



**STATE OF ILLINOIS**

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**OFFICE OF THE AUDITOR GENERAL**

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**PERFORMANCE AUDIT  
OF THE  
DEPARTMENT OF  
CHILDREN AND FAMILY SERVICES  
INVESTIGATIONS OF ABUSE AND NEGLECT**

**MAY 2019**

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**FRANK J. MAUTINO**

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**AUDITOR GENERAL**

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OFFICE OF THE AUDITOR GENERAL  
FRANK J. MAUTINO

*To the Legislative Audit Commission, the Speaker  
and Minority Leader of the House of Representatives,  
the President and Minority Leader of the Senate, the  
members of the General Assembly, and the  
Governor:*

This is our report of the Performance Audit of the Department of Children and Family Services Investigations of Abuse and Neglect.

The audit was conducted pursuant to House Resolution Number 418. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

**SIGNED ORIGINAL ON FILE**

FRANK J. MAUTINO  
Auditor General

Springfield, Illinois  
May 2019





STATE OF ILLINOIS  
OFFICE OF THE  
**AUDITOR GENERAL**

Frank J. Mautino, Auditor General

**REPORT DIGEST**

**PROGRAM AUDIT**

**Release Date:  
May 2019**

Audit performed in  
accordance with  
**House Resolution  
Number 418**

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**EXECUTIVE SUMMARY**

**Illinois Department of Children and Family Services  
Investigations of Abuse and Neglect**

House Resolution Number 418 directed the Auditor General to conduct a performance audit of the Department of Children and Family Services to review and assess the Department's protocols for investigating reports of child abuse and neglect. The resolution specifically required the audit to include a review of abuse and neglect investigations conducted by the Department in FY15, FY16, and FY17.

In this audit for the three-year period FY15-FY17, we reported that:

- The number of abuse and neglect investigations increased significantly, going from 67,732 in FY15 to 75,037 in FY17 or 10.8 percent. Within the three-year timeframe there was a notable spike in FY16 to 78,572 investigations. The increase in investigations between FY15 and FY16 represents an increase of 16.0 percent.
- The hotline is unable to take calls as they are received, resulting in call backs. The number of call backs increased substantially during FY15-FY17, from 39.6 percent of total calls in FY15 to 55.7 percent in FY17.
- Investigator caseloads were not in compliance with the B.H. Consent Decree. For FY15-FY17, 78.7 percent of investigators (729 of 926) had at least 1 month during the audit period in which they received more than 15 new assignments.
- Indication rates (the percentage of cases where there was credible evidence that the incident occurred) decreased during FY15-FY17, from 28.3 percent in FY15 to 24.8 percent in FY17.
- The Department did not always follow procedures in conducting investigations.
- The overall timeliness of completion for investigations declined significantly over the three-year period FY15-FY17. In FY15, 7.6 percent of investigations were not completed within 60 days. For FY17, 12.4 percent of investigations were not completed within 60 days.
- Investigators did not always accurately document that they assessed the need for services by completing the Level of Intervention field in the Department's information system known as SACWIS. Of indicated investigations sampled, 16 investigations (10.7%) had no Level of Intervention listed (services recommended). Further, 39 indicated investigations (26.0%) had "No Service Needed" as the Level of Intervention. Additionally, of the investigations sampled, for 64 (42.7%) we found that the Level of Intervention was inaccurate.
- For 65.3 percent of indicated investigations sampled, there was a lack of documentation regarding whether any services were received by the families involved and the duration of those services. The Department could not provide basic information for Intact Family Service cases, such as referral forms, to document that a formal referral for services was made.

The audit report contains a total of 13 recommendations to the Department.



**AUDIT SUMMARY AND RESULTS**

House Resolution Number 418 directed the Auditor General to conduct a performance audit of the Department of Children and Family Services (DCFS or Department) to review and assess the Department’s protocols for investigating reports of child abuse and neglect. The resolution specifically required the audit to include a review of abuse and neglect investigations conducted by the Department in FY15, FY16, and FY17.

According to data provided by the Department, for FY15-FY17 the number of abuse and neglect investigations increased significantly, going from 67,732 in FY15 to 75,037 in FY17 or 10.8 percent. Within the three-year timeframe, there was a notable spike in FY16 to 78,572 investigations. The increase in investigations between FY15 and FY16 represents an increase of 16.0 percent. As is shown in Digest Exhibit 1, indication rates (the percentage of cases where there was credible evidence that the incident occurred) decreased during FY15-FY17, from 28.3 percent in FY15 to 24.8 percent in FY17. (pages 5-13)

**The Department has established administrative rules and extensive policies and procedures that delineate the investigations process and protocol to be followed during investigations.**

Digest Exhibit 1 CHILD ABUSE AND NEGLECT STATISTICS FY15-FY17			
	FY15	FY16	FY17
Investigations	67,732	78,572	75,037
Indicated Reports	19,156	18,710	18,591
Percent Indicated	28.3%	23.8%	24.8%
Source: OAG analysis of DCFS data as of July 27, 2018.			

**The Department did not always follow procedures in conducting investigations.**

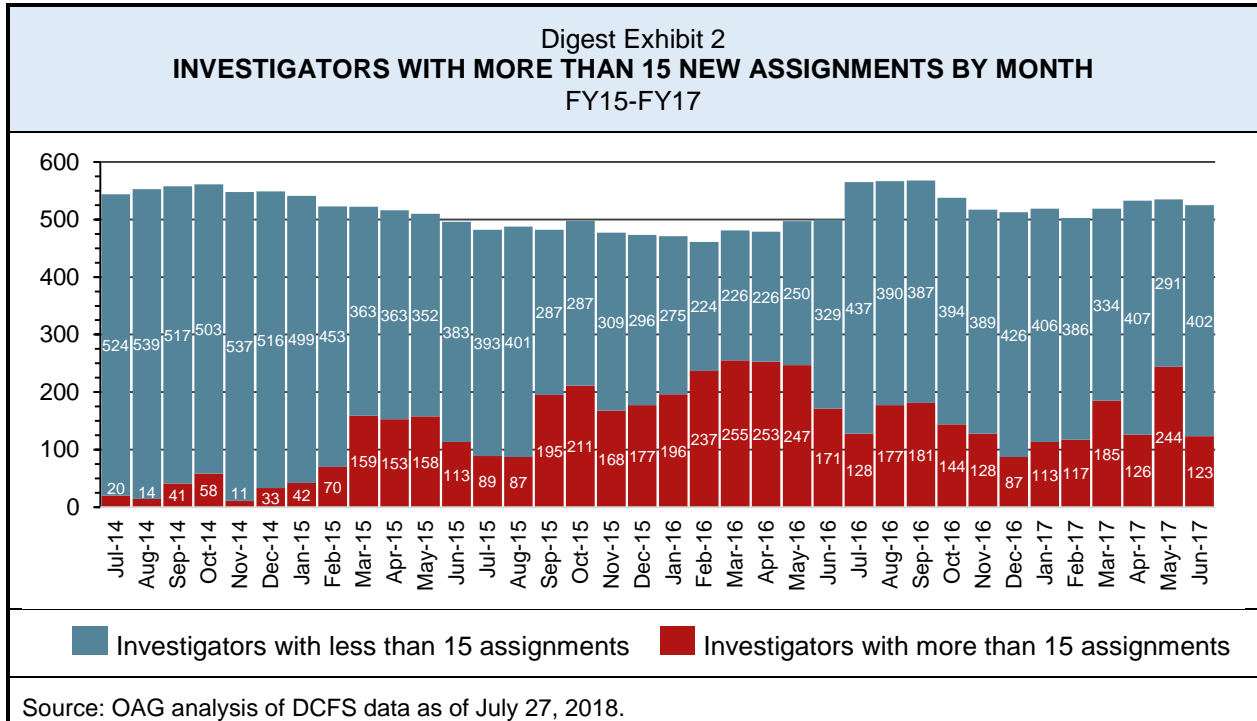
**INVESTIGATION PROTOCOL**

The Department has established administrative rules and extensive policies and procedures that delineate the investigations process and protocol to be followed during investigations. The protocol includes timelines to be followed, interviews to be conducted, forms to be completed, and documentation to be collected in completing investigations of child abuse and neglect. However, we found that the Department did not always follow procedures in conducting investigations.

