Department of Children and Family Services
Offices of Quality Enhancement and Clinical Practice
Joint Special Review

Name: Semaj Crosby Date of Birth: [redacted] Date of Death: April 27, 2017

Race: African American Gender: Female DCFS ID: [redacted] SCR #: 2298844B

Introduction and Executive Summary

This report is being written at the request of Department of Children and Family Services (DCFS) administration due to the death of Semaj Crosby on or about April 27, 2017. Seventeen month old Semaj was reported to police as missing from her family's home on April 25, 2017. A large scale search effort was made by police and volunteers around the home and neighboring areas on the evening of the report. Semaj was discovered deceased in her home the following day.

An Intact Family Services case was opened to assist this family in September 2016 following child protection investigations regarding the children not being properly supervised. The mother, age 32, and her four children, ages 10, 7, 2, and 1 lived in the home. Upon case opening, mother was reported to be nurturing to the children, but appeared to have cognitive limitations that interfered with coordinating the children's medical appointments and care. Assistance to the family was provided, and efforts were made to link the mother with supportive services. However, her participation in all therapeutic interventions for herself and her children was also impacted by her difficulty in understanding, and attending to, her children's developmental and well-being needs.

The home was noted to be frequented by individuals and other family members, some living in the home with their children, during the course of service provision. Multiple child protection investigations occurred between the time of the opening of the Intact Family Case and Semaj reported as missing. Three investigations were initiated due to reported safety issues for the seven year old child with significant behavioral health concerns. Three additional investigations involved young children of family members who were staying in the Gordon home and often provided care for Semaj and her siblings. Although both the investigators and the intact caseworker assigned to the case at differing times appear to have followed primary procedures in contact and preliminary assessments of the children and family, it is not clear that all pertinent information regarding the children's mother and caregivers residing in the family home was clarified and processed between the investigation teams and the intact family team.

The cause and the precipitating event that led to the death of Semaj remain unknown at the time of the completion of this report. She was reported to appear safe in her family's care hours before the report of her disappearance. The purpose of this case review is to examine the assessments and service intervention provided to this family to support the parents in meeting their children's safety and well-being needs. The intent of this report is to identify recommendations regarding assessment and case management practices, as well as to support

enhanced training and supervision of front line staff regarding the assessment, response, and monitoring of parental abilities and child safety.

Review Methodology

Information collection and analysis for this review includes electronic documentation contained within the DCFS State Automated Child Welfare Information System (SACWIS) and all hard copy documents contained in the Intact Family Service file.

This case review and report was completed by Christy Levine, LCSW, University of Illinois at Urbana Champaign through the DCFS Office of Quality Enhancement, and Christine Schmidt, Psy.D., DCFS Consulting Psychologist.

Child Welfare Summary: Pertinent Case Statistics

Primary Family Members:

- Sheri (AKA Sherry) Gordon: date of birth [redacted], biological mother to [redacted] and Semaj
- Semaj Crosby: date of birth [redacted], date of death 4/27/17, subject of report
- [redacted] date of birth [redacted], sibling of Semaj
- [redacted] date of birth [redacted], sibling of Semaj
- [redacted] date of birth [redacted], sibling of Semaj

Other Case Participants:

James Crosby (date of birth [redacted]) is reported to be the biological father of Sheri Gordon's children [redacted] and Semaj. He was not reported to be living in the family home in 2017, and was noted to be incarcerated at the time of the current incident involving Semaj. He was named as an indicated perpetrator of physical abuse of child [redacted] in April 2015.

Lakerisha Crosby (date of birth [redacted]), James Crosby's sister, was documented to be residing in Sheri Gordon's home with her two children on and off during 2016 and 2017. She was named as an alleged perpetrator in one child protection investigation, and involved in two child protection investigations involving her two children, [redacted] and [redacted] and her boyfriend's child, that occurred while living in Sheri Gordon's household and during Intact Family Service provision.

Wesley Sykes Jr., AKA Wesley Skyes, (date of birth [redacted] was reported to be the paramour of Lakerisha Crosby. According to Mr. Sykes, he had been residing in Sheri Gordon's home for at least a year preceding Semaj's death while on parole. He was named as an alleged perpetrator in two child protection investigations involving one of his children and Lakerisha Crosby's two children that occurred while living in Sheri Gordon's household and during Intact Family Service provision.

Darlene Crosby (date of birth [redacted]), James and Lakerisha Crosby's mother, was reported to live in Sheri Gordon's home sometimes with her daughter [redacted] (date of birth [redacted]) during 2016 and 2017. Darlene Crosby was named as an alleged perpetrator in a child protection investigation for physical abuse involving her grandchildren, Lakerisha Crosby's children, [redacted] age three, and [redacted] age one, during Intact Family Service provision in the Gordon home.

Child Protection Investigations Involving the Gordon Household Following Reports to the DCFS State Central Registry (SCR):

- SCR# 2178027A (2A 14) - Report Date: 4/24/15

Reporter stated child [redacted] (5) was identified as an alleged child victim after numerous marks, scratches, and bruises were observed on his body, and statements from his older sibling that his father "whooped" [redacted] This report resulted in father James Crosby being the indicated perpetrator of allegation # 11, Cuts, Bruises, Welts, Abrasions and Oral Injuries, after Mr. Crosby's admission that he had disciplined [redacted] with a belt after he had gotten in trouble at school. Law Enforcement Agencies Data System (LEADS) results for both parents were documented, and Domestic Violence and Substance Abuse screenings were completed on both parents. The family's nurse practitioner and local police department personnel were interviewed as part of this investigation; no school personnel or collateral contacts were noted as interviewed as part of this investigation.

