which she was placed was an out of state dialectical therapy residential program that she first entered at age 14. Over 15 months, she moved between hospitalizations at the Comprehensive Assessment and Treatment Unit, at the University of Illinois – Chicago and the dialectical behavior therapy residential program. She moved from the Comprehensive Assessment and Treatment Unit to Peoria Children's Home when she was fifteen years old. She continued to require placement changes and hospitalizations. She was psychiatrically hospitalized 19 more times before moving to Thresholds.

AE had been detained in juvenile detention centers in 2010, 2011, 2013, and 2014. AE had four arrests as a juvenile and two arrests as an adult before moving to Thresholds in Chicago. The reasons for arrests included kicking a police officer and physically assaulting a residential staff member. Just prior to admission to Thresholds, AE had been placed on adult probation in Peoria County for a forcible felony, aggravated battery.

AE moved to Thresholds on July 1, 2014, about a year before her death. When AE moved from Peoria Children's Home, she had earned over eighteen credits, putting her less than six credits short of graduation, and was at a 12th grade level. She had attended a high school with 120 students through the Special Education Association of Peoria County. Her IEP in Peoria specified, "[AE] requires a small group, highly structured environment with intensive behavioral supports in place to maintain her behavior." Though her Thresholds worker enrolled her in the local school, a school with over 1500 students, AE did not attend. AE was expected to get herself to and from school using public transportation. She enrolled in a GED program in the month before her death but had not started.

The twelve months that AE was at Thresholds included four hospitalizations, nine unauthorized leaves, and three arrests. She continued her assaultive behavior and destroying property when she became angry. AE had initially been accepted into Thresholds Transitional Living Program. Despite the staff's rigorous efforts AE began refusing to take her medication and her behavior escalated. During her time there, she was placed in more structured residential placements. Within three months of being placed there, AE had stolen another resident's cell phone. Staff intervened to prevent a physical confrontation; police were called and she was charged with theft.

[3] Although one integrated assessment indicated that AE reported she was transgender, caseworkers did not confirm this..

Less than a month prior to her 20th birthday, according to a Chicago Police report, AE threatened physical violence towards another resident. AE was arrested for simple battery and spent a night in Cook County Jail. The following day, AE was released from jail on an I-Bond. She returned to Thresholds seeking out the peer she had been fighting with the day before. She punched a staff member several times in the head and face, and damaged a fax machine and computer monitor. Police were called and she was psychiatrically hospitalized.

A week after her birthday AE was arrested for a third time after attacking another housemate, striking her head with a garbage can lid and punching her in the face. AE was taken to Cook County Jail where she remained for a little more than a month. During the course of the arrest, the Peoria bench warrant[4] was discovered. After her release from Cook County Jail, Illinois State Police transferred AE to the Peoria County Jail to answer for the warrant there. She pleaded guilty to violating probation and was held in Peoria County Jail for 21 days before returning to Chicago. The three Cook County charges were still pending at the time of her death.

Placement options for AE became limited after she was banned from Thresholds residential sites for threatening staff and she was not allowed at other sites after the resident she had attacked obtained an order of protection against AE. Thresholds notified the Department they had no placement for her within their facilities. They determined they could not serve her in their residential or transitional living programs because of her escalating violent behavior. They would have to move her to the community and serve her through their outreach program. She moved to DCFS Shelters. Thresholds, working with DCFS to find placement options, had to place AE into a Hotel, a single room occupancy hotel not affiliated with Thresholds or any other service provider. Even those options were limited. AE had no income and it was unlikely she would qualify for social security income as she was not compliant with treatment or medication.[5]

Less than a month after being released from jail, AE went to the Thresholds administrative program building. When told that she could not have money, AE had an outburst, choked a staff member, and destroyed over $1000 worth of furniture. Police were called and they advised staff to have her hospitalized instead of arresting her. Thresholds filled out a petition to initiate involuntary hospitalization. When released from the hospital a week later, she moved to the single occupancy room building. Staff made a plan to meet her in the community, not in her apartment, because of her previous violent outbursts. She had been out of the hospital for approximately six weeks when she was killed.

The initial daily log entries at Thresholds described her as accepting direction from staff, socializing with other residents, and having a good sense of humor, yet AE did not continue that pattern. Despite AE's violent behavior, impulsivity, and emotional instability, Thresholds workers described her, as others had before, as engaging but unpredictably aggressive. Although she attended therapy only sporadically, her therapist noted she voiced remorse. Staff reported

[4] AE was sentenced to probation for a charge of Battery that occurred in Peoria County. She violated the terms of her probation by failing to appear to Cook County probation after moving to Thresholds. A Warrant was issued in Peoria County on January 23, 2015. According to Peoria County court records, she appeared before the court on March 27, 2015 while in custody.

[5] Thresholds was paying for her placement, but many single room occupancy hotels require a resident to have proof of income, such a social security income.

that she responded well to strong relationships. When she had more access to the community and was off her medications, she became violent towards staff and other residents. She began staying away from her placement more often. She reported regularly using marijuana, alcohol, and other drugs when they were available. She did not feel as though she needed medication. Workers noted she often spoke about her gang involvement and her obligations to the gang. Police do not suspect that the altercation that resulted in her death was gang involved.

ANALYSIS

All but one of the families in this investigation lived in high poverty communities. Four of the homicide victims were under the age of 3 when they first entered the child welfare system. AB and KB entered state care during infancy. Laquan M and RW were 3 years old at the time they initially came into state care. All four of these children were eventually placed with relatives who became their adoptive parent or subsidized guardian. The remaining seven entered foster care well into school age. Two of the youth, AE and RO, came into state care between the ages of 9 and 10. AE's family had intact services prior to her coming into care. DJ was 12 years old when he entered care and DD and MP were 15. The remaining two, JS and DZ, were 16 years old when they first came into DCFS custody. DZ came into care after he returned from living in Pakistan. AB was 17-½ when he entered DCFS custody.

All were the victims of street violence with the exception of Laquan. Ten homicides occurred in Cook County; one happened in Winnebago County. Five homicide cases were closed with arrests. This 45% clearance rate is higher than the 26% clearance rate in Chicago.[6] Seventeen-year-old Antwone L was arrested and charged with the murder of DJ. Antwone was acquitted of the murder on the grounds of self-defense. Twenty-year-old James S, also a ward of DCFS, is the alleged murderer of DD.[7] Both lived in the same Transitional Living program. James S is in the Cook County Jail awaiting trial. RO was alleged to have been shot by 19 and 21 year olds. They are both incarcerated and awaiting trial. Two young adults, ages 19 and 20, were arrested and charged with felony murder in the death of AE. AE and the two young men attacked another young man. In self-defense, he stabbed AE and the other two attackers. Chicago Police Officer Jason Van Dyke has been charged with the murder of Laquan M.

Social, Environmental, and Community Factors

Education and Employment

Of the 10 homicide victims between the ages of 17 and 20, only one, 17-year-old MP, graduated from high school. He attended an off-campus therapeutic program of Bolingbrook High School in southwest suburban Chicago. He was murdered a few weeks after his graduation. DJ earned his alternative degree certification while he was in custody at the Illinois Department of Juvenile Justice. He was the only one in the cohort who had been sent to juvenile corrections. He had enrolled in community college when released and completed his own application to secure financial aid, but he had to withdraw from classes because the Rockford case management agency failed to secure his DCFS tuition payment forms. A year passed before the agency rectified this obstacle. DJ was killed shortly before he was to re-enroll in college. The majority of the youth had itinerant school histories, attending multiple schools with low academic ratings.

[6] The clearance rate for Illinois as a whole is 45%.
[7] A summary of James S history with the Department is attached in Appendix A.

KB attended five grammar schools and five high schools. He had a number of expulsions. Laquan M attended three grammar schools, including Montefiore, and two high schools. At the time of his death, Laquan was enrolled in an alternative school but was on suspension on the day he was killed. Both KB and Laquan had their school years disrupted frequently by stays in the Juvenile Detention Center.

Youth in this cohort faced many obstacles to educational success. Most attended public schools that have low academic ratings in communities plagued with poverty and violence. They were all functioning below grade level in Reading and Math. While some were, for a period of time, placed in a residential program, they returned to Chicago communities upon discharge. Eighteen-year-old JS did well when attending the therapeutic school at Allendale but stopped attending school within three months of returning to Chicago. AE's Individual Education Plan [IEP] at her small therapeutic school in Peoria successfully enabled her to reach the 12th grade. However, AE transferred into a large Chicago Public School. She attended no more than a few days; the Chicago Public school was 10 times the size of her rural therapeutic school.