For the audit period, the Department did not comply with investigator assignment requirements delineated in the B.H. Consent Decree. The B.H. Consent Decree requires that each child protective services investigator be assigned no more than 12 new abuse or neglect investigations per month during nine months of a calendar year and during the other three months of the calendar year, no more than 15 new investigations per month. Our analysis of primary assignments for FY15-FY17 showed that 78.7 percent of investigators (729 of 926) had at least 1 month during the audit period in which they received more than 15 new assignments. Further, our analysis showed that 32 investigators averaged more than 15 case assignments per month for the entire three-year period. In addition, there were 114 investigators who did not receive assignments for all 36 months and averaged more than 15 assignments per month for the months worked during the

**Our analysis of primary assignments for FY15-FY17 showed that 78.7 percent of investigators (729 of 926) had at least 1 month during the audit period in which they received more than 15 new assignments.**

period. Digest Exhibit 2 shows that as the total number of investigators decreased during FY16, the higher the percent of investigators who were out of compliance with the B.H. Consent Decree’s maximum allowable new assignments of 15 new assignments. The exhibit also shows that for February through April 2016 over half of all investigators were out of compliance.



We could not document that the Department had evaluated the reliability and validity of the Child Endangerment Risk Assessment Protocol (CERAP) as required by the Children and Family Services Act (20 ILCS 505/21(e)). The CERAP is a six-page safety assessment protocol designed to provide investigators with a mechanism for quickly assessing the potential for moderate to severe harm to children in the immediate or near future and for taking quick action to protect them. The Department also could not provide specific CERAP training procedures required by statute. (pages 16-25)

**STATUS AND FINAL DETERMINATION**

Our analysis for the three-year period FY15-FY17, as of July 27, 2018, showed that the status for a majority of cases, 142,766 of 221,341 investigations or 64.5 percent, was classified as expunged. Expunged investigations for the period were unfounded investigations in which most information, including the name of the alleged perpetrator, had been hidden or removed from the investigation information. An additional 78,520 (35.5%) investigations were classified as closed. For the remaining 55 investigations:

- 22 were undetermined (3 cases were FY16 and 19 cases were FY17);
- 18 were in appeal (15 cases were FY15, 1 case was FY16, and 2 cases were FY17);



- 9 were purged or concealed (all were FY15 cases);
- 3 were in review (one from each fiscal year);
- 2 were in a 20-day hold (both were FY17 cases); and
- 1 was pending approval (an FY17 case).

According to data provided by the Department, 25.5 percent of investigations (56,457 of 221,341) for the three-year period FY15-FY17 had a final determination or finding of indicated, meaning there was credible evidence that the allegation occurred. For 74.5 percent of all investigations the status was unfounded (164,864 of 221,341 investigations). As of July 2018, there were 20 investigations for FY16 and FY17 that were listed as pending. (pages 25-27)

**INVESTIGATION TIMEFRAMES**

We found that the Department needs to improve timeliness in several areas. The Department is not timely in completing intakes from callers reporting allegations of abuse and neglect. The hotline is unable to take calls as they are received, resulting in call backs. The hotline did not meet targets, and call backs increased substantially during FY15-FY17, from 39.6 percent in FY15 to 55.7 percent of total calls in FY17. The Department also does not have written procedures regarding the process for calling back individuals who report allegations of abuse or neglect that do not complete the intake process at the time of their initial call. Further, the Department does not maintain call back information electronically in its information system, known as SACWIS, for more than 90 days, which makes any long-term analysis of call back timeliness difficult.

According to investigations data provided, the Department was timely in initiating investigations for approximately 99 percent of investigations. However, required interviews with the alleged victim and perpetrator were not always completed in a timely manner. With data provided by the Department, we reviewed the timeliness of interviews with the alleged victim(s) based on whether actual contact was made and found that the alleged victim was not interviewed within 24 hours in 29.1 percent of cases for the audit period FY15-FY17. The alleged perpetrator was not interviewed within 7 days in 24.5 percent of cases for the audit period.

The overall timeliness of completion for investigations declined significantly over the three-year period FY15-FY17. In FY15, 7.6 percent of investigations were not completed within 60 days. For FY16, the percentage of investigations not completed within 60 days increased to 16.0 percent. It remained elevated in FY17 at 12.4 percent of investigations not completed within 60 days.

We reviewed the timeliness of submission of the completed investigation to the supervisor and found that for the audit period FY15-FY17, 44.2 percent of all reports without extensions were not submitted within 55 days. The highest rate of noncompliance was for FY16, in which 51.2 percent of reports did not meet the 55 day requirement for submission to the supervisor, according to data provided by the Department.

The Department’s difficulty in completing investigations in a timely manner during the audit period is further demonstrated by the number and percentage

**The hotline did not meet targets, and call backs increased substantially during FY15-FY17, from 39.6 percent in FY15 to 55.7 percent of total calls FY17.**

**The overall timeliness of completion for investigations declined significantly over the three-year period FY15-FY17.**

of investigations that received a 30-day extension. The percentage of cases receiving one or more extensions increased from 7.5 percent in FY15 to 16.1 percent in FY16 and 12.7 percent in FY17. Further, the number of investigations receiving multiple extensions also increased significantly. For instance, the number of investigations that received three extensions (an additional 90 days) increased from 274 investigations in FY15 to 1,263 investigations in FY16 and 719 investigations in FY17. In our review of cases involving an extension, it was also not always clear what the cause for the extension was or whether it rose to the level of “good cause.” (pages 30-40)

**SERVICES**

Conducting an analysis of all recommendations for services and services provided by the Department was not possible for the audit period because of inherent limitations in the data provided by the Department as well as other data reliability and consistency issues. In order to assess the services recommended and services provided, we selected a sample of 150 indicated investigations (50 each year for FY15, FY16, and FY17) and reviewed the investigations for recommended services and any services received. (pages 42-44)

**Recommendations for Services**

The Department’s policies and procedures require that during an investigation the need for services for the family involved in the investigation be assessed by the Child Protection Specialist (investigator) and the Child Protection Supervisor. Our review of 150 indicated investigations found that investigators did not always document that they assessed the need for services by completing the Level of Intervention field in the Department’s information system (SACWIS). Of the 150 indicated investigations sampled, 16 investigations (10.7%) had no Level of Intervention listed. Further, 39 investigations (26.0%) had “No Service Needed” as the Level of Intervention. For most of these cases there was no rationale regarding why no services were being recommended even though the case had been indicated. Additionally, of the investigations sampled, for 64 (42.7%) we found that the Level of Intervention was inaccurate.