The father of [redacted] was documented to live part-time in the family home with Ms. Sheri Gordon and her three children during this investigation. Ms. Gordon was the primary caregiver and stated she was not present at the time of the incident and she agreed not to physically discipline her children during the investigation. She reported that Mr. Crosby was not in the home every day. Ms. Gordon reported that she had some type of mental health related diagnosis but did not know the name. Ms. Gordon reported to the Child Protection Investigator (CPI) that she receives SSI due to this diagnosis but does not take any medications. On 6/11/15, the CPI documented discussing supportive services with Ms. Gordon, including the opening of an Intact Family Service case. Ms. Gordon reportedly replied she didn't feel she needed services at that time. [redacted] reported he caused many of the scratches to himself due to bug bites. All children in the home assessed as safe on 4/25/15 and 6/11/15; verbal children [redacted] and [redacted] reported no fear of parents; Final Finding Date 6/19/15.

- SCR# 2246407A (2A 14) - Report Date 5/24/16

An anonymous caller reported that there were approximately 30 people residing in the home located at 309 Louis Road in Joliet, Illinois. The reporter stated that the occupants openly sell drugs and they drink on the children's playground that is by their house. The children were reported to be sent to the playground to play all times of day and night; the youngest was estimated to be one year of age and the oldest seven or eight years of age. The children reportedly fight other children in the neighborhood and are encouraged to do this. Allegations # 74 Inadequate Supervision, and # 60 Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect, were accepted for investigation naming mother Sherry Gordon (AKA Sheri) as the alleged perpetrator, and child [redacted] (AKA [redacted] as the alleged child victim. The previous investigation and indicated allegations involving child [redacted] that occurred in April 2015 was not documented in either the SCR or investigation reporting possibly related the incorrect name of the mother being initially reported.

Ms. Gordon denied all allegations stating a neighbor made a false report to DCFS due to problems with the neighbor's son bullying her son, which she had confronted the neighbor about. Initially on 5/25/16, Ms. Gordon reported to the CPI that she only had two sons, [redacted] and [redacted] and that the youngest two children observed in the home ([redacted] and Semaj) were not her children but were Lakerisha Crosby's children. Lakerisha Crosby was interviewed as a collateral contact on the same day, and did not deny mother's statements of [redacted] and Semaj being her children. During the in-person contact by the CPI on 9/20/16, Ms. Gordon is documented as reporting to the CPI that [redacted] and Semaj were her children. It is unclear from documentation why the parentage of the younger children was misrepresented, or the discussion regarding the dishonesty upon discovery. This investigation was approved for an extension to complete required assessments and paperwork on 7/20/16.

Risk and safety assessments in the home were documented as completed on 5/25/16 for [redacted] and [redacted] at the initial contact, and then on 9/19/16 for [redacted] and Semaj. Family identified collateral contact Lakerisha Crosby, was interviewed during this investigation with no concerns about the allegations reported, or the care of the children. She was documented as stating that Sheri Gordon received social security disability payments and was suffering from depression and "mental health problems." Substance abuse and domestic violence screens were conducted on Ms. Gordon by CPI without documentation of any notable results. The playground identified in the report was observed to be directly behind the family's home. Substance abuse in the home was denied by the mother, the collateral contact, and [redacted] school counselor reported he appeared well cared for at school each day. The local Sheriff's Department denied any recent calls to the home. Verbal children reported being supervised, no fear of anyone in the home, and the eldest child, age nine, reported no drug use or observing intoxicated persons in the home. Both allegations were unfounded due to insufficient evidence; Final Finding Date 9/21/16.

- SCR# 2262399A (2A 50) - Report Date: 09/07/2016

Reporter stated multiple children are in the home not properly supervised. In the report the mother is identified as "Shirene" and a seven year old child as '[redacted] Reporter stated that there were at least 15 children in the home and that that a one year old child, identified as '[redacted] is outside in only a diaper and was observed in the street while traffic was present. Reporter alleged that there were drugs and alcohol use in the home and Police calls to the home had occurred. Allegation # 74 Inadequate Supervision was accepted for investigation naming Sheri Gordon as the alleged perpetrator and her three children [redacted] (7), [redacted] (2) and Semaj (10 months) were named as alleged child victims. James Crosby was documented not to live in the family home with Ms. Sheri Gordon and her four children during this investigation. Ms. Gordon was the primary caregiver for the children.

Upon interview by the CPI, Ms. Gordon stated she suspected neighbors are making calls to DCFS because they do not always get along. Ms. Gordon stated that she always supervises her children, and that she can watch the children at the park behind her home through the window. The park was estimated to be 25 yards away from the house. Upon interview by the CPI, the reporter stated that the younger children are often being supervised outside by seven year old [redacted] while the adults are in the house. Reporter stated that there may be three families residing in the home, and described the home as a "party house."

Verbal children ([redacted] and [redacted] reported being supervised at all times and having no fear of their mother. Ms. Gordon reported that she had a developmental delay for which she received SSI, but did not take any medications, nor was she under the care of a psychiatrist. The children's medical provider and collateral contacts were interviewed as part of this investigation. Child [redacted] was identified to need a medical appointment to assess his hearing, and both [redacted] and Semaj were reported to be behind on their immunizations. Mother acknowledged her limitations in having the abilities to coordinate transportation, and fill out written forms regarding the children's medical insurance coverage which may have lapsed. All children in the home assessed as safe on 9/7/16. An Intact Family Case was opened for Preventative Services; Handoff Consultation documented 9/20/16, Transitional Visit documented occurring in the family home on 9/23/16. This allegation was documented as unfounded due to insufficient evidence; Final Finding Date 9/24/16

- SCR# 2267403A (2A 19) – Report Date 10/05/2016

Reporter stated that child [redacted] hits himself in the head, stated no one cares about him, alleged mother was hitting him and leaving marks, and was observed to be always hungry, along with statements that there is no food in his home. Allegations # 76 Inadequate Food, # 10a Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare – Incidents of Violence or Intimidation, and # 11, Cuts, Bruises, Welts, Abrasions and Oral Injuries were accepted for investigation naming mother Sheri Gordon as the alleged perpetrator, and [redacted]

as the alleged child victim. A Related Information report was received by the State Central Registry (SCR) on 11/7/16 reporting [redacted] was making statements about suicide and hitting his head and body on his desk and walls. Child was screened by SASS for possible psychiatric hospitalization, and was noted to have emotional and behavioral difficulties.