All of the victims who were 17 and older were in significant need of vocational advocacy and training. Two of the homicide victims were employed. Seventeen-year-old MP worked part time in a restaurant for a few weeks before he was killed. DJ had obtained an alternative degree and attempted to enter the Job Corps while he was waiting for the college assistance, but was denied because he was still on parole. According to case notes, KB, age 20, was employed for a total of two weeks before being fired and he never obtained new employment.

The combination of unemployment and lack of enrollment in school is commonly referred to as the "Disconnection Rate." This rate is very high for African American males in Chicago between the ages of 16 and 24.[8] Chicago's overall Disconnection Rate is 13.3%, placing it ninth best among 25 metropolitan areas in the United States. However, for young African Americans, the Disconnection Rate sits at 24%, making it the sixth most disconnected among 25 metropolitan areas in the United States for this population. The Disconnection Rates in the communities where most of these wards resided was significantly higher than the rate for the rest of the city. In South Lawndale, for instance, the Disconnection Rate is 35%. It is similarly high in Englewood and other communities with a high African American population.[9] Youth Disconnection is a significant risk factor for recidivism and violence. As Disconnection was a factor for the majority of these youths, it needs to be addressed more effectively. Programs such as Safer Foundation, specifically designed to address the employment deficits of young adult ex-offenders, need to be applied to this young adult population.

Lead Exposure

Thirty-six percent (4) of the youth had a history of lead exposure. RO, KB, and JS lived in the city of Chicago at the time of their positive lead tests. Three-year-old RW was taken from a drug house on the Westside of Chicago, and tested positive for lead six months later. During the integrated assessment, JS's mother reported that he required hospitalization as an infant for high

[8] Youth Disconnection. (2016). *Measure of America*. Retrieved from http://www.measureofamerica.org/disconnected-youth/

[9] ibid

lead levels. RO tested positive for lead in 2006. At that time, 26% of the children tested for lead in the Lawndale neighborhood had high levels, compared to 15% citywide. In KB's and JS's neighborhood, Englewood, 47% of the children tested positive compared to 30% citywide in 2002. The children of Chicago are affected by lead poisoning at rates twice as high as the national average. Evens et al. researched the impact of lead toxicity of children in the Chicago Public School system.[10] Findings showed lead toxicity was associated with poorer academic achievement in reading and math and confirmed early childhood lead exposure is a major risk factor for poor academic achievement. The majority of lead poisoning cases are reported in the neighborhoods of the south and west side of Chicago, particularly the city's low-income, impoverished neighborhoods of Englewood, Austin, and Lawndale.[11] Lead poisoning in these neighborhoods is six times higher than lead poisoning in other areas of Chicago, predominantly affecting black low-income communities.[12] The Illinois Department of Public Health reported more than 10,000 children living in Chicago had blood lead levels greater than the reference point of 5 micrograms per deciliter (µg/dL) in 2013. Lead-based paint and toxic dust is commonly found in the housing of Chicago neighborhoods with limited community resources. This exposure is the primary cause for Chicago's childhood lead poisoning. Chicago relies primarily on the Section 8 federal housing policy to subsidize housing for families with low-income. Unfortunately, these are the living spaces that are exposing children to lead, and once detected, it is often too late to reverse the neurological effects it has on a young child's developing brain.[13] Research had linked lead poisoning to developmental delays, academic difficulties, violence, juvenile delinquency, and emotional and behavioral problems. According to Lead Safe Illinois, lead poisoning can cause brain and nervous system damage resulting in speech delay. Lead poisoning has also been associated with inattention, impulsivity, delays in reaction time, and hyperactivity. Even children with lead exposure below the threshold of 10 µg/dL, will lose 5 to 7 IQ points.

The Centers for Disease Control note that research has not specifically examined the impact of early childhood educational interventions on cognitive or behavioral outcomes for children with lead exposure.[14] However, early intervention programs, such as Head Start, have documented improvements in learning and developmental outcomes in children with developmental delays and educational deficits. Head Start focuses on children's health, nutrition, mental health, and social service needs, which mitigates social and economic factors that may limit a child's ability to learn. Schnur and John and the Center for Disease Control recommend children with lead exposure displaying emotional and behavioral problems would benefit from early intervention

[10] Evens, A., Hryhorczuk, D., Lanphear, B. P., Rankin, K. M., Lewis, D. A., Forst, L., & Rosenberg, D. (2015). The impact of low-level lead toxicity on school performance among children in the Chicago Public Schools: a population-based retrospective cohort study. *Environmental Health*, *14*(1), 21.

[11] Hawthorne, M. (2015, May 1). Lead paint poisons poor Chicago kids as city spends millions less on cleanup. *Chicago Tribune*. Retrieved from http://www.chicagotribune.com/news/ct-lead-poisoning-chicago-met-20150501-story.htm

[12] Epton, A., Bordens, A., & Hing, G. (2015, May 1). Chicago lead poisoning rates vary by location, time. *Chicago Tribune*. Retrieved from http://apps.chicagotribune.com/news/watchdog/chicago-lead-poisoning/index.html

[13] Hawthorne, M. (2015, December 31). Federal housing policy leaves poor kids at risk of lead poisoning. *Chicago Tribune*. Retrieved from http://www.chicagotribune.com/news/ct-cha-lead-paint-hazards-met-20151231-story.html

[14] Lead. (2016, January 29). *Centers for Disease Control and Prevention.* Retrieved from http://www.cdc.gov/nceh/lead/

programs such as Head Start and other special education and enrichment services.[15] [16] It is suggested that a nurturing and enriched environment may reduce the negative effects from lead exposure. Moodie *et al.* found that an attentive and supportive home environment led to improved educational outcomes.[17] A supportive environment included parental support of schoolwork and extra-curricular activities. One of the authors specified the need for an enriched learning environment that could include museums, art, music, and exercise;[18] enhanced stimulation not readily available in impoverished neighborhoods where lead exposure is more prevalent.

Prenatal Drug and Alcohol Exposure

Prenatal exposure to alcohol affects a developing embryo as early as the fourth week of gestation, with midline facial abnormalities as the first developmental defect observed.[19] This development may be occurring even before a woman knows she is pregnant. However, the effects of prenatal alcohol exposure are persistent throughout the pregnancy. Thus, it is important to emphasize that all children who have been affected by prenatal alcohol exposure do not necessarily have all or any of the facial features associated with Fetal Alcohol Syndrome [FAS], there are many implications to being exposed to alcohol while in utero, such as Fetal Alcohol Spectrum Disorder [FASD]. For our population, this is an unknown variable since it is difficult to get reliable retrospective information. Previous Inspector General investigations found that neither child protection nor caseworkers correctly request information during the substance abuse screening, nor do they note historical information about prenatal alcohol use.

One of the 11 youth in this cohort had a confirmed history of prenatal alcohol exposure, but several mothers had severe and chronic drug abuse, sometimes combined with homelessness and prostitution. The co-morbidity of drug and alcohol abuse raises the probability that these mothers may have drank sometime during pregnancy, placing the infant at risk for FASD.

Bell reported that from his work as a consultant at the Cook County Juvenile Detention Center, he discovered that two-thirds to three-quarters of the youths have speech and language problems, Attention Deficit Hyperactivity Disorder, intellectual disability, and specific learning disorders.[20] He noted FASD as the leading cause of these disorders. Bell also reported that the prevalence of neurobehavioral disorders associated with prenatal alcohol exposure among children seen in child protective services has thus far eluded detection. However, he noted his experience with psychiatric clinic patients who have been involved with child protective services suggests that these rates are also high. Dr. Bell believes individuals with fetal alcohol syndrome have largely

[15] Schnur, J., & John, R. M. (2014). Childhood lead poisoning and the new Centers for Disease Control and Prevention guidelines for lead exposure.*Journal of the American Association of Nurse Practitioners*, *26*(5), 238-247.
[16] Centers for Disease Control and Prevention (CDC). (2012). Low level lead exposure harms children: a renewed call for primary prevention. *Atlanta: Advisory Committee on Childhood Lead Poisoning Prevention*.
[17] Educational Services for Children Affected by Lead Expert Panel. Educational interventions for children affected by lead. Atlanta: U.S. Department of Health and Human Services;2015.
[18] Flam, F. (2016, February 19). Don't live in Flint? Lead is still your problem. *Chicago Tribune*. Retrieved from http://www.chicagotribune.com/news/opinion/commentary/ct-lead-poisoning-water-flint-children-20160218-story.html
[19] O'Neil, E. (2010, September 28) Facial abnormalities of fetal alcohol syndrome (FAS). *Embryo Project Encyclopedia*.
[20] Bell, C. (2014). Fetal Alcohol Exposure Among African Americans. *Psychiatric Services*, 65(5), p. 569

gone undiagnosed, and with no intervention and neurodevelopmental difficulties, they may find it difficult to be productive adults (i.e. maintain employment etc.).[21]

As FASD is considered to be a continuum disorder, some children will display deficits in many areas of functioning, while others may display mild problems in one or two domains. Children with histories of prenatal alcohol exposure may exhibit difficulty in their ability to apply knowledge and skills, and to process some types of sensory information. They may also struggle with symptoms of inattention, impulsivity, emotional and behavioral dysregulation, impaired working memory, planning, and organization.