**Investigators did not always document that they assessed the need for services by completing the Level of Intervention field in the Department’s information system.**

For Intact Family Services (IFS) provided through the Department, investigators have the responsibility to discuss and offer these services if the final investigation finding of indicated has been recommended. The Department did not document that Intact Family Services were discussed and offered to all families with indicated investigation findings as is required by Department procedures. Only 20 of 150 (13.3%) indicated investigations reviewed contained documentation of a recommendation for Intact Family Services (IFS). An additional 3 investigations had recommendations for multiple services, which included IFS; therefore, 23 of 150 indicated investigations had a recommendation of IFS. For 33 of 150 investigations (22.0%), community services were recommended. We could not determine whether any services were recommended or what the specific services were for 67 of 150 (44.7%) indicated investigations reviewed. The remaining 27 investigations included recommendations for placement, already receiving

services, no services needed, multiple services, Intact Family Recovery, and Norman Cash Assistance. (pages 44-48)

**Services Provided**

We sampled 150 indicated cases for the audit period and found that for 98 cases (65.3%), there was a lack of documentation regarding whether any services were received by the families involved and the duration of those services. The Department could not provide basic information for Intact Family Service cases, such as referral forms, to document that a formal referral for services was made. The Department also could not provide auditors with the number of families served by each IFS contractor each year for the audit period. For investigations involving the Norman Cash Assistance program, the Department could not provide all approval forms. For community services, there are no formal forms for referrals to community based services, and the Department is not documenting these services as required by procedures. Therefore, it is difficult to determine if the families actually received services from community providers. (pages 48-56)

**The Department could not provide basic information for Intact Family Service cases, such as referral forms, to document that a formal referral for services was made.**

**VICTIM DEMOGRAPHICS**

During the audit period, the number of indicated children decreased every year while the total number of alleged victims increased. According to data provided by the Department as of July 27, 2018, for the three-year period FY15-FY17 there were 221,341 investigations involving a total of 358,545 children, 96,576 of whom had at least one indicated allegation.

Auditors could not obtain a reliable count of the number of unique victims because of limitations with the data provided by the Department. Each person in the SACWIS system is assigned a unique PersonID. However, auditors found that there were over 8,000 instances where the same child had been assigned multiple PersonIDs. Therefore, auditors could not obtain a reliable count of the number of unique child victims over the audit period because of data limitations.

For the 221,341 investigations for FY15-FY17, there were 450,483 total allegations, with an overall indication rate of 25.5 percent. The most common allegations were “Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect” and “Inadequate Supervision.” A total of 52,502 children were the alleged victims of sexual abuse during FY15-FY17, and 32,439 children were the alleged victims of serious harm.

**Age**

Children under the age of one were the most frequent alleged victims of abuse or neglect (8.1% of all victims) and also the most likely to be indicated victims (13.3% of all indicated victims). After the age of one, the number of indicated allegations of abuse or neglect trends downward.

**Race and Ethnicity**

For race, children who were identified as White or Black/African-American made up 96.4 percent of all alleged victims (62.5% White and 33.9% Black/African-American) and 97.1 percent of all indicated victims (62.4% White and 34.7% Black/African-American). Data provided by the

Department showed that 2.3 percent of alleged victims did not have a race recorded. For ethnicity, children with a Hispanic ethnicity comprised 15.6 percent of all alleged victims and 16.7 percent of indicated victims.

### **Gender**

For gender, there was an even split between male and female victims. Males accounted for 49.7 percent of all alleged victims and females were 49.6 percent. For indicated victims, males accounted for 49.4 percent and females were 50.3 percent.

### **Geographic Location**

Auditors found that 25.6 percent of all investigations occurred in Cook County, followed by Lake County with 4.1 percent. There were investigations of alleged abuse or neglect in all 102 counties in Illinois. (pages 58-67)

### **RECOMMENDATIONS**

The audit report contains a total of 13 recommendations to the Department of Children and Family Services. The Department generally agreed with the recommendations in the report. Appendix H to the audit report contains the agency responses.

This performance audit was conducted by staff of the Office of the Auditor General.

**SIGNED ORIGINAL ON FILE** \_\_\_\_\_

JOE BUTCHER  
Division Director

This report is transmitted in accordance with Sections 3-14 and 3-15 of the Illinois State Auditing Act.

**SIGNED ORIGINAL ON FILE** \_\_\_\_\_

FRANK J. MAUTINO  
Auditor General

FJM:MSP

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## GLOSSARY OF TERMS

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**ANCRA** – The Abused and Neglected Child Reporting Act (325 ILCS 5) is the State statute that governs the reporting and investigating of child abuse and neglect.

**B.H. Consent Decree** – A class action lawsuit was filed against the Department in 1988 alleging that it failed to provide adequate services to children in its custody. In 1991, the parties entered into a consent decree known as the B.H. Consent Decree (88 C 5599 (N.D. Ill.)). A restated consent decree was filed in 1997, and the Consent Decree continues to be modified as needed.

**CERAP** – The Child Endangerment Risk Assessment Protocol is a six-page safety assessment protocol designed to provide a mechanism for quickly assessing the potential for moderate to severe harm to children in the immediate or near future and for taking quick action to protect them.

**Closed Investigation** – An investigation has been completed, a decision has been rendered on the case, and it has been approved and closed.

**Expunged Investigation** – An unfounded investigation where the records are unviewable or an indicated investigation in which the retention period has lapsed. According to ANCRA, all information identifying the subjects of an unfounded report shall be expunged from the register, except as provided by statute.

**Indicated Investigation** – An investigation of suspected child abuse/neglect has revealed credible evidence that the abuse/neglect occurred.

**Intact Family Recovery (IFR)** – A program which targets families in Cook County where an infant has been born exposed to controlled substances and provides comprehensive services to families during the process of recovery from alcohol and other drug abuse.

**Intact Family Services (IFS)** – A program designed to provide short term voluntary services intended to make reasonable efforts to stabilize, strengthen, enhance, and preserve family life by providing services that enable children to remain safely at home.

**Norman Cash Assistance Program** – Provides assistance when cash assistance is needed to purchase an item to prevent a child from being placed in, or to return a child home from, DCFS care.

**Placement** – The care of children for whom the Department is legally responsible who require a living arrangement away from their families due to abuse or neglect and for whom the Department has determined that family preservation services are not appropriate because such services are not in the child's best interest or would not protect the child from imminent risk of harm.

**Purchase of Service (POS) Providers** – Organizations contracted by DCFS to provide services.

**SACWIS** – The Statewide Automated Child Welfare Information System is the DCFS computer system for investigative, child, and family case information.

**Unfounded Investigation** – An investigation of suspected child abuse/neglect has revealed no credible evidence that the abuse/neglect occurred.





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## Chapter One

# INTRODUCTION AND BACKGROUND

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## REPORT CONCLUSIONS

House Resolution Number 418 directed the Auditor General to conduct a performance audit of the Department of Children and Family Services (DCFS or Department) to review and assess the Department's protocols for investigating reports of child abuse and neglect. The resolution specifically required the audit to include a review of abuse and neglect investigations conducted by the Department in FY15, FY16, and FY17.

