STATE OF ILLINOIS
OFFICE OF THE
AUDITOR GENERAL
Frank J. Mautino, Auditor General

SUMMARY REPORT DIGEST

DEPARTMENT OF CORRECTIONS

Compliance Examination
For the Two Years Ended June 30, 2020

Release Date: October 13, 2021

FINDINGS THIS AUDIT: 60			
	New	Repeat	Total
Category 1:	4	13	17
Category 2:	22	21	43
Category 3:	0	0	0
TOTAL	26	34	60

FINDINGS LAST AUDIT: 46

AGING SCHEDULE OF REPEATED FINDINGS			
Repeated Since	Category 1	Category 2	Category 3
2018	7	21,30,31	
2016	13,14,15,16	17,33,41,43	
2014	4	27,36,37	
2012	3,11	19,29,40,42	
2010	18		
2006		34,60	
2008	1,2,6,8	22,28	
2000		35,46	
1998		32	

INTRODUCTION

This digest covers the Compliance Examination of the Department of Corrections (Department) for the two years ended June 30, 2020. The Department's Financial Statement Audit covering the year ended June 30, 2020 was previously issued under separate cover. In total, this report contains 60 findings, 8 of which were reported in the Financial Audit.

SYNOPSIS

- (**20-9**) The Department failed to meet requirements of a settlement agreement and court order for the provision of mental health services to mentally ill inmates in custody of the Department.
- (**20-12**) The Department lacked an adequate internal control structure over the reporting of census data events to the Department of Central Management Services.
- (**20-14**) The Department did not implement evidence-based programming or comply with related provisions of the Illinois Crime Reduction Act of 2009 during the examination period.
- (**20-41**) The Department had not implemented adequate internal controls related to cybersecurity programs and practices.
- (**20-57**) The Department did not timely provide all requested documentation to the auditors.

Category 1: Findings that are **material weaknesses** in internal control and/or a **qualification** on compliance with State laws and regulations (material noncompliance).

Category 2: Findings that are **significant deficiencies** in internal control and **noncompliance** with State laws and regulations.

Category 3: Findings that have **no internal control issues but are in noncompliance** with State laws and regulations.

DEPARTMENT OF CORRECTIONS
COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2020

EXPENDITURE STATISTICS (In Thousands)	2020	2019	2018
Total Expenditures	**$ 1,538,460**	**$ 1,582,892**	**$ 1,949,212**
OPERATIONS TOTAL	$ 1,523,497	$ 1,566,414	$ 1,931,581
% of Total Expenditures	99.0%	99.0%	99.1%
Personal Services	971,547	1,013,315	897,224
Other Payroll Costs (FICA, Retirement)	77,150	80,350	71,610
All Other Operating Expenditures	474,800	472,749	962,747
AWARDS AND GRANTS	$ 14,719	$ 15,151	$ 17,090
% of Total Expenditures	1.0%	1.0%	0.9%
REFUNDS	$ 9	$ 43	$ 187
% of Total Expenditures	0.0%	0.0%	0.0%
PERMANENT IMPROVEMENTS	$ 235	$ 1,284	$ 354
% of Total Expenditures	0.0%	0.1%	0.0%
Total Receipts	$ 54,966	$ 60,501	$ 50,822
Average Number of Employees			
Divisions and Centers (Excluding ICI)	12,587	12,341	11,985
Illinois Correctional Industries (ICI)	94	93	105

AGENCY DIRECTOR
During Examination Period: John R. Baldwin, Acting (7/1/18-5/19/19), Gladyse Taylor, Acting (5/20/19-5/31/19) Rob Jeffreys, Acting (6/1/19 - 5/31/20), Rob Jeffreys (effective 6/1/20)
Currently: Rob Jeffreys

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

FAILURE TO MEET COURT-ORDERED MENTAL HEALTH SERVICE REQUIREMENTS

The Department failed to meet requirements of a settlement agreement and court order for the provision of mental health services to mentally ill inmates in custody of the Department during the examination period.