Research has demonstrated that children with FASDs have significant structural and functional changes in the brain.[22] Areas of the brain responsible for executive functioning, emotional and behavioral regulation, and cognitive functioning are particularly susceptible to the effects of prenatal alcohol exposure. Cerebral damage often results in a wide range of dysfunction, including: difficulty with transitions; poor motor planning; poor problem solving skills; concrete thinking (i.e., which may interfere with arithmetic skills and abstract thinking); attentional deficits; difficulty applying learning to different situations; trouble interpreting social cues; problems regulating responses (i.e. to sensation; explosive tempers; bad judgment); and difficulty following and understanding directions.[23] [24] Skills and knowledge may be mastered, then lost. As a result, the child may have difficulty following through with directives. While the child may express understanding of a concept for days on end, they may later subsequently "lose" that information. Thus, children with FASDs require patient teaching and re-teaching. Regulating responses to various sensory experiences can present another level of challenge in dealing with the day-to-day world. As such, he/she needs additional structure and support to complete more complex tasks and may benefit from visual cues or breaking down multicomponent tasks into smaller units.

Gang Involvement

Seven of the 17 and older youth claim specific gang affiliation. All but one of the victims were alleged to have been peripherally involved with gangs. The meaning and reality of gang involvement has changed greatly during the past decade in a way that has perhaps put youths, such as these victims, at an even greater risk for violence in these communities. Previously, large swaths of the inner city of Chicago were controlled by large, well-structured street gangs. These were organized around a criminal enterprise, namely the street sale of illicit drugs.

In recent years, these gangs have broken up into small cliques who claim to control small patches of these communities, frequently confined to a few square blocks.[25] These groups are loosely

[21] Bell, C. (2015, July 18). Dr. Carl Bell says fetal alcohol syndrome 'biggest public health problem for African-Americans since slavery.' *Inquisitr*. http://www.inquisitr.com/2262013/dr-carl-bell-says-fetal-alcohol-syndrome-biggest-public-health-problem-for-african-americans-since-slavery/#OeFso5ohlsAldl8p.99

[22] Chasnoff, I. J., et al. (2008). FASD across the span of childhood: A handbook for parents and providers. *Children's Research Triangle*.

[23] Bell, C. (2014). Fetal alcohol exposure among African Americans. *Psychiatric Services*, 65(5), p. 569

[24] Chasnoff, I. J., et al. (2008). FASD across the span of childhood: A handbook for parents and providers. *Children's Research Triangle*.

[25] Hughes, L. A. (2013). Group cohesiveness, gang member prestige, and delinquency and violence in Chicago, 1959–1962. *Criminology*, *51*(4), 795-832.

organized and not necessarily around a specific criminal activity. This development has put youth in these communities even more at risk. Merely traveling around their neighborhood, on foot, can be a perilous task. The disputes between members of these small factions are frequently petty or retaliatory in nature.[26] These disputes are triggered by what might appear to be trivial matters, such as a previous fight, an insult, or a taunt delivered through social media. Lethal violence is, in most instances, the first resort to settling these disputes. This development coincided with an ever increasing availability of guns in these communities. These weapons were also characterized by their enhanced lethality. It was not unusual for youths such as these to have high-powered handguns, capable of accommodating multi-round clips, in their possession. Thus it was common for the sites of these murders to be strewn with numerous spent shell casings.

The proliferation of smaller gangs also presents a significant risk for youth who are placed in shelter care facilities and group homes. Several of the youth in this cohort investigation complained prior to or subsequent to being placed in these facilities that moving about in that particular area of the city would be a risky proposition for them. The expression of this fear is, in most instances, real and not manipulative. In many of these neighborhoods, just being an unrecognized face could invite violence. The effect that this fear has on the ability of these wards to successfully adjust to a placement cannot be underestimated. It also impacts their ability to participate successfully in the treatment and programming being offered to them.

Gun Violence

Gun violence has become ubiquitous in many of the communities in which the youth live, putting them at an increased risk to be victimized by gun violence. Eighty two percent (9) of this group of homicide victims died as a result of a gunshot wound; eight were African American. This is congruent with both national and local statistics. In 2014, 2,374 black males between the ages of 15 to 24 died as a result of a homicide in the United States. Of these, 93% (2,219) were firearms related. Included amongst Chicago's 436 homicides in 2014 were 83 black males ages 13 to 20. Of those 83, all but two died as a result of gunshot injury. Of the 488 total homicides in Chicago in 2015, 20% (96) were black males between the age of 13 and 20. All of these deaths were firearm related.

The majority of these victims come from communities with a high minority population and a low socio-economic profile. When placed in foster care, transitional living programs, adoptive homes, or with a subsidized legal guardian, these children are likely to remain in impoverished communities. All of these youth were placed in communities in Chicago where gun violence is disproportionately prevalent.

Six of the youths either had a criminal record with gun charges or documentation of involvement with weapons in their case record. In two cases, involving MP and DJ, guns were found at the scenes of their murders. In DJ's case, the gun found on the ground had not been fired and the person charged with his murder testified that DJ had pulled a gun on him. In MP's case, it was unclear if the gun was his or belonged to the son of his unlicensed caregiver, who was wounded and fled the scene, or to their assailant.

[26] Weisel D. (2002). The evolution of street gangs: An examination of form and variation. In Reed W., Decker S. (Eds.), *Responding to gangs: Evaluation and research* (pp. 25-65). Washington, DC: U.S. Department of Justice, National Institute of Justice.

Four of the victims previously had indications of gun possession. DD had a posted picture of himself holding a gun on Facebook. A judge ordered him into custody after this picture was presented at court. In the case of DD, a UIR should have been generated by Aunt Martha's St. Florian Group Home staff after they learned that he posted the picture of himself holding a gun on social media. RW brought a gun to his foster home, prompting his foster parent to take him to the shelter and to demand immediate removal. The incident generated an Unusual Incident Report, but the police were never notified to secure the weapon. KB's aunt petitioned the court to vacate guardianship after the police searched her home for a gun that had allegedly been used in a murder. AB pleaded guilty in Juvenile Delinquency Court to Unlawful Use of a Weapon, a forcible felony, after police found him to be in possession of a loaded handgun.

Unusual Incident Reports of Wards with Guns

Inspector General investigators reviewed 48 Unusual Incident Reports from 2011 to 2015 and contemporaneous Department case notes for the youth involved, where the incident was coded as ward possessing or having access to a firearm or ammunition.[27] Of these Unusual Incident Reports [UIRs], 75% involved youth over 18. Six of the incidents were reported after staff, family, or foster parents noted gun activity depicted on social media.

In 1999, the Department issued Administrative Procedure 18 defining the actions staff should take in response to a ward that has or is suspected to have a gun in their possession. The procedure directs staff to immediately contact law enforcement for assistance.

The Administrative Procedure specifies that Department or private agency staff should not search for or seize the weapon, though they may direct law enforcement to the reported location of firearms or ammunition.[28] The procedure is meant not only for the protection of the youth, foster families, and staff but also for the protection of their communities.

The Office of the Inspector General analysis showed several cases in which law enforcement was not contacted. Moreover, despite the clarity of Administrative Procedure 18 and the severe potential for harm, Department monitors failed to review the UIRs to ensure that law enforcement was contacted.