According to data provided by the Department, for FY15-FY17 the number of abuse and neglect investigations increased significantly, going from 67,732 in FY15 to 75,037 in FY17 or 10.8 percent. Within the three-year timeframe there was a notable spike in FY16 to 78,572 investigations. The increase in investigations between FY15 and FY16 represents an increase of 16.0 percent. Indication rates decreased during FY15-FY17, from 28.3 percent in FY15 to 24.8 percent in FY17.

### **Investigation Protocol**

The Department has established administrative rules and extensive policies and procedures that delineate the investigations process and protocol to be followed during investigations. The protocol includes timelines to be followed, interviews to be conducted, forms to be completed, and documentation to be collected in completing investigations of child abuse and neglect. However, we found that the Department did not always follow procedures in conducting investigations.

For the audit period, the Department did not comply with investigator assignment requirements delineated in the B.H. Consent Decree. The B.H. Consent Decree requires that each child protective services investigator be assigned no more than 12 new abuse or neglect investigations per month during nine months of a calendar year and during the other three months of the calendar year, no more than 15 new investigations per month. Our analysis of primary assignments for FY15-FY17 showed that 78.7 percent of investigators (729 of 926) had at least 1 month during the audit period in which they received more than 15 new assignments. Further, our analysis showed that 32 investigators averaged more than 15 case assignments per month for the entire three-year period. In addition, there were 114 investigators who did not receive assignments for all 36 months and averaged more than 15 assignments per month for the months worked during the period.

We could not document that the Department had evaluated the reliability and validity of the Child Endangerment Risk Assessment Protocol (CERAP) as required by the Children and Family Services Act (20 ILCS 505/21(e)). The CERAP is a six-page safety assessment protocol designed to provide investigators with a mechanism for quickly assessing the potential for moderate to severe harm to children in the immediate or near future and for taking quick action

to protect them. The Department also could not provide specific CERAP training procedures required by statute.

### **Status and Final Determination of Investigations**

Our analysis for the three-year period FY15-FY17, **as of July 27, 2018**, showed that the status for a majority of cases, 142,766 of 221,341 investigations or 64.5 percent, was classified as expunged. Expunged investigations for the period were unfounded investigations in which most information, including the name of the alleged perpetrator, had been hidden or removed from the investigation information. An additional 78,520 (35.5%) investigations were classified as closed. For the remaining 55 investigations:

- 22 were undetermined (3 cases were FY16 and 19 cases were FY17)
- 18 were in appeal (15 cases were FY15, 1 case was FY16, and 2 cases were FY17);
- 9 were purged or concealed (all were FY15 cases);
- 3 were in review (one from each fiscal year);
- 2 were in a 20-day hold (both were FY17 cases); and
- 1 was pending approval (an FY17 case).

According to data provided by the Department, 25.5 percent of investigations (56,457 of 221,341) for the three-year period FY15-FY17 had a final determination or finding of indicated, meaning there was credible evidence that the allegation occurred. For 74.5 percent of all investigations the status was unfounded (164,864 of 221,341 investigations). As of July 2018, there were 20 investigations for FY16 and FY17 that were listed as pending.

### **Timeframes for Completing and Closing Investigations**

We found that the Department needs to improve timeliness in several areas. The Department is not timely in completing intakes from callers reporting allegations of abuse and neglect. The hotline did not meet targets and call backs increased substantially during FY15-FY17, from 39.6 percent to 55.7 percent of total calls. The Department also does not have written procedures regarding the process for calling back individuals who report allegations of abuse or neglect that do not complete the intake process at the time of their initial call. Further, the Department does not maintain call back information electronically in SACWIS for more than 90 days, which makes any long-term analysis of call back timeliness difficult.

According to investigations data provided, the Department was timely in initiating investigations for approximately 99 percent of investigations. However, required interviews with the alleged victim and perpetrator were not always completed in a timely manner. With data provided by the Department, we reviewed the timeliness of interviews with the alleged victim(s) based on whether actual contact was made and found that the alleged victim was not interviewed within 24 hours in 29.1 percent of cases for the audit period FY15-FY17. The alleged perpetrator was not interviewed within 7 days in 24.5 percent of cases for the audit period.

The overall timeliness of completion for investigations declined significantly over the three-year period FY15-FY17. In FY15, 7.6 percent of investigations were not completed within 60 days. For FY16, the percentage of investigation not completed within 60 days increased to 16.0 percent. It remained elevated in FY17 at 12.4 percent of investigations not completed within 60 days.

We reviewed the timeliness of submission of the completed investigation to the supervisor and found that for the audit period FY15-FY17, 44.2 percent of all reports without extensions were not submitted within 55 days. The highest rate of noncompliance was for FY16, in which 51.2 percent of reports did not meet the 55 day requirement for submission to the supervisor, according to data provided by the Department.

The Department's difficulty in completing investigations in a timely manner during the audit period is further demonstrated by the number and percentage of investigations that received a 30-day extension. The percentage of cases receiving one or more extensions increased from 7.5 percent in FY15 to 16.1 percent in FY16 and 12.7 percent in FY17. Further, the number of investigations receiving multiple extensions also increased significantly. For instance, the number of investigations that received three extensions (an additional 90 days) increased from 274 investigations in FY15 to 1,263 investigations in FY16 and 719 investigations in FY17. In our review of cases involving an extension, it was also not always clear what the cause for the extension was or whether it rose to the level of "good cause."

### **Services**

Conducting an analysis of all recommendations for services and services provided by the Department was not possible for the audit period because of inherent limitations in the data provided by the Department as well as other data reliability and consistency issues. In order to assess the services recommended and services provided, we selected a sample of 150 indicated investigations (50 each year for FY15, FY16, and FY17) and reviewed the investigations for recommended services and any services received.

### **Recommendations for Services**

The Department's policies and procedures require that during an investigation the need for services for the family involved in the investigation be assessed by the Child Protection Specialist (investigator) and the Child Protection Supervisor. Our review of 150 indicated investigations found that investigators did not always document that they assessed the need for services by completing the Level of Intervention field in the Department's information system known as SACWIS. Of the 150 indicated investigations sampled, 16 investigations (10.7%) had no Level of Intervention listed (services recommended). Further, 39 investigations (26.0%) had "No Service Needed" as the Level of Intervention. For most of these cases there was no rationale regarding why no services were being recommended even though the case had been indicated. Additionally, of the investigations sampled, for 64 (42.7%) we found that the Level of Intervention was inaccurate.

For Intact Family Services (IFS) provided through the Department, investigators have the responsibility to discuss and offer these services if the final investigation finding of indicated has been recommended. The Department did not document that Intact Family Services were discussed and offered to all families with indicated investigation findings as is required by Department procedures. Only 20 of 150 (13.3%) indicated investigations reviewed contained documentation of a recommendation for Intact Family Services (IFS). An additional 3 investigations had recommendations for multiple services, which included IFS; therefore 23 of 150 indicated investigations had a recommendation of IFS. For 33 of 150 investigations (22.0%), community services were recommended. We could not determine whether any services were recommended or what the specific services were for 67 of 150 (44.7%) indicated investigations reviewed. The remaining 27 investigations included recommendations for

placement, already receiving services, no services needed, multiple services, Intact Family Recovery, and Norman Cash Assistance.