Upon interview by the CPI, [redacted] and the older sibling in the home denied all allegations. Collateral contact Darlene Crosby denied all allegations and any abuse or neglect of children in the home. Medical personnel confirmed primary medical care was in place for children with no concerns of abuse or neglect to the children. The Intact Family Caseworker denied ever seeing any marks or bruises on any of the children and felt transportation was the mother's "biggest" problem; she also confirmed that Sheri Gordon provides day care for Lakerisha Crosby's two children daily. Parenting skill services were reported as in place and a plan to get the children appropriate bedding reported in progress. All allegations were unfounded due to insufficient evidence; Final Finding Date 12/2/16.

- SCR# 2268015A (2A 19) - Report Date 10/10/16

Reporter states that children [redacted] age one, and sibling [redacted] age three, both have scratches, bruises and marks on their bodies that look like they are injuries from the use of a belt. Their mother Lakerisha Crosby is living in the home of Sheri Gordon and her four children, who were not named as alleged victims. Allegation #11, Cuts, Bruises, Welts, Abrasions and Oral Injuries was accepted for investigation naming grandmother Darlene Crosby as the alleged perpetrator, after mother reported the alleged child victims were in her care, while she was at work. Sheri Gordon and her children were interviewed and observed as part of this investigation, as Sheri was identified as one of the caregivers of the children, and the bruising may have occurred in her home. Ms. Gordon denied observing any physical discipline of [redacted] and [redacted] involving belts or other objects.

No marks or bruising was observed on either of the children by the CPI on the day of the report. Mother, Lakerisha Crosby, reported to CPI that she believed the report was made by the father of the children, Abe Walker, regarding his dislike of the clothing that the children wore. Collateral family contacts [redacted] and [redacted] denied concerns regarding physical abuse of the children. Contact with the intact service provider for the Gordon case was not documented. Grandmother denied the allegations and this report was unfounded due to insufficient evidence; Final Finding Date 12/9/16.

- SCR# 2267403B (2A 19) – Report Date 11/30/16

Reporter stated seven year old [redacted] stated that he wanted to kill himself with a knife. Reporter was concerned and felt child should be hospitalized although father was at the school taking [redacted] home, and was refusing to allow hospitalization. [redacted] was noted to have been released from a hospital a few days earlier due to suicidal statements. Allegation #79, Medical Neglect was accepted for investigation naming father James Crosby as the alleged perpetrator and child [redacted] as the alleged victim. [redacted] was confirmed to be on psychotropic medication

and seeing a mental health provider. Mother "Sherry" Gordon was noted to be the primary caregiver for all four of the children in the home, while Mr. Crosby lived elsewhere.

Mother and father reported to CPI that the medical card for [redacted] had expired, that they had no transportation, and that their finances were too low to refill [redacted] prescription. Both parents agreed to take him to a local hospital for reassessment later during the day of the report and reported they would prefer the child stay in the local area instead of going back to the hospital in a different city. Mental health appointments had been scheduled for 12/14 and 12/16/16. [redacted] was transported back to the previous hospital in Forest Park, Il. Supervisory Consultation notes discuss the parent's need for assistance and education regarding their child's multiple psychiatric diagnoses and treatment. Contact regarding this assessment and intervention with the Intact Family Service caseworker not documented to have occurred. The allegation was unfounded for Medical Neglect of [redacted] due to insufficient evidence; Final Finding Date 12/9/16.

- SCR# 2283384A (2A 17) – Report Date 1/20/17

Reporter states that seven year old [redacted] reported that mother hit him in the head with a shoe repeatedly and hits the younger siblings in the home. Child reported not feeling safe due to mother hitting him. Allegation # 10a Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare – Incidents of Violence or Intimidation was accepted for investigation naming mother Sheri Gordon as the alleged perpetrator and [redacted] as the alleged child victim.

Upon questioning by the CPI, [redacted] denied all allegations and statements. Both verbal children in the home denied excessive corporal punishment and personnel at [redacted] and [redacted] school reported no concerns about abuse or neglect. The Intact caseworker was contacted by the CPI and did not have concerns related to the allegations, but did report parenting classes had not been completed due to transportation issues, that [redacted] and Semaj had not had 0-3 developmental screenings, and that the family case had been set to be closed prior to the initiation of this investigation. This investigation was unfounded for allegation 10a due to insufficient evidence; Final Finding Date 1/27/17.

- SCR# 1790259B (2A 17) – Report Date 2/16/17

Reporter stated that source [redacted] contacted the police after observing a mark on her child [redacted] (age 1) leg upon changing his diaper. The mark was reported to have looked fresh upon the SCR report; it was described as three inches on the back of the child's right leg and covering a portion of the child's calve. The child was picked up by the girlfriend of Wesley Sykes (father), Lakerisha Crosby, who facilitates the visitation. The mother has a pending domestic violence case against the father; the court order says no direct contact between the parents and mom communicates with dad's girlfriend via Facebook regarding the pick-up and drop-off of [redacted] to the father. The mother did not know the father's home address and it is unknown whether the father's girlfriend resides with Wesley. Allegation #11, Cuts Bruises Welts Abrasions and Oral Injuries for child [redacted] [redacted] and Allegation #60,

Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect for children [redacted] and [redacted] were accepted for investigation naming Wesley Sykes and Lakerisha Crosby as alleged perpetrators. This report is pending at the time of this report.