Eighteen UIRs did not document any communication with law enforcement. Two of the 18 UIRs reported that staff confiscated a weapon (a .38 caliber gun and a BB gun) with no documentation of what the staff did with the gun or whether law enforcement was contacted**.** In two cases, foster parents contacted caseworkers to report that the youth brought a gun into the foster home. RW, one of the wards killed, reportedly brought a gun into his foster home in July 2011. The UIR states the foster family brought RW to the shelter and called the caseworker, but there is no

[27] The Office of Information Technology Services provided the Office of the Inspector General with the UIR's. As the system had to rely on the coding of the incident, this is likely an undercount and not reliable data. For example, if the UIR was coded as "Assault of a ward alleged" and the narrative reported possession of a gun, it would not have been included.

[28] Other duties include completing an Unusual Incident Report and convening a clinical staffing.

documentation, either in case notes or the UIR system, that law enforcement was contacted.[29] In the other foster home case, the only notation about law enforcement is that the foster parents were told to contact law enforcement. In another case, staff contacted Project Safe Neighborhood, but did not contact police. Project Safe Neighborhood will focus on removing the gun from the community, but will not provide accountability for the youth.

The remaining 13 cases present different responses, none of which included contacting law enforcement. In six of the incidents, staff only document that the youth denied, recanted or claimed that they no longer had the gun.[30] In five of the 13 incidents, staff searched for the gun or ammunition themselves[31] and did not find any. In one of those cases, the ward was arrested for battery later that month, at which time police found a gun in the facility.[32] In another of the cases resolved by search only, the UIR stated that the ward had pointed a gun at another resident. A search found no gun, and it does not appear that police were contacted. Less than a month later, police came to the facility and arrested two wards (including the ward that was alleged to have pointed a gun at another ward) for suspicion of involvement in an armed robbery.

In the two remaining UIRs, the only dispositions noted were internal counselling.

Substance Abuse

Substance abuse issues impacted the ability of all of the young adults in this cohort to maintain their placements, achieve academically, and successfully participate in services to help reach the goals outlined in their treatment plans. The most common drugs of choice for youths in this demographic are marijuana and alcohol, with the former predominating. A recent study found that abuse of hard drugs (cocaine, hallucinogens, opiates, amphetamines and sedatives) is less frequent among African Americans who had been involved in Juvenile Justice than non-Hispanic whites.[33] All 10 youths who were 17 and older admitted to using marijuana. Four of the youth were born drug and/or alcohol exposed and in-utero exposure was suspected in one additional case. Laquan M had a history of abusing PCP, a dangerous, dissociative anesthetic. Laquan's biological family, including his mother and grandmother, had a generational history of PCP and heroin abuse. The Medical Examiner noted the presence of a small amount of PCP in his system at the time of his death.

Three of the youth were court-ordered to participate in residential substance abuse treatment by the Delinquency Court as a condition of probation. One was discharged from residential substance abuse treatment for aggressive behavior, shortly after entering. During his five years with the Department, he never completed any other program, but he was not penalized. Two

[29] According to the SACWIS placement screen RW was at Aunt Martha's Youth Shelter on the date of the incident and placed at Nellum Shelter the next day.

[30] One claimed that he had thrown the gun in an alley because he was being chased by police and another claimed that he had already sold the gun.

[31] Four involved searches of the premises and one documented only a search of the person accused. Two of the five incidents also included counselling the youth internally.

[32] The agency completed a UIR regarding his arrest and it is included in the UIRs reviewed; the police had come to the facility after receiving information the ward was involved with a robbery.

[33] Welty, L. J., Harrison, A. L., Abram, K. M., Olson, N. D., Aaby, D. A., McCoy, K. P., Washburn, J. J., Telpin, L. A. (2016). Health disparities in drug and alcohol use disorders: A 12 year longitudinal study of youths after detention. *American Journal of Public Health*.

others successfully completed these programs, but the Department lacked aftercare sober housing options in which to place them after they were discharged from treatment. Instead, both were returned to placements that were not conducive to maintaining sobriety. DD predicted his relapse should he return to his prior group home. JS's caseworker strongly recommended that he not be returned to his relative foster home, because of concerns with both the home and the community. Both relapsed.

These cases underscore the need for young adult transitional sober living programs, similar to the Recovery House model of Rosecrance Health Network. Interventions' Recovery Home serves the same purpose for youth ages 16 to 19. Both programs could be utilized with DCFS youth and young adults who need to ease their transition into a substance-free lifestyle. Each of these programs offer a structured, sober, and supportive environment with on-site access to outpatient treatment service; individual, group, and family counseling; self-help groups; career/employment guidance and goal setting; incentive systems to encourage positive goal setting and reward academic and employment progress.

Laquan, who had a history of using PCP, was not referred for residential treatment. Residential treatment was not attempted because it was thought his tendencies toward explosive behavior would preclude his successful completion of a residential program. At the time of his death, Laquan was receiving services from a Clinic in Chicago, where his mother also was receiving services. He had not attended the program for three months prior to his death, at least in part because he was placed in a relative foster home in the South Shore neighborhood of Chicago, about 14 miles away, requiring transfers from train to bus on public transportation. The Regenerations Program, the foster program serving him at the time, did not transport him to the agency for continuity of treatment. Given that the youth's mother was receiving treatment at the same program, a family treatment model could have benefitted both. Instead, his caseworker referred him just before his death to an outpatient program, closer to his foster home. Laquan's caseworker did not accompany him to the referred program and he had not begun attending sessions before his death.

There was a demonstrated need for effective substance abuse treatment and aftercare transitional programming in each of these cases. The remaining six 17- to 20-year-old victims never attended drug abuse treatment although it was indicated for them. Most felt they did not need substance abuse treatment and were not cooperative with referrals. DZ was to attend treatment as a condition of his probation; however there was no documentation of a referral in his record and no repercussions for non-attendance. .

The Office of the Inspector General has made previous recommendations for DCFS youth who have substance abuse problems. The following recommendation was repeated in a December 2014 Report entitled "An Integrated Approach to Management of High Risk DCFS Wards."

> **Interventions for Substance-Abusing Youth:** [For] *an adolescent whose behavior is self-destructive and uncooperative, but is also using drugs, the Department should consider filing a petition on the minor as an Addicted Minor (ILCS 705, 405/4-1 et sec) to make use of the authority of the court in servicing such youth.* (Recommended May 1999, 97-IG-1520).

Disrupted Permanency and the Lack of Early Interventions

AB entered foster care at two months of age after his mother abandoned him with a neighbor and never returned. The mother had a history of chronic and severe substance abuse that included an extensive arrest history with convictions for possession of controlled substances and prostitution. Records from the Department of Healthcare and Family Services revealed that AB was born with a heart defect. Cocaine use during pregnancy leads to adverse effects and damage to the developing heart. Children born to mothers with a history of cocaine abuse have an increased risk for congenital heart defects.[34] [35] Ventricular Septal Defect (VSD) is one of the most common congenital heart malformations. VSD is when the wall between the ventricles of the heart does not fully close and leaves a hole.[36] [37] [38] AB remained in the same relative placement for three years until completion of adoption by his 40-year-old aunt in July 2000, when he was 5. She received an adoption subsidy of $326. AB came back into care after his adoptive aunt with a broken heart threatened the then 17-year-old because of his delinquency and gang related behavior.

KB entered foster care as an infant related to prior indicated reports of abuse against his mother to an older sibling. KB's brother had suffered burns and later a fracture that the mother could not appropriately explain. Professionals also reported that the mother appeared to be cognitively delayed and unprepared to care for an infant. In April 1998, KB tested positive for lead exposure while living in the relative foster home of a maternal aunt. After six years in DCFS care, KB's 37-year-old aunt obtained subsidized guardianship of KB and his brother. The subsidy for KB was $384. The worker determined KB did not have any developmental needs. The subsidy failed to note that KB had a history of lead exposure. KB returned to state care at 15 years old, when his aunt requested her guardianship be vacated because of KB's antisocial behavior. He had been expelled from the public schools the year before the disrupted guardianship but his school failure had begun years before. Post-adoption services were offered after he was embedded in delinquent behaviors and were ineffective.

Laquan M came from a family with generational DCFS and substance abuse involvement. At the time of his birth, Laquan's 15-year-old mother was a ward of the state. Both she and the maternal grandmother had substance abuse issues. Laquan was first placed with DCFS at age 3 but returned to the care of his mother approximately 18 months later, in 2003. At the age of 5, he re-entered foster care because of physical abuse by his mother and her boyfriend. The Department

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[34] Mone, S. M., Gillman, M. W., Miller, T. L., Herman, E. H., & Lipshultz, S. E. (2004). Effects of environmental exposures on the cardiovascular system: prenatal period through adolescence. *Pediatrics*, *113*(Supplement 3), 1058-1069.