### **Services Provided**

We sampled 150 indicated cases for the audit period and found that for 98 cases (65.3%), there was a lack of documentation regarding whether any services were received by the families involved and the duration of those services. The Department could not provide basic information for Intact Family Service cases, such as referral forms, to document that a formal referral for services was made. The Department also could not provide auditors with the number of families served by each IFS contractor each year for the audit period. For investigations involving the Norman Cash Assistance program, the Department could not provide all approval forms. For community services, there are no formal forms for referrals to community based services and the Department is not documenting these services as required by procedures. Therefore, it is difficult to determine if the families actually received services from community providers.

### **Victim Demographics**

During the audit period, the number of indicated children decreased every year while the total number of alleged victims increased. According to data provided by the Department as of July 27, 2018, for the three-year period FY15-FY17 there were 221,341 investigations involving a total of 358,545 children, 96,576 of whom had at least one indicated allegation.

Auditors could not obtain a reliable count of the number of unique victims because of limitations with the data provided by the Department. Each person in the SACWIS system is assigned a unique PersonID. However, auditors found that there were over 8,000 instances where the same child had been assigned multiple PersonIDs. Therefore, auditors could not obtain a reliable count of the number of unique child victims over the audit period because of data limitations.

For the 221,341 investigations for FY15-FY17, there were 450,483 total allegations, with an overall indication rate of 25.5 percent. The most common allegations were “Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect” and “Inadequate Supervision.” A total of 52,502 children were the alleged victims of sexual abuse during FY15-FY17 and 32,439 children were the alleged victims of serious harm.

### **Age**

Children under the age of one were the most frequent alleged victims of abuse or neglect (8.1% of all victims) and also the most likely to be indicated victims (13.3% of all indicated victims). After the age of one, the number of indicated allegations of abuse or neglect trends downward.

### **Race and Ethnicity**

For race, children who were identified as White or Black/African-American made up 96.4 percent of all alleged victims (62.5% White and 33.9% Black/African-American) and 97.1 percent of all indicated victims (62.4% White and 34.7% Black/African-American). Data provided by the Department showed that 2.3 percent of alleged victims did not have a race recorded. For ethnicity, children with a Hispanic ethnicity comprised 15.6 percent of all victims and 16.7 percent of indicated victims.

## **Gender**

For gender, there was an even split between male and female victims. Males accounted for 49.7 percent of all alleged victims and females were 49.6 percent. For indicated victims, males accounted for 49.4 percent and females were 50.3 percent.

## **Geographic Location**

Auditors found that 25.6 percent of all investigations occurred in Cook County, followed by Lake County with 4.1 percent. There were investigations of alleged abuse or neglect in all 102 counties in Illinois.

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# **INTRODUCTION**

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House Resolution Number 418, adopted June 25, 2017, directs the Auditor General to conduct a performance audit of the Department of Children and Family Services (Department) to review and assess the Department's protocols for investigating reports of child abuse and neglect (see Appendix A). The audit is to include a review of abuse and neglect investigations conducted by the Department in FY15, FY16, and FY17. The audit resolution asks the Auditor General to determine:

- 1) the status of abuse and neglect investigations;
- 2) the final determination or findings made by the Department for abuse and neglect investigations;
- 3) the time frame within which the Department completed or closed abuse and neglect investigations;
- 4) for sampled cases, recommendations made by the Department to families who were the subject of an abuse or neglect investigation, including any services provided by the Department to the child or family; and
- 5) demographic information on abuse and neglect investigations, including the age, race, and gender of children who were subjects of the abuse or neglect investigations, and, if available, the zip code and county where the abuse or neglect was alleged to have occurred.

Additionally, the audit resolution asked the Auditor General to compile a detailed report that includes a full summary on the number of lawsuits or other legal actions filed against the Department within the past three fiscal years that concern an abuse or neglect investigation and the number of lawsuits the Department settled within the past three fiscal years that concern an abuse or neglect investigation.

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# **BACKGROUND**

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The Abused and Neglected Child Reporting Act (ANCRA or the Act) charges the Department of Children and Family Services with the responsibility of receiving reports of child abuse and neglect (325 ILCS 5/2). After a report is received, the Department is statutorily mandated "to protect the health, safety, and best interests of the child in all situations in which the child is vulnerable to child abuse or neglect, offer protective services in order to prevent any

further harm to the child and to other children in the same environment or family, stabilize the home environment, and preserve family life whenever possible” (325 ILCS 5/2).

During 2017, there were several high profile child abuse and neglect cases in which children died shortly after the Department closed investigations into their alleged mistreatment, as well as the case of a 17-month-old who was found deceased in Joliet Township after prior Department probes into alleged mistreatment. There were also other news/media reports that Department investigators were overwhelmed by high caseloads and were being pressured to quickly close cases, even when they had not performed basic tasks such as contacting police and doctors.

### **Agency Organization**

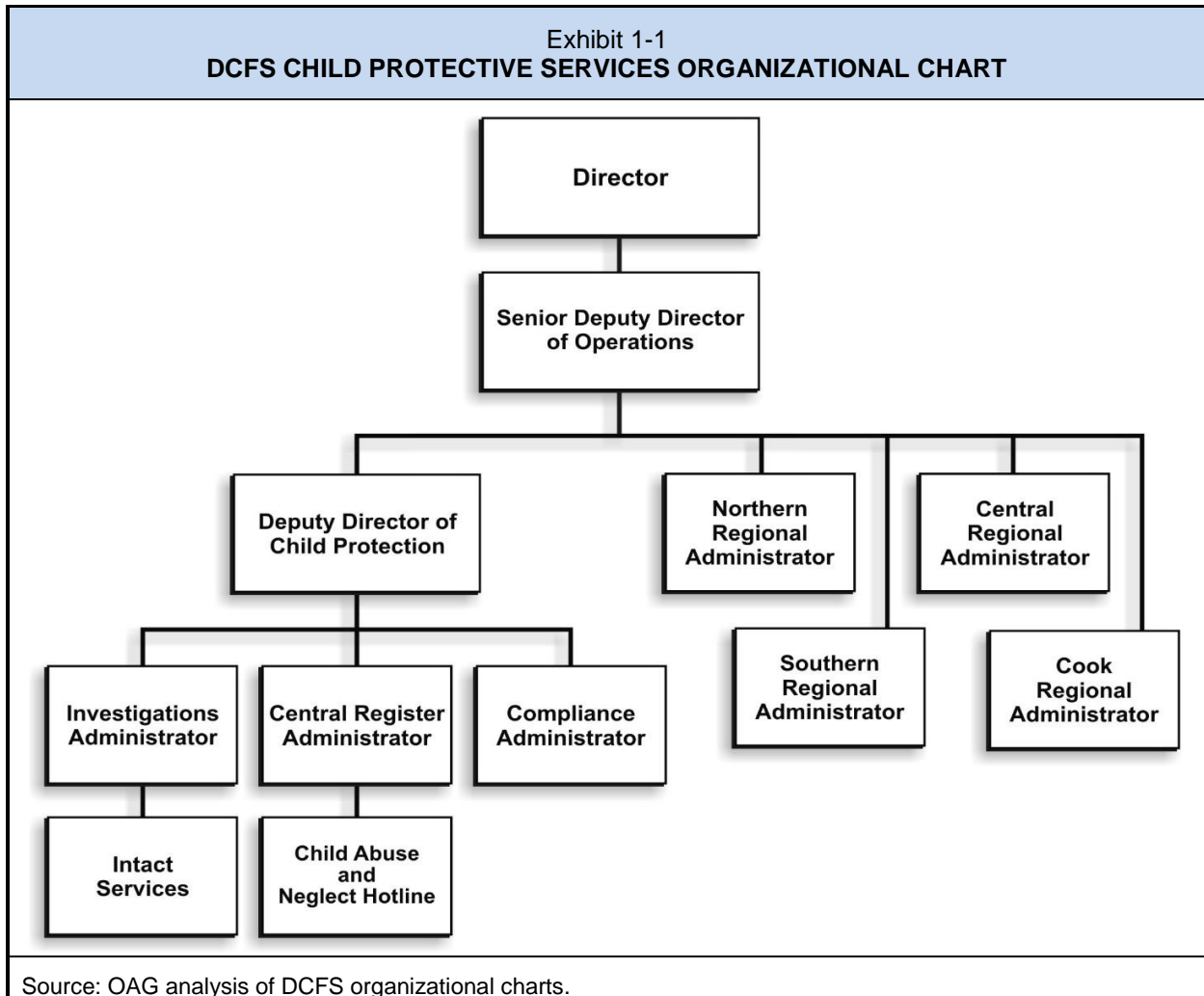
The Department experienced a change in leadership during FY17. George Sheldon, who was appointed the Director in February 2015, resigned on June 15, 2017. The Department had seven directors or acting directors in the three years prior to Mr. Sheldon being appointed, including two acting directors between the beginning of June 2014 and February 2015. On June 23, 2017, the Governor appointed Beverly Walker as Acting Director. She resigned effective February 15, 2019.

