State of Illinois Department of Children and Family Services

STATE COMPLIANCE EXAMINATION

FOR THE TWO YEARS ENDED
JUNE 30, 2022

Performed as Special
Assistant Auditors for the
Auditor General,
State of Illinois

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STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2022

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STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
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AGENCY OFFICIALS

Director	Marc D. Smith (06/15/21 - present) Marc D. Smith (Acting) (through 06/14/21)
Executive Deputy Director	Tierney Stutz (Acting) (03/06/23 - present) Vacant (01/14/23 - 03/05/23) Meaghan Jorgensen (Acting) (08/16/22 - 01/13/23) Vacant (01/01/22 - 08/15/22) Derek Hobson (through 12/31/21)
Chief of Staff	Jassen Strokosch (07/16/20 - present) Vacant (through 07/15/20)
Chief Financial Officer	Kiersten Neswick (02/16/22 - present) Joe McDonald (Acting) (01/01/22 - 02/15/22) Royce Kirkpatrick (through 12/31/21)
General Counsel	Brian Dougherty (03/13/23 - present) Carol Melton (Acting) (09/22/22 - 03/12/23) Amanda Wolfman (through 09/21/22)
Chief Internal Auditor	Phillip Dasso (01/04/21 - present) Vacant (through 01/03/21)

AGENCY OFFICES

The Department's primary administrative offices are located at:

406 East Monroe Street
Springfield, Illinois 62701

100 West Randolph Street, Suite 6-100
Chicago, Illinois 60601

MANAGEMENT ASSERTION LETTER

September 7, 2023

Roth & Co., LLP
815 W. Van Buren Street, Suite 500
Chicago, Illinois 60607

Ladies and Gentlemen:

We are responsible for the identification of, and compliance with, all aspects of laws, regulations, contracts, or grant agreements that could have a material effect on the operations of the State of Illinois, Department of Children and Family Services (Department). We are responsible for and we have established and maintained an effective system of internal controls over compliance requirements. We have performed an evaluation of the Department's compliance with the following specified requirements during the two-year period ended June 30, 2022. Based on this evaluation, we assert that during the years ended June 30, 2021, and June 30, 2022, the Department has materially complied with the specified requirements listed below.

A. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. Other than what has been previously disclosed and reported in the Schedule of Findings, the Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. Other than what has been previously disclosed and reported in the Schedule of Findings, State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered, and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

Yours truly,

State of Illinois, Department of Children and Family Services

SIGNED ORIGINAL ON FILE

Marc Smith, Director

SIGNED ORIGINAL ON FILE

Kiersten Neswick, Chief Financial Officer

SIGNED ORIGINAL ON FILE

Brian Dougherty, General Counsel

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2022

STATE COMPLIANCE REPORT

SUMMARY

The State compliance testing performed during this examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants; the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States; the Illinois State Auditing Act (Act); and the *Audit Guide.*

ACCOUNTANT'S REPORT

The Independent Accountant's Report on State Compliance and on Internal Control Over Compliance does not contain scope limitations, disclaimers, but does contain an adverse opinion on compliance and identifies material weaknesses over internal control over compliance.

SUMMARY OF FINDINGS

Number of	Current Report	Prior Report
GAS Findings	3	5
State Compliance Findings	30	25
Total Findings	33	30
GAS New Findings	1	3
GAS Repeated Findings	2*	2
GAS Not Repeated Findings	4**	1
State Compliance New Findings	9	9
State Compliance Repeated Findings	21**	16
State Compliance Not Repeated Findings	4	4

* *Finding 2022-002 was previously reported as a finding in the Department's State Compliance Examination Report for the two years ended June 30, 2020. During the current audit period, this finding has been reclassified to a GAS finding.*

* * *Finding 2022-029 was previously reported as a finding in the Department's Financial Audit Report for the two years ended June 30, 2020. During the current audit period, this finding has been reclassified to a State Compliance finding.*

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATE COMPLIANCE EXAMINATION
For the Two Years Ended June 30, 2022

SCHEDULE OF FINDINGS

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings	
2022-001	14	2020/2020	Financial Statement Preparation	Material Weakness and Material Noncompliance
2022-002	17	2020/2020	Lack of Adequate Controls Over the Review of Internal Controls for Service Providers	Material Weakness and Material Noncompliance
2022-003	20	New	Failure to Maintain Proper Segregation of Duties Over Daycare	Material Weakness and Material Noncompliance
2022-004	22	2020/1998	Incomplete Child Welfare Files	Material Weakness and Material Noncompliance
2022-005	27	2020/2012	Noncompliance with Abused and Neglected Child Reporting Act	Material Weakness and Material Noncompliance
2022-006	33	New	Noncompliance with the School Code	Material Weakness and Material Noncompliance
2022-007	35	2020/1998	Untimely Child Abuse and Neglect Determinations	Material Weakness and Material Noncompliance
2022-008	38	2020/1998	Untimely Initiation of Investigations of Child Abuse and Neglect	Material Weakness and Material Noncompliance
2022-009	40	2020/2016	Noncompliance with the Children and Family Services Act	Material Weakness and Material Noncompliance
2022-010	45	2020/2010	Noncompliance with the State Services Assurance Act for FY2008	Material Weakness and Material Noncompliance
2022-011	47	2020/2012	Lack of Documentation of Monitoring of Contracts with Provider Agencies	Material Weakness and Material Noncompliance

SCHEDULE OF FINDINGS (CONTINUED)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2022-012	49	2020/2018	Noncompliance with the Adoption Act	Material Weakness and Material Noncompliance
2022-013	51	2020/2018	Noncompliance with the Child Care Act of 1969	Material Weakness and Material Noncompliance
2022-014	56	New	Noncompliance with the Social Services Contract Notice Act	Material Weakness and Material Noncompliance
2022-015	58	2020/2018	Failure to Maintain Accurate Property Records	Material Weakness and Material Noncompliance
2022-016	61	2020/2012	Inadequate Internal Controls Over Accident Reporting	Material Weakness and Material Noncompliance
2022-017	63	2020/2012	Federal Reimbursements Not Requested Timely	Material Weakness and Material Noncompliance
2022-018	65	2020/2020	Monthly Reconciliations Not Performed Timely	Material Weakness and Material Noncompliance
2022-019	67	New	Voucher Processing Internal Controls Not Operating Effectively	Material Weakness and Material Noncompliance
2022-020	70	New	Failure to Fully Utilize the State's Enterprise Resource Planning System	Material Weakness and Material Noncompliance
2022-021	73	2020/2020	Inadequate Access Controls	Material Weakness and Material Noncompliance
2022-022	75	2020/2020	Inadequate Controls Over Applications and Data Accuracy	Material Weakness and Material Noncompliance
2022-023	77	2020/2020	Weaknesses in Cybersecurity Programs and Practices	Significant Deficiency and Noncompliance

SCHEDULE OF FINDINGS (CONTINUED)

Item No.	Page	Last/First Reported	Description	Finding Type
			Current Findings (Continued)	
2022-024	80	2020/2020	Inadequate Disaster Recovery Planning and Testing	Significant Deficiency and Noncompliance
2022-025	82	2020/2008	Employee Performance Evaluations Not Performed	Significant Deficiency and Noncompliance
2022-026	84	2020/2020	Inadequate Controls Over Employee Training Programs	Significant Deficiency and Noncompliance
2022-027	86	New	Inadequate Internal Controls Over Employee Timesheets	Significant Deficiency and Noncompliance
2022-028	88	New	Inadequate Internal Controls Over State Vehicle Maintenance	Significant Deficiency and Noncompliance
2022-029	90	2020/2020	Inadequate Internal Controls Over Census Data	Significant Deficiency and Noncompliance
2022-030	92	New	Noncompliance with Fiscal Control and Internal Auditing Act	Significant Deficiency and Noncompliance
2022-031	94	2020/2002	Untimely Approval and Filing of Contracts and Interagency Agreements	Significant Deficiency and Noncompliance
2022-032	97	New	Locally Held Funds Not Properly Invested or Used	Significant Deficiency and Noncompliance
2022-033	99	New	Noncompliance with Accountability for the Investment of Public Funds Act	Significant Deficiency and Noncompliance

SCHEDULE OF FINDINGS (CONTINUED)

Prior Findings Not Repeated

A	101	2020/2020	Inadequate Controls Over Cash
B	101	2020/2020	Inadequate Internal Controls Over Census Data
C	101	2020/2018	Inadequate General Information Technology Controls Over IMPACT
D	101	2020/2018	Insufficient Review and Documentation of Provider Enrollment Determinations and Failure to Execute Interagency Agreements
E	102	2020/2018	Noncompliance with the Child Death Review Team Act
F	102	2020/2018	Noncompliance with Statutory Mandates
G	102	2020/2020	Equipment Leases Not Properly Reported
H	103	2020/2020	Noncompliance with the Juvenile Court Act of 1987

EXIT CONFERENCE

Findings 2022-001 through 2022-003 and their associated recommendations appearing in this report were discussed with the Department personnel at an exit conference on May 23, 2023.

Attending were:

Department of Children and Family Services
Kiersten Neswick, Chief Financial Officer
James Daugherty, Chief Information Officer
Phillip Dasso, Chief Internal Auditor
Clayton Murphy, Audit Liaison
Joe McDonald, Associate Deputy Director, Budget and Finance

EXIT CONFERENCE (CONTINUED)

Sarah Tucker, Associate Deputy Director, Budget and Finance
David Riley, Payroll Administrator
Douglas Washington, Deputy Director, Contract Administration
Brian Rhodes, Public Service Administrator - Opt 3

Office of the Auditor General
Janis Van Durme, CPA, Health and Human Services Audit Manager

Roth & Company, LLP
Leilani Rodrigo, CPA, CGMA, Partner
Darlene Dizon, CPA, Manager
Lou Jonathan Cabrera, CISA, Manager

The responses to the recommendations were provided by Clayton Murphy, Audit Liaison, in a correspondence dated May 31, 2023.

The remaining findings and recommendations appearing in this report were discussed with Department personnel at an exit conference on August 30, 2023.

Attending were:

Department of Children and Family Services
Marc Smith, Director
Brian Daugherty, General Counsel
Jassen Strokosh, Chief of Staff
Tierney Stutz, Acting Executive Deputy Director
Kiersten Neswick, Chief Financial Officer
Phillip Dasso, Chief Internal Auditor
Clayton Murphy, Audit Liaison
Brian Turner, Associate Chief Financial Officer
Joe McDonald, Associate Deputy Director, Budget and Finance
Douglas Washington, Deputy Director, Contract Administration
Heather Tarczan, Deputy Director, Communications
Julie Barbosa, Chief Deputy Director, Strategy & Performance Execution
David Nika, Associate Deputy Director, Data Management
Suzanne Isenberg-Chhabra, Deputy Director, Permanency
Kristina Hendrick, Administrative Assistant II
Maureen Jones, Project Administrator, Permanency & Intact

EXIT CONFERENCE (CONTINUED)

Office of the Auditor General
Janis Van Durme, CPA, Health and Human Services Audit Manager
Kathy Lovejoy, Principal of IS Audits

Roth & Company, LLP
Leilani Rodrigo, CPA, CGMA, Partner
Darlene Dizon, CPA, Manager
Lou Jonathan Cabrera, CISA, Manager

The responses to these recommendations were provided by Clayton Murphy, Audit Liaison, in correspondences dated August 31 and September 1, 2023.

Roth&Co

INDEPENDENT ACCOUNTANT'S REPORT ON STATE COMPLIANCE AND ON INTERNAL CONTROL OVER COMPLIANCE

Honorable Frank J. Mautino
Auditor General
State of Illinois

Report on State Compliance

As Special Assistant Auditors for the Auditor General, we have examined compliance by the State of Illinois, Department of Children and Family Services (Department) with the specified requirements listed below, as more fully described in the *Audit Guide for Financial Audits and Compliance Attestation Engagements of Illinois State Agencies (Audit Guide)* as adopted by the Auditor General, during the two years ended June 30, 2022. Management of the Department is responsible for compliance with the specified requirements. Our responsibility is to express an opinion on the Department's compliance with the specified requirements based on our examination.

The specified requirements are:

A. The Department has obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law.

B. The Department has obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use.

C. The Department has complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

D. State revenues and receipts collected by the Department are in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts is fair, accurate, and in accordance with law.

E. Money or negotiable securities or similar assets handled by the Department on behalf of the State or held in trust by the Department have been properly and legally administered and the accounting and recordkeeping relating thereto is proper, accurate, and in accordance with law.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants, the standards applicable to attestation engagements contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the Illinois State Auditing Act (Act), and the *Audit Guide*. Those standards,

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the Act, and the *Audit Guide* require that we plan and perform the examination to obtain reasonable assurance about whether the Department complied with the specified requirements in all material respects. An examination involves performing procedures to obtain evidence about whether the Department complied with the specified requirements. The nature, timing, and extent of the procedures selected depend on our judgement, including an assessment of the risks of material noncompliance with the specified requirements, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our modified opinion.

We are required to be independent and to meet our other ethical responsibilities in accordance with relevant ethical requirements relating to the engagement.

Our examination does not provide a legal determination on the Department's compliance with the specified requirements.

Our examination disclosed material noncompliance with the specified requirements during the two years ended June 30, 2022. As described in the accompanying Schedule of Findings as item 2022-003, the Department had not obligated, expended, received, and used public funds of the State in accordance with the purpose for which such funds have been appropriated or otherwise authorized by law. As described in the accompanying Schedule of Findings as items 2022-003 and 2022-011, the Department had not obligated, expended, received, and used public funds of the State in accordance with any limitations, restrictions, conditions, or mandatory directions imposed by law upon such obligation, expenditure, receipt, or use. As described in the accompanying Schedule of Findings as items 2022-001 through 2022-016 and 2022-018 through 2022-022, the Department had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations. As described in the accompanying Schedule of Findings as items 2022-001, 2022-003, and 2022-017, the Department had not ensured the State revenues and receipts collected by the Department were in accordance with applicable laws and regulations and the accounting and recordkeeping of such revenues and receipts was fair, accurate, and in accordance with law.

In our opinion, because of the significance and pervasiveness of the material noncompliance with the specified requirements described in the preceding paragraph, the Department did not comply with the specified requirements during the two years ended June 30, 2022, in all material respects.

The Department's responses to the compliance findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing and the results of that testing in accordance with the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

Report on Internal Control Over Compliance

Management of the Department is responsible for establishing and maintaining effective internal control over compliance with the specified requirements (internal control). In planning and performing our examination, we considered the Department's internal control to determine the

examination procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the Department's compliance with the specified requirements and to test and report on the Department's internal control in accordance with the *Audit Guide*, but not for the purpose of expressing an opinion on the effectiveness of the Department's internal control. Accordingly, we do not express an opinion on the effectiveness of the Department's internal control.

Our consideration of internal control was for the limited purpose described in the preceding paragraph and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies and, therefore, material weaknesses or significant deficiencies may exist that have not been identified. However, as described in the accompanying Schedule of Findings, we did identify certain deficiencies in internal control that we consider to be material weaknesses and significant deficiencies.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with the specified requirements on a timely basis. A material weakness in internal control is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material noncompliance with the specified requirements will not be prevented, or detected and corrected, on a timely basis. We consider the deficiencies described in the accompanying Schedule of Findings as items 2022-001 through 2022-022 to be material weaknesses.

A significant deficiency in internal control is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance. We consider the deficiencies described in the accompanying Schedule of Findings as items 2022-023 through 2022-033 to be significant deficiencies.

As required by the *Audit Guide*, immaterial findings excluded from this report have been reported in a separate letter.

The Department's responses to the internal control findings identified in our examination are described in the accompanying Schedule of Findings. The Department's responses were not subjected to the procedures applied in the examination and, accordingly, we express no opinion on the responses.

The purpose of this report is solely to describe the scope of our testing of internal control and the results of that testing based on the requirements of the *Audit Guide*. Accordingly, this report is not suitable for any other purpose.

SIGNED ORIGINAL ON FILE

Chicago, Illinois
September 7, 2023

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SCHEDULE OF FINDINGS - CURRENT FINDINGS
For the Two Years Ended June 30, 2022

2022-001 **FINDING** Financial Statement Preparation

The Department of Children and Family Services' (Department) year-end financial statements in accordance with generally accepted accounting principles (GAAP) submitted to the Illinois Office of Comptroller contained errors.

During the audit of Department's financial statements, we noted the following:

- Receipts from a private organization's grant (totaling $1,592,000) were deposited in the Special Revenue Fund - Special Purpose Fund 0582 (Fund 0582), while expenditures related to this grant were paid from and recorded in the General Revenue Fund 0001 (Fund 0001). The error resulted in an understatement of General Revenue Fund revenues and overstatement of Special Revenue Fund revenues by $1,592,000. An adjustment to correct the error was recorded by Department management.

  Department management stated it had planned to expend the grant funds from Fund 0582, which was supported by its appropriations. However, an accounting system limitation ultimately prevented the Department from using its automated processes on this fund, so expenditures were shifted to the Fund 0001.

- Two health and social services expenditures (totaling $1,084,744) pertaining to fiscal year 2021 were recorded as expenses in fiscal year 2022. The error resulted in an overstatement of beginning net position and an understatement in current year expenditures. The error in Fund 0001 was deemed immaterial by the Department and was not corrected.

  Department management stated failure to report the expenditures in fiscal year 2021 was due to a staff failure to follow established protocols when using current year appropriations for expired year expenditures related to pay for State revolving fund invoices.

- Three fiscal year 2022 expenditures payable to a State of Illinois component unit (totaling $894,805) were recorded as accounts payable and accrued liabilities. The error in Fund 0001 was deemed immaterial by the Department and was not corrected.

  Department management indicated the payables were misclassified due to employee error.

2022-001 **FINDING** Financial Statement Preparation (Continued)

- Financial statement Note 14, *Commitments and Contingencies,* pertaining to a significant litigation case was not originally disclosed in the Department's draft financial statement footnote disclosures. An adjustment to correct the error was recorded by Department management.

  Department management indicated the footnote was not originally drafted due to employee error.

GASB Codification Sections 1300 and 1700: *Fund Accounting* and *Budget and Budgetary Accounting*, respectively, requires that when funds are expended by the Department for allowable operating purposes, corresponding revenue generated from those expenditures should be recognized in the same fund.

GASB Codification Section 1500: *Reporting Liabilities*, requires the Department to accrue a governmental fund liability and expenditure for expenditures and transfers in the period in which the government incurs the liability. It also requires the Department to disclose in its notes to the financial statement significant contingent liabilities not requiring accrual.

In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Effective internal controls should include procedures to ensure adherence to GAAP and to ensure the appropriate presentation of financial statement amounts (which includes having transactions be reported in the correct account and in the correct period in which they were incurred).

GAAP financial reporting errors occurred that materially misstated the Department's draft financial statements. In addition, accurate and timely financial statements of the Department's financial information for GAAP reporting purposes is important due to the impact adjustments could have on the Statewide financial statements. (Finding Code No. 2022-001, 2020-001)

2022-001 **FINDING** Financial Statement Preparation (Continued)

RECOMMENDATION

We recommend the Department implement internal control procedures to ensure accurate financial statements preparation.

DEPARTMENT RESPONSE

The Department agrees with the recommendation and has implemented a corrective action plan. Due to unprecedented vacancies in the Division of Budget & Finance, review procedures in place were not able to be followed to catch the misstatements identified in the auditor's review of our financial statements. The Department uses a consulting firm to assist with compiling their financial statements and has since been able to fill its CPA position. To further ensure the accuracy of future financial statements, the Department added senior management positions to its approved headcount to provide duplicity and support to be better able to manage the ebbs and flows of staffing levels and add expertise to ensure the accuracy of Departmental financial statements.

2022-002 **FINDING** Lack of Adequate Controls Over the Review of Internal Controls for Service Providers

The Department of Children and Family Services (Department) had not implemented adequate internal control reviews over its service providers.

The Department entered into agreements with various service providers to assist in processes to operate effectively and efficiently such as: (1) information technology hosting, (2) payroll processing, (3) provides maintenance of information and reporting of putative father registry, (4) and processing of Supplemental Security Income (SSI) eligibility.

We requested the Department provide a population of service providers utilized during the audit period to determine if the Department had reviewed the internal controls over the service providers. In response to the request, the Department provided a listing of service providers; however, it did not provide documentation demonstrating the population was complete and accurate.

Due to these conditions, we were unable to conclude the Department's population records were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AU-C § 330.27-.29 and AT-C § 205.36).

Even given the population limitations noted above, we performed testing of three out of five service providers identified by the Department. During our testing, we noted the Department had not:

- Developed a process for identifying service providers.
- Obtained System and Organization Control (SOC) reports or conducted independent internal control reviews of the three (100%) service providers.
- Conducted an analysis to determine the impact of noted deviations within the SOC report.
- Monitored and documented the operation of the Complementary User Entity Controls (CUECs) related to the Department's operations.
- Obtained and reviewed SOC reports for subservice providers or performed alternative procedures to determine the impact on its internal control environment.

2022-002 **FINDING** Lack of Adequate Controls Over the Review of Internal Controls for Service Providers (Continued)

- Developed procedures for monitoring service providers' performance.

In addition, we noted the contract between the Department and one (33%) service provider did not contain a requirement for an independent review to be completed.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology (NIST), Maintenance and System and Service Acquisition sections, requires entities outsourcing their information technology environment or operations to obtain assurance over the entities' internal controls related to the services provided. Such assurance may be obtained via System and Organization Control reports or independent reviews.

In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal administrative controls, to provide assurance revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports to maintain accountability over the State's resources.

Department management indicated the lack of resources and dependence on standard language in State of Illinois contracts resulted in the weaknesses.

Without having obtained and timely reviewed SOC reports, or another form independent internal control reviews, the Department does not have assurance the service providers' internal controls are adequate. In addition, failure to review compliance of service providers with contractual terms could result in obligations and services not being met. (Finding Code No. 2022-002, 2020-028)

RECOMMENDATION

We recommend the Department:

- Develop a process for identifying service providers and maintain documentation of such.

- Obtain SOC reports or conduct independent internal control reviews of the service providers.

2022-002 **FINDING** Lack of Adequate Controls Over the Review of Internal Controls for Service Providers (Continued)

- Conduct an analysis to determine the impact of noted deviations within the SOC report.

- Monitor and document the operation of the CUECs related to the Department's operations.

- Obtain and review SOC reports for subservice providers or perform alternative procedures to determine the impact on its internal control environment.

- Develop procedures for monitoring service providers' performance.

- Review contracts with service providers to ensure applicable requirements over the independent review of internal controls are included.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendations. The Department, through collaboration with DoIT@DCFS, will review and update its procedures related to contracting with service providers. This review and update will address the following components:

- Identification and documentation of 3rd party service providers,
- Including appropriate language in Department contract boiler plate language to ensure applicable requirements over the independent review of internal controls are included,
- Ensuring SOC reports are obtained from service providers and subservice providers to be reviewed and analyzed to determine any impact and actions necessary based on the contents of the SOC report or conduct an internal review of the service providers on an established frequency, and
- Ensuring procedures for monitoring and documentation of CUECs related to the Department's operations and service providers' performance are adequate.

2022-003 **FINDING** Failure to Maintain Proper Segregation of Duties Over Daycare

The Department of Children and Family Services (Department) failed to maintain proper segregation of duties over access to the Department's daycare providers' licensing information, child care information and billing system.

The Department maintains data related to entities who provide daycare services to the children in the State's care and specific data related to the children themselves. As a result of these services, the Department makes payment to these entities. During the audit period, the Department expended $34,778,402 related to daycare services.

We conducted testing of the users' access right to daycare providers' licensing information, child care information and billing system to determine if proper segregation of duties had been implemented. Individuals should not have the ability to establish a daycare provider, a child-in-care, and to submit and approve billings and payments. Our testing results noted 45 of 2,348 (2%) users had rights to enter, modify and delete daycare providers' information, child information and billing information. As a result, the Department failed to maintain proper segregation of duties.

We also reviewed the Department's user access review reports to the daycare providers' licensing information, child care information and billing system for three months, noting three of seven (43%) monthly reports had not been reviewed.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Access Control section, requires entities to implement internal controls to ensure proper segregation of duties and review of users' access rights.

The Department's Mainframe Account Review-Work Procedures stated the Department's Data Stewards are to review user access review reports within 30 days of receipt.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires all State agencies to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfer of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

Department management indicated the weaknesses were due to oversight and lack of resources.

2022-003 **FINDING** Failure to Maintain Proper Segregation of Duties Over Daycare (Continued)

Failure to maintain proper segregation of duties over access to the Department's daycare providers' licensing information, child care information and billing system and data could result in improper manipulation of data and payments. (Finding Code No. 2022-003)

RECOMMENDATION

We recommend the Department implement proper segregation of duties and ensure no one individual has the rights to enter, modify, and delete daycare providers' information, child information and billing information. Additionally, we recommend the Department complete the monthly user access reviews.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department has begun the process of conducting an extensive review of its daycare processes and will make all necessary changes to ensure appropriate segregation of duties are in place over the Daycare system. The Department will also review its procedures over access rights review to ensure they are up to appropriate standards.

2022-004 **FINDING** Incomplete Child Welfare Files

The Department of Children and Family Services' (Department) Child Welfare and Foster Care and Intact Family Case files lacked required documentation and not all case procedures were performed timely.