- SCR# 2290813A (2A 19) – Report Date 3/4/17

Reporter stated three year old [redacted] is the suspected victim of sexual abuse and is in the hospital receiving a medical examination. Allegation # 11 Cuts, Bruises, Welts, Abrasions and Oral Injuries, Allegation #19 Sexual Penetration, and Allegation # 22b-Substantial Risk of Sexual Abuse - Sibling of Sex Abuse Victim (alleged child victim [redacted] were accepted for investigation naming Mr. Wesley Sykes as the alleged perpetrator. Mr. Sykes is Lakerisha Crosby's paramour and was reported to be residing in Sheri Gordon's home and had been in a caregiver role for the children. Related Information reports were received by SCR on at 2:35 pm and 9:20 pm on the day of the report regarding mother's location at a hotel with the children, and alleging that the mother's story had changed as she had stated that an aunt was with the children as well as the alleged perpetrator. Mr. Sykes' whereabouts were documented as unknown after he reportedly left the home after the bruising and vaginal swelling were discovered on [redacted] by Lakerisha Crosby.

Ms. Sheri Gordon's children [redacted] and Semaj were not named as victims, only as other children in the home in this investigation and were documented as observed without outward signs of abuse or neglect on 3/8/17. Contact with the intact service provider for the Gordon case was not documented. CPI interviews with the examining physician were noted to include that there was no evidence of sexual penetration. The bruising to [redacted] thighs was reported by the physician to appear to be "grab marks" that were highly unlikely to have been caused on the day of the report (Saturday) but had likely occurred two to three days earlier. This report was Unfounded for allegations #19 Sexual Penetration, and # 22b Substantial Risk of Sexual Abuse - Sibling of Sex Abuse Victim, due to insufficient evidence, and Indicated for allegation # 11 Cuts, Bruises, Welts, Abrasions and Oral Injuries with difficulties noted by the examining doctor in precisely dating the incident; Final Finding Date 5/3/17.

- SCR# 2298844A (2A 50) - Report Date 4/21/17

Reporter states seven year old [redacted] is in need of psychiatric hospitalization due to suicidal ideation and statements and mother is refusing to have him admitted to the hospital. The child reported to the reporter that mother had not refilled his prescription for psychotropic medication, which reporter stated has led to changes in his behavior at school. Allegation #79 Medical Neglect was accepted for investigation naming mother Sheri Gordon as the alleged perpetrator and [redacted] as the alleged child victim.

[redacted] was transported to the local hospital and interviewed by CPI on the day of the report. Documentation of the interview with [redacted] notes he stated he did want to shoot himself with a BB gun but did not know where to get one. He stated he does not love his family and does not want to live with them and that his "granny and aunt" hurt him at home when he gets in

trouble by hitting him with their hands and a belt. He stated that he goes to therapy every week to talk to "some lady." He stated he feels safe at home and wants to go home. Intact family Service caseworker was interviewed and stated she has never seen [redacted] act out at home and that she visits the family bi-weekly.

In-person contact between the assigned investigator and mother and other children in the home, including Semaj, was documented to have occurred on 4/25/17 at 2:50 pm in the family home. The home was reported to have dirty furniture, walls, carpeting, and clothing on bedroom and bathroom floors, but no immediate safety concerns were noted. The family was reported to be leaving to go get ice cream, with the aunt and grandmother, but went back into the house to meet with the CPI. Lakerisha Crosby was also interviewed in the home at 3:55 pm and she did not have concerns about [redacted] and stated she and her mother were in the home because she was asked to help Sheri Gordon with the kids by the children's father (James Crosby) while he was incarcerated. This investigation is noted as unfounded due to insufficient evidence, but still pending at the time of the writing of this report.

- SCR# 2298844B (2A 50) - Report Date 4/26/17

Reporter stated one year old Semaj Crosby is missing from the family home, and there may have been a two hour gap in mother noticing her missing and making a police report. The reporter asked to speak to the CPI who had been in the home and observed the children on 4/25/17; Allegation #74 Inadequate Supervision, was accepted for investigation naming mother Sheri Gordon as the alleged perpetrator and child Semaj Crosby as the alleged victim. The child was found deceased in the family home on 4/27/17. Allegation #51, Death by Neglect, was added to this investigation for Semaj. Companion reports and investigations naming Darlene Crosby (SCR 2301083A), and Lakerisha Crosby (2290813B), were initiated on 4/27/17 due to the death of Semaj because both women were reported in the home, in addition to Ms. Gordon, at the time of her disappearance. Allegation #60, Substantial Risk of Physical Injury/Environment Injurious to the Health and Welfare for the three minor children in their care was accepted for investigation and all reports are pending at the time of the completion of this report.

Other Family Member History

Darlene Crosby has had contact with DCFS in a parent role due to allegations of inadequate supervision, and was the head of household in a service case opened for Neglect from March of 1993 through June of 1993, and a Preventative Service case from April 2010 through April 2011. [redacted] and [redacted] and [redacted] have had previous contact with DCFS child welfare services while still in child roles. Wesley Sykes has a documented history of domestic violence and reported being on parole while residing in Ms. Gordon's home.

Intact Family Service Case Intervention

A Tier 1 Intact Family Services case was initiated with Ms. Gordon and her children after the family's case was opened for Preventative Services, following the unfounded child protection investigation regarding inadequate supervision in September 2016. The Handoff Conference between the child protection team to the intact family team was documented to have occurred 9/20/16. A possible hearing impairment for the eldest child and delayed immunizations for Semaj were noted. The need for children's bedding and "parenting" was noted. Mother was reported to be pregnant. The Transitional Visit occurred at the family home on 9/23/16 with CPI, the intact caseworker, and Ms. Gordon and her children noted as present. The Home Safety Checklist was completed without obvious safety issues observed by the caseworker. Bedding for the children was needed due to old bedding being discarded due to bed bugs. Children observed to be playing and free from observable signs of abuse or neglect on this date. Ms. Gordon's reported pregnancy was not documented as discussed.