[35] Meyer, K. D., & Zhang, L. (2009). Short-and long-term adverse effects of cocaine abuse during pregnancy on the heart development. *Therapeutic advances in cardiovascular disease*, *3*(1), 7-16.

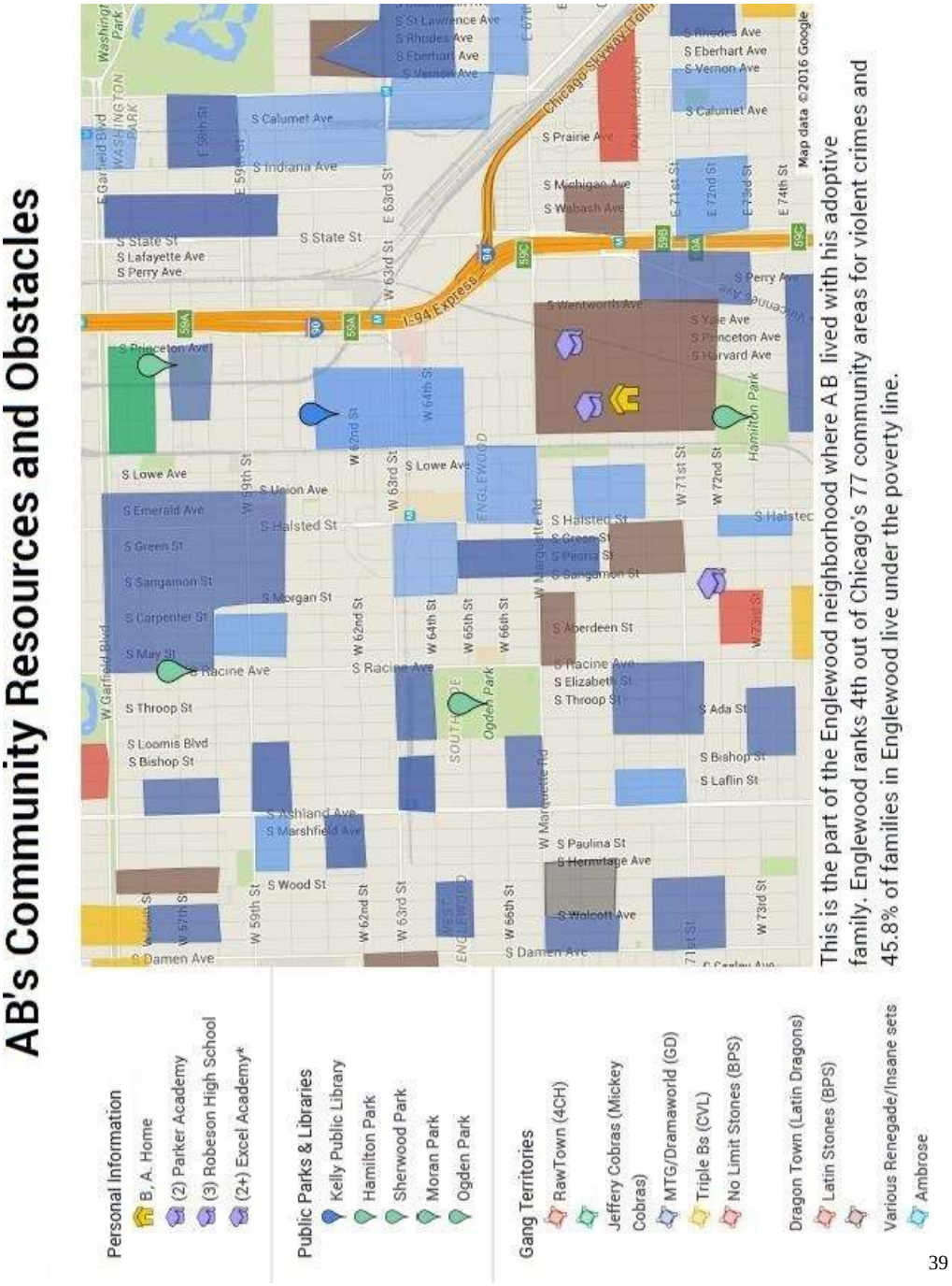
[36] MedlinePlus Medical Encyclopedia. (2013, November 11). Ventricular septal defect. *National Institutes of Health: U.S. National Library of Medicine*. Retrieved from https://www.nlm.nih.gov/medlineplus/ency/article/001099.htm

[37] Meyer, K. D., & Zhang, L. (2009). Short- and long-term adverse effects of cocaine abuse during pregnancy on the heart development. *Therapeutic Advances in Cardiovascular Disease*, *3*(1), 7-16.

[38] Mone, S. M., Gillman, M. W., Miller, T. L., Herman, E. H., & Lipshultz, S. E. (2004). Effects of environmental exposures on the cardiovascular system: prenatal period through adolescence. *Pediatrics*, *113* (Supplement 3), 1058-1069.

placed him in a traditional foster home, but he was removed a month later following reports of sexual abuse. The Department then placed Laquan with his 68-year-old great-grandmother. Laquan would remain in this home in the city's Austin neighborhood and his great-grandmother obtained subsidized guardianship in January 2008. At the time of guardianship, the great-grandmother was 74 years old caring for 11-year-old Laquan. While the subsidy agreement included weekly individual in-home, it did not offer a specialized rate for the great-grandmother who received $422 monthly. Because of the guardian's age, the Department required designation of a back-up caregiver, and Laquan's great aunt was named as the Backup Caregiver. The great-aunt stated that she and the great grandmother attended Laquan's final Child Protection court hearings where the great aunt affirmed she would care for Laquan if the great grandmother could not. However, when the great-grandmother died five years later the Department did not execute the Back-Up Caregiver agreement. Delinquency court was unaware of the existence or DCFS' policy of Back-Up Caregiver plans. Then great aunt was not contacted for placement of Laquan. He re-entered foster care with his sister and was placed with a 24-year-old relative who could not control either youth.

RW, who was born with intrauterine substance exposure, remained in the care of his mother while she attended substance abuse treatment. RW's prenatal drug exposure would go on to provide difficulty for the youth with both school and behavior issues throughout childhood. At the age of 3, RW's mother abandoned him in a drug house on Chicago's Westside and DCFS obtained custody of the 3-year-old in January 1999. Several months later, while living in a relative placement, RW tested positive for lead exposure. RW continued living in the same building when his grandmother became his foster parent. RW received special education services to address delays related to his encephalopathy and learning disability. RW was adopted by his 60-year-old maternal grandmother, though she suffered from chronic heart disease. At the time of the adoption in August 2007, the grandmother only received $301 a month. RW's family received the least amount of subsidized financial support despite his medical diagnoses, special education needs, and documented substance and lead exposures. Four years after the adoption, his 64-year-old grandmother said she could no longer care for him because of his delinquent and gang-related behavior.



39

[39] The gang territory map was created by compiling and cross-referencing several online sources:

Chicago Gang Map. (2015). *TheRealStreetz.com*. Retrieved from http://www.therealstreetz.com/2015/05/07/chicago-gang-map/

Chicago Gang Map 2015. (2015). [Google map of gang territories retrieved on 2/29/2016]. Retrieved from https://www.google.com/maps/d/viewer?mid=zjXUB8UVgnvM.kMb_DJfSkT2k&hl=en_US

Chicago Gang Map 2015 WIP. (2015). [Google map of gang territories retrieved on 2/29/2016]. Retrieved from https://www.google.com/maps/d/viewer?mid=zDZvSJjLCDcY.kJt704ch_hqo

Ramos, E. (2016). In Chicago, gangs abound, but there are they?. *WBEZ 91.5*.Retrieved from https://www.wbez.org/shows/wbez-news/in-chicago-gangs-abound-but-where-are-they/0d956c2e-171a-483a-8666-f5228d98812d

[40] Ibid.