During our sample testing of 60 child welfare case files managed by the Department staff (CFS) and purchase of service (POS) contractors, we noted the following:

Case File Deficiency	Case File Requirement	Authority
2 of 60 (3%) Statewide Automated Child Welfare Information System (SACWIS) Risk Assessments could not be found in the files. (1 POS & 1 CFS cases) 7 of 60 (12%) SACWIS Risk Assessments were not completed timely. (3 POS - 16 to 129 days late) (4 CFS - 4 to 33 days late)	When child welfare staff are engaged in preliminary activities, the SACWIS Risk Assessment is to be completed within 30 days of the case opening.	DCFS Administrative Procedure #5 (Section5.2 (C))
1 of 60 (2%) Integrated Assessment was completed but not signed and dated. As such, we were unable to determine whether the assessment was completed timely. (1 POS case) 44 of 60 (73%) Integrated Assessments were not completed timely. (32 POS - 19 to 589 days late) (12 CFS - 4 to 377 days late)	Integrated Assessment forms are to be completed within 40 calendar days of the case opening or placement.	DCFS Administrative Procedure #5 - Update November 22, 2016 and DCFS Administrative Procedure #5 (Section 5.3)
27 of 60 (45%) Initial Service Plans were not completed timely. (17 POS - 1 to 178 days late) (10 CFS - 6 to 138 days late)	Initial service plans are to be completed within 45 calendar days of the case opening or placement.	DCFS Administrative Procedure #5 - Update November 22, 2016 and DCFS Administrative Procedure #5 (Section 5.4)

2022-004 **FINDING** Incomplete Child Welfare Files (Continued)

Case File Deficiency	Case File Requirement	Authority
6 of 60 (10%) children's photos were not indicated as being taken and maintained in SACWIS or in case files. (5 POS & 1 CFS cases)	The date the photo is obtained must be included in SACWIS or related documentation should be in case files.	DCFS Procedure 301.150, PT 2021.06
20 of 60 (33%) children's fingerprints were not indicated as being taken and maintained in SACWIS or in case files. (15 POS & 5 CFS cases)	The date the fingerprint is obtained must be included in SACWIS or related documentation should be in case files.	DCFS Procedure 301.150, PT 2021.06
15 of 60 (25%) Medical & Dental Consent forms (CFS 431 and CFS 415) were not found in the case file. (13 POS & 2 CFS cases) 3 of 60 (5%) Medical & Dental Consent forms (CFS 431 and CFS 415) were found in the case files but not signed. (2 POS & 1 CFS cases)	Forms CFS 431 and CFS 415 must be maintained to provide consent for ordinary and routine medical and dental or surgical treatment.	DCFS Administrative Procedure #5, (Appendix C, Section VI)
11 of 60 (18%) Initial Placement Checklists (CFS 418-J) were not found on file. (10 POS & 1 CFS cases) 5 of 60 (8%) Initial Placement Checklists (CFS 418-J) completed dates were blank, thus, we were not able to determine proper completion of the form. (5 POS cases)	Form CFS 418-J must be maintained for all children placed in substitute care to document any special needs of the child.	DCFS Procedure 315.85(b)

2022-004 **FINDING** Incomplete Child Welfare Files (Continued)

Case File Deficiency	Case File Requirement	Authority
7 of 60 (12%) Permanency Planning Checklist (CFS 483) were not found in the case file. (5 POS & 2 CFS cases) 1 of 60 (2%) Permanency Planning Checklist (CFS 483) was not signed and dated by the Worker and/or Supervisor, thus, we were not able to confirm if the form was properly completed. (1 POS case)	Form CFS 483 must be completed to help the caseworker determine whether reunification is no longer an appropriate goal for a child and whether the child's current placement would be an appropriate home for adoption or subsidized guardianship.	DCFS Procedure 315.330
15 of 60 (25%) Child Identification Forms (CFS 680) were not maintained in the case files. (10 POS & 5 CFS cases)	Form CFS 680 is one of three required components to child identification information along with photos and fingerprints.	DCFS Procedure 301.150, PT 2021.06
4 of 60 (7%) Registration Case Opening Forms (CFS 1410) could not be provided for our review, thus, we were not able to determine timeliness. (4 POS cases) 46 of 60 (77%) Registration Case Opening Forms (CFS 1410) were not completed timely. (31 POS - 2 to 593 days late) (15 CFS - 3 to 676 days late) 1 of 60 (2%) Registration Case Opening Forms (CFS 1410) screening date is blank and incomplete, thus we were not able to determine timeliness. (1 POS)	The CFS 1410, Registration Case Opening Forms are to be completed within 24 hours of the case opening decision unless received from child protection, in which case it should be completed immediately by data entry staff.	DCFS Administrative Procedure #5 (Section 5.3)

2022-004 **FINDING** Incomplete Child Welfare Files (Continued)

Additionally, we utilized the administrative case reviews (ACR) for the same sample to test compliance with the Illinois Administrative Code's (Code) (89 Ill. Admin. Code 316.60) 21-day notification requirement. Our sample of 60 cases contained 91 ACRs, which generated 173 notifications to all parties involved. We noted the following:

- One ACR (1%) was not completed every six months.
- One notification (0.5%) was sent with less than 21 days' notice.
- One notification (0.5%) was not found in the case files.

The Code (89 Ill. Admin. Code 316.60) and DCFS Administrative Procedure #5 require written notification of the date, time, place, and purpose of the ACR be mailed to all parties involved 21 days in advance of the ACR meeting.

Further, 2 of the 60 (3%) child welfare case files tested were Adoption Assistance (AA) and Subsidized Guardianship Home (SGH), in which we noted the following:

- For two (100%) cases, annual re-certification of adoption assistance form, CFS 1800-Q Adoptions Assistance/Subsidized Guardianship Medicaid Information were not found in the case file.
- For two (100%) cases, annual re-certification of the child's Medicaid benefits form, CFS 1800-R Status of Continued Medicaid Eligibility was not found in the case file.

DCFS Procedure 302.310 on Adoption Assistance requires the Department to annually mail to the adoptive parent(s) and maintain the CFS 1800-Q, Adoption Assistance/Subsidized Guardianship Medicaid Information form and CFS 1800-R Status of Continued Medicaid Eligibility form in the case file.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 1998. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated exceptions were a result of staffing turnover and competing priorities.

2022-004 **FINDING** Incomplete Child Welfare Files (Continued)

Failure to follow established Department procedures, regulation and State law concerning welfare of children could result in inadequate care, unauthorized services or misuse of State funds. (Finding Code No. 2022-004, 2020-006, 2018-004, 2016-001, 2014-002, 12-2, 10-2, 08-2, 07-1, 06-1, 05-3, 04-2, 03-1, 02-2, 00-10, 99-5, 98-6)

RECOMMENDATION

We recommend the Department continue in its efforts to develop ways to automate various recordkeeping functions and that the Department follows the procedures established concerning the welfare of children. The fulfillment of those procedures should be adequately documented.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department recognizes that procedures written before many of the advances since made through the use of software technology and the physical copies of forms to be placed in a physical file to be considered compliant leave the Department in between two worlds - digital and paper, with the Department training staff to utilize the former. For example, medical and dental consent, several of the checklists as well as case opening "forms" are all located in digital (SACWIS) but are currently also required to be located in a physical paper file. The Department will have these matters resolved through the implementation and use of IllinoisConnect, which is working concurrently with policy to ensure our procedure reflects what is captured in the software, phasing out paper files. Additionally, items such as fingerprints and photos in the file have been addressed by the Department with self-imposed corrective action to ensure these items are captured and stored in the digital record.

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act

The Department of Children and Family Services (Department) failed to comply with several sections of the Abused and Neglected Child Reporting Act (Act) (325 ILCS 5) during the examination period.

We tested several sections of the Act and noted the following exceptions:

- The Act (325 ILCS 5/4.4) states whenever the Department receives a report of child abuse and neglect for a newborn infant whose blood, urine, or meconium contains any amount of a controlled substance, the Department must immediately communicate the report to the State's attorney's office of the county in which the infant was born.

  During our testing, the Department did not immediately communicate the investigation reports to the State's attorneys' offices for 17 (28%) of 60 reports of child abuse and neglect for infants exposed to controlled substances. Specifically, we noted the State's attorneys' offices were notified between 218 to 920 days from report date.

  Department management stated the issues were due to investigators vetting test results to ensure the results were confirmed and accurate.

  Failure to timely communicate reports to the State's attorneys' offices when the Department receives a report of child abuse and neglect for a newborn infant whose blood, urine, or meconium contains any amount of a controlled substance delays the State's attorneys in assisting with the child and results in noncompliance with the Act.

- The Act (325 ILCS 5/4.4c) states whenever the Department receives a report of suspected abuse or neglect of a child and the child is alleged to have been abused or neglected while receiving care in a hospital, including a freestanding psychiatric hospital licensed by the Department of Public Health (DPH), the Department shall notify the Director of Public Health and the Director of Healthcare and Family Services (HFS) of the report.

  During our testing, the Department notified the Directors of DPH and HFS of the report of suspected abuse or neglect of a child alleged to have been abused or neglected while receiving care in a hospital 34 days to 885 days from the investigation date for 15 of 15 (100%) reports tested.

  Department management indicated there was not a mechanism to monitor and track the field investigator notifications due to employee oversight.

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act (Continued)

Failure to notify within a reasonable timeframe the Director of DPH and HFS when the Department receives a report of suspected abuse or neglect of a child alleged to have been abused or neglected while receiving care in a hospital prevents the DPH and HFS from taking an immediate action to care for the child.

- The Act (325 ILCS 5/7.3c) states the Department, in cooperation with the Department of Human Services, shall report to the Governor and the General Assembly on an annual basis the effectiveness of the programs designed to test the most effective approaches to case management protocols for Department clients with substance abuse problems.

  During our testing, we noted the Department did not submit the fiscal year 2021 and 2022 reports to the General Assembly or Governor documenting the case management protocols and program's effectiveness.

  Department management stated the required reports were not submitted due to oversight.

  Timely submission of annual reports on the community-based system of integrated child welfare and substance abuse services to the General Assembly and Governor is necessary for compliance with the Act and provides information on the effectiveness of programs initiated.

- The Act (325 ILCS 5/7.22a(c)) requires the Department to submit to the General Assembly reports summarizing the number of Unfounded Review and Indicated Reports of Child Abuse and Neglect (report). The initial report after the effective date of the Act (325 ILCS 5/7.22a(c)) was due on November 21, 2019, and all subsequent reports have been required to be filed on December 1 and June 1 of each year.

  During testing, we noted the Department was required to file four reports during the examination period. The results of our testing indicated the Department failed to timely file 2 (50%) of the reports required. Specifically, we noted the reports due on December 1, 2021 and June 1, 2022, were submitted to the General Assembly 8 and 104 days late, respectively.

  Department management stated the required reports were not submitted timely due to oversight.

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act (Continued)

Timely submission of annual reports on the number of Unfounded and Indicated Review Reports to the General Assembly is necessary for compliance with the Act and provides information on the metrics of Department investigations and the recommendations for reforms of the investigation system.

- The Act (325 ILCS 5/8.6) states the Department must send a copy of its final findings from an indicated report of child abuse and neglect to the child's school within 10 days of completing an investigation of alleged physical or sexual abuse under the Act.

  During testing, we noted the Department did not timely notify the children's school for 40 of the 40 (100%) indicated reports tested. Specifically, we noted the schools were notified 129 to 890 days late.

  Department management stated the issues noted were due to investigator's reluctance to violate the privacy of the family by telling the school private matters of the child.

  Failure to timely notify a child's school on the results of Indicated Review Reports related to alleged physical and sexual abuse limits the school's awareness on the situation of its student, in order to timely provide appropriate care and support to the child while attending the school.

- The Act (325 ILCS 5/7) requires the Department within 24 hours to orally notify local law enforcement personnel and the office of the State's attorney of the involved county of the receipt of any report alleging the death of a child, serious injury to a child, including, but not limited to, brain damage, skull fractures, subdural hematomas, and internal injuries, torture of a child, malnutrition of a child, and sexual abuse to a child, including, but not limited to, sexual intercourse, sexual exploitation, sexual molestation, and sexually transmitted disease in a child age 12 and under.

  During testing, we noted the Department did not timely notify the local enforcement personnel and the office of the State's attorney of the involved county for 5 of 25 (20%) reports tested. Specifically, we noted the local enforcement personnel and the office of the State's attorney were notified 5 to 43 days late.

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act (Continued)

Department management stated the issues were due to investigators vetting test results to ensure the results were confirmed and accurate prior to sending the notifications.

Failure to timely notify the local law enforcement personnel and the office of the State's attorney of the involved county of the receipt of any report alleging the death of a child, serious injury to a child prevents the law enforcement personnel and State's attorney office to investigate the suspected child abuse and neglect.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2012. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan. (Finding Code No. 2022-005, 2020-019, 2018-017, 2016-014, 2014-017, 12-13)

RECOMMENDATION

We recommend the Department perform the following:

- Immediately refer all reports of child abuse and neglect for a newborn infant whose blood, urine, or meconium contains any amount of a controlled substance to the appropriate State's attorney's office and to update procedures and provide training to staff to accomplish compliance with the Act.
- Notify the Director of DPH and HFS within a reasonable timeframe, when the Department receives a report of suspected abuse or neglect of a child and the child is alleged to have been abused or neglected while receiving care in a hospital.
- Ensure the timely submission of all reports required by the Act to the General Assembly and Governor.
- Strengthen its monitoring and procedures for investigators to ensure they provide copy of its final findings from an indicated report of child abuse and neglect to the child's school within 10 days of completing an investigation of alleged physical or sexual abuse under the Act.
- Ensure local law enforcement personnel and the office of the State's attorney of the involved county of the receipt of any report alleging the death of a child, serious injury to a child are timely notified.

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act (Continued)

DEPARTMENT RESPONSE

The Department agrees and is committed to compliance with the Abused and Neglected Child Reporting Act. While the Department did refer in *every* instance, the report of a newborn infant whose blood, urine, or meconium contained any amount of a controlled substance to the State's attorney in the county of the child's birth, we did not do so immediately. There are two responses in process regarding this finding. One: the Department now automates this procedure. When a hotline worker assigns this allegation (e.g., substance exposed infant) the system automatically issues a letter to the State's attorney of the county of birth of the newborn. This automation will commence by 12/31/2023 should legislation on this remain. Two: the reluctance of Department investigators to immediately report the birth of a substance exposed infant to the State's attorney is supported by experts in child welfare and addiction, including Illinois Plans of Safe Care. This is further supported by many in the General Assembly. We look forward to identifying a way for our investigators to assess and connect to the appropriate supports when an infant is born substance exposed but not be statutorily required to immediately notify the State's attorney.

We appreciate the auditor's recommendation to Notify the Director of DPH and HFS *within a reasonable timeframe*, when the Department receives a report of suspected abuse or neglect of a child, and the child is alleged to have been abused or neglected while receiving care in a hospital. However, statute makes no mention of a specific time frame in when this is to occur and the Department does indeed notify the Director of DPH and HFS every time. Recognizing the importance of a *reasonable timeframe*, the Department has given itself a self-imposed corrective action item pending the launch of IllinoisConnect, a letter to the director of DPH and HFS will be autogenerated whenever an allegation of abuse or neglect is made involving a child while they were receiving care in a hospital. This portion of IllinoisConnect is anticipated to launch by the end of 2023.

The Department agrees with the auditor's recommendation and will work to ensure required reports are submitted to the General Assembly and Governor timely.

We agree with the auditor's recommendation to strengthen our monitoring and procedures for investigators to ensure they provide a copy of its final findings from an indicated report of child abuse and neglect to the child's school within 10 days of completing an investigation of alleged physical or sexual abuse under the Act. Of note, in September of 2022, the Chief Deputy of Child Protection and the State Central Registry along with the Deputy of Child Protection, visited all 10 subregions across the

2022-005 **FINDING** Noncompliance with Abused and Neglected Child Reporting Act (Continued)

State and met with every child protection supervisor, area administrator and regional administrator, issuing a memorandum in September 2022, instructing staff of this requirement and providing clear direction on how to execute this procedure. Across the state, investigators implored change to the existing statute as they believe this requirement violates the privacy of the family by revealing (only to the public school administrators) the private matters of the child.

The Department agrees with the auditor's recommendation that the Department must ensure local law enforcement personnel and the office of the State's attorney of the involved county of the receipt of any report alleging the death of a child, serious injury to a child are timely notified. The Department makes this notification 100% of the time, only 5% of which may be considered not timely. To address this, the Department has automated this notification to occur immediately to the state's attorney office from the hotline upon assignment of an applicable allegation.

It is important to note that during the timeframe of this audit, 2020 – 2022, the world faced a global pandemic, agencies such as Illinois DCFS and others across the country, including business around the world faced critical staffing challenges as people sought ways to pivot during this historic time. With a smaller staff, due to retirements, people exiting their jobs and weakened workforce Illinois DCFS continued to deliver exceptional programs and services to the children and families of Illinois.

2022-006 **FINDING** Noncompliance with the School Code

The Department of Children and Family Services (Department) failed to comply with the School Code (Code) (105 ILCS 5/22-85(j)).

During our testing of 25 alleged incident of sexual abuse investigations, we noted that for 24 of 25 (96%) indicated investigations tested, the Department did not timely notify the relevant schools when an investigation of an alleged incident of sexual abuse was completed. Specifically, we noted the notifications were sent to relevant schools between 431 to 908 days from the investigation report date.

The Code (105 ILCS 5/22-85(j)) requires the Department to notify the relevant school when an agency investigation of alleged incident of sexual abuse is completed. The Abused and Neglected Child Reporting Act (Act) (325 ILCS 5/8.6) requires the Department within 10 days after completing an investigation of alleged physical or sexual abuse, if the report is indicated, to send a copy of its final finding report to the school that the child who is the indicated victim of the report attends.

Department management stated issues noted were due to investigator's reluctance to violate the privacy of the family by telling the school private matters of the child.

Failure to timely notify relevant schools when an investigation of an alleged incident of sexual abuse is completed limits the school's awareness on the situation of its student, in order to timely provide appropriate care and support to the child while attending the school. Further, it represents noncompliance with the Code and the Act. (Finding Code No. 2022-006)

RECOMMENDATION

We recommend the Department to timely notify the relevant school of the child involved in the investigation when the investigation of alleged incident of sexual abuse is completed.

DEPARTMENT RESPONSE

We agree with the auditor's recommendation that we strengthen our monitoring and procedures for investigators to ensure statutory compliance by providing a copy of its final findings from an indicated report of child abuse and neglect to the child's school within 10 days of completing an investigation of alleged physical or sexual abuse under the Act. In September of 2022, the Chief Deputy of Child Protection and the State Central Registry along with the Deputy of Child Protection, visited all 10 subregions across the state and met with every child protection supervisor, area administrator and

2022-006 **FINDING** Noncompliance with the School Code (Continued)

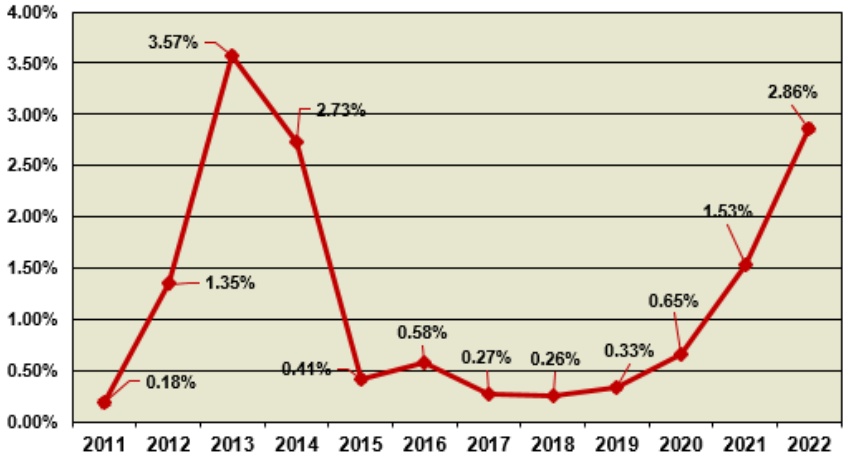
regional administrator, issuing a memorandum in September 2022, instructing staff of this requirement and providing clear direction on how to execute this procedure. Across the state, investigators implored change to the existing statute as they believe this requirement violates the privacy of the family by revealing (only to the public-school administrators) the private matters of the child.

2022-007 **FINDING** Untimely Child Abuse and Neglect Determinations

The Department of Children and Family Services (Department) did not make timely determinations of whether reports of child abuse and neglect were "indicated" or "unfounded" as required by the Abused and Neglected Child Reporting Act (Act).

The Act (325 ILCS 5/7.12) requires the Child Protective Service Unit to determine, within 60 days, whether a report is "indicated" or "unfounded". It further provides the Department may extend, for up to an additional 30 days, the period in which individual cases are determined. Reasons for which the determination period may be extended include, but are not limited to, the following circumstances (89 Ill. Adm. Code 300.110(i)(3)(D)): a) State's attorneys or law enforcement officials have requested that the Department delay making a determination due to a pending criminal investigation; b) medical or autopsy reports needed to make a determination are still pending after the initial 60 day period; c) the report involves an out-of-state investigation and the delay is beyond the Department's control; or d) multiple alleged perpetrators or victims are involved necessitating more time in gathering evidence and conducting interviews.

The Department's Monitoring/Quality Assurance Division compiles statistics in the Department's application identified as the Statewide Automated Child Welfare Information System (SACWIS) to track reports that are not determined to be either "unfounded" or "indicated" in compliance with the Act (within 60 days of receipt of the report, or within 90 days if a 30-day extension is permitted). Following is a summary of those statistics:



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total Reports Requiring Determinations	63,023	65,499	66,918	67,705	67,714	77,052	75,014	80,698	86,946	80,814	86,719	93,936
Determinations Not in Compliance	115	884	2,386	1,846	279	444	201	207	287	526	1,330	2,683

2022-007 **FINDING** Untimely Child Abuse and Neglect Determinations (Continued)

As indicated in the chart above, the Department did not make timely determinations within 60 days in 1,330 of the 86,719 (1.53%) reports and in 2,683 of the 93,936 (2.86%) reports of child abuse and neglect referred to the Department during fiscal years 2021 and 2022, respectively.

After receiving the statistics above, we selected 60 of the 4,013 investigation reports noted as not being completed within 60 days for further detailed testing in order to determine if the Department was meeting the 60-day requirement or if the SACWIS data contained in the chart was incorrect. For 30 investigation reports sampled (50%), we confirmed the Department did not meet the statutory 60-day requirement or after a granted extension was allowed for. Specifically, we noted the investigation reports were determined 1 to 335 days after the required due date.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 1998. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated they reviewed the small number of reports noted in the statistics above and determined that they were nearly entirely data entry errors (e.g., placing the commencement in a note category other than "in person" or "attempt"). For the exceptions noted in the auditor's sample, Department management indicated these were due to employee oversight.

Failure to make timely determinations of reports of abuse and neglect could delay the implementation of a service plan and result in further endangerment of the child and is a violation of the Act. (Finding Code No. 2022-007, 2020-007, 2018-005, 2016-002, 2014-003, 12-3, 10-3, 08-3, 07-2, 06-2, 05-4, 04-5, 03-2, 02-3, 00-8, 99-11, 98-10)

RECOMMENDATION

We recommend the Department determine reports of child abuse or neglect in compliance with the timeframe mandated by the Act.

DEPARTMENT RESPONSE

The Department agrees with the recommendation that we determine reports of child abuse or neglect in compliance with the timeframe mandated by the Act. The Department also finds it important to note that we have resolved this matter and there are currently no overdue reports. Additionally, it should be noted that only 1-2% of 86,000 - 93,000 investigations reflected from one of 102 counties that was producing

2022-007 **FINDING** Untimely Child Abuse and Neglect Determinations (Continued)

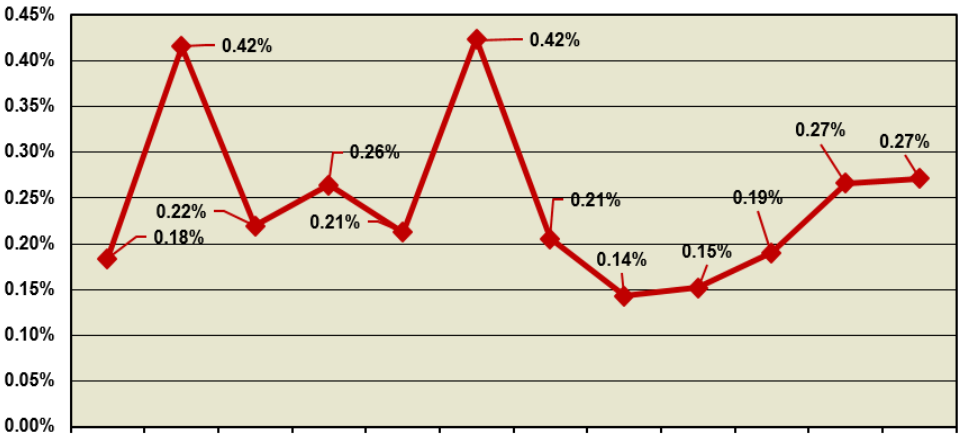
noticeable errors, which has since been rectified. The majority of the reports that became "overdue" were caused when one supervisor failed to enter the allocated extension in the software. Retraining has since been provided to rectify this error. The Department is confident that that there will not be any substantial noncompliance reporting in the next audit.

2022-008 **FINDING** Untimely Initiation of Investigations of Child Abuse and Neglect

The Department of Children and Family Services (Department) did not timely initiate investigations of child abuse and neglect within 24 hours of receipt of the report as required by the Abused and Neglected Child Reporting Act (Act).

The Act (325 ILCS 5/7.4(b)(2)) requires child abuse and neglect investigations "be commenced within 24 hours of receipt of the report."

The Department's Monitoring/Quality Assurance Division compiles statistics and reports on instances of noncompliance with the Act, based on data extracted from the Department's data warehouse and the Department's Statewide Automated Child Welfare Information System (SACWIS). These reports are a summary of activity entered into SACWIS by the field offices. Department supervisors conduct weekly manual reviews of the reports of child abuse and neglect to monitor whether all investigations are initiated timely and in compliance with the Act. The Monitoring/Quality Assurance Division has compiled the following statistics:



	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Total Investigations	63,011	65,963	66,891	67,720	67,708	78,383	75,000	81,299	86,946	80,816	86,738	94,704
Investigations Not in Compliance	116	274	147	179	144	332	154	116	132	154	231	257

As indicated in the chart above, the Department did not timely initiate an investigation for 231 of the 86,738 (0.27%) reports and for 257 of the 94,704 (0.27%) reports of child abuse and neglect in fiscal years 2021 and 2022, respectively.