Caseworker visits to the home were documented to have occurred approximately weekly or more often during the months of October, November, and December 2016, and then at least two times a month during 2017. In addition to Ms. Gordon's four children, Lakerisha Crosby's two children were observed in the home regularly being babysat by Sheri Gordon. During October 2016 it appeared that both Darlene and Lakerisha Crosby (and their children) were living in the Gordon Home. The caseworker noted that she discussed with Ms. Gordon that it appeared that she was being taken advantage of by the Crosbys', and was noted to be making "excuses" for them being in the home. The caseworker documented that they refused to help Ms. Gordon with the household bills and help with transportation. The caseworker reminded Ms. Gordon that this was her home, subsidized through the Section 8 Program and that others should not be living there. The Crosbys' were reported to the caseworker to have moved out on 11/02/16. Darlene and Lakerisha Crosby, their children, and Lakerisha Crosby's "husband" were noted back in the home on or about 12/16/16. On 12/21/16, Ms. Gordon reported she and her four children slept in one bedroom. The caseworker documented asking Ms. Gordon if she felt safe with Darlene Crosby in the home, to which she replied yes.

Chronic issues in paying household bills and access to transportation and medical appointments for the children were noted during caseworker contacts. Ms. Gordon's sister was reported to receive Sheri Gordon's SSI money monthly as the "overseer of the account." Electric power was shut off in the home on 10/25/16 during a caseworker visit. Cash assistance of over $900.00 for household Items and bedding for the children was provided to Ms. Gordon in December 2017 through DCFS. Other cash assistance from a community agency to pay outstanding utility bills

was also noted. Ms. Gordon utilized her LINK benefits for food for the children, which was observed regularly in the home.

In January 2017, the home and carpeting were noted to be dirty and an initial plan to have the carpet steam cleaned was made. This plan did not proceed immediately due to lack of funds; by April the carpet was deemed too damaged to be cleaned. The home was noted to be sparsely furnished at case opening, and problems in maintaining home cleanliness was noted, but was not assessed to have risen to a level of being a danger to the children's health or safety by either intact or investigative staff who observed the home. Clutter and clothing on the bedroom floors and excessive garbage in the kitchen, and the need for it to be cleaned up, was noted by the caseworker as discussed with the mother during the last contact documented in the family home on 4/24/17. Observation of Semaj in the home was documented on this date at 1:30 pm relating that she appeared clean and appropriately dressed with no outward signs of abuse or neglect noted.

Parent coaching services were linked to the family but problems in appointments and transportation impacted effective interventions. The initial parent coach started services and there were immediate problems with transportation and the setting of appointments. The service provider was concerned that mother did not understand when appointments were scheduled, showed up when appointments were not scheduled, and the provider appeared to have discontinued services. When the caseworker spoke to Sheri about transportation, she stated she did not have the funds to catch a bus as it costs "$1.74" each way. Scheduling of, and transportation to, medical appointments for the children became a primary focus during the intact family case.

Five young males and one female were noted to have answered the door in the Gordon home for the caseworker on 10/11/16, 11/18/16, 11/21/16, 11/22/16, 11/28/16, and 1/20/17. Documentation regarding their identity, if they were household members, or the extent of their caretaker role for the children was not noted. Follow-up conversations with Ms. Gordon regarding the identity of people living in and frequenting her home, and decision making related to who she is allowing to be in caregiver roles for her children, was not clearly denoted in caseworker or supervisory documentation.

During this Intact Family Service case child protection investigations involving both Darlene and Lakerisha Crosby and Wesley Sykes took place. All three individuals, and their three involved children, were household members or frequented the home during the period of Intact Family Service intervention. Sheri Gordon is not documented as telling her intact family caseworker of other child protection investigations involving her, her children, or other household members.

Caseworker Supervision

Supervisory sessions between the Intact Family Services supervisor and caseworker were documented to have occurred on 9/26/16, 11/3/16, 11/4/16, 11/29/16, 12/1/16, 12/21/16, 1/31/17, 2/28/16, 2/28/17, 3/28/17, 4/21/17, and 4/24/17. Seven of those supervision notes were recorded as entered into SACWIS on 4/26/17, the day after Semaj was reported missing, and one of those supervision notes was amended on 4/27/17 to include family contact dates and dates of supervision. This late entry of narrative information regarding the majority of documentation of supervisory consultations with the caseworker can significantly impact the assessment of effective guidance afforded to the caseworker, and challenge the credibility of the supervision process.

Initial supervision noted the need for additional furniture and bedding in the home, the unmet medical needs of two of the children, and identified concerns about others living in the Gordon home with small children. Mother was noted to have cognitive deficits and was receiving SSI and parenting services were to be put into place. Child [redacted] was mentioned in supervision and the supervisor reported that he would be receiving mental health services and medication management in the community after his repeated psychiatric admissions. In a supervisory consultation documented to have occurred on April 21, 2017, the supervisor noted concerns about the mother's ability to understand testing [redacted] needed due to her reported impaired cognition, and requested the caseworker request medical and school records. Child protection investigation documentation notes the caseworker reported that the case had been set for closure in both January 2017, and April 2017, by the Intact Family Services agency. These decisions were reversed after additional child protection investigations were initiated on 1/27/17 and on 4/21/17.

Clinical Analysis of Case Management

The following records were reviewed for the purposes of this clinical assessment:

- Integrated Assessment Report, dated 11/4/2016
- DCFS Contact and Supervisory Notes, dated 9/20/16 through 4/27/17
- DCFS Quality Assurance and Clinical Review Referral Form, dated 4/29/17
- Psychological Evaluation of [redacted] from [redacted] Hospital, dated 11/17/2016

Semaj's family initially came to the attention of DCFS in September of 2016 following allegations of inadequate supervision and drug use in the home. These allegations were ultimately unfounded and an intact family case was opened in order to provide the family with

housing support and parenting assistance. Following the opening of the intact case, there were four additional investigations, assigned to three child protection teams, alleging medical neglect and excessive corporal punishment by Ms. Gordon in regards to her son, [redacted] Three additional allegations of child maltreatment were reported and investigated related to other adults living in the home. During the first several months after case opening the caseworker completed weekly visits, at minimum, at which point she transitioned to biweekly visits. Ongoing caseworker supervision is documented. Records indicate that the Agency began the paperwork to prepare for case closing prior to April 24, 2017, but that these efforts were put on hold following a report of medical neglect related to Ms. Gordon's alleged refusal to psychiatrically hospitalize [redacted] on April 21, 2017.