KB's Community Resources and Obstacles

Personal Information

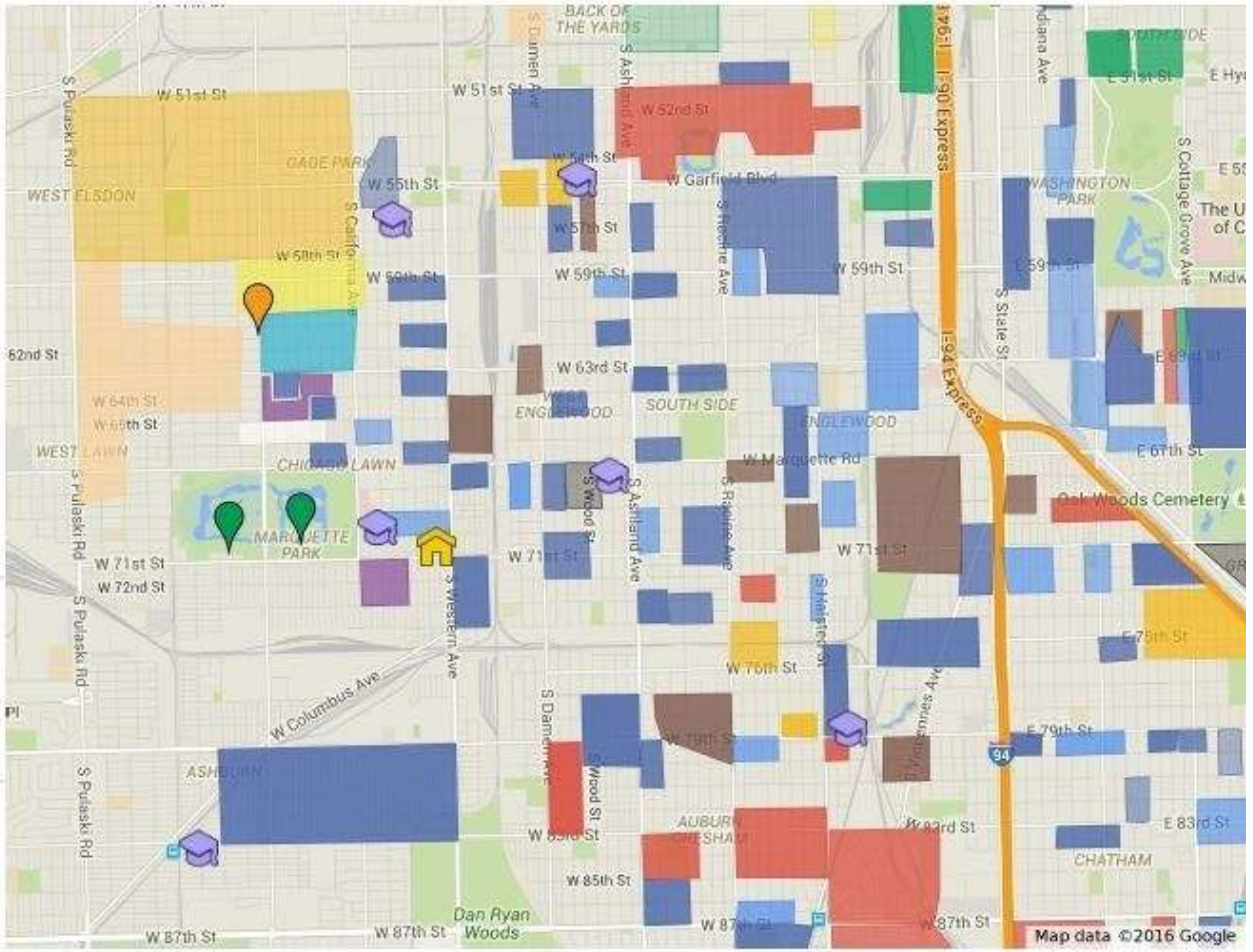
- B, K. Home
- (2+) McKay Elementary
- (2) Gage Park High School
- (2+) Ashburn Elementary*
- (2+) Haley Elementary*
- (1) Davis Elementary*
- (0) Vivian Summers*
- (2) Fenger High School*
- (2) Phillips High School*
- (2) Chicago Vocational HS*
- (GED) ASN Institute*
- (2+) CICS Basil*

Public Parks & Libraries

- Chicago Lawn Public Library
- Marquette Park
- Tarkington Park

Gang Territories

- RawTown (4CH)
- Jeffery Cobras (Mickey Cobras)
- MTG/Dramaworld (GD)
- Triple Bs (CVL)



This is the part of the Chicago Lawn neighborhood where K B lived with his adoptive family. Chicago Lawn ranks 27th out of Chicago's 72 community areas for violent crimes and 28.6% of families live under the poverty line.

[40]

[41] Ibid.

Laquan M's Community Resources and Obstacles

Personal Information

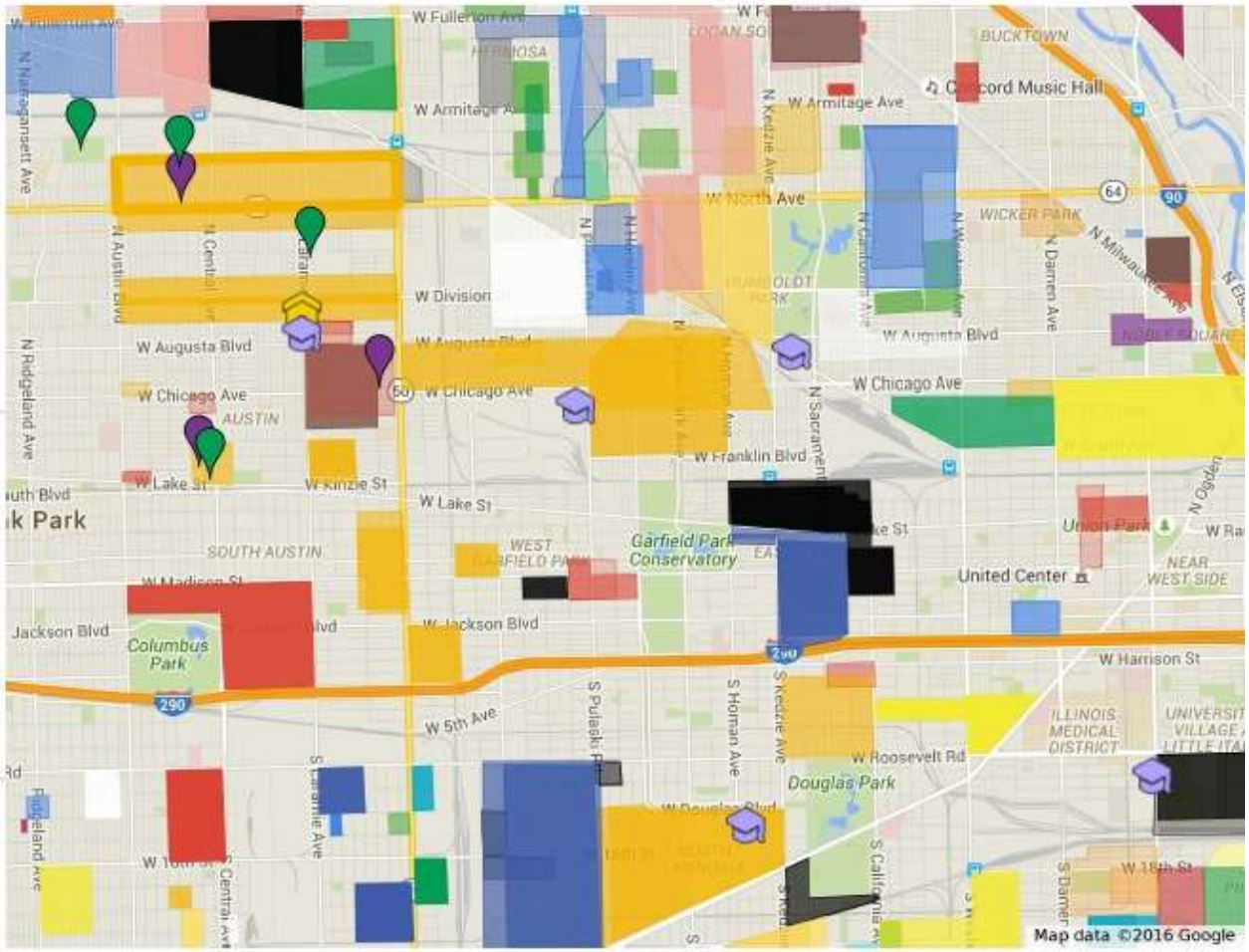
- M, L. Home
- (2+) Hay Elementary*
- (3) Orr High School
- (0) Lathrop Elementary*
- (0) Montefiore*
- (0) Sullivan House Alternative*
- (0) UCAN Academy*

Public Parks & Libraries

- Chicago Ave Public Library
- Austin Public Library
- North Austin Public Library
- Amundsen Park
- Austin Town Hall Park
- La Follette Park
- Galewood Park

Gang Territories

- RawTown (4CH)
- Jeffery Cobras (Mickey Cobras)
- MTG/Dramaworld (GD)
- Triple Bs (CVL)
- No Limit Stones (BPS)



This is the part of the Austin neighborhood where Laquan M lived with his adoptive family. Austin ranks 9th out of Chicago's 77 community areas for violent crimes and 27.2% of families in Austin live under the poverty line.