The Abused and Neglected Child Reporting Act requires that there be a central register of all cases of suspected child abuse or neglect reported and maintained by the Department under the Act. The Division of Child Protection operates the State Central Register (SCR) including the abuse and neglect hotline and is responsible for conducting child abuse and neglect investigations. Child Protection receives reports of alleged abuse or neglect through the 24-hour child abuse hotline at the SCR. An investigation of reported child abuse or neglect is generally required to be initiated within 24 hours of its receipt at the SCR. The investigation is conducted for the purpose of determining whether credible evidence of child abuse or neglect exists and whether the family can benefit from any services. The Deputy Director of Child Protection reports directly to the Senior Deputy Director of Operations. *Exhibit 1-1* shows an organizational overview of Child Protective Services.

When such service needs are identified, Department staff arranges for those services to be initiated. The intensity, duration, and protective character of the services recommended is determined by whether the report is determined to be credible and ruled indicated or determined to be not credible and ruled unfounded.

**The mission of the Department of Children and Family Services is to:**

- Protect children who are reported to be abused or neglected and to increase their families' capacity to safely care for them;
- Provide for the well-being of children in DCFS care;
- Provide appropriate, permanent families as quickly as possible for those children who cannot safely return home;
- Support early intervention and child abuse prevention activities; and
- Work in partnerships with communities to fulfill this mission.



### Regions and Offices

ANCRA requires the Department to establish a Child Protective Service Unit within each geographic region as designated by the Director of the Department (325 ILCS 5/7.2). As is shown in *Exhibit 1-2*, there are four regions in the State (Northern, Central, Southern, and Cook). The Department has field offices located throughout these regions of the State that report to a Regional Administrator. Child Protection Specialists (investigators) as well as case workers for other areas of operations, such as permanency (placement/foster care), are located at the regional and field offices. Each Regional Administrator reports directly to the Senior Deputy Director of Operations.

Exhibit 1-2 DEPARTMENT OF CHILDREN AND FAMILY SERVICES REGIONAL AND FIELD OFFICES			
City	Location/Address		
<b>Northern Region</b>			
<b>Aurora</b>	<b>8 East Galena Blvd. (Regional Office)</b>		
DeKalb	760 Peace Road		
Elgin	595 State Street		
Freeport	1826 South West Avenue		
Glen Ellyn	800 West Roosevelt Road		
Joliet	1619 West Jefferson Street		
Kankakee	505 South Schuyler		
Rockford	200 South Wyman		
Sterling	2607 Woodlawn Avenue		
Waukegan	2133 Belvidere Road		
Woodstock	113 Newell Street		
<b>Cook North Region</b>			
Chicago	1911/1921 South Indiana		
Deerfield	1755 Lake Cook Road		
<b>Cook Central Region</b>			
Chicago	1026 South Damen		
Chicago	1240 South Damen		
Maywood	1701 South 1st Avenue		
<b>Cook South Region</b>			
Chicago	6201 South Emerald		
Harvey	15115 South Dixie Highway		
<b>Central Region</b>			
Bloomington	401 Brown Street		
Canton	1607 East Chestnut Street		
Carlinville	1022 North High Street		
<b>Champaign</b>	<b>2125 South First Street (Regional Office)</b>		
Charleston	825 South 18th Street		
Danville	401 North Franklin Street		
Decatur	2900 North Oakland Avenue		
Galesburg	467 East Main Street		
Jacksonville	46 North Central Park Plaza		
Jerseyville	108 South State		
Lincoln	405 North Limit		
Ottawa	1580 First Avenue		
Peoria	2001 North East Jefferson Street		
<b>Peoria</b>	<b>5415 North University Avenue (Regional Office)</b>		
Quincy	107 North 3rd Street		
Rock Island	500 42nd Street		
Springfield	1124 North Walnut Street		
<b>Springfield</b>	<b>4500 South 6th Street Road (Regional Office)</b>		
Taylorville	115 West Bidwell Street		
Urbana	508 South Race		
<b>Southern Region</b>		<b>City</b>	<b>Location/Address</b>
<b>Southern Region (Continued)</b>		<b>Southern Region (Continued)</b>	
		<b>East St. Louis</b>	<b>10 Collinsville Avenue (Regional Office)</b>
		Effingham	401 West Industrial Avenue
		Granite City	1925 Madison Avenue
		Harrisburg	324 East Raymond
		<b>Marion</b>	<b>2309 West Main Street (Regional Office)</b>
		Marion	107 Airway Drive
		Metropolis	200 West 5th Street
		Mt. Vernon	321 A Withers Drive
		Murphysboro	1210 Hanson Street
		Olney	1408 Martin
		Sparta	202 West Jackson Street
		Wood River	1407 Vaughn Road
Note: A field office in Pekin (Central Region) closed during the audit period, in November 2015. Source: OAG analysis of DCFS data.			



When a report of suspected child abuse or neglect is received at the SCR, it is transmitted to the appropriate Child Protective Service Unit. The Child Protective Service Units are required to perform certain functions assigned by the Act (325 ILCS 5/). These include:

- Investigating reports of alleged abuse or neglect and commencing these investigations within 24 hours of receipt of a report, unless it's an emergency (325 ILCS 5/7.4(b)(2)); and
- Providing or arranging for comprehensive emergency services to children and families (325 ILCS 5/7.4(b)(3)).