Throughout the duration of the case, Ms. Gordon was described to be nurturing and caring towards her children. Concerns were expressed, however, about the presence of potential cognitive impairments and/or learning disabilities that contributed to her difficulties securing medical and developmental interventions for her children, as well as transporting her children and herself to appointments. Ms. Gordon self-reported a history of developmental delays for which she received SSI, though she was uncertain of specifics. She reported that she had been diagnosed with learning disabilities as a child and had participated in special education services prior to her graduation from high school in 2003. Based on a review of records, it appears as though Ms. Gordon was not only motivated to comply with DCFS recommendations, but appeared to appreciate the support such services afforded her when she was able to take advantage of such assistance. At times, however, potential cognitive and/or adaptive limitations may have impacted her ability to fully engage and remain consistent in services, as well as to maintain an appropriate and safe home environment for her children. In addition, potential cognitive, learning, and/or adaptive limitations may have impacted Ms. Gordon's efforts to ensure that her children's' developmental, medical, and mental health needs were addressed. While there were clearly concerns noted throughout the case about Ms. Gordon's potential cognitive and adaptive limitations, the extent of her potential limitations is unknown. Given the combined multitude of risk factors associated with this case, Ms. Gordon's functional abilities should have been more thoroughly investigated and potentially formally assessed.

As noted, Ms. Gordon's potential cognitive and/or learning difficulties may have impacted her ability to ensure her children's health and mental health needs were adequately addressed. In particular, her middle son, [redacted] has a long history of emotional and behavioral difficulties for which he received special education services at a therapeutic day school. Since the time of the opening of the case in September of 2016, [redacted] was psychiatrically hospitalized on three separate occasions for suicidal ideation. It is important to note that hospital records describe considerable concerns about highly agitated and self-harming behavior, in combination with

persistent suicidal ideation. In addition, [redacted] reported feeling unloved and wanting more time with his mother. While the origins of [redacted] mental health struggles are unknown, it is clear that he required intensive parenting and therapeutic support, as well as constant supervision and monitoring. Of concern, hospital records do not document ongoing communication between the hospital and the caseworker, nor do they indicate the presence of the caseworker or other Agency representatives at [redacted] discharge staffing. As such, coordination of [redacted] aftercare was inherently limited to Ms. Gordon's understanding and interpretation of post-discharge recommendations. Following [redacted] psychiatric hospitalizations, Ms. Gordon displayed difficulty coordinating [redacted] therapeutic services and ensuring that he consistently received his psychotropic medications. While the caseworker's attempts to encourage Ms. Gordon to fill [redacted] prescriptions are well-documented in the case notes, there were clearly monetary, logistical, and potentially cognitive/learning barriers in regards to Ms. Gordon's ability to be fully successful in this endeavor. Also of concern, there is no documentation to suggest that the intact caseworker consulted with [redacted] school or educational team about his emotional and behavioral functioning, or about potential concerns or strengths of the family. As the lead member of the family's treatment team, the caseworker and Agency should have ensured that Ms. Gordon fully understood her son's mental health struggles, as well as his educational and treatment needs. Given the extent of [redacted] mental health struggles, Ms. Gordon was clearly in need of intensive parenting and therapeutic assistance to support her ability to help keep [redacted] safe and to promote his overall health and development.

Ms. Gordon's ability to maintain sanitary conditions in her home and to keep up with household bills presented another level of challenge throughout the duration of the case. Dependent upon the visit, the home was at times observed by the caseworker to be appropriate with no obvious safety hazards. More often, however, concerns were noted about messy or dirty conditions, including heavily soiled carpet that was ultimately determined to be too damaged to benefit from professional cleaning. In part, limited financial resources contributed to challenges in keeping the house clean, especially as the home did not have a kitchen table or chairs for the children to eat on. As a result, the children were observed to eat all over the house, which resulted in substantial mess. During one visit, the caseworker observed Ms. Gordon to sweep debris from the floor into a corner of the house. The caseworker was able to successfully access and utilize Norman funds in December of 2016 to obtain beds and bedding for the children, who were previously sleeping on air mattresses and/or the floor. By April of 2017, however, the beds were determined to be broken and unusable soon after they were purchased, potentially due to a lack in follow-through in putting the beds together. In addition, there were clothes all over the bedroom (which was described to be a safety hazard), the bathroom was observed to be messy (though not hazardous), the

smoke detector was dying, and the kitchen contained trash that needed to be taken out to the garbage.

Case notes do not document concerns about significant pest infestation, though photos taken during the search for Semaj document numerous cans of RAID. It is unknown if these cans were placed on the counter during or after the search, or if they were in a secure location inaccessible to the young children residing in the home prior to the search. In addition, a roach infestation was reported by law enforcement officials who reported it necessary to cover their shoes during the search. Given the extent of the roach infestation described in reports following Semaj's discovery, it is not clear why this issue was not observed, reported, or addressed, during visits to the home. Furthermore, there does seem to be discrepancy between the caseworker's report of a messy, though not necessary deplorable, home environment and subsequent law enforcement reports that detail "deplorable" home conditions.