2022-008 **FINDING** Untimely Initiation of Investigations of Child Abuse and Neglect (Continued)

After receiving the statistics above, we selected 60 of the 488 investigations noted as not being initiated within 24 hours for further detailed testing in order to determine if the Department was meeting the 24-hour requirement or if the SACWIS data contained in the chart was incorrect. For 42 investigations sampled (70%), the Department did not meet the statutory 24-hour requirement. Specifically, we noted the Department initiated an investigation 0.10 hours to 58 days after the required timeframe.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 1998. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated they reviewed the small number of reports noted in the statistics above and determined that they were nearly entirely data entry errors (e.g., placing the commencement in a note category other than "in person" or "attempt"). For the exceptions noted in the auditor's sample, Department management indicated these were due to employee oversight.

Failure to respond to a report of abuse or neglect within 24 hours could result in further endangerment to the child and is a violation of the Act. (Finding Code No. 2022-008, 2020-008, 2018-006, 2016-003, 2014-004, 12-4, 10-4, 08-4, 07-3, 06-3, 05-5, 04-6, 03-3, 02-4, 00-7, 99-10, 98-9)

RECOMMENDATION

We recommend the Department initiate investigations of all child abuse and neglect reports within 24 hours of receiving the report as mandated by the Act.

DEPARTMENT RESPONSE

The Department agrees with the recommendation to initiate all child abuse and neglect reports within 24 hours of receiving the report as mandated by the Act. The fact that less than 1% of cases were not initiated within 24-hours is a testament to our hardworking staff and their commitment to compliance and serving the children of Illinois. The Department encourages our staff to always ensure their own safety first and foremost when meeting the 24-hour timeframe and to always enter this note in the software as a contact note and not a case note (which causes the system to not read this as an initiation).

2022-009 **FINDING** Noncompliance with the Children and Family Services Act

The Department of Children and Family Services (Department) did not comply with the Children and Family Services Act (Act) (20 ILCS 505).

We tested several sections of the Act and noted the following exceptions:

- The Act (20 ILCS 505/2.2) requires the Department to submit an annual report by December 31 of each year to the General Assembly regarding youth-in-care waiting for placements. In addition, the Act requires the Department to post the report on the Department's website.

  During our testing, we noted the Department submitted the fiscal year 2021 annual report 124 days late. In addition, we noted the Department did not post the fiscal year 2021 and fiscal year 2022 reports on its website.

  Department management stated required reports were not submitted timely and was not posted on its website due to oversight.

- The Act (20 ILCS 505/5d) created the Direct Child Welfare Service Employee License Board (License Board) to assist the Director of the Department in updates to licensure rules. In accordance with the Act, the nine Board members are required to serve 3-year terms, and cannot be reappointed if the reappointment would cause the member to serve for longer than 6 consecutive years.

  During our testing, we noted the License Board had three vacant positions as of June 30, 2022, and two members of the License Board have served longer than 6 consecutive years.

  Department management stated the License Board vacancies and continued services were due to management oversight.

- The Act (20 ILCS 505/21) requires the Department to provide each parent or guardian and responsible adult caregiver participating in a safety plan a copy of the written safety plan as signed by each parent or guardian and responsible adult caregiver and by a representative of the Department. In addition, the Department is also to provide each parent or guardian and responsible adult caregiver participating in a safety plan information on their rights and responsibilities. The rights and responsibility information are required to include, but need not be limited to, information on how to obtain medical care, emergency phone numbers, and information on how to notify schools or day care providers as appropriate.

2022-009 **FINDING** Noncompliance with the Children and Family Services Act (Continued)

During our testing of 40 participants, we noted the following:

- For three (8%) participants tested, the Department was unable to provide a copy of the written safety plan.

- For three (8%) participants tested, the Department was unable to provide documentation supporting it had provided the parent, guardian, or responsible adult caregiver with safety plan information on their rights and responsibilities.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of its essential transactions to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management indicated it was unable to provide the missing documentation due to employee error.

- The Act (20 ILCS 505/41) requires the Department to submit to the General Assembly a report of employee assaults and threats on employees by January 1, April 1, July 1, and October 1 of each year.

  During our testing of eight quarterly reports during the examination period, we noted five reports (63%) were not submitted in time or were not submitted at all to the General Assembly. Specifically, we noted 4 reports were submitted 4 to 24 days late, and 1 report was not submitted at all.

  Department management stated the required reports were not submitted timely due to oversight.

- The Act (20 ILCS 505/35.7) requires the Department's Quality Assurance staff to annually prepare public reports detailing the Department's compliance with the Error Reduction Implementation Plan (Plan) and alert the Director to staffing needs or other needs to accomplish the goals of the Plan. The annual report is to be transmitted to the Director, the Department's Office of the Inspector General (OIG), and all management staff involved in the Plan.

  During our testing, we noted the Department's Quality Assurance staff did not prepare or file the required reports during fiscal year 2021 and fiscal year 2022.

2022-009 **FINDING** Noncompliance with the Children and Family Services Act (Continued)

Department management stated the Department's last plan was developed in 2018, and historically, the Quality Assurance division has not had the necessary staff to perform the duties outlined in this section of the Act. The current Quality Assurance leadership is awaiting a new Plan to assess the capacity of the Quality Assurance division to support implementation of a new Plan. As such, Department management further stated that due to the continuing restrictions imposed by the COVID-19 pandemic, and the enormous mandatory training agenda for frontline and administrative staff advanced by the Department's Office of Learning and Professional Development, the OIG suspended its project to develop a new Plan during the examination period.

- The Act (20 ILCS 505/42) requires the Department to submit a report with a detailed review of the foster care survey results to the Governor and the General Assembly no later than December 1, 2021 and every 5 years thereafter. As described in the Act, the foster care survey is a standardized survey to gather feedback from children who are aging out of foster care and from children who have transitioned out of the foster care system. The survey includes requests for information regarding the children's experience with and opinion of State foster care services, the children's recommendations for improvement of such services, the amount of time the children spent in the foster care system, and any other information deemed relevant by the Department.

  During our testing, we noted the Department submitted the survey results report due December 1, 2021, 357 days late.

  Department management stated the required report was not submitted timely due to oversight.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2016. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Failure to timely submit required reports delays the Governor and General Assembly in being current with issues regarding youth-in-care waiting for placements, standardized foster care survey results, and the Department's employee assaults and threats on employees. Failure to maintain and/or provide each parent or guardian and responsible adult caregiver participating in a safety plan increases the risk that all responsible parties will not follow the plan's guidance exposing the child to unnecessary safety concerns. The License Board not consisting of all the required

2022-009 **FINDING** Noncompliance with the Children and Family Services Act (Continued)

members lessens its effectiveness in conducting its activities. Finally, failure to prepare and submit annual reports as required by the Act increases the likelihood that the Director would not be alerted to staffing needs or other needs to accomplish the goals of the Error Reduction Implementation Plan. (Finding Code No. 2022-009, 2020-020, 2018-018, 2016-015)

RECOMMENDATION

We recommend the Department to timely submit all reports to the Governor and General Assembly required by the Act. We also recommend the Department ensure a signed written safety plan is provided to each parent or guardian and responsible adult caregiver participating in a safety plan, and the Department retain a copy of said safety plan. Further, we recommend the Department appoint members of the License Board and enforce term limits to comply with the intent of the Act. Finally, we recommend the Department review the requirements concerning the Error Reduction Implementation Plan and take appropriate measures to implement initiatives to accomplish the intended purposes as outlined in the Act or seek legislative remedy.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department is committed to ensuring that everyone has the information they need and will work to ensure all required reports are submitted to the General Assembly and Governor moving forward.

The Department is committed to utilizing safety plans with parents to avoid children entering foster care whenever possible, we are also committed to ensuring that that the signed safety plan is in the file. Three occurrences where the paper copy was not in the file has been addressed with the field including reminders at all individual, site, team and regional meetings.

The License Board members who had served on the Board for longer than 6 consecutive years were transitioned off the Board in February 2023. The reconstituted License Board currently has eight (8) members in good standing and only one (1) remaining vacancy, "General Public" representative. The Department has advertised the General Public vacancy four (4) times since February 2023 and interviewed candidates, but they did not meet statutory qualifications. The most recent General Public representative vacancy announcement was posted 7/19/2023 and ends 8/18/2023. The License Board will review applications soon thereafter and schedule interviews as appropriate. The Department will continue to repost the vacancy if necessary, until it is filled.

2022-009 **FINDING** Noncompliance with the Children and Family Services Act (Continued)

The OIG has sent the Department a draft ERT training plan on how to proceed next, which is pending approval by the Department leadership.

As it relates to employee assaults and threats to employee's report; changes in procedure, as to when the report is created, have been implemented to achieve timely report submission moving forward.

2022-010 **FINDING** Noncompliance with the State Services Assurance Act for FY2008

The Department of Children and Family Services (Department) did not increase and maintain the number of bilingual frontline staff as required by the State Services Assurance Act for FY2008 (Act) (5 ILCS 382/3-15).

At June 30, 2007, the Department had 154 bilingual frontline staff. Therefore, it is required by the Act to maintain a bilingual frontline staffing level of 194. As of July 1, 2022, the Department employed 139 bilingual frontline staff.

The Act required that on or before July 1, 2008 the Department shall increase and maintain the number of bilingual on-board frontline staff by 40 over the level that it maintained on June 30, 2007.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2010. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated they continue to struggle to identify qualified applicants to meet the frontline staff bilingual recruitment requirement.

Failure to comply with this statute could lead to the Department not being able to provide adequate services to families for which English is not their first language. (Finding Code No. 2022-010, 2020-014, 2018-011, 2016-009, 2014-006, 12-16, 10-12)

RECOMMENDATION

We recommend the Department comply with the Act or, alternatively, if determined that the bilingual frontline staffing level required by the Act is not representative of its needs, seek a legislative remedy to the statutory requirement.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department has invested in robust efforts to recruit bilingual employees particularly within the last six-months, using a marketing/public relations company to help leverage their expertise in diversifying messaging and outreach through earned and paid media. Additionally, the Department will intensify its efforts to recruit bilingual employees through targeted "on the spot" hiring events, job fairs community and legislative outreach. Additional bonuses for bilingual employees are also offered. While the needs of the bilingual population continue to grow, at no time have the needs of the hotline or other Department services been impaired. All bilingual families are being serviced and all

2022-010 **FINDING** Noncompliance with the State Services Assurance Act for FY2008 (Continued)

bilingual calls are being answered immediately with no wait time. We also have a translation service available to bridge the gap while we continue to recruit and retain highly qualified staff.

2022-011 **FINDING** Lack of Documentation of Monitoring of Contracts with Provider Agencies

The Department of Children and Family Services (Department) did not adequately document the monitoring of its provider agencies for compliance with contract terms.

The Department could not provide documentation demonstrating it had conducted monitoring of its non-substitute care service provider agencies. The non-substitute care provider agencies provide services which include, but are not limited to, counseling, habilitation, advocacy centers, system-of-care grants, and other child specific services. Specifically, we noted the Department was unable to provide documentation it had conducted monitoring, as specified in the contracts, for 12 of 60 (20%) contracts tested. For these 12 provider agencies, appropriations totaled approximately $17,259,430 from the awards and grant appropriations line item during fiscal years 2021 and 2022. Total grants expended for the 12 contracts during fiscal years 2021 and 2022 totaled $15,593,544, which was paid from the General Revenue Fund 0001 ($6,183,102), the Children's Services Fund 0220 ($9,302,792), and the DCFS Special Purpose Fund 0582 ($107,650). Due to the Department being unable to provide documentation to demonstrate it had conducted monitoring, we cannot determine whether annual reviews required to be submitted by 9 of 12 grantees were performed by Department staff.

According to the Department's Policy Guide 2013.07 "Non-Substitute Care Contract Monitoring Process and Requirements", Part V (b), the Comprehensive Program Monitoring Review is required on each contract for non-substitute care services during the 3rd quarter of each fiscal year (January - March). The annual monitoring review shall be documented in writing following the format in the Non-substitute Care Contract Monitoring Database.

In addition, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to ensure State resources are used efficiently and are safeguarded against loss. All the contracts tested contained language requiring fiscal and program monitoring by the Department. The Department's performance of the monitoring should result in and be documented by the Department utilizing a monitoring report with corrective action plans when necessary. At a minimum, the Department should conduct on-site monitoring reviews of providers' services and performance, including reviews of all documentation maintained which support charges billed annually.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2012. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

2022-011 **FINDING** Lack of Documentation of Monitoring of Contracts with Provider Agencies (Continued)

Department management acknowledges that all programs are not monitored in the same manner and exceptions noted were due to workforce changes and limited source of knowledge base.

Failure to monitor the performance of contracted services could lead to overpayments and payments for services not performed in accordance with contract terms and requirements. Thorough fiscal and administrative monitoring, including reviews of provider billing support and documenting that service delivery is in accordance with program plans and performance goals, is an essential oversight responsibility of the Department. (Finding Code No. 2022-011, 2020-013, 2018-010, 2016-008, 2014-009, 12-7)

RECOMMENDATION

We recommend the Department perform and document adequate monitoring on all contracts to ensure contract payments are for services received and program plans and performance goals of the provider agencies are achieved.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department will ensure staff serving in the contract monitoring role are performing monitoring duties pursuant to program plans. The Department added regional leadership roles to increase the oversight of regional based staff after facing staffing shortages during the time of this audit which was also during the global pandemic. The Department is also pursuing a new performance monitoring tool to aid in tracking and documentation of monitoring agency contracts.

2022-012 **FINDING** Noncompliance with the Adoption Act

The Department of Children and Family Services (Department) did not comply with the Adoption Act (Act).

The Act (750 ILCS 50/4.1(b)(3)) requires the Department, no later than September 24, 2017, to distribute a written list of all pre-adoption approval requirements to all Illinois licensed child welfare agencies performing adoption services and all out-of-state agencies approved.

In order to conduct testing of the Act, we requested the Department provide us a population of licensed child welfare agencies performing adoption services during the examination period. The Department subsequently provided the requested population to us. However, during our testing of 5 agencies selected from the population, we noted the Department erroneously included one child welfare agency that did not perform adoption services during the examination period. Due to this condition, we were unable to conclude the Department's population were sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36).

Department management stated the Department erroneously included a service provider who was not applicable to the matter being addressed.

Even given the population limitations noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we performed testing of 40 adoption agencies. During testing, we noted the Department could not provide documentation to demonstrate it had distributed a written list of all pre-adoption approval requirements to 10 (25%) adoption agencies.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Department management stated it did not retain documentation of its distributions of written list of all pre-adoption approval requirements due to employee oversight and competing priorities.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2018. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

2022-012 **FINDING** Noncompliance with the Adoption Act (Continued)

Without the Department providing complete and adequate documentation to enable testing, we were impeded in completing our procedures and providing useful and relevant feedback to the General Assembly regarding the Department's distribution of the pre-adoption approval requirements to Illinois licensed child welfare agencies and out-of-state agencies performing adoption services. (Finding Code No. 2022-012, 2020-021, 2018-019)

RECOMMENDATION

We recommend the Department maintain documentation to demonstrate it distributes a written list of all pre-adoption approval requirements to all Illinois licensed child welfare agencies performing adoption services and all out-of-state agencies approved under the Act.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. All Illinois licensed child welfare agencies performing adoption services are provided with a written list of all pre-adoption approval requirements by the Department. Given the infinite number of out-of-state providers, it is impossible to reach all of those providers and the Department intends to ask for a revision to statute. Further, the Department has created a self-imposed a corrective action plan and has listed the adoption pre-approval requirements on our website.

2022-013 **FINDING** Noncompliance with the Child Care Act of 1969

The Department of Children and Family Services (Department) failed to comply with the Child Care Act of 1969 (Act) (225 ILCS 10).

We tested several sections of the Act and noted the following exceptions:

- The Act (225 ILCS 10/4(b-5)) requires the Department to notify the quality-of-care concerns applicant of its decision and the basis for its decision in writing. Per the Act (225 ILCS 10/2.22a), a quality-of-care concerns applicant is defined as an applicant for a foster care license or renewal of a foster care license where the applicant or any person living in the applicant's household:
  (1) has had a license issued under this Act revoked;
  (2) has surrendered a license issued under this Act for cause;
  (3) has had a license issued under this Act expire or has surrendered a license, while either an abuse or neglect investigation or licensing investigation was pending or an involuntary placement hold was placed on the home;
  (4) has been the subject of allegations of abuse or neglect;
  (5) has an indicated report of abuse or neglect;
  (6) has been the subject of certain types of involuntary placement holds or has been involved in certain types of substantiated licensing complaints, as specified and defined by Department rule; or
  (7) has requested a youth-in-care's removal from the home, either orally or in writing, on 5 or more occasions.

  During our testing of five quality-of-care concerns applicant, we noted one (20%) quality-of-care concerns applicant was not notified of the Department's decision and the basis for its decision in writing.

  Department management stated the noted issue was caused by oversight.

  Failure to notify the quality-of-care concerns applicant of the Department's decision in writing results in applicants not knowing the results of their application and represents noncompliance with the Act.

- The Act (225 ILCS 10/5.2(b)) requires the Department to notify child care facilities, on an ongoing basis of the provisions of this section, the Children's Product Safety Act (CPSA), and of the comprehensive list of unsafe children's products as provided and maintained by the Department of Public Health available on the Internet in plain nontechnical language that will enable each child care facility to effectively inspect children's products and identify unsafe

2022-013 **FINDING** Noncompliance with the Child Care Act of 1969 (Continued)

children's products. The Department is also required to adopt rules to maintain data on childcare facilities without Internet access and to ensure the childcare facilities without Internet access register for available mailing lists of pertinent recalls distributed in paper form.

During our testing, we noted the Department has forms to encourage facilities to sign up for mailings lists through the Consumer Product Safety Commission (CPSC). However, the Department does not currently have a mechanism to confirm with the specific facilities on an on-going basis that they are registered with CPSC and therefore receive mailed notifications. We also noted the Department has not adopted rules to maintain data on childcare facilities without Internet access and to ensure the childcare facilities without Internet access register for available mailing lists of pertinent recalls distributed in paper form. Finally, we noted the Department does not have special procedures concerning the notification to licensed facilities when the unsafe children's product list is updated.

Department management stated these noted exceptions were caused by staffing and leadership changes, oversight, and competing and conflicting federal mandates for the CPSA.

Not adopting rules to maintain data on childcare facilities without Internet access, ensuring those childcare facilities register for available mailing lists of pertinent recalls in paper forms, confirming with the CPSC that specific facilities are registered, and not having procedures concerning the notification to licensed facilities when the unsafe children's product list is updated impairs the Department's ability to ensure the safety of children in childcare facilities.

- The Act (225 ILCS 10/7.3(b) thru 225 ILCS 10/7.3(e)) requires a private child welfare agency that places youth-in-care in foster family homes, at least once every 30 days to make a site visit to every such home where it has placed a youth-in-care. The purpose of the site visit is to verify that the child continues to reside in that home and to verify the child's safety and well-being. The private child welfare agency must document the verification in its records. The Department is required to periodically (but no less often than once every 6 months) review the child placement records of each private child welfare agency that places a youth-in-care. If a private child welfare agency fails to comply with the requirement, the Department must suspend all payments to the agency until the agency complies. In addition, the Act requires that if a child placed in a foster family home is missing, the foster parent must promptly report that fact to the Department or to the child welfare agency that place the child

2022-013 **FINDING** Noncompliance with the Child Care Act of 1969 (Continued)

in the home. If the foster parent fails to make such a report, the Department shall put the home on hold for the placement of other children and initiate corrective action that may include revocation of the foster parent's license to operate the foster family home. A foster parent who knowingly and willfully fails to report a missing foster child under the Act is guilty of a Class A misdemeanor. If a private child welfare agency determines that a youth-in-care whom it has placed in a foster family home no longer resides in that home, the agency must promptly report that fact to the Department. If the private child welfare agency fails to make such a report, the Department shall put the agency on hold for the placement of other children and initiate corrective action that may include revocation of the agency's license.

During our testing, we noted the Department has no procedure in place to perform the following:

- Suspend all payments to a private child welfare agency if it fails to at least once every 30 days make a site visit to every such home where it has placed a youth-in-care, and/or fails to document the verification of the visit within its records.

- Put the foster home on hold for placement of other children and initiate corrective action if the foster home fails to report to the Department or to the child welfare agency that the child placed in a foster family home is missing.

- Put on hold for placement of other children and initiate corrective action of the private child welfare agency's license if it fails to promptly report to the Department that a youth-in-care whom it has place in foster family home no longer reside in that home.

Department management stated issues noted were caused by staffing and leadership changes, oversight, and organizational shifts.

Not having procedures in place to comply with the requirements of the Act creates an increased risk that the Department will make payments to ineligible private child welfare agency and hinders the Department's ability to assess the safety and welfare of its youth-in-care.

- The Act (225 ILCS 10/12(g)) requires the Department to maintain a website listing of private child welfare agencies licensed by the Department that provide adoption services and other general information for biological parents

2022-013 **FINDING** Noncompliance with the Child Care Act of 1969 (Continued)

and adoptive parents. The website shall include, but not be limited to, agency addresses, phone numbers, e-mail addresses, website addresses, annual reports, agency license numbers, the Birth Parent Bill of Rights, the Adoptive Parents Bill of Rights, and the Department's complaint registry.

During our testing, we noted the Department's website did include all the required information for the private child welfare agencies; however, the website did not include the most recent annual reports for all the private child welfare agencies listed. Specifically, the website did not include the annual reports for fiscal years 2019 through 2022.

Department management stated issues noted were due to oversight.

Failure to post the most recent annual reports for all the private welfare agencies hinders the relevant 3rd parties' ability to assess the information of those taking care of the State's youth-in-care.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2018. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan. (Finding Code No. 2022-013, 2020-022, 2018-020)

RECOMMENDATION

We recommend the Department: (1) notify in writing the decision made to quality-of-care applicants; (2) adopt rules to maintain data on child care facilities without Internet access, ensure those child care facilities register for available mailing lists of pertinent recalls in paper forms, confirm with the CPSC that specific facilities are registered, and have procedures concerning the notification to licensed facilities when the unsafe children's product list is updated; (3) adopt procedures to suspend all payments to a private child welfare agency if it fails to comply with the requirements of the Act and put on hold for placement of other children and initiate corrective action like revocation of the agency's license if it fails to promptly report to the Department that a youth-in-care whom it has place in foster family home no longer reside in that home; and (4) maintain a complete website listing of child welfare agencies licensed by the Department to provide adoption services.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. There are procedures in place to report youth in a missing status when applicable. Agency Performance

2022-013 **FINDING** Noncompliance with the Child Care Act of 1969 (Continued)

monitoring has the ability and has exercised their discretion in conducting agency utilization reviews. In the event of a significant contractual breach, the Department can halt services. Going forward there will be better clarity as to what can trigger an agency being placed on "hold" as outlined in statute. Of note, payments to an individual provider can be halted immediately. Organizational shifts and competing mandates contributed to the lack of practice clarity in this regard.

The Department agrees that the occurrence of one quality-of-care concern applicant not being notified in writing of the Department decision regarding their license or renewal demonstrates non-compliance. While this specific applicant was confirmed to have been verbally notified, this instance was used as a reminder to all licensing staff of the requirement to notify of the decision in writing.

The Department agrees with the auditor regarding findings related to childcare facilities without internet access and we are committed to ensuring childcare facilities are aware of all information released by the Child Product Safety Commission. It is important to note that the CPSA states that per Sec. 6A they do not provide a service where hard copy updates of Unsafe Children's Products and recalls are mailed to the person making the request. To align with the CPSA, an amendment of the Child Care Act of 1969 was recently passed by both Illinois Houses on May 4, 2023. The amendment requires that the Department of Children and Family Services shall establish and maintain a database on the safety of consumer products and other products, or substances regulated by the Department that is: (1) publicly available; (2) searchable; and (3) accessible through the Internet website of the Department. The amendment removes language regarding childcare facilities without internet.

The Department developed a system to comply with the amendment and is prepared to execute this on January 1, 2024, when the legislation goes into effect. Additionally, the DCFS Sunshine website currently provides access to the Unsafe Children's Product & U.S. Consumer Product Safety Commission to view and print down the comprehensive list of unsafe children's products.

The Department of Licensing will designate two people (one as a backup to the other) who will provide the previous two calendar years updated 596Q forms to the Office of Communications by December 1 of each year to be posted on the website per the Child Welfare Act of 1969. The CCA required registration for available mailing when the CPSA only provides e-mail registration. The Department forms were in alignment also with the CCA that requires changes. For licensing to comply, the CCA needed to conform so that both laws were aligning; this has since been updated. The Department will update its rules, procedures and forms to come into compliance.

2022-014 **FINDING** Noncompliance with the Social Services Contract Notice Act

The Department of Children and Family Services (Department) failed to comply with the Social Services Contract Notice Act (Act) (30 ILCS 596/20).

The Act requires any contract between the Department and an authorized service provider for the provision of social services may be terminated, suspended or reduced by either party to the contract for any or no reason upon 30 days prior written notice to the party. A written notice issued by the Department is to include the date upon which the authorized service provider must submit its final invoice to the Department for payment of services rendered.

In order to conduct testing over the Act, we requested the Department provide us a population of terminated, suspended, or reduced contracts during the examination period. The Department subsequently provided the population, however during our testing over the accuracy and completeness of the population, we noted the Department inadvertently included one fiscal year 2020 contract noted as being terminated in the fiscal year 2021 contract termination population. Further, we noted the population included one contract sampled that showed different contract numbers between the written notice and the contract with the authorized service provider.

Due to this condition, we were unable to conclude the Department's population was sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36). Even given the population limitations noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we performed testing of 13 terminated, suspended, or reduced contracts.