In April of 2019, the United States District Court issued a permanent injunction after finding the Department was "not in substantial compliance" with the settlement agreement entered by the parties in December 2015. The permanent injunction issued by the District Court, *Rasho v. Walker*, 376 F.Supp.3d 888 (C.D. Ill. 2019) ("the court order"), ordered the Department to provide mental health treatment to prisoners, as well as to provide medication management, mental health evaluations, and necessary mental health staff throughout the correctional system.

The Department reported it failed to meet hiring requirements

The Department's facility certifications reported not all court-ordered requirements were met

Based on the auditor's review of staffing levels reported by the Department, the Department failed to meet hiring requirements from the effective date of the permanent injunction through Fiscal Year 2020. In addition, in the report created by the Department to certify each facility's compliance with court-ordered requirements, the Department reported numerous facilities did not meet all court-ordered requirements for some mental health service areas. (Finding 9, pages 51-58)

The auditors recommended the Department allocate the necessary resources and take all reasonable and appropriate measures in order to meet court-mandated staffing and reporting requirements.

Department agreed facility certifications of compliance are accurately reflected in the report

Department indicated facility certifications it submitted to the Court are only the facility's opinion

The Department accepted the recommendation and agreed the audit accurately reflects the publicly available data within facility certifications that self-identify compliance with the permanent injunction in *Rasho*. The Department also stated the facility certifications provide no more than an opinion of those at the facility level regarding their compliance with the order. The Department stated its quarterly reports fully explain how and why it has complied with the 29 data points set forth in the injunction. The Department further responded by stating it has, at all times, during the effective date of the permanent injunction provided appropriate and constitutionally required mental health care to its population. The Department stated its compliance with the 29 requirements within the Rasho permanent injunction throughout the entire system (28 facilities), based solely on facility certifications, indicates it has averaged 91.28% (The Department stated that in this calculation, a facility is considered compliant with a mandate within the Rasho permanent injunction if it rates its compliance 85% or more, consistent with National Commission on Correctional Heath Care standards) compliance over the span of the audit cycle.

In an accountant's comment, we noted the Department's response contradicts evidence examined, as follows:

Department's response contradicts evidence

- When other quarterly report components documenting compliance by each facility are considered, the quarterly reports still disclose noncompliance with court-ordered requirements.

- The documentation provided to the auditors does not provide sufficiently appropriate audit evidence to establish the Department's compliance with the staffing requirements of the court order.

- The Department cannot both certify to the Court that the Department's submissions certify each facility's compliance as required by the court order, while also indicating to the auditors that those certifications are not the Department's opinion.

Compliance rates cited by the Department are misleading

Facility certifications reported all facilities were not compliant with all court requirements

- The compliance rates cited by the Department are misleading and incorrectly imply the Department has exceeded court-ordered compliance requirements. Each of the facilities did not meet at least 85% compliance with each of the 29 directives based on facility certifications, as reported by the Department to the Court.

UNTIMELY AND INACCURATE REPORTING OF CENSUS DATA EVENTS

The Department lacked an adequate internal control structure over the reporting of census data events to the Department of Central Management Services (CMS).

During testing, we noted the following problems:

Events for 44% employees tested were entered into CMS' records 15 or more days after occurrence

- Fifty-three of 120 (44%) employees tested had 69 events occur impacting CMS' census data records where we noted it took between 15 and 152 days from the occurrence of the event to when this information was entered into CMS' records. Six of these noted incidents were also reported in Finding 2020-005.

- One of 120 (1%) employees tested had a discrepancy between the change date recorded within CMS' records and the Department's records. We noted the reported date within CMS' census data records was 202 days after the event purportedly occurred according to the Department's records. This exception was also reported in Finding 2020-005.

Records lacked support for the date transactions were reported to CMS

- Five of 120 (4%) employees tested had transactions reported to CMS where the Department's underlying records lacked support for when Department personnel actually reported the transaction to CMS. (Finding 12, pages 67-68)

We recommended the Department implement controls to ensure reportable events are timely and accurately transmitted to CMS and

records are properly completed and maintained to support transactions reported.