Of concern, case notes document numerous unknown individuals coming and going from the home between the time of case opening and the time of Semaj's death. At times, some of these unknown individuals appeared to be caring for the children. In addition, contact notes clearly document the caseworker's attempts to discuss the on and off residence of Semaj's paternal grandmother, Darlene Crosby, paternal aunt, Lakerisha Crosby, and other paternal relatives in the home. Case notes report that the adult paternal relatives appeared to contribute little in the way of financial, household, transportation, or child care assistance, and in fact appeared to take advantage of Ms. Gordon. Ms. Gordon provided a significant amount of childcare for Lakerisha Crosby's children, though was not reported to be paid for her services. The caseworker advised Ms. Gordon numerous times that her Section 8 housing may even be in jeopardy because of the presence of the Crosby women and others in the home. Ms. Gordon was reported to appear afraid of Darlene and Lakerisha Crosby, though unable and/or unwilling to prompt them to leave permanently. Also of concern, both Lakerisha Crosby and Darlene Crosby were involved in allegations related to Lakerisha's children, in October of 2016 and then again in February and March of 2017. None of Ms. Gordon's children were identified as potential victims in the allegations, despite their known residence in the home.

Discussion of Findings

Multiple reports noting concern about young children being cared for by three related caregivers living in the same home were reported to the State Central Registry over a 10 month period. Three of the child protection investigations involved physical abuse allegations to children who were age three and under, and one seven year old child with multiple reports had

a significant history of emotional and behavioral disturbance for which he had been placed in a therapeutic day school. This pattern of reports, coupled with the vulnerability of the children, should have been recognized as requiring comprehensive assessment and intensive interventions by both Intact Family and Investigative staff.

Tracking of allegations, review of historical information, and complete information regarding household composition, was hampered by report sequencing practices. Critical exploration into the family dynamics, the use of collateral contact information during investigations, and informed dialogue between all of the assigned investigators and supervisors, was a missed opportunity for in-depth assessment of ongoing risk factors in the home. The pattern of involvement of Lakerisha Crosby, and her one and three year old children in multiple child protection investigations over the 10 month period, upon closer review, could have included consideration of interventions specifically targeting this family unit, in addition to the Gordon family unit.

A standard of practice for front end child protection and direct service intact family service teams to coordinate efforts and interventions with this family was missing. Strong communication, coordination, and supervisory involvement was needed between the investigative and intact teams in order to provide a comprehensive perspective, and to enact planning to implement effective interventions through services and supports to address the underlying issues and conditions that led to the child protection investigations. A family team approach, with the family, DCFS, the contracted intact family service provider, the school, and the involved community providers, to assess, address, and problem solve around the chronic suicidal statements made by the seven year old child was not initiated. This lack of team coordination prevented adequate support of Ms. Gordon in her efforts to parent a son with significant mental health needs.

Supervisory support and guidance to both the investigators and intact caseworker was noted to occur regularly. However, the scope of the supervision appeared limited and failed to explore and plan for the multiple areas of the parenting environment impacted by the mother's potential cognitive, adaptive, and emotional difficulties, including the manner in which these factors may have influenced her ability to navigate her relationships with her family members and to ultimately keep her children safe. Guidance and planning to effectively assess Ms. Gordon's understanding of her children's needs and maintain a safe environment for her children was minimally provided. Direct contact with the older children's schools was not monitored, and the caseworker's attendance at [redacted] hospital discharge staffing was not discussed in intact family supervisory documentation. In addition to the mother's areas of personal vulnerability, the timely and thorough assessment of the child welfare and criminal histories of persons either living in the home, or frequently having access to the children, as

well as the capacities of these persons to be in caregiver roles for the children, was not completed. Due to late entry of documentation of supervisory consultations on the Intact Family Service case, the credibility of the supervisory sessions can be called into question.

In May 2016, the Department began using the Eckerd Rapid Safety Feedback technology and case analysis as a tool to help the Department identify children at risk and in need of greater intervention, but such technology currently focuses on investigations and has not at the time of this writing been extended to intact families. The department should consider expansion of this technology for utilization in intact family cases.

Despite consistent case management activity, client contact, and regular supervision on the part of the Intact Family Service provider, including several positive and helpful interventions, the family continued to struggle with a range of risk factors likely related to Ms. Gordon's overall vulnerability combined with the stressors of poverty and single handedly raising four children. Ms. Gordon's self-reported cognitive limitations potentially influenced every aspect of this case, yet the impact of her potential limitations were never addressed, nor was she ever referred for further evaluation to determine the implications of her reported struggles on her parenting abilities. Concerns about Ms. Gordon's cognitive struggles likely affected her ability to maintain a clean and safe home environment for her family, which presented an ongoing area of risk throughout the duration of the case. In addition, Ms. Gordon's potential victimization by Semaj's and [redacted] paternal relatives and multiple unknown persons in the home at different times became an ongoing risk factor that likely impacted the ultimate safety of the children. A comprehensive perspective of case dynamics was further hampered by report sequencing practices involving tracking of allegations, review of historical information, and complete information regarding household composition.

Appropriate and long-term community and family supports for both Ms. Gordon and her children, especially in addressing [redacted] significant behavioral health concerns, should have been clearly identified and planned for to support the mother's long-term capacity to provide a safe environment for the young children in her care, prior to any consideration of closing the family's case. While it is beyond the scope of this report to determine what additional services might have been available and prescribed, it does not appear that Ms. Gordon was resistant to further help. The Department is urged to prepare and make public an assessment of possible services available to this family and others in similar circumstances in that community, including recommendations about how the Department and the community might better assess and support vulnerable children and families.