During our testing, we noted the following:

- For three (23%) contracts tested, the Department did not provide written notice to authorized service providers providing social services upon 30 days. The Department's notifications were sent 26 to 22 days prior to the contract's stated termination date.

- For 13 (100%) contracts tested, the Department's written notice did not include the date upon which the authorized service provider must submit its final invoice to the Department for payment of services rendered.

Department management stated the issues were due to oversight and data entry errors.

2022-014 **FINDING** Noncompliance with the Social Services Contract Notice Act (Continued)

Failure to provide a timely written notice, not including the final invoice date in the written notice to authorized service provider providing social services, and failure to maintain an accurate contract termination population could lead to improper payments to authorized service providers and it further impeded our ability to complete the auditing procedures which provides useful and relevant feedback to the General Assembly regarding the Department's compliance with the Act. (Finding Code No. 2022-014)

RECOMMENDATION

We recommend the Department ensure that the authorized service provider is provided 30 days written notice for any contract between a State agency and an authorized service provider for the provision of social services terminated, suspended or reduced by either party to the contract for any or no reason. In addition, we recommend the Department ensure the written notice includes the date upon which the authorized service provider must submit its final invoice to the Department for payment of services rendered and ensure the contract number in the written notice and the contract termination listing is accurate.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation regarding the Social Services Contract Notice Act, written notices of non-renewal/terminations will be made timely. These notices will also include the date which providers must submit final invoices for payment, which is usually within the Fiscal Year in which services were delivered.

2022-015 **FINDING** Failure to Maintain Accurate Property Records

The Department of Children and Family Services (Department) did not maintain adequate internal controls over its property and related fixed asset records.

During our testing of Department's quarterly Agency Reports of State Property (Form C-15) filed with the Office of Comptroller (Comptroller), we noted the Department's State property listing could not be reconciled with the ending balances reported in the Form C-15 for the fourth quarter ended June 30, 2021. Specifically, we noted an irreconcilable difference of $507,585 between the Department's property listing and the Form C-15.

Due to these conditions, we were unable to conclude whether the Department's population records were sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36) to test the Department's equipment.

Even given the population limitations noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we performed the following tests:

List to Floor and Floor to List Testing:

During our physical inspection of 25 equipment items, we noted one equipment item (4%), totaling $2,272, did not have a tag number. In addition, during our tracing of 25 equipment items to the Department records, we noted one equipment item (4%), a computer storage center controller, could not be traced to the property records.

The Statewide Accounting Management System (SAMS) Manual (Procedure 29.10.10) requires the Department to maintain detailed property records and update property records as necessary to reflect the current balance of the State property. Such detailed records are to be organized by major asset category and include information such as the equipment tag number, location, item function and activity, among others.

Further, the Illinois Administrative Code (44 Ill. Admin. Code 5010.210) requires the Department to mark each piece of State-owned equipment in its possession with a unique identification number.

Additions testing:

During our testing of additions, we noted 2 of 30 (7%) equipment acquisitions, totaling $2,300, were added to the Department's property records 191 and 329 days after the equipment acceptance dates.

2022-015 **FINDING** Failure to Maintain Accurate Property Records (Continued)

The Illinois Administrative Code (44 Ill. Admin. Code 5010.400) requires the Department to adjust property records within 90 days of acquisition, change, or deletion of equipment items.

Filing of Form C-15 to the Comptroller:

The Department did not submit 4 of 8 (50%) quarterly Form C-15s for fiscal year 2021 and fiscal year 2022 to the Comptroller on a timely basis. Specifically, the Form C-15s were submitted 4 to 137 days late.

The SAMS Manual (Procedure 29.20.10) requires the Form C-15 to be filed on a quarterly basis and submitted to the Comptroller no later than the last day of the month following the last day of the quarter.

Filing of Annual Inventory Certification to the Department of Central Management Services (CMS):

The Department submitted its fiscal year 2021 annual inventory certification to CMS 26 days late.

The Illinois Administrative Code (44 Ill. Admin. Code 5010.460) requires the Department to complete and certify the Department's annual physical inventory of State equipment and submit a complete property listing to CMS on dates designated by CMS. The Department's designated due date was July 1, 2021.

Department management stated exceptions noted were due to employee turnover, lack of training, and competing priorities.

Failure to maintain accurate property records and timely file reports represents noncompliance with State laws and regulations and increases the potential for fraud and theft of State property. Further, without the Department providing complete and adequate documentation to enable testing, we were impeded in completing our procedures and providing useful and relevant feedback to the General Assembly regarding the Department's compliance requirements over its property during fiscal year 2021. (Finding Code No. 2022-015, 2020-016, 2018-014)

RECOMMENDATION

We recommend the Department strengthen its controls over the recording and reporting of its State property and equipment transactions to ensure property records accurately

2022-015 **FINDING** Failure to Maintain Accurate Property Records (Continued)

reflect equipment on-hand in accordance with State regulations, equipment items are properly inventoried and tagged, and reports are timely submitted.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The property control manager enters all items on a quarterly basis so that C-15 reports can be submitted timely and within the parameters of the deadline. This ensures all items are entered into the system within 90 days. When items are received, the procurement department sends purchase order packets to the property control manager, informing them of the delivery date, price, item description, location, etc. With this information, the property control manager can decide which type of property tag the item requires (a barcode tag or a red/white property sticker) and apply the correct tag based on department policy and IOC regulations. When items come in large quantities/bulk, the warehouse managers assign tags to all items and keep them with the items until they are removed from the warehouse, allowing the property control manager to enter all tag information immediately instead of waiting for each item to be delivered.

Annual inventory was successfully completed for FY23 and all 64 DCFS sites were fully inventoried. All discrepancies were sent to CMS for deletion and a schedule is already in place for completing inventory at all sites in FY24. The server and IT discrepancies that were noted are currently being reviewed by their respective department leads. New procedures are being developed allowing these units to work more closely with the property control manager.

Additionally, there are two new positions that were hired in the Property Control Unit, to assist with critical staffing shortages. One is a property control liaison in Cook County that will serve as direct backup to the property control manager so there is always someone in the agency that can handle property control if someone is out. The Department also hired a new office coordinator for the property control manager to help manage all tasks and ensure all reporting, inventory, tagging, etc. is done within the specified guidelines.

2022-016 **FINDING** Inadequate Internal Controls Over Accident Reporting

The Department of Children and Family Services (Department) failed to maintain adequate internal controls over accident reports.

After selecting a sample of accidents involving State vehicles during the examination period and completing our examination procedures, we noted discrepancies between the Department's population and the Auto Liability Report of accidents produced from the Department of Central Management Services' (CMS) database. Specifically, we noted there were two accidents for which we received support from the Department which were not reported to CMS, and, therefore, were left off of the Auto Liability Report obtained from CMS. In addition, there was one accident reported in CMS' Auto Liability Report but was not included in the Department's list. Therefore, we noted the Department failed to provide a complete and accurate population of accidents that occurred during the examination period.

Department management stated the listing did not reconcile due to the confusion as to the type of accidents needed to be reported to CMS by the vehicle coordinator.

Due to these conditions, we were able to conclude the Department's population records for operation of automobile accidents were not sufficiently precise and detailed under the Attestation Standards promulgated by the American Institute of Certified Public Accountants (AT-C §205.36).

Even given the population limitations noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we noted the following issue:

The Department did not timely file its Motorist's Report of Illinois Motor Vehicle Accident Reports (Form SR-1) for 3 of 4 (75%) accidents tested. The accidents were reported between 1 and 20 days late.

The Illinois Administrative Code (44 Ill. Admin. Code 5040.520(i)) and the CMS Vehicle Guide requires all accidents reported on Form SR-1 be sent to CMS no later than seven days after the accident has occurred.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2012. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated the late reporting of the accidents to DCMS was due to delay of employee's submission of information to the vehicle coordinator and due to a technical issue in submitting the reports in the DCMS reporting system.

2022-016 **FINDING** Inadequate Internal Controls Over Accident Reporting (Continued)

Untimely submission of accident reports could delay an investigation, impair the State's ability to defend itself against claims, or delay settlement of claims made against the State. Further, without the Department providing complete and adequate documentation to enable testing, we were impeded in completing our procedures and providing useful and relevant feedback to the General Assembly regarding the Department's compliance with the Code. (Finding Code No. 2022-016, 2020-017, 2018-015, 2016-012, 2014-016, 12-15)

RECOMMENDATION

We recommend the Department implement internal controls to ensure it adequately tracks all motor vehicle accidents to make certain they are timely reported to CMS.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department has recently hired a new facilities manager in each region after an unprecedented loss of staff during COVID, which is during this time of this audit. in each region to assist with car maintenance including timely accident reporting. Vehicles at each field office are closely monitored by an assigned on-site vehicle coordinator who is trained on the proper reporting of any accident of the vehicle located at their facility. These on-site coordinator report to the regional facilities manager all accidents; who in turn report to the agency vehicle coordinator for proper reporting to CMS Division of Vehicles within the seven-calendar day reporting requirement. The facilities managers provide next step directions to the coordinator or make and/or arrange for the repair arrangements themselves.

The addition of the regional facilities managers and on-site vehicle coordinators has already proven to be successful.

2022-017 **FINDING** Federal Reimbursements Not Requested Timely

The Department of Children and Family Services (Department) failed to timely request reimbursement of federally supported programs.

Of 48 grants supported by federal programs in fiscal year 2022, 16 (33%) of these had receivables at the end of the fiscal year that were 70% or greater than the year's total reimbursable costs. Listed below is a breakdown of prior year receivables, current year reimbursable costs, amount received in the current year, and end of the year receivables for those five grants (amounts in thousands):

Grant ID	Prior Year Receivable	Current Year Reimbursable Cost	Current Year Receipts	Current Year Receivable	Current Year Receivables as % of Current Year Reimbursable Costs
1348	$ 47	$ –	$ –	$ 47	N/A*
1345	$ 19	$ –	$ –	$ 19	N/A*
1353	$ 2	$ –	$ –	$ 2	N/A*
1359	$ 32	$ –	$ –	$ 32	N/A*
1361	$ 32	$ –	$ –	$ 32	N/A*
1380	$ 130	$ (32)	$ –	$ 98	N/A*
1391	$ 61	$ –	$ –	$ 61	N/A*
1396	$ 700	$ 257	$ 257	$ 700	272%*
1398	$ 10	$ 47	$ 24	$ 33	70%
1402	$ 96	$ 58	$ –	$ 154	266%*
1403	$ –	$ 39	$ –	$ 39	100%
1405	$ –	$ 6	$ –	$ 6	100%
1130	$ 8,779	$ 12,419	$ 8,779	$ 12,419	100%
1137	$ –	$ 11,920	$ –	$ 11,920	100%
1137	$ –	$ 4,600	$ –	$ 4,600	100%

** Because the current year receivable exceeded the current year reimbursable cost, the % is greater than 100%, or, if the current year reimbursable cost was $0, is N/A.*

The Illinois State Collection Act of 1986 (30 ILCS 210/3) states that it is the responsibility of each State agency to timely collect amounts owed to that agency. Good cash management practices require that monies owed the State be requested in a timely manner.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2012. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management indicated that due to the nature of the federal entitlement grants the Department participates in an initial analysis of spending that meets eligibility requirements must be done prior to a State's fiscal year end. Further, an

2022-017 **FINDING** Federal Reimbursements Not Requested Timely (Continued)

additional analysis needs to be performed to ensure the Department maximizes its federal return by applying eligible expenditures to the most advantageous federal program. Department management stated the additional, detailed analysis is done as part of the quarterly reporting requirements of the federal government after the quarter is complete which identifies the additional funds available to be reported on the Department's financial statements. The delay in performing the analyses described above was due to competing priorities of staff at a time when this process was made more complicated due to additional funds made available for the COVID-19 pandemic relief. The additional COVID-19 pandemic funds had a cascading effect on the Department's small, multiyear grants creating carryover from year to year.

Delays in collecting monies owed to the Department deprive the State of available cash resources with which to administer operations and programs. (Finding Code No. 2022-017, 2020-018, 2018-016, 2016-011, 2014-012, 12-10)

RECOMMENDATION

We recommend the Department comply with the Illinois State Collection Act of 1986 by requesting earned federal reimbursements in a reasonable timeframe.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation which has also been implemented by drawing all funds available no later than 60 days after they are earned. It is important to note that the Department, like other agencies across the state and businesses around the world, had been understaffed during this reporting period for a number of reasons including the global pandemic. While the Department continues to make unprecedented strides and is reaching staffing levels not seen in 15 years, it has taken us some time to rebound and find qualified staff.

2022-018 **FINDING** Monthly Reconciliations Not Performed Timely

The Department of Children and Family Services (Department) did not timely perform monthly reconciliations of the Department's accounting and financial data to the Office of Comptroller (Comptroller) records.

During our sample testing of monthly reconciliations of Department records to the Comptroller records in the Statewide Accounting Management System (SAMS), we noted the following

- Seven of 8 (88%) Appropriations Status Report (SB01) monthly reconciliations tested were not performed on a timely basis. The untimely reconciliations ranged from 1 to 225 days late.

- Seven of 8 (88%) Object Expense/Expenditures by Quarter Report (SA02) reconciliations tested were not performed on a timely basis. The untimely reconciliations ranged from 1 to 225 days late.

- Two of 8 (25%) Revenue Status Report (SB04) monthly reconciliations tested were performed 2 days late.

- Two of 8 (25%) Cash Report (SB05) monthly reconciliations tested were performed 2 days late.

- The Department did not perform reconciliations of the Agency Contract Report (SC14) or the Obligation Activity Report (SC15) during fiscal years 2021 and 2022. The Comptroller's records show the Department had $374,923,125 and $405,792,676 in contracts at June 30, 2021 and June 30, 2022, respectively.

The SAMS Manual (Procedure 07.30.20) outlines the requirements for agencies to complete the above monthly reconciliations of accounting and financial information to SAMS within 60 days of month end.

Further, during our testing of the Department's five locally-held fund's monthly bank reconciliations for fiscal year 2021 and fiscal year 2022, we noted the following:

- Seven of 120 (6%) monthly bank reconciliations tested, were performed 2 to 308 days late.

- For one of 120 (1%) monthly bank reconciliation tested, the Department did not document the date the reconciliation was performed, thus we were unable to determine if the reconciliation was performed within 60 days of the applicable month's end.

2022-018 **FINDING** Monthly Reconciliations Not Performed Timely (Continued)

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfers of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources. Good internal control practices include reconciliations that are timely and adequately prepared within 60 days of month end.

Department management stated failure to complete monthly reconciliations for Reports SC14 and SC15 and other delays in completing monthly reconciliations were due to competing priorities of staff time caused by long-term staffing vacancies in key management positions in the Finance Division.

Timely reconciliations are an important internal control procedure and mechanism that allows the Comptroller to take necessary corrective action in the event irreconcilable differences between Department and Comptroller records occur. (Finding Code No. 2022-018, 2020-024)

RECOMMENDATION

We recommend the Department develop procedures and properly train designated staff to accurately perform monthly reconciliations on a timely basis.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department continues to carry vacancies in key management positions that are responsible for reconciliation of accounts. To combat the fluidness of hiring and vacancy rates, the Department has added both managerial and support level headcount to provide additional support as well as duplicity in coverage to better react to vacancies and the time it takes to back fill positions. Several of these positions are in the advanced stages of the hiring process and the Department looks forward to being able to be fully staffed.

2022-019 **FINDING** Voucher Processing Internal Controls Not Operating Effectively

The Department of Children and Family Services' (Department) internal controls over its voucher processing function were not operating effectively during the examination period.

Due to our ability to rely upon the processing integrity of the Enterprise Resource Planning (ERP) System operated by the Department of Innovation and Technology (DoIT), we were able to limit our voucher testing at the Department to determine whether certain key attributes were properly entered by the Department's staff into the ERP System. In order to determine the operating effectiveness of the Department's internal controls related to voucher processing and subsequent payment of interest, we selected a sample of key attributes (attributes) to determine if the attributes were properly entered into the State's ERP System based on supporting documentation. The attributes tested were 1) vendor information, 2) expenditure amount, 3) object(s) of expenditure, and 4) the later of the receipt date of the proper bill or the receipt date of the goods and/or services.

Our testing noted 9 of 140 (6%) attributes were not properly entered into the ERP System. Therefore, the Department's internal controls over voucher processing were not operating effectively.

The Statewide Accounting Management System (SAMS) (Procedure 17.20.20) requires the Department to, after receipt of goods or services, verify the goods or services received met the stated specifications and prepare a voucher for submission to the Comptroller's Office to pay the vendor, including providing vendor information, the amount expended, and object(s) of expenditure. Further, the Illinois Administrative Code (Code) (74 Ill. Admin. Code 900.30) requires the Department maintain records which reflect the date goods were received and accepted, the date services were rendered, and the proper bill date. Finally, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance expenditures are properly recorded and accounted for to maintain accountability over the State's resources.

Due to this condition, we qualified our opinion because we determined the Department had not complied, in all material respects, with applicable laws and regulations, including the State uniform accounting system, in its financial and fiscal operations.

Even given the limitations noted above, we conducted an analysis of the Department's expenditures data for fiscal years 2021 and 2022 to determine compliance with the State Prompt Payment Act (Act) (30 ILCS 540) and the Code (74 Ill. Admin. Code 900.70). We noted the following noncompliance:

2022-019 **FINDING** Voucher Processing Internal Controls Not Operating Effectively (Continued)

- The Department owed 306 vendors interest totaling $6,134 in fiscal years 2021 and 2022; however, the Department had not approved these vouchers for payment to the vendors.

  The Act (30 ILCS 540) requires agencies to pay vendors who had not been paid within 90 days of receipt of a proper bill or invoice interest.

- The Department did not timely approve 23,543 of 561,330 (4%) vouchers processed during the examination period, totaling $96,476,729. We noted these late vouchers were submitted by the Department to the Comptroller's Office between 1 and 373 days late.

  The Code (74 Ill. Admin. Code 900.70) requires the Department to timely review each vendor's invoice and approve proper bills within 30 days after receipt.

In addition, during our testing of 40 travel vouchers, we noted one (3%) out-of-State travel request was not approved by the employee's deputy director prior to travel date. Specifically, the travel request was approved 62 days late.

Furthermore, we selected 60 vouchers from the children's personal and physical maintenance (CPPM) appropriation line to test for reasonableness and adequacy of support. In many instances, multiple payments were made to a vendor or provider on a single voucher. The 60 vouchers included 313 payments, totaling $256,978. During our testing, we noted 3 of 60 (5%) vouchers were not approved in a timely manner, ranging from 1 to 13 days late.

The Department's Administrative Procedure #12, Travel Guide for Department Employees, requires when traveling out-of-State on "ward related" business, staff must first obtain approval from the responsible Deputy Director.

The Code (74 III. Admin. Code 900.70) requires the approval of bills within 30 days after receipt thereof.

Department management stated the majority of the exceptions noted were due to the global hiring crisis which resulted in the Fiscal Division operating at a vacancy rate around 50% during most of the engagement period.

2022-019 **FINDING** Voucher Processing Internal Controls Not Operating Effectively (Continued)

Failure to properly enter the key attributes into the State's ERP System when processing a voucher for payment hinders the reliability and usefulness of data extracted from the ERP System, which can result in improper interest calculations and expenditures. In addition, failure to timely process proper bills and approve vouchers for payment of interest due represents noncompliance with the Code, Department procedures, and the Act. Further, failure to obtain approval from the Deputy Director prior to out-of-State travel results in noncompliance with the Department's procedures. (Finding Code No. 2022-019)

RECOMMENDATION

We recommend the Department design and maintain internal controls to provide assurance its data entry of key attributes into the ERP System is complete and accurate. We also recommend the Department process proper bills within 30 days of receipt and timely approve vouchers for payment to vendors. In addition, we recommend the Department's Deputy Director approve out-of-State travel prior to the employee's travel date, if able.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendations and understands the importance of timely payment for the goods and services provided to support our state's youth in care. The Department has added both managerial and support level headcount to better enforce the internal controls already in place to ensure vouchers submitted to the Department are processed timely and accurately. The Department has also implemented a process to ensure timely processing of Prompt Payment Interest vouchers when there are delays in processing payments to the vendors of the Department. The Department also continues to review its data processing systems to ensure its data is reliable, complete and accurate.

2022-020 **FINDING** Failure to Fully Utilize the State's Enterprise Resource Planning System

The Department of Children and Family Services (Department) did not utilize all the capabilities of the State's Enterprise Resource Planning (ERP) System which resulted in unnecessary inefficiency.

The State's implementation of an ERP System centralized the finance, procurement, grants management, and asset management processes by replacing outdated manual systems and technologies. The ERP System can enhance transparency of data, reduce processing time, and improve the timeliness of financial reporting. During the examination period, the ERP System's processing integrity was sufficient to enable reliance upon the ERP System's processing of transactions.

For commodities and property inventories, the ERP System has several functionalities which reduce the amount of manual transactions and processing time, such as the "shopping cart" feature that creates a purchase order, tracks receipt of the goods or service along with the vendor's related invoice, helps generate the voucher fields necessary for the processing of payment to the vendor, records inventory and property transactions, and enables financial reporting to the Comptroller's Office.

During our examination, we noted the Department recorded financial transactions, however, the Department did not utilize the General Ledger, Grants Management, and Controlling ERP Modules and did not fully utilize the Accounts Payable and Funds Management ERP Modules.

- The General Ledger module records the financial transactions of an agency and the State's chart of accounts.

- The Grants Management module maintains the budget, obligations, actual expenditures, revenues, etc. associated with each specific grant.

- The Controlling module collects, analyzes, distributes, allocates, and reports on financial data according to cost objects.

- The Accounts Payable module records and manages accounting data for all vendors.

- The Funds Management module maintains, tracks, and reports on revenues, expenditures, commitments, obligations, and transfers for each fund and budget.

Government Auditing Standards (§ 1.02) states the concept of accountability for use of public resources and government authority is key to our nation's governing processes.

2022-020 **FINDING** Failure to Fully Utilize the State's Enterprise Resource Planning System (Continued)

Management and officials entrusted with public resources are responsible for carrying out public functions and providing service to the public effectively, efficiently, economically, and ethically within the context of the statutory boundaries of the specific government program.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that resources are utilized efficiently, effectively, and in compliance with applicable laws. Good internal controls over compliance include ensuring the full capabilities of the ERP System are used to efficiently process, record, and report transactions.

Department management stated its utilization of the ERP System was determined, in part, by the needs of (1) automation for its high volume board voucher process for child care expenditures as well as (2) the ability to validate appropriateness of case related payments against its case management system. The ERP system does not have solutions in place for either of these needs, so these processes must remain in its legacy systems which are then interfaced into the State's ERP System.

Failure to fully utilize the State's ERP System could result in outdated systems not being supported, untimely financial information and the lack of full transparency and result in the inefficient usage of State resources. (Finding Code No. 2022-020)

RECOMMENDATION

We recommend the Department work with the Department of Innovation and Technology to transition and fully utilize the General Ledger, Grants Management, Controlling, Accounts Payable, and the Funds Management modules of the ERP System.

DEPARTMENT RESPONSE

The Department accepts the auditor's recommendations. The Department worked very closely with the Department of Innovation and Technology (DOIT) throughout the implementation of the ERP System. Due to the need to ensure the stability of the State's system of child welfare, it was determined, with the approval of the State of Illinois Chief Information Officer, that the legacy systems in place could not be retired because as many as 20,000 automated monthly payments directly support the families that keep our youth safe, clothed and fed. Decisions were made to maintain most of

2022-020 **FINDING** Failure to Fully Utilize the State's Enterprise Resource Planning System (Continued)

our legacy systems and integrate with the ERP system while the Department moved forward with its plan to develop a new Comprehensive Child Welfare Information System (CCWIS) compliant system. The contracts awarded to develop this system include provisions to utilize the ERP system to its fullest extent. The finance portion of development is scheduled to begin in the latter portion of FY25. Until that time, the Department continues to assess its ability to utilize the ERP system while maintaining the integrity of its legacy systems to ensure the most efficient and effective use of State resources while utilizing the ERP system to ensure Statewide access to financial data for transparency and accountability.

2022-021 **FINDING** Inadequate Access Controls

The Department of Children and Family Services (Department) had not implemented adequate procedures and processes related to its applications' access and controls.

The Department utilizes several applications to carry out its mission which includes the Statewide Automated Child Welfare Information System (SACWIS) and the Department's accounting system (MARS). During our testing of access controls to these two applications, we noted:

- The Service Access Request and Electronic Communication and Distribution Procedures (Procedures) did not require reviews of access rights to applications. Additionally, the Procedures did not document access provisioning requirements for contractors.

- Six of nine (67%) terminated employees' access to MARS were not disabled within five business days from termination date. The terminated employees' access were disabled 11 to 25 days after the 24-hour requirement.

- Six of 19 (32%) terminated employees' access to SACWIS were not disabled within five business days from termination date. The terminated employees' access were disabled 5 to 292 days after the 24-hour requirement.

- A review of SACWIS users' access was not conducted during the examination period.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Access Control section, requires entities to implement internal controls to ensure timely termination of access rights and review of users' access rights.

Best business practices require entities to disable terminated employees' user accounts within 24 hours from termination date.

2022-021 **FINDING** Inadequate Access Controls (Continued)

Department management indicated weaknesses noted were due to oversight and a lack of staffing.

The lack of adequate controls over access could result in unauthorized access and disclosure of confidential information. (Finding Code No. 2022-021, 2020-010)

RECOMMENDATION

We recommend the Department perform the following:

- Update the Service Access Request and Electronic Communication and Distribution Procedures to include a requirement to review access rights and access provisioning requirements for contractors.

- Ensure terminated users' access is timely terminated.

- Conduct annual review of users' access to all of the Department's applications.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department will collaborate on updating Service Access Request and Electronic Communication and Distribution Procedures. With the start of the IllinoisConnect Project mid-year 2022, DoIT@DCFS is developing appropriate policies and procedures around all aspects of the system, including but not limited to, documentation requirements, interface testing, accuracy and completeness of data and change documentation. Industry best practices will be followed which encompass all recommendations from the auditors. In addition, the Department is currently developing an optimized technology enabled workflow for all employees which separate from the Department to more timely address access controls. The Department will collaborate with DoIT@DCFS to establish a periodic review of users' access.