Department accepted the recommendation but responded timeliness of entering some changes is out of its control

The Department accepted the recommendation and stated the Department strives to enter changes within a few days of receiving the required paperwork and approvals from the employees. The Department also responded that CMS policy allows employees to submit paperwork for an approved leave of absence or other changes for an indefinite amount of time on or after the date the event occurs and therefore, the timeliness of entering some changes into the CMS system is entirely out of the Department's control.

Department response is contradictory

In an accountant's comment, we noted Department officials contradict themselves by accepting the recommendation that they should implement controls to ensure reportable events, including leaves of absences, are reported timely to CMS, while simultaneously rejecting this recommendation by stating an unspecified CMS policy – which had not previously been disclosed during this examination – allows employees an indefinite amount of time to submit the paperwork for reporting leaves of absences or other changes. We continue to believe the Department should implement controls to ensure all reportable events are timely and accurately transmitted to CMS.

Department should implement controls to ensure events are timely and accurately transmitted

NONCOMPLIANCE WITH EVIDENCE-BASED PROGRAMMING REQUIREMENTS OF THE ILLINOIS CRIME REDUCTION ACT OF 2009

The Department did not implement evidence-based programming or comply with related provisions of the Illinois Crime Reduction Act of 2009 (Act) during the examination period. We noted:

Policies, rules, and regulations were not adopted for a standardized risk assessment tool

- The Department did not adopt policies, rules, and regulations regarding the adoption, validation, and utilization of a statewide standardized risk assessment tool for supervised and incarcerated individuals during the engagement period.

All required training not provided during the examination period

- The Department had not provided all of its Parole Division employees with intensive and ongoing training and professional development services to support the implementation of evidence-based practices on all required topics during the examination period.

No evaluation system for the effectiveness of evidence-based practices

- The Department did not design, implement, or make public a system to evaluate the effectiveness of evidence-based practices.

- The Department did not annually submit to the Sentencing Policy Advisory Council a comprehensive report on the success of implementing evidence-based practices. (Finding 14, pages 71-72) **This finding has been repeated since 2016.**

We recommended the Department fully implement an evidence-based programming system, including policies, procedures and

regulations for risk assessment; employee training; a system to evaluate effectiveness; and annual reporting, to fulfill its mandated duties.

Department accepted recommendation

The Department accepted the recommendation and stated it has fully implemented the Ohio Risk Assessment System (System) to provide evidence-based programming to the individuals in the Department's custody as well as those on parole. The Department further responded all staff within the Department who are required to use the system have been trained and training continues as new staff are hired. The Department also stated COVID-19 restrictions during 2020 hindered the completion of the training since a portion of the assessment (face to face interviewing) could only be conducted in person.

WEAKNESSES IN CYBERSECURITY PROGRAMS AND PRACTICES

The Department had not implemented adequate internal controls related to cybersecurity programs and practices.

We noted the Department:

Comprehensive security program not developed

- Had not developed a formal, comprehensive, adequate, and communicated security program (policies, procedures, and processes) to manage and monitor the regulatory, legal, environmental, and operational requirements.

Risk assessment results not addressed and/or corrective actions not documented

- Had not addressed the results of the risk assessment and/or documented the corrective actions included in the mitigation plan.
- Had not developed a data classification policy.
- Had not developed a policy or procedure related to data wiping.
- Had not ensured cybersecurity awareness training was completed for 808 of 13,958 (6%) registered employees.

Cybersecurity roles and responsibilities not documented and communicated

- Had not ensured cybersecurity roles and responsibilities were documented and communicated. (Finding 41, pages 121-122) **This finding has been reported since 2016.**

We recommended the Department:

- Develop a formal, comprehensive, adequate, and communicated security program (policies, procedures, and processes) to manage and monitor the regulatory, legal, environmental, and operational requirements.
- Address the results of the risk assessment and/or document the corrective actions included in the mitigation plan.
- Develop a data classification policy.
- Develop a policy or procedure regarding the method and responsibilities for data wiping.
- Ensure all Department employees participate in cybersecurity awareness training.

- Ensure cybersecurity roles and responsibilities are documented and communicated.

Department accepted recommendation

The Department accepted the recommendation and responded it is working to ensure recommendations in safeguarding all aspects of Information Technology are established and provided for awareness and compliance.