Lessons Learned and Recommendations

1. *DCFS should review the sequencing process of reports by the State Central Registry (SCR). In a 12 month period of time the family experienced multiple reports with multiple differing SCR numbers. Because reports were unfounded a new SCR number was given with each new report. This process does not lend itself to linking and understanding history and trends. Rules for sequencing are defined by statute, however, maintaining a sense of a pattern in these cases is critical and needs to be addressed. Consideration should also be given to tracking a common address in which child victims and other children reside. Change to the current method of sequencing and linking reports had been previously identified in a recommendation by the Death Review Team. Statutory clarification, a review of DCFS Procedures 431, and further discussion on next steps on the matter were in process previous to this review and report.*

2. *Supervisors must consistently ensure Child Abuse and Neglect Tracking System and Law Enforcement Agencies Data System checks are conducted by casework and investigative staff on all persons living in and frequenting the home, particularly when there are concerns about residents who appear to be taking advantage of the caregiver and/or impacting the caregiver's ability to parent.*

3. *When caregivers self-report a history of developmental delays, including cases in which a caregiver reports to have received special education services as a child, struggles with basic math or reading, and receives SSI benefits related to a developmental disability, the caregiver's functional abilities related to parenting and decision making must be thoroughly explored. A review of documentation regarding the parent's qualifying conditions for SSI benefits, and obtaining information from other collateral contacts regarding the parent's abilities and limitations should be secured to complete the family assessment. DCFS should establish a protocol for screening caregivers when concerns about cognitive functioning arise. DCFS could explore the possibility of utilizing the regional consulting psychologists to perform an abbreviated cognitive assessment in situations in which there is a positive screen. Dependent upon a client's performance on an abbreviated measure of cognitive functioning, a caregiver may or may not be referred to a comprehensive psychological evaluation.*

4. *DCFS should review the definition of, and procedures related to, the assessment of minimum parenting standards, including number of people living in a defined space, and what constitutes acceptable living conditions for children under six years of age.*

5. *DCFS should review current procedures regarding multiple Subsequent Oral Reports occurring on open Intact Family Service Cases. Communication at the supervisory level as well as the caseworker and investigator level should be emphasized to help ensure, improve, and support communication on effective and specific family interventions, ongoing areas of risk in the home, child safety, and decision making around Juvenile Court involvement.*

6. *DCFS should provide training for intact family supervisors regarding steps in the family assessment and intervention process when parents have developmental disabilities and are caring for young children. This may assist in structuring caseworker visits to the home to effectively support skill building, lead to more accurate assessment of the risks in the home due to the parent's cognitive functioning, and promote better planning for the family's after care needs to impact the long term well-being of the children.*

7. *When questions about the home conditions persist, and when there are observable signs of significant mess, disrepair, or infestation, cases should be kept open until the caregiver evidences signs of having internalized housekeeping routines and rules, particularly when there are young children in the home. If a caregiver is unable to consistently adhere to basic housekeeping practices, they should be further assessed to evaluate if there are any underlying cognitive, emotional, or psychological factors impacting their ability to maintain a generally appropriate environment.*

8. *When children present with serious mental health or emotional/behavioral struggles, Intact Family Service provision should intervene and ensure that the caregiver receives psychoeducation and understands the dynamics of the child's struggles, particularly when high risk symptoms, such as suicidality, exist. In such cases, it is imperative that the caseworker ensure that the parent not only understands, but is able to implement, all treatment recommendations.*

9. *Intact Family Service caseworkers should participate in hospital discharge planning for children and ensure that feasible plans are put into place for the child and family. This includes facilitating support from the child's treatment team with the caregiver to ensure the caregiver understands their child's diagnosis and recommended treatment interventions, including specific high risk behaviors that might prompt psychiatric consultation and/or assessment.*

I have received and reviewed the attached report regarding Semaj Crosby.

George H. Sheldon
Director
Illinois Department of Children and Family Services

5/25/17
Date

Appendix 1 – Case Data

- DCFS Case ID#: [redacted]
- Pending SCR# if applicable: 2298844A and 2298844B
- Child Name: Semaj Crosby
- Case Open Date: Family case: 9/23/16
    - Child case: NA
- Case Open Reason: Preventative Services
- Family Case Close Date: NA
- Family Case Close Reason: NA
- Child Case Close Date: NA
- Child Case Close Reason: NA
- Most Recent Indicated Allegation Code(s): 11
- Underlying Conditions and Issues: Custodial mother with reported cognitive impairment, young child with chronic mental/behavioral health concerns, chronic issues in meeting household expenses, lack of transportation, incarcerated father for two children.
- Child DOB: [redacted]
- Child DOD: 4/27/17
- Age at time of death: 17 months
- Race: AA
- Sex: Female
- Cause of Death: Unknown, child's body found under a couch in the family home; full autopsy pending.
- Permanency Goal: NA
- Living arrangement at time of death: HMP
- If death occurred in foster care, list placement type at time of death: NA
- Assigned Agencies:
  Children's Home and Aid Intact Family Services Team 2A IN
  DCFS Division of Child Protection Team 2A 50
- Reviewers: Christy Levine and Christine Schmidt

Appendix 2

Listing of Occurrences of Child Protection Investigations Involving Children Residing or Being Cared For at Address 309 Louis Road Joliet, Illinois

4/24/15 (2A 14) #11 Indicated; James Crosby inflicted bruising to [redacted]

5/24/16 (2A 14) #74 and #60 Unfounded; Sheri Gordon to [redacted]

9/7/16 (2A 50) #74 Unfounded; Sheri Gordon to [redacted] Semaj

9/23/16 - Intact Family Service Case opened for Sheri Gordon

10/5/16 (2A 19) #76, 10a, 11 Unfounded; Sheri Gordon to [redacted]

10/10/16 (2A 19) #11 Unfounded; Darlene Crosby to [redacted] and [redacted]

11/30/16 (2A 19) #79, Unfounded; James Crosby to [redacted]

1/20/17 (2A 17) #10a, Unfounded; Sheri Gordon to [redacted]

2/16/17 (2A 17) #11 and 60; Pending Wesley Sykes and Lakerisha Crosby to [redacted] (#11), [redacted] and [redacted] (#60)

3/4/17 - (2A 19) #11, 19, and 22b; Unfounded #19 for [redacted] and #22b for [redacted] Indicated #11 [redacted] to [redacted]

4/21/17 - (2A 50) #79; Pending Sheri Gordon to [redacted]

4/26/17 - (2A 50) #74 and #51, Pending, Sheri Gordon to Semaj Crosby; #60, Pending, Sheri Gordon to children [redacted] and [redacted] Companion Pending reports naming Darlene Crosby and Lakerisha Crosby as alleged perpetrators, adding risk of harm allegations for [redacted] and [redacted] and [redacted]