2022-022 **FINDING** Inadequate Controls Over Applications and Data Accuracy

The Department of Children and Family Services (Department) did not maintain adequate internal controls over the accuracy of its applications and data.

The Department utilizes several applications to carry out its mission, including the Statewide Automated Child Welfare Information System (SACWIS) and the Department's accounting system (MARS). During our testing, we noted:

- The Authorized Child Care Payment Procedures did not document the requirements to ensure the accuracy and completeness of data, correction of errors, avoidance of duplicate data, and the balancing of data with source information for SACWIS.
- The Department's reports on Child Abuse and Neglect Determinations and Initiation of Investigations of Child Abuse and Neglect from SACWIS contain data entry errors. Specifically, we noted date and time of determination and initiation of investigations were not accurately entered in SACWIS. See Findings 2022-007 and 2022-008 for further details.
- The Department provided SACWIS data during our follow ups to recommendations noted in the Status of Performance Audit Recommendations section of the Department's State Compliance Examination report for which we could not either confirm the data's accuracy or we noted the data was inaccurate. Specifically, data accuracy issues arose during the following testing procedures:
    - Recommendation 3 in the Status of Performance Audit Recommendations of the *Management Audits for the Management Audit of the Department of Children and Family Services Search for Missing Children*.
    - Recommendation 16 in the Status of Performance Audit Recommendations of Management Audits for the *Performance Audit of the Department of Children and Family Services LGBTQ Youth-In-Care*.
- We requested the Department provide a population of changes to SACWIS and MARS during the examination period. The Department provided a population; however, the Department did not provide documentation demonstrating the population was sufficiently precise and detailed under the Professional Standards promulgated by the American Institute of Certified Public Accountants (AT-C § 205.36). Even given the population limitations noted above which hindered the ability of the accountants to conclude whether selected samples were representative of the population as a whole, we selected a sample of changes and noted no exceptions.

2022-022 **FINDING** Inadequate Controls Over Applications and Data Accuracy (Continued)

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance that revenues, expenditures, and transfer of assets, resources, or funds applicable to operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports and to maintain accountability over the State's resources.

The Framework for Improving Critical Infrastructure Cybersecurity and the Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Configuration Management section, requires entities to document their controls to ensure controls over changes to applications and data are properly documented, tested, authorized, and reviewed.

Department management indicated exceptions noted were due to oversight and competing priorities.

The lack of adequate internal controls over Department applications and data could result in unauthorized changes and incomplete and inaccurate data. In addition, failing to maintain sufficient change records increases the risk of unauthorized changes or inaccurate data not being detected and hindered our ability in providing relevant feedback to the General Assembly. (Finding Code No. 2022-022, 2020-009)

RECOMMENDATION

We recommend the Department:

- Develop procedures to document the requirements for ensuring the accuracy and completeness of data, correction of errors, avoidance of duplicate data, and the balancing of data with source information for SACWIS.
- Ensure documentation is maintained demonstrating change populations are complete and accurate.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. With the start of the IllinoisConnect Project mid-year 2022, DoIT@DCFS is developing appropriate policies and procedures around all aspects of the system, including but not limited to, documentation requirements, interface testing, accuracy and completeness of data and change documentation. Industry best practices will be followed which encompass recommendations from the auditors.

2022-023 **FINDING** Weaknesses in Cybersecurity Programs and Practices

The Department of Children and Family Services (Department) had not implemented adequate practices and controls to protect confidential information.

It is the mission of the Department to protect the children of the State. As a result of their mission, the Department maintains large volumes of confidential information including abuse records, health information, Social Security numbers, bank account numbers, etc.

The Illinois State Auditing Act (30 ILCS 5/3-2.4) requires the Auditor General to review State agencies and their cybersecurity programs and practices. During our examination of the Department's cybersecurity program, practices, and control of confidential information, we noted the Department had not:

- Developed formal security policies and procedures to ensure its resources and data were adequately protected:
    - Cybersecurity plan,
    - Project management framework,
    - Data classification plan, and
    - Risk management methodology.
- Performed a comprehensive risk assessment to identify and classify data to ensure adequate protection of confidential or personal information most susceptible to attack.
- Developed policies and procedures for reviewing and monitoring security implementation and violations.

Additionally, 21 of 60 (35%) staff sampled had not completed the annual cybersecurity training and acknowledged receipt and compliance with the Department's policies.

The Framework for Improving Critical Infrastructure Cybersecurity and the Security and Privacy Controls for Information Systems and Organizations (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology require entities to consider risk management practices, threat environments, legal and regulatory requirements, mission objectives and constraints in order to ensure the security of their applications, data, and continued business mission.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use and misappropriation and maintain accountability over the State's resources.

2022-023 **FINDING** Weaknesses in Cybersecurity Programs and Practices (Continued)

The Data Security on State Computers Act (20 ILCS 450/25) requires every employee to annually undergo training by the Department of Innovation and Technology (DoIT) concerning cybersecurity.

Department management indicated a significant amount of effort would be needed to manage the Cyber Security training requirements within the Department's current system, and as such, the Department lacks the adequate staffing levels to achieve this.

The lack of adequate cybersecurity programs and practices could result in unidentified risk and vulnerabilities, which could ultimately lead to the Department's confidential and personal information being susceptible to cyber-attacks and unauthorized disclosure. (Finding Code No. 2022-023, 2020-029)

RECOMMENDATION

We recommend the Department:

- Develop adequate policies and procedures to ensure its resources are adequately protected.
- Complete a comprehensive risk assessment of its computing resources to identify confidential and personal information to ensure such information is protected from unauthorized disclosure.
- Classify its data to identify and ensure adequate protection of information.
- Ensure all employees complete the annual cybersecurity training.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. Many improvements have been completed to protect the DCFS systems and computing equipment. Efforts continue including implementing a more secure VPN solution, and changing server configurations to be more secure.

A risk assessment was completed in January 2022, performed in cooperation with the Department of Innovation and Technology Risk Assessment team.

Data Classification will be accomplished as the first part of the IllinoisConnect Project, and with every release, as new data elements are added to that application.

As of the start of IllinoisConnect mid-year of 2022, DoIT@DCFS will not modify existing procedures; appropriate procedures will be implemented as part of the IllinoisConnect Project. Data classification will be part of all releases.

2022-023 **FINDING** Weaknesses in Cybersecurity Programs and Practices (Continued)

The IllinoisConnect Project contract requires the establishment, training, documenting of a comprehensive tracking and reporting solution. The first part of this capability is planned for Release 5 (scheduled for November 2023) with supplemental capabilities in Release 7 (October 2025) and Release 9 (July 2026).

2022-024 **FINDING** Inadequate Disaster Recovery Planning and Testing

The Department of Children and Family Services' (Department) Disaster Recovery Plan (Plan) contained weaknesses and recovery testing had not been conducted.

The Department maintained several critical systems including, among others, the Case Management System (CYCIS), the Medicaid Billing System, and the Statewide Automated Child Welfare Information System (SACWIS).

During our testing of the Department's Plan, we noted it did not address:

- prioritization of applications and data,
- escalation procedures,
- recovery testing requirements,
- roles and responsibilities, and
- an inventory of hardware and software.

In addition, we noted the Department did not conduct disaster recovery testing during the examination period.

The *Security and Privacy Controls for Information Systems and Organizations* (Special Publication 800-53, Fifth Revision) published by the National Institute of Standards and Technology, Contingency Plan section, requires entities to have an updated and regularly tested contingency plan as baseline security controls integral to ensuring the timely recovery of applications and data.

The Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department to establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds, property, and other assets and resources are safeguarded against waste, loss, unauthorized use, and misappropriation and maintain accountability over the State's resources.

Department management indicated the lack of Office of Information Technology Services (OITS) resources lead to the weaknesses. OITS has not been able to acquire the resources to update the disaster recovery processes and manage execution of disaster recovery testing.

Without an adequately documented and tested contingency plan, the Department cannot ensure its critical systems could be recovered within an acceptable period, and therefore minimizing the impact associated with a disaster. (Finding Code No. 2022-024, 2020-030)

2022-024 **FINDING** Inadequate Disaster Recovery Planning and Testing (Continued)

RECOMMENDATION

We recommend the Department update its Plan to reflect the current environment and once updated, the Plan should be reviewed, updated, and tested at least annually.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendations. The SACWIS has a Disaster Recovery Plan adequate to protect the function of the Department. A complete Disaster Recovery Plan is required of the IllinoisConnect Project and will develop testing procedures and plans, including, at minimum, annual testing of those plans. This will encompass all critical systems by the completion of Release 9 of the IllinoisConnect Project on or about July 2026.

2022-025 **FINDING** Employee Performance Evaluations Not Performed

The Department of Children and Family Services (Department) did not complete or conduct annual performance evaluations on a timely basis.

Upon examination of 60 personnel files, we noted the Department did not complete performance evaluations for 13 (22%) employees during fiscal year 2021 and 12 (20%) employees during fiscal year 2022.

Personnel rules issued by the Illinois Department of Central Management Services (80 Ill. Admin. Code 302.270) require performance records to include an evaluation of employee performance prepared by each agency not less than annually. Annual evaluations support administrative personnel decisions by documenting regular performance measures.

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2008. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management indicated, as it did previously, monthly notifications are provided to each respective supervisor and their chain of command with the notification of three timeframes for evaluations. The Department also stated not having salary increases tied to the completion of performance evaluations decreases supervisors' diligence in meeting these deadlines as they juggle the more pressing daily functions of their jobs.

Employee performance evaluations are an effective management tool for helping employees work toward common goals. Performance evaluations are a systematic and uniform approach used for the development of employees and communication of performance expectations. (Finding Code No. 2022-025, 2020-015, 2018-012, 2016-010, 2014-015, 12-11, 10-11, 08-15)

RECOMMENDATION

We recommend the Department enforce the existing policies regarding timely completion of performance evaluations.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The agency continues to send out monthly notifications to each respective supervisor and their chain of command with three timeframes (overdue, due, coming due). At the end of the fiscal

2022-025 **FINDING** Employee Performance Evaluations Not Performed (Continued)

year management encourages managers to complete evaluations by sending an email for all overdue evaluations, promotions and discipline. The completion of an updated evaluation is required for a cost-of-living increase to be given to merit compensation staff by end of fiscal year. The Office of Employee Services will continue to remind managers in meetings and ask the Office of Communications to post an announcement quarterly regarding completion of evaluations and the impact to the organization.

2022-026 **FINDING** Inadequate Controls Over Employee Training Programs

The Department of Children and Family Services (Department) did not maintain internal controls to ensure employees completed the required training programs or to ensure they were completed in a timely manner.

While performing tests of personnel records, we selected a sample of 60 employees to determine if training programs were being performed timely. We noted the following exceptions as a result of our testing:

- Three of 10 (30%) employees hired during fiscal year 2021 completed the initial ethics and harassment and discrimination prevention training programs 8 to 168 days late.

- One of 5 (20%) employees hired during fiscal year 2022 completed initial ethics and harassment and discrimination prevention training programs 77 days late.

- Four of 45 (9%) employees did not complete the ethics and harassment and discrimination prevention training programs during fiscal year 2021.

The State Officials and Employees Act (Act) (5 ILCS 430/5-10 thru 5 ILCS 430/5-10.5) requires each officer, member, and employee to the ethics training program and harassment and discrimination prevention training program annually. In addition, the Act (5 ILCS 430/5-10 through 5 ILCS 430/5-10.5) requires an employee newly hired or appointed a position to complete an initial ethics training and harassment and discrimination prevention training within 30 days after commencement of their office or employment.

Department management indicated employees failed to comply with notices to perform the training.

Failure to complete or timely complete the ethics training may result in employees not being made aware of specific ethical requirements. Sexual harassment training provides education to allow employer and employee to recognize sexual harassment and understand their rights and responsibilities. (Finding Code No. 2022-026, 2020-027)

RECOMMENDATION

We recommend the Department establish and implement monitoring procedures to ensure each employee timely completes the annual trainings as required by various laws and regulations.

2022-026 **FINDING** Inadequate Controls Over Employee Training Programs (Continued)

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department continues to improve its internal processes to ensure timely completion of employees Ethics Training and Sexual Harassment Prevention and Discrimination training by including them as part of the agency-wide onboarding process for new employees, and by establishing a strategic reminder process for current employees and supervisors about their training compliance status, which is monitored throughout the year. To ensure that new employees complete their required trainings with 30 days of employment, employees are advised of this requirement during their onboarding. Once their employment begins, DoIT@DCFS issues the employee training portal ("OneNet") credentials, enabling them access to the portal to complete trainings electronically. Through the administrative report functions of the training portal, the Department can monitor training completion data in real time.

A hurdle new employees may face in successfully completing online training within 30 days of employment relates to routine delays in issuing a new employee's OneNet account, which is the only way to complete training electronically. These delays have resulted in employees being employed for longer than 30 days without receiving their credentials. Likewise, when employees leave DCFS there has not been a consistent process for deactivating their OneNet accounts. This results in the Ethics Office receiving data that indicates an employee has not completed training when in fact they are no longer employed at DCFS. The Ethics Office continues to work with the Office of Employee Services and DoIT@DCFS to streamline this process and assign specific responsibilities to ensure timely electronic training access for new employees.

As a result of these collaborative efforts, training compliance has improved significantly and for calendar year 2023 and the Department is currently at 94 and 95% employee training compliance for ethics and sexual harassment discrimination prevention training, respectively.

2022-027 **FINDING** Inadequate Internal Controls Over Employee Timesheets

The Department of Children and Family Services (Department) did not maintain adequate internal controls over its employees' time reporting.

While performing tests of employees' time reporting, we selected a sample of 60 employees and noted the following exceptions:

- Eleven of 60 (18%) timesheets were not approved by the employee's direct supervisor.
- Three of 60 (5%) timesheets were not timely approved by the employee's direct supervisor. Specifically, the timesheets were approved 33 to 114 days from the last date of the pay period.
- Five of 49 (10%) employees with benefit time usage were not approved by the employee's direct supervisor.
- Five of 29 (17%) employees with overtime hours were not approved by the employee's direct supervisor.
- One of 60 (2%) timesheets could not be located by the Department. As a result, we could not perform testing.

In addition, during our test of employees' leave of absences, we noted leave of absences for 2 of 15 (13%) employees sampled were not properly approved by their direct supervisor.

The State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Further, according to the Department Employee Handbook, Chapter 2, employees must submit an Employee Request Form for Use of Benefit Time (CFS-728) to correspond with the absence noted on the daily timesheet. Employees are also required to request the use of the benefit time on the CFS-728 and to submit it reasonably in advance of the date(s) to be used. Supervisors are required to approve the CFS-728. In addition, Chapter 2, Section 6, of the Department Employee Handbook states, in order to earn overtime, employees must submit a completed Overtime or Compensatory Time Request Form (CFS-734) to their supervisor and that overtime must be approved by

2022-027 **FINDING** Inadequate Internal Controls Over Employee Timesheets (Continued)

the supervisor in advance before compensation will be authorized, except as otherwise provided in supplemental agreements.

Department management stated these exceptions were due to human error and the limitations of keeping a complete file record for the paper-based overtime approval and timesheet process.

Failure to obtain proper approval of overtime may cause an employee to be compensated for overtime hours that were not actually performed or warranted. In addition, failure to obtain and retain adequate documentation of timely supervisors' approval for timesheets and benefit time usage may lead to inaccuracies on employee's benefit time balances and reported compensated balance totals recorded in the Department's and the Statewide financial statements. Furthermore, failure to ensure all employees comply with time reporting requirements results in noncompliance with the Department's Employee Handbook. Finally, failure to retain timesheets of all employees' time hindered our ability to perform testing. (Finding Code No. 2022-027)

RECOMMENDATION

We recommend the Department strengthen its internal controls over timekeeping to ensure timesheets are completed, timely approved, and retained. We also recommend the Department ensure employees' overtime hours, benefit time usage, and leave of absences are properly approved.

DEPARTMENT RESPONSE

The Department agrees with the auditor's findings. The Department now conducts in person timekeeper training on a regular basis for new timekeepers throughout the state. Within a day of training, timekeepers receive a follow-up to recap what was discussed in the training, as well as provide them with the Timekeeping Calendar so they are aware of all important dates and deadlines. In addition, the Department sends out time sheet instructions to employees, timekeepers and supervisors as problems are identified to ensure they are being corrected. The Department also now screens timesheets headed for archiving, sending requests to timekeepers and supervisors when errors are noted, or signatures are missing. The Department will be transitioning to a new HCM Timekeeping system that will resolve many of the issues listed in the finding, especially supervisor approvals which will be done on the front end.

2022-028 **FINDING** Inadequate Internal Controls Over State Vehicle Maintenance

The Department of Children and Family Services (Department) did not maintain adequate internal controls to ensure its vehicles were properly maintained.

During our review of maintenance records for six vehicles, we noted the following:

- Five vehicles (83%) did not receive vehicle maintenance (oil change and tire rotation) on scheduled intervals. Department records showed the State vehicles were driven 118 to 1,052 miles more than allowed by the maintenance policy before the required oil change or tire rotation maintenance was performed.

- Two vehicles (33%) did not undergo an annual inspection in fiscal year 2021.

- Two vehicles (33%) did not undergo an annual inspection in fiscal year 2022.

The Vehicle Guide of the Department of Central Management Services (CMS) requires oil changes every 3,000 miles or 12 months, whichever comes first for passenger vehicles 10 years or older; or every 5,000 miles or 12 months, whichever comes first for 9 years-old and newer passenger vehicles, as well as a tire rotation on all passenger vehicles in conjunction with every second oil change.

In addition, the Illinois Administrative Code (Code) (44 Ill. Admin. Code 5040.410(a)) requires the Department to have all of its vehicles undergo an annual inspection by CMS or an authorized vendor.

Department management stated due to retirements, employees working from home, and the lack of Business/Facility Managers in each region this year, some vehicles have not been maintained and serviced properly.

Failure to exercise adequate internal controls over vehicles maintenance could result in the State incurring unnecessary costs and additional repairs to, and shorten useful lives of, its vehicles. Further, it represents noncompliance with Code and CMS Vehicle Usage Program. (Finding Code No. 2022-028)

RECOMMENDATION

We recommend the Department review and strengthen its internal controls over monitoring its fleet to ensure State vehicles receive timely and proper maintenance in accordance with State laws and regulations.

2022-028 **FINDING** Inadequate Internal Controls Over State Vehicle Maintenance (Continued)

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department has recently hired a new facilities manager in each region after an unprecedented loss of staff during COVID, which is during this time period of this audit. in each region to assist with car maintenance including timely accident reporting. Vehicles at each field office are closely monitored by an assigned on-site vehicle coordinator who is trained on the proper reporting of any accident of the vehicle located at their facility. The on site coordinators report to all maintenance to the regional facilities manager; who in turn report to the agency vehicle coordinator for proper reporting to CMS Division of Vehicles within the seven-calendar day reporting requirement. The facilities managers provide next step directions to the coordinator or make and/or arrange for the repair arrangements themselves.

2022-029 **FINDING** Inadequate Internal Controls Over Census Data

The Department of Children and Family Services (Department) failed to ensure the pension and other postemployment benefits (OPEB) plans' census data reconciliation was performed accurately.

Census data is demographic data (date of birth, gender, years of service, etc.) of the active, inactive, or retired members of a pension or OPEB plan. The accumulation of inactive or retired members' census data occurs before the current accumulation period of census data used in the plan's actuarial valuation (which eventually flows into each employer's financial statements), meaning the plan is solely responsible for establishing internal controls over these records and transmitting this data to the plan's actuary. In contrast, responsibility for active members' census data during the current accumulation period is split among the plan and each member's current employer(s). Initially, employers must accurately transmit census data elements of their employees to the plan. Then, the plan must record and retain these records for active employees and then transmit this census data to the plan's actuary.

We noted the Department's employees are members of both the State Employees' Retirement System of Illinois (SERS) for their pensions and the State Employees Group Insurance Program sponsored by the State of Illinois, Department of Central Management Services (CMS) for their OPEB. In addition, we noted these plans have characteristics of different types of pension and OPEB plans, including single employer plans and cost-sharing multiple-employer plans. Finally, we noted CMS' actuaries use SERS' census data records to prepare the OPEB actuarial valuation.

During our review of the Department's census data reconciliation, we noted 7 (22%) of 32 reconciliation discrepancies tested were noted as discrepancies (i.e., reconciling items) when the original SERS census data was correct. As a result, the Department communicated to SERS that the census data was incorrect and had SERS subsequently update their records with incorrect information. SERS responded it did not update its census data information because SERS believed the data provided to the Department (and the actuary) was correct.

For employers participating in plans with multiple-employer and cost-sharing characteristics, the American Institute of Certified Public Accountants' *Audit and Accounting Guide: State and Local Governments* (AAG-SLG) (§ 13.177 for pensions and § 14.184 for OPEB) notes the determination of net pension/OPEB liability, pension/OPEB expense, and the associated deferred inflows and deferred outflows of resources depends on employer-provided census data reported to the plan being

2022-029 **FINDING** Inadequate Internal Controls Over Census Data (Continued)

complete and accurate along with the accumulation and maintenance of this data by the plan being complete and accurate. To help mitigate against the risk of a plan's actuary using incomplete or inaccurate census data within similar agent multiple-employer plans, the AAG-SLG (§ 13.181 (A-27) for pensions and § 14.141 for OPEB) recommends an employer annually reconcile its active members' census data to a report from the plan of census data submitted to the plan's actuary, by comparing the current year's census data file to both the prior year's census data file and its underlying records for changes occurring during the current year.

Also, the State Records Act (5 ILCS 160/8) requires the Department to make and preserve records containing adequate and proper documentation of the organization, functions, policies, decisions, procedures, and essential transactions of the Department designed to furnish information to protect the legal and financial rights of the State and of persons directly affected by the Department's activities.

Further, the Fiscal Control and Internal Auditing Act (30 ILCS 10/3001) requires the Department establish and maintain a system, or systems, of internal fiscal and administrative controls to provide assurance funds applicable to operations are properly recorded and accounted for to permit the preparation of reliable financial and statistical reports.

Department officials indicated the errors with the discrepancies noted during the initial reconciliation were due to employee oversight.

Failure to accurately reconcile active members' census data reported to and held by SERS to the Department's records could result in each plan's actuary relying on incomplete or inaccurate census data in the calculation of the State's pension and OPEB balances, which may result in a misstatement of these amounts. (Finding Code No. 2022-029, 2020-003)

RECOMMENDATION

We recommend the Department accurately complete the SERS annual reconciliation process for its active members' census data from its underlying records to a report of the census data submitted to each plan's actuary.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Payroll Administrator has established communication channels with the Office of Employee Services' Payroll Processor to ensure timely requests and deadlines are adhered.

2022-030 **FINDING** Noncompliance with the Fiscal Control and Internal Auditing Act

The Department of Children and Family Services' (Department) failed to fully comply with the Fiscal Control and Internal Auditing Act (Act).

During our review of the Department's internal audit activities for fiscal years 2021 and 2022, we noted the internal audits of the Department's major system of internal accounting and administrative controls including testing of the obligation, expenditure, receipt and use of public funds of the State and of funds held in trust to determine whether those activities are in accordance with applicable laws and regulations were not completed during fiscal years 2021 and 2022. Specifically, the Office of Internal Audit did not audit 3 of the Department's 11 (27%) identified major systems of internal accounting and administrative controls within the two-year cycle. There were three internal audit reports completed and issued during fiscal year 2022 and none in fiscal year 2021.

The Act (30 ILCS 10/2003(a)) requires the internal auditing program to include: (1) a two-year plan, identifying audits scheduled for the pending fiscal year, approved by the chief executive officer before the beginning of the fiscal year; (2) audits of major systems of internal accounting and administrative control to be performed at least once every two years and must include testing of the obligation, expenditure, receipt and use of public funds of the State and of funds held in trust to determine whether those activities are in accordance with applicable laws and regulations; and grants received or made by the designated State agency to determine that grants are monitored, administered, and accounted for in accordance with applicable laws and regulations; and (3) reviews of the design of major new electronic data processing systems and major modifications of those systems before their installation to ensure the systems provide for adequate audit trails and accountability.

Department management stated staffing issues and increased audit liaison responsibilities made it impossible to fully comply with the Act.

The lack of timely internal audits over all major systems inhibits the Department's ability to monitor the effectiveness of its system of internal controls and results in noncompliance with the Act. (Finding Code No. 2022-030)

RECOMMENDATION

We recommend the Department implement controls to ensure completion of audits of major systems of internal accounting and administrative control at least once every two years.

2022-030 **FINDING** Noncompliance with the Fiscal Control and Internal Auditing Act (Continued)

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. Since the reporting period of this audit and the pandemic, which caused the Department to lose a number of staff for a variety of reasons, the Department has been working to increase headcount across the agency including within the Office of Internal Audit to ensure adequate audit coverage per the Fiscal Control and Internal Auditing Act and guidance found in the Statewide Accounting Management System manual. The Department is pleased to report that our headcount is currently the highest it has been in 15 years with 3,200 employees and is working to ensure divisions are adequately staffed.

2022-031 **FINDING** Untimely Approval and Filing of Contracts and Interagency Agreements

The Department of Children and Family Services (Department) did not have fully approved contracts prior to commencement of services and did not file the contracts with the Office of Comptroller timely.

During our review of 60 contracts (totaling $153.8 million), including purchase of care contracts, executed during the two years ended June 30, 2022, we noted the following:

- 27 contracts (45%), totaling $120.4 million, were executed subsequent to the start date of the contract. The contract execution dates ranged from 7 to 167 days after the commencement of service.

- Eight contracts (13%), totaling $9.0 million, were not timely submitted to the Office of Comptroller. Specifically, these contracts were filed between 4 and 35 days late.