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## **CHILD ABUSE AND NEGLECT INVESTIGATIONS DATA**

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House Resolution Number 418 asks the Auditor General to review the Department's investigations of abuse and neglect including the status, final determination, time frames, services, and demographic information. In order to conduct our review of these issues, we relied on data provided by the Department. The Government Accountability Office (GAO) Yellow Book (section 6.66) requires that auditors should assess the sufficiency and appropriateness of computer-processed information regardless of whether this information is provided to auditors or auditors independently extract it. Further, the Yellow Book states that the assessment of the sufficiency and appropriateness of computer-processed information includes considerations regarding the completeness and accuracy of the data for the intended purposes.

The Department had significant issues producing accurate reports on child abuse and neglect investigations statistics during the audit period and while we were conducting the audit. These issues were caused primarily by inadequate and antiquated information systems. However, we also identified concerns with the quality of the data contained in the Department's primary information system, the Statewide Automated Child Welfare Information System (SACWIS). While recognizing the shortcomings of the data provided, in our opinion, the data was reliable enough to use in the general context of addressing the audit's objectives including sampling services.

On January 26, 2018, auditors met with Department of Children and Family Services and Department of Innovation and Technology officials and requested data to support statistics presented in the Department's Executive Statistical Summary reports for the audit period (FY15-FY17). According to officials, in August 2017, the linkage between the system that contains the abuse and neglect investigations information (SACWIS) and the system used for producing the statistical reports (NOMAD) broke, rendering them unable to produce statistical reports.

During the course of the audit, the Department could not produce monthly abuse and neglect statistical reports for at least eight months (August 2017 through March 2018). On April 17, 2018, the Department released a "Message From The DCFS Director Regarding Public Release of Data" and reissued abuse and neglect statistics for the past five years (FY13-FY17) that were presented in its executive statistical reports. According to the Director's message, the Department has been severely hampered by woefully out-of-date technology, half-finished information systems, and reporting that required multiple manual steps.

### **Limitations of Provided Data**

After reviewing abuse and neglect data from SACWIS, auditors concluded that the Department needs to continue to work to improve the quality of its abuse and neglect data and

improve controls that are in place to ensure abuse and neglect data is accurate. For example, this could be accomplished by limiting the amount of manual data entry by using more drop-down choice menus and reducing the amount of missing data by forcing more required fields in order to save a record. On July 27, 2018, the Department provided auditors with a download of data for intakes, investigations, and victim demographics for the audit period FY15-FY17. This data had several limitations and shortcomings including:

- **Inconsistent Data Entry** – For example, we identified 39 different spellings for the City of Chicago in the data we were provided.
- **Missing Data** (i.e., unknown, null, or blank fields) – As an example, the place of occurrence field contained 11.8 percent (26,174) of investigations listed as NULL, which is returned when a field is blank. An additional 7.7 percent (17,061) of addresses could not be verified through the US Postal Service. Therefore, the total number of investigations in which the occurrence address was unknown or unverified was 19.5 percent.
- **Input Errors and Incorrect Information** – When an allegation is received at the hotline an intake is created. When an intake is completed it is sent to a field office for investigation. Data provided by the Department showed investigations that were begun prior to the intake being completed. For example, there were 666 times where the victim contact date and time was prior to the intake end date and time and 4,554 times where the initial Child Endangerment Risk Assessment Protocol (CERAP) date was prior to the intake end date and time. In order to account for individuals on an unduplicated basis, they are assigned unique IDs in SACWIS (known as PersonIDs). We found 909 alleged victims who had the same PersonID but more than one date of birth and 333 alleged victims who had the same PersonID but more than one gender (195 victims were listed as both male and female and 138 were listed as a gender and unknown).
- **Individuals With Multiple PersonIDs** - We found 8,061 individuals that may have multiple PersonIDs. The number of IDs for any one individual ranged from 2 to 4 different IDs. Therefore, **counts of individuals, such as those involving demographics, are likely inflated in some cases.** Issues with PersonIDs are discussed further in Chapter Five of this report.

The Department's reissued published statistics may still include inaccurate data. Although the reissued data generally matched data provided to us by the Department, there were some instances in which we question the accuracy of specific types of reports. For instance, the Department's statistical reports for substance exposed infants appears to include children with no recorded date of birth. Our analysis showed that many of these cases may not meet the definition of substance exposed infant (under age one).

In response to our follow-up, officials stated that concerns about data accuracy are largely a matter of the original source and the existence of several different technology systems with overlapping information but separate data origination practices. According to officials, "the issue really is the substantial reliance on human data entry, the number of systems in use with different users and different purposes, and the lack of dynamic adaptation to changing practices."

The Department also needs to update its SACWIS manual. According to Department officials, the manual for SACWIS has not been updated since 2001. During the audit, the Department could not provide auditors with a list of the field definitions for data included in SACWIS. Auditors had to develop definitions for the SACWIS data fields utilized for our data requests and have officials review and comment on those field definitions. Due to the lack of an updated SACWIS manual, the Department could not provide auditors with a list of which fields were required to be entered, the type of data entry for each field, or any other data entry controls.

ANCRA requires that there shall be a central register of all cases of suspected child abuse or neglect reported and maintained by the Department under the Act. Through the recording of initial, preliminary, and final reports, the central register shall be operated in such a manner as to enable the Department to: (1) immediately identify and locate prior reports of child abuse or neglect; (2) continuously monitor the current status of all reports of child abuse or neglect being provided services under the Act; and (3) regularly evaluate the effectiveness of existing laws and programs through the development and analysis of statistical and other information (325 ILCS 5/7.7).

Producing accurate data and timely reports is critical to monitoring agency performance and regularly evaluating the effectiveness of existing laws and programs as is required by ANCRA. Further, not producing timely and accurate reports can lead to the perception that there is a lack of transparency with lawmakers and other stakeholder interest groups.

<b>CHILD ABUSE AND NEGLECT DATA</b>	
<p><b>RECOMMENDATION</b></p> <p><b>1</b></p>	<p><i>The Department of Children and Family Services 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:</i></p> <ul style="list-style-type: none"> <li>• <i>Ensuring that proper controls are in place for SACWIS data entry, or any future child abuse and neglect information systems, in order to ensure that data is collected and is reliable; and</i></li> <li>• <i>Maintaining updated manuals including data field definitions.</i></li> </ul>
<p><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The Department agrees with the recommendation. Steps to improve the quality of the Child Abuse and Neglect Data have been taken:</p> <p>Current Steps In Action:</p> <ul style="list-style-type: none"> <li>• Several SACWIS releases have release improvements to data quality.</li> <li>• Data Field definitions are being assembled into a Data Dictionary.</li> </ul> <p>Planned Steps:</p> <ul style="list-style-type: none"> <li>• Project is being sourced to execute soon to execute data cleanup on Child Abuse and Neglect Data.</li> <li>• CCWIS program will replace current systems offering more advanced data validation capabilities.</li> <li>• CCWIS requires a Data Quality plan which will address data quality controls throughout the lifecycle of Child Abuse and Neglect data [sic].</li> </ul>

**Other Inherent Data Limitations**

In addition to the data issues discussed above, there are also practices that may result in duplicate data and counts. For example, per Department Procedure 300.30(b), the Department will initiate multiple investigations for a single incident if there are multiple alleged perpetrators who do not reside in the same house or if there are multiple independent families who reside in the same house. Therefore, the Department does not track or report child abuse or neglect incidents, but instead reports either investigations or victims. Additionally, if an incident at a facility involves multiple employees, a separate report is taken for each alleged perpetrator. This can lead to duplication in the data reported because there can be multiple investigations related to the same incident and the same victims involved with multiple investigations related to the same incident. This may inflate the number of victims because the single incident is reported as multiple investigations. As an example, for the audit period there were 14 instances in which multiple investigations were initiated for a single death. Therefore, these 14 allegations resulted in 33 separate investigations. This was because there were multiple alleged perpetrators.