[41]

Dually-Involved Youth

Except for 14-year-old RO, all of the youth were dually-involved with child welfare and juvenile justice. According to information provided to the Office of the Inspector General from Cook County Probation and DCFS Legal, there are 95 youth with dual involvement (open cases in Juvenile and Child Protection Courts). Additionally, judges from Cook County Juvenile Delinquency court have appointed DCFS guardian of 174 youth who were not previously in DCFS custody. However, of these 269 youth, only 156 have an assigned probation officer. Effective collaboration between the child welfare and juvenile justice agencies greatly enhances the possibility for a positive outcome.[42] Nationally, studies show that African American youth are overrepresented amongst those children who are involved with both child welfare and juvenile justice.[43] This is also the case in Illinois, especially in Cook County.

The two jurisdictions of child protection and juvenile justice should not function in ignorance of each other. If a child is dually-involved, the delinquency court will exercise a greater influence on the outcome for the child because of the sanctions available. While a child protection judge can recommend services for a child victim, the judge cannot order the youth to comply with services. Delinquency Court will most likely be the final arbiter relative to what course of action will be pursued on this youth's behalf. While the probation officer answers to the judge in the delinquency court and the caseworker to the judge in child protection court, they should both be encouraged to provide their perspective and knowledge of this youth to the respective courts. The decisions that these courts make should be informed by both of these perspectives. In Laquan's case, child protection failed to execute his great-grandmother's backup plan for his great-aunt to become his back up guardian. Juvenile Justice was not aware of the DCFS policy requiring backup caregiver plans for elderly relative or foster parents assuming guardianship. Presently, there are no venues for joint conferences between the Delinquency and Child Protection Courts on a youth who is dually-involved. Although there are joint working committees and an expectation that probation officers and child welfare workers will coordinate their efforts, the system is fraught with holes. While DCFS workers should be required to attend all delinquency hearings and probation officers should attend the youth's permanency, this investigation found that the strength of child welfare caseworker's involvement with the delinquency division appeared to be dependent on the characteristic of the individual workers, rather than an adherence to a policy of coordination. This investigation found that critical assessments or reports completed by the probation department were routinely not in the child protection records. The Youth Assessment and Screening Instrument (YASI) and violence risk assessments can now be shared between Probation and the Department of Juvenile Justice and should likewise be shared with Child Protection. If the juvenile is committed to the Illinois Department of Juvenile Justice, the collaboration would have to be between that department and DCFS. The need for effective collaboration is no less crucial than that between child protection, delinquency courts, and probation.

While a delinquency judge made an effort to actively involve child welfare in one case, there is no legal framework in Illinois to integrate these hearings. There are models in other jurisdictions,

[42] Cusick, G.R., Goerge, R. M., & Bell, K. C. (2009). From corrections to community: The juvenile reentry experience as characterized by multiple systems involvement. *Chapin Hall at the University of Chicago*.

[43] H. Huang et al. (2012). The journey of dually-involved youth: The description and prediction of rereporting and recidivism. *Children and Youth Services Review* 34 254-260.

such as the King County, Washington's System Integration Initiative that provide a framework worth exploring. Idaho also provides a statutory framework for combining the two proceedings when it is determined to be in the child's best interests.

In Illinois, any juvenile convicted of an offense described in the statute as a forcible felony is required to be sentenced to a five-year probation term that can only be terminated at the end of that term or when the youth reaches his or her majority. Three of the youth (AB, DD, and JS) had juvenile forcible felony convictions for offenses including Aggravated Unlawful Use of a Weapon, Robbery, and Attempt residential burglary. Consequently, the jurisdiction of the delinquency court over this youth and the involvement with the probation department would continue, in many instances, until guardianship was vacated. With these types of dually-involved wards, enlisting the assistance of Probation could be the lifeline for the youth. One youth, the only female in the cohort had a forcible felony charge of Aggravated Battery as an adult. This 20-year-old had a serious history of mental illness, substance abuse, violence, and non-compliance. Her behavior was a threat to citizens and contributed to her death. The criminal court, unlike juvenile court, offers no lifeline in these precarious situations.

There are cases in which a dually-involved child's interests are best served through the Abuse and Neglect Courts and the Juvenile Justice courts sharing information and working together to address chronic problems, such as substance abuse. Such coordination would benefit the Department's work, in allowing more directed and appropriate services to address chronic issues.

Youth in Cohort in Regenerations Program

The Regenerations Program of Lutheran Child and Family Services (LCFS) is designed specifically to work with dually-involved wards. LCFS partners with Youth Advocate Programs to provide the services necessary to stabilize youth in the community and reduce recidivism. The model adheres to the principles of Balanced and Restorative Justice addressing competency, development and community safety in equal measure. The guidelines for the program describe a multi-dimensional or wrap-around approach to the needs of the client and their family, including licensing relative foster parents within 90 days. LCFS recruits and trains foster parents for alternative placements when living with family is not possible. Written into the program is a "No Reject, No Eject" policy. Three of the youth in this group, KB, AB, and Laquan M, were part of the Regenerations Program.

KB received services through the Regenerations Program for almost five years, from the time he was 15 to 20. During that time, he did not attend school, did not participate in court-ordered substance abuse treatment, and violated the conditions of his probation. Foster parents requested his removal because of frequent unauthorized absences and his threatening and aggressive behavior toward the foster parents or their family members. Despite his obstinate refusal to cooperate, KB was provided a monthly stipend of $300. On one occasion, he threatened the caseworker when she refused to provide his stipend. The worker subsequently relented and gave him a partial payment. The effectiveness of his continued involvement in this program was questionable. KB had a Juvenile felony charge of Aggravated Battery and Robbery that was reduced on a plea to misdemeanor Battery and Theft, with 30 days served in detention, allowing the Delinquency court to terminate him early rather than fulfill the mandatory five-year probation for a forcible felony.

The specialized foster care model included in the Regenerations Program would be best applied to the younger delinquent population. KB needed interventions when he was 10 and failing in school. The services of the Regenerations Program should include support to relative and traditional foster parents, guardians and adoptive parents in distressed communities at the first instance of school failures, juvenile arrests, substance abuse, and serious mental illness before the road to dual involvement. This early intervention would enhance the prospects for a positive outcome. At present, DCFS is pursuing a pilot program to provide short term residential stabilization to dually-involved youths with four agencies: UCAN, Lutherbrook, Indian Oaks Academy, and Lawrence Hall Youth Services.

The pilot document for this program suggests a heavy reliance on the Child and Adolescent Needs and Strengths Instrument for evaluation of the client's progress in the program and the appropriate level of care. In addition to this evaluation, the youth should also be assessed for risk of violence, both as victims and perpetrators, and their programs should be individualized to address this risk. The Youth Assessment and Screening Instrument (YASI) and violence assessments can now be shared between Probation and the Department of Juvenile Justice and should likewise be shared with Child Protection. Those DCFS or private agency caseworkers servicing this population should be trained on the use of YASI for a cross agency measurement of progress.

The Cook County Juvenile Probation Department has recently implemented a pilot program, Violence Intervention Probation. The program targets juveniles who have been arrested for gun related offenses in certain high crime geographical areas. The program involves collaboration between traditional probation, the Intensive Probation Gang School Safety Team and the Probation Department's clinical unit. This program includes probation officers from the Gang School Safety Team monitoring social media activity of the youths in an effort to identify and eliminate any online gang/violence related activity. The intensive monitoring included in this model may be effectively applied to dually-involved youth. Social media activity often chronicles their activities including threats, use of drugs, and possession of firearms. It was specifically mentioned in the case notes of three of these victims. This real time information is critical to the safety of youth, their families, and communities, and should be available either through the Probation Department or directly from Chicago Police Department to the DCFS personnel, who are working with this population.

The Department should request the assistance of the Cook County Probation Department to train these specialized caseworkers on the ins and outs of probation, delinquency court and Gang Safety. Likewise, DCFS should offer a specialized training for probations staff on related DCFS policies and expectations. Without a mutual understanding, real collaboration is unlikely.