In addition, during our review of nine intergovernmental agreements (totaling $1.7 million), we noted four agreements (44%), totaling $0.5 million, were executed subsequent to the start date of the agreement. The agreement execution dates ranged from 13 to 345 days after the commencement of service.

As noted in the Department's Code of Regulations (89 Ill. Admin. Code 357.110), "purchase of service providers under contract to the Department must comply with Federal and State laws and regulations and Department rules. When the provider signs the purchase of service contract, this signature shall be the provider's certification of compliance with the applicable laws, regulations, and rules." It is prudent business practice to require contracts to be signed by all parties prior to the commencement of services. In addition, the standard contracts utilized by the Department in procuring these services include the following term: Section 1.3.2: Vendor shall not commence billable work in furtherance of the Agreement prior to final execution of the Agreement except where permitted pursuant to 30 ILCS 500/20-80.

The Illinois Procurement Code (Code) (30 ILCS 500/20-80) states whenever a grant, or a contract liability, except for: (1) contracts paid from personal services, or (2) contracts between the State and its employees to defer compensation in accordance with Article 24 of the Code, exceeding $20,000 is incurred by any State agency, a copy of the contract, purchase order, grant, or lease shall be filed with the Office of Comptroller within 30 calendar days thereafter. Contractors shall not be paid for any supplies that were received or services that were rendered before the contract was reduced to writing and signed by all necessary parties.

2022-031 **FINDING** Untimely Approval and Filing of Contracts and Interagency Agreements (Continued)

This finding was first reported in the Department's *State Compliance Examination* for the two years ended June 30, 2002. In the subsequent years, the Department has been unsuccessful in implementing a corrective action plan.

Department management stated various factors, unique and systemic, resulted in the late filling of Department contracts during the course of the last two fiscal years. A decrease and transition of experienced contract management/analysis workforce, established shortcomings of the existing information and data technology applications and programs, increase in workload responsibilities (that included late in the fiscal year rate changes, based on the Governor's office/State General Assembly's budgetary approval), provider/vendor collaboration with negotiating contract terms, unprecedented new program additions and revisions to existing Department programming, and repercussions of the ongoing COVID-19 pandemic were a few of the causes that resulted in the late execution of some Department contracts.

Failure to obtain approval before the beginning of the contract period does not bind the parties to comply with applicable laws, regulations, and rules and may result in improper and unauthorized payments. In addition, failure to file contracts with the Office of Comptroller on a timely basis resulted in noncompliance with State statutes and regulations. (Finding Code No. 2022-031, 2020-012, 2018-009, 2016-007, 2014-008, 12-9, 10-6, 08-6, 07-5, 06-5, 05-7, 04-7, 03-5, 02-7)

RECOMMENDATION

We recommend the Department ensure all contracts and agreements are approved and signed before the beginning of the contract or agreement period. We also recommend the Department strengthen controls to ensure contracts are filed with the Office of Comptroller in accordance with the State statutes.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. The Department will continue to review its processes to improve timeliness in the contract approval process and ensure contracts are submitted to the Comptroller timely. The Office of Contract Administration conducted an analysis of its staff to workload ratio and determined that additional headcount was necessary to fulfill its duties; headcount was approved, and the division is working through the hiring process. The Division has also converted the majority of its contract to multi-year contracts which will reduce administrative

2022-031 **FINDING** Untimely Approval and Filing of Contracts and Interagency Agreements (Continued)

burden and allow the Department to obligate contracts timely. Further, the Department is revising its internal timelines to expedite the contract process each fiscal year and it is the Departments intent to utilize the Comptroller's pre-filing mechanism.

2022-032 **FINDING** Locally Held Funds Not Properly Invested or Used

The Department of Children and Family Services' (Department) locally held funds 1207 (Herrick House) and 1117 (Katherine Schaffner Bequest) monies are not being used for a beneficial purpose for the Department.

The Herrick House Fund contained $13,363 as of June 30, 2022. The fund was opened on March 25, 1983 with money received by the Department from the Circuit Court of the 9th Judicial Circuit, Orange County, Florida, in satisfaction of a last will and testament of an individual's estate. The money was to be used specifically for the Herrick House in Bartlett, Illinois, which no longer exists. During the engagement period, Herrick House monies were maintained solely in a money market account. The monies are not being used or actively invested. For fiscal years 2021 and 2022, the account earned less than $1 per month each year. There was no other activity in this account during fiscal years 2021 and 2022.

The Katherine Schaffner Bequest Fund (1117) contained $845,009 as of June 30, 2022. During the engagement period, the Katherine Schaffner Bequest monies were maintained in an Institutional Asset Management account. While the monies are being invested and earning a positive rate of return, the monies are not being used for any beneficial purpose for the Department. There was no activity in this account other than interest deposits during fiscal years 2021 and 2022. According to the Department, a bequest of $91,000 from the Katherine F. Schaffner Trust was received by the Department in December 1980 to be used exclusively for the use and benefit of the Herrick House's Children's Center. Because Herrick House no longer exists, the money has been held in the accounts until dissolution is decided.

The Illinois Public Funds Investment Act (30 ILCS 235) requires that public funds be prudently invested. Good business practice necessitates the funds be used for beneficial purposes.

Department management stated both funds are restricted in their use due to specifications of donor requests. Department management stated the home these funds were entrusted to the Department to support has been closed and the Department was not given authority to use the funds in other capacities.

The current inactivity of the Herrick House Fund and the Katherine Schaffner Bequest Fund represents funds that potentially could be used for other Department purposes, should proper dissolution be decided. (Finding Code No. 2022-032)

2022-032 **FINDING** Locally Held Funds Not Properly Invested or Used (Continued)

RECOMMENDATION

We recommend the Department seek a legislative or legal remedy for the utilization of the monies maintained in the Herrick House Fund and Katherine Schaffner Bequest Fund.

DEPARTMENT RESPONSE

The Department agrees with the auditor's recommendation. Due to the age of the original bequest for these funds, documentation to dissolve the fund cannot be located. The Department has had conversations with the Attorney General's office for assistance and will continue to work with them to seek a resolution to resolve this finding in order to utilize these funds to the benefit of the State of Illinois.

2022-033 **FINDING** Noncompliance with Accountability for the Investment of Public Funds Act

The Department of Children and Family Services (Department) did not fully comply with the requirements of the Accountability for the Investment of Public Funds Act (Act) in its posting of information concerning monies held outside of the State Treasury.

The Department's monthly online posting of information concerning investment of public funds appeared on a page on the Department's website with the title "Investment of Public Funds Reporting." During our sample testing of eight monthly reports, we noted the following:

- Two of eight (25%) monthly reports did not report the balances as of the last day of the month or the average daily balance of the preceding month.
- Eight of eight (100%) monthly reports did not contain the total monthly investment income and yield.
- Eight of eight (100%) monthly reports did not report the asset allocation of the investments made.
- Two of eight (25%) monthly reports were not posted by the 15th day of the following month. Specifically, the reports were posted one and four days late.

The Act (30 ILCS 237/10) requires the Department to make "sufficient information concerning the investment of any public funds" available on the Internet and updated by the 15th of each month. Furthermore, the reports are to identify the amount of funds held by the Department on the last day of the month or the average daily balance of the preceding month, total monthly investment income, the asset allocation of the investments made by the agency and a complete listing of institutions approved to do business with the Department.

Department management stated these reporting requirements are included in the procedures of the Department, but lack of timely reporting was due to oversight. In addition, Department management stated certain information required by the Act, such as the balances as of the last day of the month, average daily balance of the preceding month, the asset allocation of the investments and total monthly investment income, is not available to the Department from the asset management company.

Failure to publish online all required information related to the investment of public funds denies the public information concerning the balances held by the Department and is noncompliance with the Act. (Finding Code No. 2022-033)

2022-033 **FINDING** Noncompliance with Accountability for the Investment of Public Funds Act (Continued)

RECOMMENDATION

We recommend the Department review the requirements of the Act and ensure all information required therein is made available online at such times and frequencies as prescribed. We also recommend the Department work with its asset management company to obtain monthly reports which provide the required information mandated by the Act.

DEPARTMENT RESPONSE

The Department agrees with and has implemented the auditor's recommendation. The Department worked with its investment company to receive information monthly to report required information per the Act and has conducted training with staff to ensure they understand the time requirements.

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SCHEDULE OF FINDINGS - PRIOR FINDINGS NOT REPEATED
For the Two Years Ended June 30, 2022

A. **FINDING** (Inadequate Controls Over Cash)

During the prior engagement, the Department of Children and Family Services (Department) did not exercise adequate controls over cash receipts and monthly reconciliations.

During the current engagement, our sample testing indicated the Department significantly improved its internal controls over cash. Exceptions were noted relating to the Department's timeliness of performing its cash reconciliations; however, they had no financial statement impact. As a result, this finding was reported as not repeated for financial statement audit report purposes, but is reported in the Department's *State Compliance Examination Report* as Finding 2022-018. (Finding Code No. 2020-002)

B. **FINDING** (Inadequate Internal Controls Over Census Data)

During the prior engagement, the Department did not develop or retain adequate supporting documentation for its personnel transactions and did not have a reconciliation process to provide assurance census data submitted to its pension and other postemployment benefits (OPEB) plans was complete and accurate.

During the current engagement, exceptions were noted during our sample testing of the Department's reconciliation process. However, while instances of noncompliance were noted, they had no financial statement impact. As a result, this finding was reported as not repeated for financial statement audit report purposes, but is reported in the Department's *State Compliance Examination Report* as Finding 2022-029. (Finding Code No. 2020-003)

C. **FINDING** (Inadequate General Information Technology Controls Over IMPACT)

During the prior engagement, the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department (collectively, the Departments) failed to establish and maintain adequate general information technology internal controls (general IT controls) over the operation of the State of Illinois' Illinois Medicaid Program Advanced Cloud Technology system (IMPACT).

During the current engagement, the Department executed an interagency agreement with HFS documenting specific roles and responsibilities relating to IMPACT. As outlined in the interagency agreement, HFS is responsible for maintaining adequate general information technology internal controls over IMPACT. (Finding Code No. 2020-004, 2018-002)

D. **FINDING** (Insufficient Review and Documentation of Provider Enrollment Determinations and Failure to Execute Interagency Agreements)

During the prior engagement, the Department failed to execute an interagency agreement with the Department of Healthcare and Family Services (HFS) establishing adequate internal controls over the operation of the State of Illinois' Illinois Medicaid Program Advances Count

Technology system (IMPACT) and failed to sufficiently review and document eligibility requirements either prior to the approval of eligibility, and/or during the required monthly screenings for enrolled providers.

During the current engagement, the Department executed an interagency agreement with HFS documenting specific roles and responsibilities relating to IMPACT. During our testing over the Department's assigned responsibilities defined in the interagency agreement, we noted no exceptions. (Finding Code No. 2020-005, 2018-003)

E. **FINDING** (Noncompliance with the Child Death Review Team Act)

During the prior engagement, the Department's child death review teams did not complete required reviews of child deaths in accordance with timeframes established by the Child Death Review Team Act (Act). For mandated cases in which the review was complete and the date the investigation closed was provided, we noted 5 of 280 (2%) reviews were not conducted within 90 days from the close of the investigation. These reviews ranged from 17 to 38 days over the 90-day allowance.

During the current engagement, our sample testing indicated child death reviews were conducted by the Department's child death review team within the time period established by the Act. (Finding Code No. 2020-011, 2018-007)

F. **FINDING** (Noncompliance with Statutory Mandates)

During the prior engagement, the Department failed to comply with portions of the Civil Administrative Code (Code) (20 ILCS 5/5-535) regarding appointments to the Children and Family Services Advisory Council and failed to comply with portions of the Department of Children and Family Services Statewide Youth Advisory Board Act (Act) (20 ILCS 527/15) regarding holding quarterly/monthly meetings.

During the current engagement, our testing indicated the Department appointed the required number of members to the Children and Family Services Advisory Council in accordance with the Code. In addition, we noted the Department's Statewide Youth Advisory Board held quarterly and monthly meetings as required by the Act. (Finding Code No. 2020-023, 2018-021)

G. **FINDING** (Equipment Leases Not Properly Reported)

During the prior engagement, the Department did not properly record and report capital equipment leases as part of its inventory of State-owned equipment.

During the current engagement, the Department implemented GASB Statement No. 87, *Leases* and the Office of Comptroller has issued new guidance regarding lease reporting. We tested the resulting updates to the reporting of leases to the Office of Comptroller and noted an

immaterial instance of noncompliance which is reported in the Department's *Independent Accountant's Report of Immaterial Findings*. (Finding Code No. 2020-025)

H. **FINDING** (Noncompliance with the Juvenile Court Act of 1987)

During the prior engagement, the Department did not provide proper notifications of planned child placement changes as required by the Juvenile Court Act of 1987 (Act) (705 ILCS 405). Specifically, we noted the Department did not notify parties of the planned placement change in writing, or the Department could not comment on or provide documentation of notifications of planned placement changes in writing.

During the current engagement, the Department reported there were no cases which triggered the Department's responsibility under the Act, specifically relating to Section 2-23(3.5). As a result, this finding will be considered not repeated. (Finding Code No. 2020-026)

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
For the Two Years Ended June 30, 2022

As part of the compliance examination for the two years ended June 30, 2022 of the State of Illinois, Department of Children and Family Services (Department), we followed up on the status of the following performance audits performed by the Office of the Auditor General.

- **Management Audit of the Department of Children and Family Services Search for Missing Children** (released December 2014)
  - This audit originally contained nine recommendations. Since the compliance examination for the two years ended June 30, 2016, the auditors have followed up on the remaining eight partially implemented recommendations. As part of the compliance examination for the two years ended June 30, 2022, the auditors note that all eight recommendations continue to be partially implemented.

- **Performance Audit of the Department of Children and Family Services Placement of Children** (released September 2016)
  - This audit originally contained four recommendations. Since the compliance examination for the two years ended June 30, 2018, the auditors have followed up on the remaining four partially implemented recommendations. As part of the compliance examination for the two years ended June 30, 2022, the auditors note that all four recommendations continue to be partially implemented.

- **Performance Audit of the Department of Children and Family Services Investigations of Abuse and Neglect** (released May 2019)
  - This audit originally contained 13 recommendations. In the prior compliance examination for the two years ended June 30, 2020, the auditors noted three recommendations had been implemented, four recommendations had been partially implemented, and six recommendations had not been implemented. As part of the compliance examination for the two years ended June 30, 2022, the auditors followed up on the status of the remaining 10 recommendations, noting an additional two have been implemented, thereby leaving seven partially implemented recommendations and one not implemented recommendation.

- **Performance Audit of the Department of Children and Family Services LGBTQ Youth In Care** (released February 2021)
  - The audit contained 16 recommendations directed to the Department. As part of the compliance examination for the two years ended June 30, 2022, auditors followed up on the status of the recommendations noting 4 were implemented, 6 were partially implemented, and 6 were not implemented.

The follow-up we conducted was only for those recommendations that have not been fully implemented by the Department in prior years.

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
For the Two Years Ended June 30, 2022

The exhibit below summarizes the current status of the recommendations. Recommendations that were followed up on during this audit are detailed in the following pages.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Audit	Total Number of Recommendations	Status		
		Implemented	Partially Implemented	Not Implemented
Search for Missing Children	9	1	8	0
Placement of Children	4	0	4	0
Investigations of Abuse and Neglect	13	5	7	1
LGBTQ Youth In Care	16	4	6	6

Source: Summary of current status of past performance audits.

Search for Missing Children

The Illinois Office of the Auditor General conducted a management audit of the State of Illinois, Department of Children and Family Services (Department or DCFS) search for missing children pursuant to House Resolution Number 120. The audit was released in December 2014 and contained nine recommendations to the Department. As part of the compliance examination for the two years ended June 30, 2016, auditors followed up on the status of the recommendations. Recommendation 1 of 9 was determined to be fully implemented during the two years ended June 30, 2016. The remaining 8 recommendations were followed up on as part of the compliance examinations for the two years ended June 30, 2018, and June 30, 2020, and remained partially implemented. As part of the compliance examination for the two years ended June 30, 2022, we followed up on the status of the remaining recommendations.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Audit	Rec. No.	Recommendation Description	Status		
			Implemented	Partially Implemented	Not Implemented
Search for Missing Children	2	CFS 906 Form		X	
Search for Missing Children	3	Data Accuracy		X	
Search for Missing Children	4	CIRU Notification		X	
Search for Missing Children	5	Caseworker Notification		X	
Search for Missing Children	6	Report Missing Wards		X	
Search for Missing Children	7	Complete All Agency Forms		X	
Search for Missing Children	8	Supervisory Review		X	
Search for Missing Children	9	Training and Monitoring		X	

Source: Summary of current and past performance audits.

Recommendation 2 - CFS 906 Form

DCFS should prevent overpayments by ensuring that CFS 906 forms are completed, submitted, and entered in a timely manner.

Current Status: Partially Implemented

The auditors noted in 8 of the 60 (13.3%) instances where a child went missing that were selected for testing, the CFS 906 form had not been filed within 24 hours of when the child had been reported missing. For testing purposes, the auditors considered the file to be in compliance with the 24-hour rule if the date of the CFS 906 form was the day following the date the child went missing.

Further, the auditors noted in 9 of the 60 (15%) instances where a child went missing, the CFS 906 form could not be provided by the Department, thus the auditors could not confirm that the CFS 906 forms were completed timely, or at all.

Recommendation 3 - Data Accuracy

DCFS should emphasize to all involved in the reporting and locating of missing children the need to accurately enter information into case files and to correct discrepancies when identified.

Current Status: Partially Implemented

During the current examination, the auditors noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, so the auditors could not compare the initial CFS 1014 forms to the notes in SACWIS to ensure their accuracy.

In addition, during fieldwork, the auditors also tested whether Department supervisors were conducting reviews of the initial CFS 1014 form. Department Procedure 329, Locating and Returning Missing, Runaway, and Abducted Children, provides the documentation of supervisor reviews through the submission of the CFS 1014 form. As a result of the Department being unable to provide the 8 initial CFS 1014 forms noted above, the auditors also could not test documentation of supervisor reviews.

Lastly, in 2 of the 52 (3.8%) instances where a child went missing, the initial CFS 1014 form were completed, however, there was no supervisory review noted on the forms.

Recommendation 4 - CIRU Notification

DCFS should improve controls to ensure that the CIRU is immediately informed when a DCFS caseworker is notified that a ward has gone missing, as per Procedure 329.

Current Status: Partially Implemented

Department Procedure 329 requires caseworkers to notify the CIRU within one hour of when they receive notification that a child is missing. The date when the CIRU is notified is documented in the initial CFS 1014 form; however, this form does not have a field to indicate the time.

During the current examination, the auditors noted in 16 of the 60 (26.7%) instances where a child went missing, the CIRU had not been notified within an hour of the child being reported missing. For testing purposes, if the auditors were unable to determine the time the CIRU was notified from the notes in SACWIS, they considered the file to be compliant if CIRU was notified the same day as the child was reported missing.

Further, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm CIRU was notified timely, or at all.

Recommendation 5 - Caseworker Notification

DCFS should establish (1) a field in SACWIS to require caseworkers to enter the date and time when they first learned about a missing ward; (2) procedures for the caseworker to acknowledge notification of the missing ward; and (3) a process to ensure that searches are conducted for missing wards in a timely manner, including after business hours or on weekends.

Current Status: Partially Implemented

During the current examination, the auditors noted the Department did include a field in SACWIS for the date and time caseworkers received notification of a missing child. However, as previously noted above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm the recording of the date and time the caseworkers received notification of a missing child.

Further, Department Procedure 329 requires caseworkers to notify law enforcement within three hours of learning that a child is missing and provide them with a photograph of the child. The auditors noted in 12 of the 60 (20%) instances where a child went missing, law enforcement was not notified within three hours of when the child had been reported missing, and thus a photograph of the child was not submitted to law enforcement within three hours of when the child had been reported missing. For testing purposes, the auditors considered the file to be compliant if the CFS 1014 form's date was the same day when the child was reported missing, unless otherwise documented in the notes.

Finally, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm if law enforcement was notified timely, or at all.

Recommendation 6 - Report Missing Wards

DCFS should report the missing wards to required parties within the time established in its procedures, including to NCMEC, juvenile courts, and parents/guardians and require supervisors to sign-off on the CFS 1014 to document their review.

Current Status: Partially Implemented

Department Procedure 329 requires the notification of the National Center for Missing and Exploited Children (NCMEC) within three hours of when the child was reported missing.

During the current examination, the auditors noted in 22 of the 60 (36.7%) instances where a child went missing the NCMEC was not notified within 3 hours of when the child was reported missing.

Procedure 329 also states that the parents, guardian or legal custodian, juvenile court of jurisdiction and/or guardian ad litem should be notified within three hours of when the child was reported missing. The auditors noted in 16 of the 60 (26.7%) instances where a child went missing, the parents, guardian or legal custodian, juvenile court, and/or guardian ad litem were not notified within three hours of when the child was reported missing. For testing purposes, the auditors considered the file to be compliant if the date notified was the same day as the child was reported missing.

Finally, as previously stated above, the auditor noted in 8 of the 60 (13.3%) instances where a child went missing, the initial CFS 1014 form could not be provided by the Department, thus the auditors could not confirm whether NCMEC, parents, guardian or legal custodian, juvenile court, and/or guardian ad litem were notified timely, or at all. The auditors also could not determine if the supervisor had reviewed the initial CFS 1014 for 8 instances.

Recommendation 7 - Complete All Agency Forms

DCFS should ensure that all its internal forms are completed in a timely manner as specified in DCFS procedures, including the CFS 1014 Missing Children Recovery Report. In addition, DCFS should debrief missing wards when they are found, and document the interview.

Current Status: Partially Implemented

Department Procedure 329 requires the caseworker or supervisor to complete a Missing Child De-Briefing form (CFS 680-A form) and a CFS 1014 - Child Recovery form, within two business days from the date the child returned.

During the current examination, the auditors noted in 26 of the 60 (43.3%) cases tested, the CFS 680-A form had not been completed in a timely manner. Specifically, the auditors noted the form was completed by the caseworker or supervisor 2 to 62 days after the two business day requirement.

In addition, the auditors noted in 8 of the 60 (13.3%) instances where a child went missing, the CFS 680-A form could not be provided by the Department, thus, the auditors could not confirm whether the form was completed timely, or at all.

Lastly, the auditors noted in 14 of the 60 (23.3%) instances where a child went missing, the CFS 1014 - Child Recovery form could not be provided by the Department, thus the auditors could not confirm whether the caseworker or supervisor had completed the CFS 1014 - Child Recovery form timely, or at all.

Recommendation 8 - Supervisory Review

DCFS should comply with its written procedures which require that supervisory meetings with caseworkers be documented when searching for missing wards. Supervisors should review the documents completed by caseworkers and sign off to demonstrate their review.

Current Status: Partially Implemented

Department Procedure 329 requires the supervisor to document their review via the submission of the initial CFS 1014 form and via a note in their supervisor file on a weekly or daily basis.

During the current examination, the auditors noted in 16 of 60 (26.7%) instances where a child went missing, the Department could not provide evidence of the supervisor's note in their file.

Recommendation 9 - Training and Monitoring

Given the lack of documentation and noncompliance found in this audit, DCFS should:

- *Provide training to its caseworkers and supervisors on missing children;*
- *Review its search procedures for missing children for possible modifications; and*
- *Give the CIRU (or another unit within DCFS) the responsibility to monitor actions taken by caseworkers and supervisors to report and locate missing children, and to report to management the degree to which the Department's policies and procedures are being followed.*

Current Status: Partially Implemented

Department Procedure 329 was last revised in response to this original recommendation in FY18 and training has since been conducted to make caseworkers and supervisors aware of the revised requirements. As stated in the revised procedure, it is the CIRU responsibility for monitoring caseworkers' and supervisors' compliance with Procedure 329.

During the current examination, the auditors noted the Department could not provide documentation of any reports from caseworkers or supervisors to Department management, or any other monitoring mechanisms, ensuring the CIRU staff were being compliant with Procedure 329.

Placement of Children

The Illinois Office of the Auditor General conducted a performance audit of the State of Illinois, Department of Children and Family Services' (Department or DCFS) compliance with its obligations to place children in its care in placements consistent with their best interests. This audit was conducted pursuant to Senate Resolution Number 140. The audit was released in September 2016 and contained four recommendations to the Department. As part of the compliance examination for the two years ended June 30, 2018, the auditors noted 3 of the 4 recommendations were not implemented, and 1 of the 4 recommendations was partially implemented. The 4 recommendations were subsequently followed up on as part of the compliance examination for the two years ended June 30, 2020 and the auditors noted all 4 recommendations had been partially implemented. As part of the compliance examination for the two years ended June 30, 2022, we followed up on the status of the remaining recommendations.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Audit	Rec. No.	Recommendation Description	Status		
			Implemented	Partially Implemented	Not Implemented
Placement of Children	1	Administrative Rules and Procedures		X	
Placement of Children	2	Internal Forms and Case Files		X	
Placement of Children	3	Planning Meeting and Matching Process		X	
Placement of Children	4	Tracking information		X	

Source: Summary of current and past performance audits.

Recommendation 1 - Administrative Rules and Procedures

The Department should review existing administrative rules and internal policies and procedures on the placement of children. The Department should make necessary revisions to update the rules and procedures to reflect current practice and to implement any needed changes.

The Department should also examine areas that lack policies and procedures on the placement of children and implement procedures as needed.

Current Status: Partially Implemented

As noted in the compliance examination for the two years ended June 30, 2020, the Department has implemented policies, procedures, and forms regarding the children who are psychiatrically hospitalized (Procedures 301.110) and children in emergency shelters (Procedures 301.55). However, the auditors continue to note as they did in the prior examination report, that while the Department has implemented policies regarding specific payments for children in detention facilities, it lacks detailed procedures regarding the temporary placement of children in these detention facilities.