FAILURE TO PROVIDE REQUESTED DOCUMENTATION IN A TIMELY MANNER

The Department did not provide all requested documentation to the auditors in a timely manner.

4 letters sent documenting delays and requesting Department's assistance

During the engagement, outstanding request listings were sent up to four times a month to the Department. Further, four letters were sent from the Office of the Auditor General to the Department during the audit documenting the delays encountered and requesting assistance necessary to complete the financial audit and State compliance examination of the Department and the financial audit of the Statewide financial statements. As of May 11, 2021, documents related to 491 (47%) requests were provided after the time frame for responses agreed upon with the Department as follows:

47% of requested documents were untimely provided

Days Received After the Due Date of Request	Total Number of Items Past Due
1 to 14	267
15 to 30	102
31 to 60	79
61 to 90	29
90 to 120	8
Over 120	6
Total	**491**

Further, some requests for documentation from correctional facilities were never provided to the facility auditors and therefore were considered as exceptions during testing. Those instances have been reported as part of other findings.

Department agreed to timeframe for responding to audit requests

Department management agreed to provide requested documents within three weeks of receipt of requests at the beginning of the pandemic, then within two weeks of requests effective August, 2020. Beginning in mid-November 2020, the Department agreed to return to prior audits' practice of providing documents and responses to exceptions and potential audit findings within one week of receipt. (Finding 57, pages 150-153)

We recommended the Department allocate the necessary resources in order to provide requested information to auditors in a timely manner.

Department accepted recommendation

The Department accepted the recommendation and stated it takes great comfort in knowing that none of the delays mentioned in this finding caused the delay in completing the Statewide Annual Comprehensive Financial Report (ACFR). The Department further responded it was very clear that reducing the timeframe for a response from 3 weeks down to 2 and then 1 would be extremely difficult to achieve given the constraints of the COVID 19 restrictions and other issues experienced by the Department. The Department stated it made every effort possible to comply, however, it listed contributing factors for delays.

In an accountant's comment, we noted the Department is not in a position to evaluate the effect the Department's delays may impose on the Statewide Annual Comprehensive Financial Report, the Department's financial audit, or the Department's State compliance examination. The auditors concluded the Department did not provide timely information to the auditors, which is noncompliance with the Illinois State Auditing Act. The facts in the finding clearly demonstrate this noncompliance. The timelines established for providing audit requests were reasonable for a routine post audit.

21% of documents provided over 3 to 5 weeks after date requested

Audit document requests were clearly communicated in writing to enable the Department to provide the requested information. The auditors routinely followed up with the Department on outstanding, incomplete, and unresponsive documents, and as detailed in the finding, the Department at times took months to provide complete, responsive documents. A total of 224, or 21% of all requests made, were provided over 2 weeks late (3 to 5 weeks after the date requested).

The auditors made repeated requests for the Department to notify the auditors if they believed any facts were in error. The Department did not raise any concerns with the facts until it submitted its finding response.

Difficulties experienced obtaining timely information and cooperation

Both the finding and the Department's response demonstrate the difficulty the auditors experienced in obtaining timely information and cooperation during this post audit.

OTHER FINDINGS

The remaining findings pertain to financial reporting; noncompliance and control weaknesses regarding laws, rules, regulations, and grant agreements; fiscal and administrative responsibilities; and information technology controls. We will review the Agency's progress towards the implementation of our recommendations in our next compliance examination.

ACCOUNTANT'S OPINION

The accountants conducted a compliance examination of the Department for the two years ended June 30, 2020, as required by the Illinois State Auditing Act. The accountants qualified their report on State compliance for Findings 2020-001 through 2020-016 and 2020-018 individually, and 2020-023, 2020-024, 2020-044, 2020-049, 2020-051, 2020-053, 2020-054, 2020-056 and 2020-058 in the aggregate. Except for the noncompliance described in these findings, the accountants stated the Department complied, in all material respects, with the requirements described in the report.

This compliance examination was conducted by Adelfia LLC.

SIGNED ORIGINAL ON FILE

JANE CLARK
Division Director

This report is transmitted in accordance with Section 3-14 of the Illinois State Auditing Act.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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