The Dually Involved Committee consists of representatives from the judiciary, Juvenile Probation, and DCFS, and provides the opportunity to work collaboratively on the implementation of pilot initiatives, such as the Regenerations Residential Pilot, and could recommend other approaches to work with this difficult population. In November 2015, the Department announced the initiation of The Conscience Community Network (CCN) to serve 50 dually-involved youth in four Illinois Counties (Cook, Franklin, Jefferson, and Lake). The CCN

is a collaborative model, using evidenced-based treatments.[44] Progress on this model could be shared with the Cook County Dually Involved Committee.

A highly focused education and employment intervention that includes substance abuse and mental health services should be implemented for dually-involved young adults. The Safer Foundation has long provided these types of services to youth and young adults in this category. The Isaac Ray Center has been providing mental health services to youth in the Cook County Temporary Juvenile Detention Center for a number of years. Halfway houses and substance-free transitional living programs could be established using the expertise of these two agencies to provide a safe targeted therapeutic environment for this population with tight collaboration with the Cook County Sheriff's Office, adult probation, and the adult Redeploy program. Monthly stipend would be based on the young adult's cooperation and performance.

Thresholds

Individuals diagnosed with mental illness are no more likely than the general population to be violent. However, the MacArthur Violence Risk Assessment Study provided strong evidence that a mentally ill individual who is also a substance abuser is significantly more likely to commit violence; at highest risk are those living with them.[45] The prevalence rate for violence within a year of discharge from a mental health facility for patients diagnosed with both substance abuse and a mental health disorder was as high as 43%.[46]

Thresholds serves mentally ill youth and young adults through the age 20; referrals to the program come from DCFS, Illinois State Board of Education and Juvenile Justice. The mentally ill transitional living program is almost exclusively mentally ill DCFS wards. Thresholds is most often the service provider for youth with the most serious issues through both their residential and transitional living programs. Yet their model relies on a level of maturity and cooperation that is unachievable for some of the youth placed there.

AE had a history of violent behavior prior to the Department's placement with this agency. In addition, she abused substances and had a history of non-compliance with mental illness treatment. AE came to Thresholds five credits short of graduation. AE never attended school at Thresholds despite being at a 12th grade level when entering Thresholds. Thresholds enrolled her in a school with ten times more students and had an unreasonable expectation that she would use public transportation. She should have been assigned a case aide to anchor her in going to school. In the absence of her going to school, they did not use credit recovery or an internet based program to finish school. There have been other cases at Thresholds of youth transferring from small therapeutic school settings and small schools in rural areas, who fail to achieve and are overwhelmed in the large Chicago public school setting.

[44] The OIG has previously recommended targeted interventions. (See 02-IG-1136 January 2003, 15-IG-2385, June 2015 and "An Integrated Approach to Management of High-Risk DCFS Wards" December 2014).
[45] Steadman, H.J., Mulvey, E.P., Monaham, J., Robbins, P.C., Appelbaum, P.S., Grisso, T., Roth, L.H., & Silver, E. (1998). Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. *Archives of General Psychiatry,* 55, 393-401.
[46] Ibid

Cook County Criminal Court has a mental health court for property crimes, not for crimes against persons. Violence precludes young adults from being able to use these specialized courts. Cook County Jail does not want to be the repository for mentally ill individuals who abuse substances. The Division of Alcoholism and Substance Abuse residential treatment programs designed to serve Mentally Ill Substance Abusers exclude those with a history of violence. Thresholds made strong attempts to serve AE. Her behavior necessitated that she be stepped up to more structured residential placement, though even that proved unsuccessful for her. Thresholds initiated involuntary hospitalizations but inpatient hospitalization service those with acute mental illness in need of stabilization. Patients stay an average of 5-7 days, being released once stabilized. A person can only be involuntarily hospitalized if they have been deemed a danger to themselves or others.

Eventually her violent behavior led to the need for her to be placed outside of Thresholds sponsored housing at an SRO hotel; Thresholds had an ethical obligation to protect other residents from the dangers she presented. The ethical obligation belongs not only to Thresholds, but also to the Department.

A partial redacted copy of this report will be shared with: the Presiding Judge of the Cook County Child Protection Division, the Presiding Judge of the Cook County Juvenile Justice Division, the Acting Director of the Cook County Juvenile Probation and Court Services, the Superintendent and Deputy Superintendent of the Chicago Police Department, the Cook County Sheriff and the Illinois African-American Family Commission.

RECOMMENDATIONS

Programming and Prevention Services

1. To counter the lure of gangs and guns, the Department must offer programs in severely economically disadvantaged neighborhoods, such as Englewood, Lawndale and Austin, that include, remedial tutoring and enhanced learning opportunities for DCFS wards and children who have achieved permanency through subsidized guardianship or adoption who have reading and/or math scores two grades below level, and to offer the opportunity for pro-social recreational programs with safe passage (transportation) for these children.

Educational Services

2. When a special education youth in a residential program outside of the City of Chicago is transferring to a therapeutic/specialized, foster/relative home or transitional living program in Chicago, the Regional educational advisor from the sending community and the receiving Chicago Regional educational advisor should in advance of the school transfer to develop a transitional plan with the receiving school and the receiving agency assuring that the youth receives timely and appropriate special education services. The youth should be involved in the planning and afforded the opportunity to visit the receiving school prior to the transfer and the Department should fund an educational mentor to assist the youth for the first six weeks of the school transfer. The educational

mentor should provide transportation for the first six weeks and assist the youth in adjusting.

3. The Department should explore identification of entities that can offer credit recovery programs similar to the one at Maryville Madden Shelter.

Substance Abuse Recovery

4. Similar to the Rosecrance model, the Department should develop a supportive recovery transitional living program for its young adults in Cook County who are in their early stages of recovery. The program should offer individual, group and family counseling, educational and employment services with an incentivized goal setting in these areas.

5. The Department should utilize The Addicted Minor Act to obtain court ordered treatment for dually involved youth who are in need of substance abuse treatment in lieu of violating their delinquency probation.

Dually Involved Youth

6. For effective collaboration Cook County Region DCFS should pursue an agreement with the Cook County Probation Department to cross train the dually involved specialized caseworkers and the youth's assigned probation officers. The training should cover the ins and outs of probation, delinquency court and gang safety and the DCFS related policies and expectations. The trainings should be conducted biannually and include a discussion component provided by experienced caseworkers and probation officers on gang involvement and lessons learned.

7. The Department should request the Illinois Justice Project/Juvenile Justice Leadership Data Collection and Information Sharing Workgroup and the Dually-Involved Committee consider proposing legislation or rules that would permit sharing of information and coordination between the Cook County Juvenile Justice Courts and the Cook County Abuse and Neglect Courts in Illinois, when in the best interests of dually-involved youth.

8. The Department should request that the Office of Administration of the Illinois Court (AOIC) allow the Department to receive all Delinquency court assessments such as the Youth Assessment and Screening Instrument (YASI) and Violence Risk Assessment for wards of the Department. For consistency of measurements across agencies the Department should administer the YASI on those dually involved youth who end their probation or parole but continue under the Department's guardianship.

9. The Department should request to participate in the Gang School Safety Team real time monitoring approach for wards with gun/gang/violence activity including related social media.

10. The Department must review all UIRs involving a ward with a gun or ammunition to ensure that Administrative Procedure 18, requiring notification of law enforcement, has been followed.

11. The Department should develop a violence and substance free therapeutic community based model similar to a halfway house model for youth 18 and over involved with the criminal court system or dually involved with adult and juvenile courts for crimes against a person. The programming should require that the youth: enter into a nonviolence contract, obtain a minimum of part time employment, participate in continuing education through the City of Chicago Community Colleges (technical certification program, GED, or Associate Arts degree) or credit recovery or alternative school programs for youth who can earn a high school diploma. The therapeutic model should clearly define a no-violence contract with each youth who enter the program. If the terms of the shelter's non-violence contract are violated the Department should immediately inform the Juvenile Court and Adult probation of the violation and the intention of the Department to request termination of the youth's wardship. Programming should include Safer Foundation and the Isaac Ray Center.

12. The Department should explore collaboration with the Illinois DHS Division of Mental Health, Division of Alcoholism and Substance Abuse, and the Cook County Sherriff's Office to develop a stabilization strategy for DCFS Cook County young adults with mental illness and substance abuse problems who are charged with person crimes that exclude them from the criminal mental health court.

13. The African American Family Commission should review the findings in this report to develop recommendations for legislation or other necessary reforms.