Recommendation 2 - Internal Forms and Case Files

The Department should ensure that required forms are being utilized and that required documentation is consistently maintained in case files. The Department should also explore the feasibility of maintaining forms in its primary case management system.

Current Status: Partially Implemented

During the current examination, Department management stated the Department no longer utilized the Discharge and Aftercare Plan (PHT 965-1 form), however, the current Department Procedures 301.110 still refer to the use of this form.

In addition, the auditors noted the ERC Intake & Referral (CFS 1901 form) form continues to be under development alongside other clinical work by the Child Services within the Department.

Lastly, Department management stated, as it did in the prior examination, the internal placement of children forms are not currently maintained in the Statewide Automated Child Welfare Information System (SACWIS); however, it is currently engaged in a multi-year program for the new Comprehensive Child Welfare Information System (CCWIS) that will replace the current SACWIS to modernize child case management and address the issues of paper form maintenance. As of June 30, 2022, CCWIS program began, however, completion of the development and full implementation of CCWIS is expected to be done in 2026, with releases to production every 6 to 9 months.

Recommendation 3 - Planning Meeting and Matching Process

The Department should implement policies and procedures for its matching process to ensure that the planning meeting is held promptly and to improve the timeliness of the matching process.

Current Status: Partially Implemented

The auditors noted that little progress appears to have been made during FY22 regarding this recommendation. As was reported in the prior examination, when children are admitted to an emergency shelter, the shelter is considered a temporary placement. The Department holds a planning meeting, which is called the Clinical Intervention for Placement Preservation (CIPP) meeting to determine the level of care and possible placements for the child. The Department implemented a policy in Department Procedures 301.55 requiring the meeting to be held within 15 days of shelter admission, to ensure the planning meeting is promptly held. This meeting determines the recommended level of care for the child. The Department management further states the Department's Placement Administration, with the Department of Innovation and Technology, is currently in the final stages of testing or implementing a new application called Match Maker. Match Maker will allow for a more timely and efficient matching process and will allow matches to providers to be driven by the provider's profile based on services and population they serve including capacity. Match Maker will allow the placement team efficient communication concerning referral

status while collecting data on responsiveness and outcomes from providers. As of June 30, 2022, the Department is in the process of testing and implementing the Match Maker.

Updated program plans for FY24 outline an expected time from referral to admission into congregate care settings.

Recommendation 4 - Tracking information

The Department should make necessary changes to track information in its computer systems to ensure processes are working and better monitor children in its custody. These changes should enable DCFS to readily report information.

Current Status: Partially Implemented

The auditors noted that little progress appears to have been made during FY21 and FY22 regarding this recommendation. As was reported in the prior examination, Department management stated the Department is currently engaged in a multi-year program to implement CCWIS. CCWIS will replace and modernize a vast majority of information technology systems utilized by the Department, which includes the current case management solutions known as the Statewide Automated Child Welfare Information System (SACWIS) and the Child & Youth Centered Information System (CYCIS). CCWIS is expected to automate many of the manual paper-based processes the Department currently relies on for day-to-day operations. As of June 30, 2022, CCWIS had begun, however, completion of the development and full implementation of CCWIS is expected to be done in 2026, with releases to production every 6 to 9 months.

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
For the Two Years Ended June 30, 2022

Investigations of Abuse and Neglect

The Office of the Auditor General (OAG) conducted a performance audit of the State of Illinois, Department of Children and Family Services (Department or DCFS) Investigations of Abuse and Neglect pursuant to House Resolution Number 418, of the 100th General Assembly. The audit was released in May 2019 and contained a total of 13 recommendations to the Department. The recommendations were followed up on as part of the compliance examination for the two years ended June 30, 2020. At that time, it was reported that three recommendations had been implemented, four recommendations had been partially implemented, and six recommendations had not been implemented. As part of the compliance examination for the two years ended June 30, 2022, we followed up on the status of the remaining recommendations.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Audit	Rec. No.	Recommendation Description	Status		
			Implemented	Partially Implemented	Not Implemented
Investigations of Abuse and Neglect	1	Child Abuse and Neglect Data		X	
Investigations of Abuse and Neglect	2	Investigator Assignments		X	
Investigations of Abuse and Neglect	3	Child Endangerment Risk Assessment Protocol		X	
Investigations of Abuse and Neglect	4	Hotline and Intake		X	
Investigations of Abuse and Neglect	5	Investigation Timeliness			X
Investigations of Abuse and Neglect	6	Investigation Extensions		X	
Investigations of Abuse and Neglect	7	Assessing the Need for Services		X	
Investigations of Abuse and Neglect	8	Recommendations for Services	X		
Investigations of Abuse and Neglect	12	Norman Cash Assistance		X	
Investigations of Abuse and Neglect	13	Community Based Services	X		

Source: Summary of current and past performance audits.

Recommendation 1 - Child Abuse and Neglect Data

The Department should continue to take steps to improve the quality of the data contained in its child abuse and neglect information systems and statistical reports. These steps should include:

- *Ensuring that proper controls are in place for Statewide Automated Child Welfare Information Systems (SACWIS) data entry, or any future child abuse and neglect information systems, in order to ensure that data is collected and is reliable; and*
- *Maintaining updated manuals including data field definitions.*

Current Status: Partially Implemented

During the current examination, according to the Department, it has taken steps to improve the quality of the Child Abuse and Neglect Data in SACWIS including:

- Several SACWIS releases have made improvements to data quality; and
- Data Field definitions are being assembled into a Data Dictionary.

According to Department officials, there were data improvements done as part of a SACWIS release, however, no documentation was provided to the auditors to show what changes were made and the degree of data quality improvement. Also, Department officials indicated it is in the process of implementing the new Comprehensive Child Welfare Information System (CCWIS) that will replace the current SACWIS to modernize child case management, data clean up, and developing a Data Quality Plan. Further, during the examination period, the auditors noted a Data Dictionary was developed which has defined the SACWIS fields.

Recommendation 2 - Investigator Assignments

The Department should take steps to ensure investigator assignments are in compliance with the requirements of the B.H. Consent Decree.

Current Status: Partially Implemented

During the current examination, according to the Department, it hired 568 new investigators during FY21 and FY22. On March 12, 2021, the Department established an implementation plan to address investigator caseloads. The implementation plan has two phases which includes hiring, onboarding, and retention of child protection investigators (Phase I) and assessing whether the steps taken in Phase I have brought the Department into compliance with Paragraph 26(a) of the B.H. Consent Decree, or whether the Department must take further action to achieve Compliance (Phase II). On March 31, 2022, the Department submitted its first annual report on Implementation Plan to Address Investigator Caseloads with the Clerk of the United States District Court for the Northern District of Illinois, Eastern Division. Based on the review of the report, the Department has exerted efforts to comply with the requirements of B.H. Consent decree which includes increasing the number of case investigators, satisfaction of required meetings and reporting, as well as improving processes to effectively handle caseloads. Additionally, the Department has provided regular updates to Plaintiffs' counsel and the Special Master regarding "elevated support sites" where (1) 30.0% or more of the investigators at the site were assigned more than 15 new investigations in one month; and (2) the vacancy percentage at the site was 6.0% of greater. The parties continue to meet on a monthly basis to address the Department's efforts on the strategies in the implementation plan and remain committed to achieving the goals set out in the implementation plan as well as Paragraph 26(a) of the Restated Consent Decree.

Recommendation 3 - Child Endangerment Risk Assessment Protocol

The Department should:

- *Ensure that Child Endangerment Risk Assessment Protocols (CERAPs) are completed for investigations and that they are completed in a timely manner;*
- *Ensure that CERAPs are completed and that they are completed in a timely manner when Intact Family Services are provided; and*
- *Evaluate the reliability and validity of the CERAP annually and develop written procedures related to CERAP training as is required by the Children and Family Services Act.*

Current Status: Partially Implemented

During the current examination, the auditors reviewed investigations data for FY21 and FY22 and found that 3.73% percent of initial CERAPs were not completed in a timely manner. The auditors also reviewed a sample of 25 investigations to determine if CERAPs were being completed timely. The testing results indicated all the initial and final CERAPs were completed timely.

In addition, the Department provided a copy of the FY21 Annual Evaluation of the CERAP prepared by the University of Illinois' Children and Family Research Center to the auditors and they noted the predictive reliability of the CERAP was reviewed as part of the evaluation. The FY22 Annual Evaluation was held by the statutory advisory group due to the beginning of the use of the new safety assessment tool, SAFE model. Due to the nature of the changes to the current safety assessment tool, the advisory group did not complete a report for 2022. The advisory group requested the General Assembly for a pause in CERAP reporting due to the lack of data available for the new SAFE model. The advisory group plans to report again in 2025, when data becomes available.

Further, the auditors noted the CERAP training was part of the Department's Office of Learning and Professional Development training for child protection employees. Each child protection employee is required to successfully pass the CERAP examination with a minimum score of 70%.

Recommendation 4 - Hotline and Intake

The Department should:

- *Develop formal written procedures for call backs including required timeframes for creating intakes;*
- *Ensure that the process for completing call backs is in accordance with written procedures by answering and returning hotline calls in a timely manner;*
- *Begin maintaining complete information regarding the time it takes to return the hotline calls of those reporting allegations of child abuse or neglect for an amount of time that would allow for long-term analysis; and*
- *Continue to increase the utilization of online reporting as appropriate.*

Current Status: Partially Implemented

During the current examination, the Department developed procedures for call backs including required timeframes for creating intakes. In addition, training was provided to employees on creation of callbacks. The Department maintains call back information in SACWIS and subsequently provided the auditors with a download of call back information for FY21 and FY22. The auditors' analysis of the data provided showed significant improvements, noting the call backs for FY21 and FY22 dropped to 432 and 36, respectively.

Department officials also stated the Department is continuing to develop and use on-line reporting. According to the Department, it received 24,396 on-line reports during FY21 and 39,117 during FY22.

Recommendation 5 - Investigation Timeliness

The Department should take actions to ensure that critical investigation timeframes are completed in accordance with procedures, including initiating investigations, contacting the alleged victim and perpetrator, submitting investigations for supervisory review, and completing the investigation.

Current Status: Not Implemented

The Abused and Neglected Child Reporting Act (ANCRA) requires investigations to begin within 24 hours of receipt of the report (325 ILCS 5/7.4(b)(2)), which is defined by Department administrative rules as "the time the report was received at the State Central Register" (89 Ill. Admin. Code 300.90).

The Department's administrative rules require in-person contact with the alleged victim be made within 24 hours (89 Ill. Admin. Code 300.90).

The Department's administrative rules further require that, within seven days, there must be in-person contact with the alleged perpetrator (89 Ill. Admin. Code 300.90).

Lastly, Department policies require the Child Protection Specialist to submit the completed investigation and final determination to the Child Protection Supervisor within 55 days of receipt of the report. If a 30-day extension to complete the investigation is necessary, the Child Protection Specialist is required to submit (prior to the 55th day) an extension request to the Child Protection Supervisor who will evaluate the request (Procedures 300.50a).

During the current examination, the auditors reviewed FY21 and FY22 investigations to determine the timeliness of initiating investigations, contacting the alleged victim and perpetrator, submitting investigations for supervisory review, and completing the investigation. The auditors' testing results showed the following:

- 0.6% of all investigations had untimely initiation;
- 40.0% of all investigation had untimely victim contact;
- 37.9% of all investigations had untimely perpetrator contact;

- 51.7% of investigations without an extension were not submitted for supervisor review within 55 days; and
- 5.3% of all investigations were completed in a untimely manner.

Based on the above, although the Department has established rules and procedures for timeliness requirements, it is not ensuring that the timeliness requirements are being met.

Recommendation 6 - Investigation Extensions

The Department should comply with rules and procedures and ensure:

- *Extensions are requested prior to the 55th day of the investigation;*
- *That extensions are given only for good cause;*
- *Extensions are requested and approved by appropriate staff; and*
- *Extension requests contain all required information.*

Current Status: Partially Implemented

During the current examination, Department officials stated all requests and approvals for extensions are documented in the SACWIS. In the narrative section on the extension request, the Child Protection Specialist list the reasons the investigation cannot be completed within 55 days, activities to be completed, who is responsible for completing each activity, and the expected date of completion. The extension request are reviewed and approved by the Child Protection Supervisor and Area Administrator. The date and time of the Area Administrator's approval of additional extensions must be documented in a contact note.

The auditors sampled 10 FY21 and FY22 investigations that had at least one extension. The auditors' testing results noted all 10 investigations' extensions were properly approved, for a good cause, and contain all required information. However, the auditors also noted that for 9 of 10 investigations the initial extension request was not submitted within 55 days. The testing results noted the initial extension requests were submitted 7 to 157 days after the 55-day requirement.

The auditors also reviewed the 10 investigations with the most extensions and found that:

- These 10 investigations had a total of 180 extensions at the time we received our investigations data; and
- None of the initial requests for an extension were submitted within 55 days.
- All investigations were extended for a good cause and were properly approved.

Recommendation 7 - Assessing the Need for Services

The Department should:

- *Make the Level of Intervention a required field in SACWIS and revise the Level of Intervention options to more accurately reflect current practices, and*
- *Include a rationale for indicated investigations in which there is a Level of Intervention of "No Service Needed."*

Current Status: Partially Implemented

During the current examination, Department officials stated the Level of Intervention is required for each investigation.

The auditors analyzed data provided by the Department regarding the Level of Intervention and found the following:

- The Level of Intervention is a required field in SACWIS, however, of 181,442 investigations completed during FY21 and FY22, 13,387 (7.4%) had a blank Level of Intervention; and
- No changes have been made to the Level of Intervention options in SACWIS (Intact Family Services is not an option that can be selected and there is no rational when "no services" are recommended).

The auditors also reviewed a sample of 25 indicated investigations and found that the rationale for the Level of Intervention was inaccurate for 14 of 25 (56.0%) investigations. Specifically, the auditors noted the investigations had a blank Level of Intervention.

Recommendation 8 - Recommendations for Services

The Department should:

- *Formally document when services are offered and whether those services are refused; and*
- *Consider establishing guidelines or policies to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.*

Current Status: Implemented

According to Department procedures, the investigator has the responsibility to discuss and offer the family Intact Family Services if the final finding of indicated has been recommended. The family should also be informed of community services (Procedures 300.130(a)(2)(A)).

In September 2022, subsequent to the examination period, the Department's Procedure 300 was updated to include procedures on documentation of services being offered or refused and guidelines to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.

The Department's SACWIS has a text box on the investigation Decision tab to enter the name, address, and contact person of the provider to which the family has been referred. The narrative box would always be available for use but would be a required entry if the Level of Intervention is either "Referral for Community-Based Services" or "No Service Needed".

The auditors reviewed a sample of 25 indicated investigations to determine whether there was documentation that services were offered or refused. The auditors' review found all investigations'

casefiles contained documentation that Intact Family Services (IFS) were offered and refused, if applicable.

Recommendation 12 - Norman Cash Assistance

The Department should document all purchases made with Norman Cash Assistance funds. The Department should also update its cash assistance request approval policies to reflect the current organizational structure of the agency.

Current Status: Partially Implemented

During the current examination, the Department had updated procedures for the Norman Cash Assistance Program, however, the updated procedures and modifications were pending review and final approval as of June 30, 2022. According to Department officials, the proposed changes seek to increase the amounts of Norman Cash Assistance that various positions can approve. These changes will also provide more clarity on the cash assistance approval protocol and provide flexibility to assist families in a more streamlined fashion. These considerations were in review with the Office of Child and Family Policy as of the end of the auditors' fieldwork.

The Department also provided the auditors a list of 13,237 Norman Cash expenditures for FY21 and FY22. The auditors reviewed a sample of 10 Norman Cash expenditures to determine if documentation and approval of the expenditure was available. The Department provided documentation and approval forms for the 10 expenditures and the testing results indicated all expenditures were properly approved.

Recommendation 13 - Community Based Services

The Department should follow existing Department procedures including:

- *Documenting referrals for community based services including the duration and frequency of the services and the conditions/circumstances that the services are designed to mitigate; and*
- *Verifying whether the family is following through with the community services.*

Current Status: Implemented

In October 2022, subsequent to the examination period, the Department implemented Enterprise Service Request 183 which added a narrative field and a requirement for an explanation of Level of Interventions when values of "Referral for Community-Based Services" or "No Services Needed" is selected as a Level of Intervention in SACWIS. This requirement will not allow the investigation to be completed until this element is satisfied with a response. This is not a traditional note but the narrative created is directly linked to the Level of Intervention that speaks to the referral to community base services and is only required in the two instances mentioned.

The auditors also reviewed a sample of 25 indicated investigations to determine if community services referrals were being documented and whether services were being followed through. The auditors' review found that all investigations had services offered, all with IFS cases. In addition, the auditors noted 11 of the cases which were marked "Referral for Community-Based Services" received community-based services.

STATE OF ILLINOIS
DEPARTMENT OF CHILDREN AND FAMILY SERVICES
STATUS OF PERFORMANCE AUDIT RECOMMENDATIONS
For the Two Years Ended June 30, 2022

Department of Children and Family Services LGBTQ Youth in Care
The Office of the Auditor General conducted a performance audit of the State of Illinois, Department of Children and Family Services (Department or DCFS) LGBTQ Youth in Care pursuant to Senate Resolution Number 403. The audit was released in February 2021 and contained a total of 16 recommendations to the Department. During the current examination, OAG auditors conducted the first follow-up of these recommendations.

STATUS OF PAST PERFORMANCE AUDIT RECOMMENDATIONS
As of June 30, 2022

Audit	Rec. No.	Recommendation Description	Status		
			Implemented	Partially Implemented	Not Implemented
LGBTQ Youth In Care	1	Computer Systems and Tracking			X
LGBTQ Youth In Care	2	Reviewing Rights With Youth In Care			X
LGBTQ Youth In Care	3	LGBTQ Procedures			X
LGBTQ Youth In Care	4	LGBTQ Training	X		
LGBTQ Youth In Care	5	Oversight and Monitoring of Appendix K		X	
LGBTQ Youth In Care	6	Complaints	X		
LGBTQ Youth In Care	7	Child/Caregiver Matching Process			X
LGBTQ Youth In Care	8	Shelter Bed Availability		X	
LGBTQ Youth In Care	9	Foster Home Recruitment	X		
LGBTQ Youth In Care	10	LGBTQ Youth In Care Information			X
LGBTQ Youth In Care	11	Foster Care Files	X		
LGBTQ Youth In Care	12	Sibling Visitation Plans		X	
LGBTQ Youth In Care	13	Normalcy Activity Documentation			X
LGBTQ Youth In Care	14	Emergency Placements		X	
LGBTQ Youth In Care	15	Psychiatric Lockouts		X	
LGBTQ Youth In Care	16	Waiting For Placement Report		X	

Source: Summary of LGBTQ Youth In Care performance audit recommendations and current status.

Recommendation 1 - Computer Systems and Tracking

The Department should ensure that it is accurately capturing youth in care data. Additionally the Department should consider:

- *Implementing a single case management system for all youth in care; and*
- *Electronically tracking clinical referrals, which would include LGBTQ referrals.*

Current Status: Not Implemented

The OAG's February 2021 audit found that the Department was reliant on outdated, inadequate, and sometimes nonexistent computer systems for tracking and maintaining data and files for youth in care. Having outdated, and in some cases non-existent, electronic systems to track data for youth in care made it difficult to collect and analyze information related to certain aspects of the audit resolution. It also made it difficult for the Department to track and produce relevant information. In some cases information must be continuously manually manipulated in order to produce the information that is available.

The Department utilized multiple computer systems, primarily SACWIS (Statewide Automated Child Welfare Information System) and CYCIS (Child and Youth Centered Information System). Officials maintained a separate database for youth in care that is populated with data from both SACWIS and CYCIS. Maintaining two case management systems that require data to be pulled from both and combined increases the risk that inaccurate data may be produced. Having two case management systems can lead to data not matching between the two systems. For instance, permanency goals are listed in both SACWIS and CYCIS. There are different SACWIS and CYCIS codes for the permanency goals and the language might not match between the two sources.

The OAG auditors also found that the Division of Clinical Practice did not effectively track LGBTQ youth in care because there is no computer system that tracks clinical referrals. During the audit period the LGBTQ Coordinator was located in the Division of Clinical Practice. Because there were no fields in SACWIS that capture LGBTQ data, the only way LGBTQ youth in care are tracked was through referrals to the Division of Clinical Practice. Referrals were received in a variety of ways, including through faxed or emailed referral forms, phone calls, or emails. Information on youth in care with referrals was tracked through a shared file directory with access limited to clinical staff who need to know the information. Additionally, the LGBTQ Coordinator and the Deputy Director of Behavioral Health each maintained separate spreadsheets of the LGBTQ youth in care that have been referred to the Division of Clinical Practice. The use of a shared file directory and spreadsheets maintained by individual employees means that referrals or services received by youth in care cannot be effectively tracked, particularly over a length of time.

During the current examination, the OAG auditors found that the Department had not implemented a single case management system. According to Department officials, the new Comprehensive Child Welfare Information System (CCWIS) will be the sole case management system for DCFS. According to the Department, the new CCWIS program, which started in July 2022, after the audit

period, includes a data cleansing of the child welfare data for movement to the new system. This should improve the quality of child welfare data. Additionally, the program includes the development of a Data Quality Plan for the Department to monitor data quality.

The OAG auditors found that the Department also had not implemented an electronic clinical referral system. According to Department officials, the CCWIS program will include the ability for case workers to submit and track referrals to providers electronically.

Recommendation 2 - Reviewing Rights with Youth in Care

The Department should ensure that all Department and private agency caseworkers review the CFS 496-1 form (Illinois Foster Child and Youth Bill of Rights form) with all youth in care within the first 30 days of coming into care, every six months prior to the administrative case review, and annually as is required by statute and Department procedures.

Current Status: Not Implemented

The OAG's February 2021 audit found that the Department was not ensuring that caseworkers review the Foster Children's Bill of Rights Act with youth in care as is required by law and in accordance with Department procedures. Each youth in care, by law, has the right to receive a copy of the Foster Children's Bill of Rights and have it fully explained by the Department when they are placed in the care of the Department (20 ILCS 521/5(28)).

In order to document the review of the Foster Children's Bill of Rights with the youth in care, the Department utilizes the Illinois Foster Child and Youth Bill of Rights form (CFS 496-1 form).

To determine if a CFS 496-1 form was being completed for each youth in accordance with applicable statutes and Department procedures, the OAG auditors requested the files for a random sample of 68 youth that were in the care of the Department during 2017-2018. The OAG auditors also requested the files of 91 youth in care that the Department identified as LGBTQ. The OAG auditors received 132 of the 159 files requested. Four youth in care did not require a 496-1 form during 2017-2018.

- For 71 of 128 (55.5%) youth in care, the OAG auditors could not document that a CFS 496-1 form was ever reviewed with the youth in care during 2017-2018.
- For 52 of 128 (40.6%), a signed form was in the file but there were also missing forms. Only 5 of 128 (3.9%) files had all the required CFS 496-1 forms.

Failing to review the CFS 496-1 forms with youth in care means that youth in care and/or their caregivers might be unaware of the youth's rights and where to seek help for addressing potential violations of those rights.

During the current examination, the OAG auditors found that the Department has not improved in reviewing CFS 496-1 forms. The OAG auditors requested files for 25 youth in care, and 24 required CFS 496-1 forms. The Department provided a total of 19 forms for 16 youth in care that were completed during FY21 and FY22. For 8 youth (33.3%), the OAG auditors noted the Department

could not demonstrate a CFS 496-1 form was ever reviewed with the youth in care during FY21 and FY22.

Recommendation 3 - LGBTQ Procedures

The Department should conduct a review of all statutes, administrative rules, Department procedures, and forms to ensure a consistent LGBTQ policy throughout the Department and to eliminate any conflicts within existing procedures.

Current Status: Not Implemented

The OAG's February 2021 audit found that the Department did not implement the requirements of DCFS Procedures 302 Appendix K (Appendix K) in a timely manner. Further, the Department failed to monitor the requirements of Appendix K including whether Purchase of Service (POS) agencies have adopted LGBTQ policies that are at least as extensive as Appendix K. Other Department procedures also have not been updated to reflect the requirements in Appendix K. Although Appendix K was updated in May 2017, the Department did not implement some requirements in a timely manner and others had not been fully implemented as of December 31, 2018.

The OAG auditors also found that the Department did not have consistent policies for the treatment of LGBTQ youth in care. The requirements of Appendix K have not been incorporated into other procedures such as those for licensing foster homes, permanency planning, and placement and visitation services.

During the current examination, the OAG auditors found that none of the statutes, administrative rules, or Department procedures had been updated since the release of the performance audit. Additionally, while the Department provided drafts of updates to procedures, including Procedure 302 Appendix K, and forms, all the provided drafts were in the process of finalization and not yet implemented. Therefore, no changes were made to DCFS statute, rules, procedures, or forms by June 30, 2022.

Recommendation 4 - LGBTQ Training

The Department should fully implement and provide the training required by Appendix K. This would include:

- *Ensuring that all required individuals have completed training;*
- *Ensuring that annual training is given as required to all child welfare workers, including those at POS agencies;*
- *Continuing to work to revise PRIDE training for foster parents to include training for LGBTQ competency; and*
- *Requiring employees of residential facilities that serve youth in care of the Department to complete LGBTQ competency training.*

Current Status: Implemented

The OAG's February 2021 audit found that the Department did not implement the training requirements contained in the Foster Children's Bill of Rights Act and those of Appendix K to Procedures 302 in a timely manner. Although Appendix K to Procedures 302 was updated in May 2017 to require training in LGBTQ competency, the Department did not begin training staff until more than two years later in June 2019. The OAG auditors found that there are a large number of staff that have not received the training required by Appendix K. For example, according to the Office of Learning and Professional Development, for FY18 there were 2,812 POS agency staff that needed to receive ongoing training for their child welfare employee licenses alone and, as of January 22, 2020, only 1,390 POS agency employees had completed the training (49.4%). Further, the Department was not timely in updating training materials for certain populations that were required to receive training in LGBTQ competency. The Department also does not require staff at residential facilities to receive training in LGBTQ competency.

During the current examination, the OAG auditors found that the Department had policies in place to ensure all required individuals had completed the training, revised the training for foster parents, and is providing LGBTQ training to employees of residential facilities.

According to Department officials, the Department tracks "Office of Learning and Professional Development (OLPD) offered trainings through Virtual Training Center (VTC). Supervisors and managers are responsible for ensuring their staff complete required trainings. The VTC sends out reminders to the identified target staff and their supervisor of record via email until the required training is complete." The Department provided a report that showed that as of November 18, 2021, 80.0% of DCFS and POS direct service staff, supervisors, and managers had completed the required LGBTQ training. The Department provided data that showed that as of June 30, 2022, 2,974 Department employees, and 3,830 POS employees had completed the training.

The Department provided an information transmittal dated October 25, 2021 that stated that "LGBTQI+ Children and Youth in Care Training is now a mandatory part of the required in-service training for Foster Family Home License." The training is required to be completed as part of the required in-service training for the Foster Family Home License. The license shall not be renewed until the training was completed. The Department also provided a copy of the LGBTQI+ caregiver training.

The Department is now providing LGBTQ training to employees of residential facilities. The Department provided a training report that showed that 851 employees at 46 facilities had completed the training.

Recommendation 5 - Oversight and Monitoring of Appendix K

The Department should provide oversight and monitoring of POS agencies for compliance with Appendix K and ensure that all agencies have established policies at least as extensive as those required by their contract and Appendix K.

Current Status: Partially Implemented

The OAG's February 2021 audit found that employee and contractor oversight was inadequate to ensure accountability or corrective actions. The OAG auditors contacted the Department's Office of Affirmative Action and the Office of the Inspector General (OIG) to discuss any investigations or actions taken involving LGBTQ discrimination by an employee. According to the Department's Office of Affirmative Action and the OIG there have been no allegations reported alleging discrimination against a youth in care on the basis of sexual orientation or gender identity.

The OAG auditors also found the Department's oversight and monitoring of POS agencies was insufficient and that the Department was not ensuring that agencies had established policies required by Appendix K and their contract agreements. Appendix K requires all agencies to adopt LGBTQ policies that are at least as extensive as Appendix K (including, without limitation, policies providing for employee discipline, up to and including termination, for conduct in violation of the non-discrimination policy). Contract agreements for FY18 and FY19 required that all children and youth be treated in a manner consistent with the Department's non-discrimination guidelines as outlined in the Department's rules and procedures, including but not limited to Appendix K.

The OAG auditors conducted a survey of POS agencies and received survey responses from 51 of those agencies. Of these 51 agencies responding, 39 (76.5%) responded that they had implemented policies that were at least as extensive as Appendix K. Only 14 agencies provided copies of their policies and several of these were either established after the survey was sent or did not discuss discrimination against youth in care.

During the current examination, the OAG auditors found that the Department had provided some oversight and monitoring of POS agencies, however, the Department had not yet ensured that every POS agency has policies that are at least as extensive as Appendix K. The Department's Agency Performance Monitoring and Execution Team (Team) developed field education related to Appendix K and the audit. The goal was to have every POS agency, DCFS leadership and staff receive the training during FY22. A shortened practice tip sheet/info sheet was developed by Team and distributed in April 2021 to all POS agencies. Additionally, in September 2021 the Department released an information transmittal. The information transmittal was distributed to all POS permanency and intact family services workers and supervisors, foster home licensing representatives and supervisors, ILO/TLP program administrators and staff, and congregate care facility administrators and staff. The information transmittal provided guidance and reaffirmed expectations as it related to support and well-being of LGBTQI+ youth in care. The Team also identified key stakeholders per agency and provided training information for existing staff. According to Department officials, the Department obtained copies of policies from sampled POS agencies to verify policies are as extensive as Appendix K.

Recommendation 6 - Complaints

The Department should:

- *Update the computer system used by the Advocacy Office to log and track complaints; and*
- *Track recommendations made by youth and the experiences of youth in care that have reported violations.*

Current Status: Implemented

The OAG's February 2021 audit found that the Department's Advocacy Office computer system was outdated and needed to be improved. Although complaint information was provided for 2017-2018, it had to be compiled manually. The current system also did not allow for case tracking to ensure that the desired outcome is achieved. The Advocacy Office also did not track recommendations made by youth or the experiences of youth in care that have reported violations. The CFS 496-1 form is used to inform youth of care of their rights and how to report violations of those rights. The Department does not document any recommendations from youth in care nor are there any requirements for the Department to track recommendations.

During the current examination, the OAG auditors noted the Department implemented a case management system for the Advocacy Office. According to Department officials, the Case Management System provides the ability for a report that tracks recommendations made by youth in care. The Department provided a download of FY22 complaints to the OAG auditors, which showed a total of 9,958 were received. The data included fields for type of complaint and the outcome.

Recommendation 7 - Child/Caregiver Matching Process

The Department should follow its matching procedures and ensure that a formal and documented matching process is being utilized for all placements. That process should include an assessment of any sexual orientation or gender identity needs for the youth in care.

Current Status: Not Implemented

The OAG's February 2021 audit found that the Department did not follow its procedure that required the use of the Child/Caregiver Matching Tool (CFS 2017 form) for every placement (Procedure 315.75) and to complete required forms for matching youth with placements. Our review of youth in care files for 2017-2018 showed that the required CFS 2017 form was rarely utilized to match youth with caregivers that were willing and capable to provide a stable placement.

The OAG auditors sampled a total of 159 youth in care case files for youth that were in the care of the Department during 2017 and 2018. This included a random sample of 68 youth in care as well as 91 youth in care that the Department identified as LGBTQ. The OAG auditors received 132 of 159 files requested. As part of that review the OAG auditors checked to see if there was documentation that the CFS 2017 form was being utilized as is required and whether the youth's

sexual orientation or gender identity was taken into account during the matching and placement process. File testing showed that the form was used very rarely. The OAG auditors determined there were 97 youth that had a new placement during 2017-2018. For the 97 youth files that auditors determined should have contained at least one CFS 2017 form for 2017-2018, the Department could only provide 7 (7.2%). The seven forms were completed between January 2017 and December 2018, with four completed in 2017 and three completed in 2018.

The OAG auditors followed up with the Department on the issues of missing CFS 2017 forms. According to the Department, the use of the CFS 2017 form was suspended in February 2017 in the Lake County and Mt. Vernon Immersion Sites "in an effort to streamline work processes for direct service staff." The practice of suspending the use of the CFS 2017 form was also "informally" rolled out statewide. However, the CFS 2017 form is the only form required by procedures to be used for assessing placements. Without following Department procedures and utilizing the CFS 2017 form, it is unclear how the Department is assessing whether caregivers are capable and willing to provide a stable placement for the youth.

During the current examination, the OAG auditors found that the Department had not implemented changes to the child/caregiver matching process. According to Department officials, the Department has not changed nor updated its procedures requiring a CFS 2017 Form. Additionally, the Department has not updated the procedures for the matching process.

The OAG auditors also noted the Department's matching process does not include any consideration of sexual orientation and gender identity expression (SOGIE). According to Department officials, the new CCWIS will include SOGIE.

Recommendation 8 - Shelter Bed Availability

The Department should take steps to increase the available number of shelter beds throughout the State.

Current Status: Partially Implemented

The OAG's February 2021 audit found that the number of emergency shelter beds in Illinois decreased dramatically between FY15 and FY19, leaving some areas of the State with no beds for youth in crisis. The Department's Statewide Emergency Shelter System was established to provide children/youth with a safe, nurturing and therapeutic environment during a time of crisis. The Department contracts with private agencies across the State to serve as emergency shelters and to provide the children/youth in the emergency shelter with daily activities including social, emotional, medical, educational and recreational activities. An emergency shelter is intended to serve as a temporary, short-term placement for children/youth and is not considered a long term placement.

The Department provided the OAG auditors with the available number of shelter beds by region for the period FY15-FY19. The total number of shelter beds dropped from 163 in FY15 to 47 in FY19. Cook region shelter beds dropped from 109 in FY15 to 30 in FY18 and FY19. As of FY19, the Central and Northern regions had no shelter beds. The amount of expenditures for Youth Emergency

Shelters decreased from $12.9 million in FY17 to $5.4 million in FY19. It is unclear where youth in crisis are taken when no shelter beds exist or when no shelter beds are available. Without an adequate number of shelter beds available, the Department may not always be able to initially place youth in care in an adequate setting. Further, when youth are not properly placed it can put their safety at risk.

During the current examination, the OAG auditors found that as of June 30, 2022 there were a total of 53 shelter beds statewide, an increase of 6 from FY19. The Cook region had 34 beds, the Southern region had 12, the Northern region had 7, and the Central region had no shelter beds. Both the Cook and Northern regions increased the number of beds from FY19 to FY22, whereas the Southern region decreased the number of beds, and there was no change in the Central region. While there was an overall increase in the number of shelter beds, the Southern region saw a decrease and there are still no shelter beds in the Central region.

Recommendation 9 - Foster Home Recruitment

The Department should continue its efforts to recruit foster homes that are affirming of LGBTQ youth in care.

Current Status: Implemented

In The OAG's February 2021 audit, the OAG auditors reported that although the Department had taken some steps to recruit foster homes that are affirming of LGBTQ youth in care, these efforts had not been successful in leading to licensure. The Department provided documentation of events held to specifically recruit LGBTQ affirming foster parents, but documentation provided showed that none of these resulted in a foster parent obtaining a license.

During the current examination, the OAG auditors found that the Department attended multiple Pride events during FY21 and FY22. The Department Chief of LGBTQI+ attended the Illinois State Fair in August 2021 and assisted in recruiting foster parents. Twenty-one inquiries were submitted online within one week of this effort. During FY22, the Department attended four LGBTQI+ specific events, including the Springfield Pride Festival, the Lake County Pride Festival, the Aurora Pride Festival, and the Chicago Pride Parade. According to the Department, a total of 73 inquiries were received at the events and within one week of those events.

According to the Department, while many recruitment events during FY21 were cancelled due to COVID-19, Department officials attended a total of 88 events during FY21 and FY22. These events included other events that were not specific to any Pride events. The Department held both in person and virtual recruitment presentations. During FY21 and FY22 the Department collected a total of 13,908 inquiries and 2,861 qualified potential foster parents were referred to be licensed.

Recommendation 10 - LGBTQ Youth in Care Information

The Department should solicit information from youth in care willing to provide it regarding their sexual orientation and gender identity for purposes of placement as well as identifying and offering any necessary services.

Current Status: Not Implemented

In The OAG's February 2021 audit, the OAG auditors reported that the Department did not have a formal process in place to identify LGBTQ youth. Therefore, the OAG auditors could not determine with any accuracy the total number of LGBTQ youth in care. As part of our initial documents request the OAG auditors asked for any data reports generated related to LGBTQ youth in care. DCFS officials responded that, "There are no fields within our system that capture information on LGBTQ, either for youth, clients or providers. As such, there are no reports that provide information on this data."

The OAG auditors asked Department officials responsible for LGBTQ coordination during the audit period to provide us with a list of LGBTQ youth in care for 2017 and 2018. A Department official provided a list that included a broad sweep of the referrals received within the Division of Clinical Practice with LGBTQ circumstances. This manual process was used by the Department to identify LGBTQ youth in care since data regarding sexual orientation and gender identity are not captured in SACWIS. The data provided by the Department was not always accurate and included some youth who were not in the care of the Department but were referred to the Division of Clinical Practice because of an investigation or adoption involving an LGBTQ youth. After analyzing the information provided, we determined that there were 91 unique LGBTQ youth on the list provided by the Department.

However, the 91 LGBTQ youth on the Department's list was not a complete and accurate number. During fieldwork testing the OAG auditors identified eight youth who were listed as LGBTQ by the Department but there was no documentation they actually identified as LGBTQ. The OAG auditors also identified 17 additional youth in care who may have identified as LGBTQ who were not on the list provided by the Department. These youth were identified during fieldwork testing and in information received from the Department's Monitoring Unit and the Advocacy Office. Further, as part of our survey, POS agencies were asked if they were aware of any LGBTQ youth in care and how many. Thirty-four agencies that provided case management services responded with a total of approximately 200 youth in care.

During the current examination, the OAG auditors noted the Department had not started collecting information on LGBTQ youth in care as of June 30, 2022. The Department provided screenshots of what the pages in SACWIS will look like, but according to Department officials, it would not be implemented until October 2022. The Department did provide information on a survey that was distributed to youth in care in order to gather data on LGBTQ youth, however it was an anonymous survey and was still in progress as of June 30, 2022.

Recommendation 11 - Foster Care Files

The Department should ensure that all foster care files are properly maintained.

Current Status: Implemented

In The OAG's February 2021 audit, the OAG auditors reported that the Department was unable to provide all requested youth in care files. Auditors requested the hard copy files for the 68 sampled youth in care and 91 LGBTQ youth in care. The list was initially sent to the Department on April 29, 2020, and the first files were received June 19, 2020. Files continued to be received through August 13, 2020. The Department had to obtain the files from Department and POS agency field offices in all four regions across the State. The Department was provided the list of files that were not provided on September 15, 2020, and the Department requested time to provide more files. The Department was able to provide 26 additional files. Auditors received 132 of the 159 total requested files (83.0%). Auditors did not receive 10 of 91 (11.0%) of the LGBTQ files and 17 of 68 (25.0%) of the general population sample. Of the 27 files that were not received, 24 were closed cases. The Department had five months to provide the files yet could not provide 17.0 percent of the files.

All youth in care files, whether open or closed, should be maintained in an easily accessible location. During testing auditors found examples of youth in care coming back into care after failed adoptions or coming into care multiple times. In these instances it is necessary to have the old files available to caseworkers to learn the history of the youth in care.

During the current examination, the Department provided the OAG auditors documentation of 25 of 25 requested files for testing.

Recommendation 12 - Sibling Visitation Plans

The Department should:

- *Ensure that sibling visitation plans are created for all youth in care who require one;*
- *Ensure that all sibling visitation plans are completed in a timely manner; and*
- *Clarify the timeliness requirement between the Juvenile Court Act of 1987, the Illinois Administrative Code, and Department Procedures.*

Current Status: Partially Implemented

In The OAG's February 2021 audit, the OAG auditors reported that the Department did not always create sibling visitation plans in a timely manner. Data provided by the Department showed that there were 6,189 sibling visitation plans involving 8,703 youth in care that were in effect during 2017 and 2018. Most plans were in effect for one year. Whether the sibling visitation plans were being followed was included as part of sample testing. Forty-eight of 159 youth in care (30.2%) had a sibling visitation plan. Of the 48 youth in care with a sibling visitation plan, 25 had documentation to show that the sibling visitation plans were being followed. There were seven youth in care without a sibling visitation plan that should have had one.

The Juvenile Court Act of 1987 requires that when a child comes into care and the child has siblings in care, the Department shall file with the court a sibling placement and contact plan within 10 days, excluding weekends and holidays (705 ILCS 405/2-10(2)). Department rules (89 Ill. Adm. Code 301.220(c)) and Department Procedure 301.230 require that when siblings enter care and are not in joint placement, the caseworker shall complete and file a Visitation and Contact Plan with the juvenile court within 10 days. The timeliness requirements between the statute and administrative rules/procedures do not match. The statute requires 10 business days (excluding weekends and holidays) whereas the administrative rules require 10 calendar days.

There were 14 cases sampled where a youth or sibling came into care during 2017-2018 and needed a sibling visitation plan (6 LGBTQ). Of those 14 cases, 8 (4 LGBTQ) had a plan established more than 10 calendar days after the temporary custody date. Failing to create sibling visitation plans in a timely manner can lead to youth in care not maintaining familial ties with their siblings.

During the current examination, the OAG auditors found that the Department is creating sibling visitation plans when required, but not all plans were created in a timely manner. Additionally, the Department did review the timeliness requirement between the Juvenile Court Act of 1987, Department rules, and Department procedures. Auditors sampled 25 youth in care; of those sampled that required a sibling visitation plan, there were none missing a sibling visitation plan. Auditors also sampled 10 youth in care who came into care during FY22 and had a sibling visitation plan. For the 10 youth in care, 6 (60.0%) had a plan established more than 10 calendar days after the temporary custody date.

The Department reviewed the various provisions of the Juvenile Court Act of 1987, the Illinois Administrative Code and department procedures related to the Sibling Visitation Plan to address the time frames in which the Sibling Visitation Plans should be completed by to determine whether any changes are required to be made to the department's procedures. The Department determined that no change was required. The Department stated that procedures are purposely more restrictive than the Juvenile Court Act of 1987.

Recommendation 13 - Normalcy Activity Documentation

The Department should ensure that discussions of normalcy activities are documented in case contact notes, as required by Department Policy Guide 2017.07.

Current Status: Not Implemented

In The OAG's February 2021 audit, the OAG auditors reported that caseworkers were not documenting discussions of normalcy activities as required by Department Policy Guide 2017.07. Caseworkers should discuss normalcy parenting with the caregiver at each monthly home visit, and those discussions should be documented in contact notes. Auditors found that for 75 youth in care sampled, there was some evidence of normalcy activities, including 54 LGBTQ youth in care. However, auditors also found that 82 of 95 (86.3%) youth in care did not have consistent documentation of caseworkers discussing normalcy activities and recording the discussion in contact notes. For some youth in care reviewed, normalcy activities were not applicable.

The Department defines normalcy as "allowing youth in care the opportunity to participate in age-appropriate enrichment, extra-curricular and social activities." According to the Children and Family Services Act (20 ILCS 505/7.3a(c)(1)), each child who comes into the custody of the Department is fully entitled to participate in appropriate extracurricular, enrichment, cultural, and social activities in a manner that allows the child to participate in his or her community to the fullest extent possible.

For youth in care sampled, it was sometimes difficult to track normalcy activities due to several factors, including whether a youth in care could participate. Not all youth in care could participate in normalcy activities, either due to age or being in psychiatric hospitals or detention facilities.

During the current examination, the OAG auditors found that normalcy discussions were not being consistently documented during the monthly home visits. Auditors tested 25 youth in care, and found that for 3 youth in care, normalcy activities were not applicable. For the remaining 22 youth in care, 17 had some discussion of normalcy, however, 20 of 22 (90.9%) youth in care did not have consistent documentation of caseworkers discussing normalcy activities and recording the discussion in contact notes.

Recommendation 14 - Emergency Placements

The Department should:

- *Ensure that youth in care are not placed in emergency shelters after a psychiatric hospitalization in accordance with Department procedures; and*
- *Consistently and accurately track emergency placements.*

Current Status: Partially Implemented

In The OAG's February 2021 audit, the OAG auditors reported that youth in care were remaining in emergency shelters and emergency foster care placements for more than 30 days. Department Procedure 301.55(b) states that placement in an emergency shelter should not exceed 30 days. Of the 159 youth in care the OAG auditors reviewed, there were 23, including 22 LGBTQ youth, who had an emergency placement. Twelve of 22 LGBTQ youth in care (54.5%) remained in an emergency placement for more than 30 days. Nine of the youth in care were in shelters, two in emergency foster care, and one youth in care had placements in both a shelter and emergency foster care that were longer than 30 days.

The OAG auditors also found that youth were placed in shelters after being discharged from psychiatric hospitalizations in violation of Department procedures. Department Procedure 301.55(c)(3) states that, "children/youth shall not be placed into an emergency shelter directly from a stay in a psychiatric inpatient unit." During testing the OAG auditors identified 1 placement where a youth in care was placed in an emergency shelter after discharge from a psychiatric hospital out of 23 shelter placements. While reviewing other shelter placements, auditors identified an additional two youth in care who were placed in a shelter after a psychiatric hospitalization discharge.

The Department also was not accurately recording emergency placements. During testing auditors noticed inconsistencies in how the Department listed emergency placements. Auditors found that youth were placed in emergency shelters, but the placements were not listed as shelters. By not listing placements as emergency shelters the Department makes it difficult to accurately track placements. Also, by listing the same emergency shelter as multiple foster home placements it can make it appear as though a youth in care has not remained in an emergency placement for longer than 30 days.

During the current examination, the OAG auditors found that the Department did not place youth in a shelter after discharge from a psychiatric hospital, and there were inconsistencies in the tracking of emergency placements. During testing, auditors did not find any examples of the Department placing a youth in a shelter after discharge from a psychiatric hospital. There were still inconsistencies in how emergency placements are tracked. Emergency placements can be classified as different types of placements, for example:

- An emergency shelter was "Youth Emergency Shelters," "Institution Private," and "Intensive Placement Stabilization";
- An emergency shelter was "Youth Emergency Shelters" and "Group Home"; and
- An emergency placement was both "Group Home," and "Intensive Placement Stabilization."

Recommendation 15 - Psychiatric Lockouts

The Department should ensure that protective custody of psychiatric lockout patients is taken within 48 hours as required by Department Procedures 300.

Current Status: Partially Implemented

In The OAG's February 2021 audit, the OAG auditors reported that the Department was not taking psychiatric lockout youth in care into protective custody in a timely manner, as required by Department procedures. A psychiatric lockout occurs when a youth is psychiatrically hospitalized and the parents/guardians refuse to pick up the youth when the youth is ready for discharge. Procedures 300 require that if a lockout cannot be resolved within 48 hours, the youth shall be taken into protective custody.

OAG auditors reviewed all youth who came into care and an investigation was initiated for a psychiatric lockout during 2017 and 2018 and found that in 142 of 161 instances (88.2%) the Department was not taking protective custody within 48 hours. For 44.7% of cases the youth was taken into protective custody more than one month after the investigation began, with a maximum of 182 days. This causes the youth in care to be listed as beyond medical necessity for fewer days than is actually the case.

During the current examination, the OAG auditors found that the Department improved on taking protective custody within 48 hours. Auditors sampled 25 youth who came into care and an investigation was initiated for a psychiatric lockout during FY22. In 16 of 25 instances (64.0%) the Department did not take custody within 48 hours. In four cases (16.0%), the youth was taken into protective custody more than one month after the investigation began, with a maximum of 76 days.

While the Department is still not taking custody within 48 hours for more than half of the sampled youth, there was improvement from the previous audit, particularly with cases taking more than one month.

Recommendation 16 - Waiting for Placement Report

The Department should:

- *Ensure the Youth in Care Waiting for Placement reports are filed in a timely manner;*
- *Ensure the Youth in Care Waiting for Placement reports meet the statutory requirements of the Act; and*
- *Verify that the data used to create the Youth in Care Waiting for Placement reports is accurate and that accurate data is provided to the General Assembly.*

Current Status: Partially Implemented

In The OAG's February 2021 audit, the OAG auditors reported that Department was not providing accurate and complete information to the General Assembly in the required Youth in Care Waiting for Placement annual report. Public Act 100-0087 amended the Children and Family Services Act to require that no later than December 31, 2018, and on December 31 of each year thereafter through December 31, 2023, the Department shall prepare and submit an annual report, covering the previous fiscal year, to the General Assembly regarding youth in care waiting for placements. The report must include data on three types of placements:

- emergency placements, including shelters and emergency foster homes, for longer than 30 days;
- psychiatric hospitalization beyond medical necessity; and
- remaining in a detention center or Department of Juvenile Justice (DJJ) facility solely because the Department cannot locate an appropriate placement (20 ILCS 505/2.2).

The Department filed the December 31, 2019 report (for FY19) on January 13, 2020, almost two weeks after the deadline.

The Department is required to provide data on the number of youth in care who remained in a detention facility or Department of Juvenile Justice facility solely because the Department cannot locate an appropriate placement for the youth. However, the reports the Department has filed with the General Assembly contain data on youth who remained in a detention facility more than 15 days past their discharge date, and there is nothing in the statute that allows for the Department to exclude youth who remained less than 15 days. The reports filed by the Department do not provide a clear explanation why the decision was made to only report youth held longer than 15 days.
While conducting an analysis of the FY19 shelter/emergency placement and detention/DJJ data, inaccuracies were discovered including:

- 29 youth in care who should not have been listed in the report because they were listed as being in an emergency placement since 2016 or 2017 but were shown in SACWIS as not having any shelter placements during FY19;

- 12 youth in care who should not have been listed in the report because they had a detention/DJJ release date before the beginning of FY19; and
- 13 youth in care who should not have been listed in the report because they were listed as still being held in a detention facility but were shown in SACWIS as having been released from the facility prior to the beginning of FY19.

These problems caused the number of youth in care who are listed in the Waiting for Placement report to the General Assembly to be overstated. Auditors could not draw conclusions about the beyond medical necessity data because an analysis could not be conducted due to data limitations. The data provided by the Department did not include the discharge date nor the date the youth was beyond medical necessity. Therefore, no date calculations could be conducted nor could the number of days beyond medical necessity be verified.

Auditors compared the FY19 waiting for placements data to the fieldwork testing data for the 159 sampled youth in care. Even though the audit period only covered the first six months of FY19, out of seven youth in care who were beyond medical necessity, three were not included in the beyond medical necessity data provided by the Department.

During the current examination, the OAG auditors found that the Department provided the FY20 (due December 31, 2020) and FY21 (due December 31, 2021) Youth in Care Waiting for Placement Reports. Both reports were filed late, the FY20 report on September 17, 2021 and the FY21 report on May 4, 2022. The FY21 report included information on the length of stay for emergency placements, beyond medical necessity, and remaining beyond release date. The FY20 and FY21 reports also no longer reference youth remaining in detention beyond 15 days, and instead just refers to beyond the release date. The data used to create the FY21 report includes examples of youth held for less than 15 days beyond the release date. The Department filed the reports late, however, the reports were updated to include required information and follow statutory language.

The Department provided the OAG auditors with the data used to create the FY21 report and the auditors found that there were still issues with data accuracy. The shelter care data included 15 cases where the youth in care had not been in a shelter for more than 30 days as of the end of the fiscal year. Additionally, the detention data had examples of duplicate entries and inaccurate scheduled release dates or placement dates.