### Hotline Calls, Intakes, and Investigations Data

The Department is required by statute to be capable of receiving reports of suspected child abuse or neglect 24 hours a day, 7 days a week (325 ILCS 5/7.4(a)). The Department accomplishes this through a hotline at the SCR.

According to the Department statistical reports, the total number of hotline calls increased significantly for the audit period going from 222,719 in FY15 to 252,568 in FY17 or 13.4 percent (*see Exhibit 1-3*).

Exhibit 1-3 HOTLINE CALLS AND INTAKES FY15-FY17				
	FY15	FY16	FY17	Total
Hotline Calls <sup>1</sup>	222,719	245,388	252,568	720,675
Intakes	187,182	181,288	172,907	541,377
<sup>1</sup> Hotline call data is from DCFS' Executive Statistical Summary for FY17 as of June 30, 2018. Source: OAG analysis of DCFS data as of July 27, 2018.				

When an allegation is received at the hotline an intake is created. An intake is created depending upon the type of issue being reported to the hotline. For example, an intake may be for a new abuse or neglect allegation or an ongoing case. Intakes may also be created for issues such as licensing referrals. According to data provided by the Department, the number of intakes decreased from 187,182 in FY15 to 172,907 in FY17 or 7.6 percent.

Abuse and neglect investigations increased significantly between FY15 and FY17, going from 67,732 to 75,037 or 10.8 percent. There is a notable spike in FY16 to 78,572 investigations. The increase in investigations between FY15 and FY16 represents a year over year increase of 16.0 percent.

While the number of investigations of child abuse and neglect has increased over the three-year period FY15-FY17, the percentage indicated has decreased. An indicated investigation is one in which there is credible evidence that the incident occurred. The percent of indicated investigations decreased for the three-year period from 28.3 percent in FY15 to 24.8 percent in FY17. Of note is the nearly five percent year-over-year decrease in the indication rate from FY15 to FY16. For FY16, total allegations investigated spiked to a high of 78,572, while the indicated rate sank to a low of 23.8 percent (*see Exhibit 1-4*). The numbers presented in *Exhibit 1-3* and *Exhibit 1-4* match closely to the updated numbers issued by the Department in April 2018.

Exhibit 1-4 CHILD ABUSE AND NEGLECT STATISTICS FY15-FY17			
	FY15	FY16	FY17
Investigations	67,732	78,572	75,037
Indicated Reports <sup>1</sup>	19,156	18,710	18,591
Percent Indicated	28.3%	23.8%	24.8%
<sup>1</sup> Indicated reports include those that were indicated due to review. Source: OAG analysis of DCFS data as of July 27, 2018.			

Auditors asked Department officials for any possible causes for the drop in the indication rate. Officials stated that looking at the rates for FY14 through FY18 there was a large increase in the indication rate between FY14 and FY15 before going back down in FY16 and the rates at the regional level seem to level out over the period.

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## LAWSUITS

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House Resolution Number 418 asks the Auditor General to compile a detailed report that includes a full summary on the number of lawsuits or other legal actions filed against the Department within the past three fiscal years that concern an abuse or neglect investigation and the number of lawsuits the Department settled within the past three fiscal years that concern an abuse or neglect investigation.

We met with Department officials, including the Chief Legal Counsel, to collect information regarding lawsuits and settlements. The Department provided auditors with cases and information related to the lawsuits and settlements for the audit period. Our review of documentation associated with lawsuits, settlements, and other legal actions for the audit period generally involved two types of lawsuits/settlements:

- Those that involved an alleged violation of constitutional rights; and
- Those related to appeals of an administrative review/decision by the Department.

We identified 23 lawsuits involving an allegation of a violation of constitutional rights that were related to an abuse or neglect investigation that were either filed during FY15-FY17 or a settlement or ruling was issued during the period. Of these 23 cases:

- 10 cases involved a settlement; 8 of the 10 settlements involved monetary amounts totaling \$676,000; 7 of the 10 settlements involved a change in policy or procedure;
- 4 cases were dismissed;
- 1 case was reversed; and
- 8 cases were still pending as of April 2018; however the Department was no longer a party to 3 of those cases. One of the cases still pending involves a Department provider which, according to the Department, it is legally responsible for defending.

For a detailed summary of these lawsuits and settlements see Appendix C of this report.

From information provided by the Department, we also reviewed lawsuits in which an appeal was filed after an investigation was completed in which the administrative decision was further challenged in court. In total, we identified 276 cases in which a court challenge was filed or decision was made during the three-year period FY15-FY17. Of these cases:

- 72 cases were dismissed;
- 64 cases were affirmed (meaning the Department's decision was upheld);
- 43 cases were remanded back to the Department for further review;
- 37 cases were pending as of April 2018;
- 34 cases were reversed or overturned; and
- 26 cases were settled.

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## Chapter Two

# INVESTIGATION PROTOCOL

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## CHAPTER CONCLUSIONS

The Department has established administrative rules and extensive policies and procedures that delineate the investigations process and protocol to be followed during investigations. The protocol includes timelines to be followed, interviews to be conducted, forms to be completed, and documentation to be collected in completing investigations of child abuse and neglect. However, we found that the Department did not always follow procedures in conducting investigations.

For the audit period, the Department did not comply with investigator assignment requirements delineated in the B.H. Consent Decree. The B.H. Consent Decree requires that each child protective services investigator be assigned no more than 12 new abuse or neglect investigations per month during nine months of a calendar year and during the other three months of the calendar year, no more than 15 new investigations per month. Our analysis of primary assignments for FY15-FY17 showed that 78.7 percent of investigators (729 of 926) had at least 1 month during the audit period in which they received more than 15 new assignments. Further, our analysis showed that 32 investigators averaged more than 15 case assignments per month for the entire three-year period. In addition, there were 114 investigators who did not receive assignments for all 36 months and averaged more than 15 assignments per month for the months worked during the period.

We could not document that the Department had evaluated the reliability and validity of the Child Endangerment Risk Assessment Protocol (CERAP) as required by the Children and Family Services Act (20 ILCS 505/21(e)). The CERAP is a six-page safety assessment protocol designed to provide investigators with a mechanism for quickly assessing the potential for moderate to severe harm to children in the immediate or near future and for taking quick action to protect them. The Department also could not provide specific CERAP training procedures required by statute.

### **Status and Final Determination of Investigations**

Our analysis for the three-year period FY15-FY17, **as of July 27, 2018**, showed that the status for a majority of cases, 142,766 of 221,341 investigations or 64.5 percent, was classified as expunged. Expunged investigations for the period were unfounded investigations in which most information, including the name of the alleged perpetrator, had been hidden or removed from the investigation information. An additional 78,520 (35.5%) investigations were classified as closed. For the remaining 55 investigations:

- 22 were undetermined (3 cases were FY16 and 19 cases were FY17)
- 18 were in appeal (15 cases were FY15, 1 case was FY16, and 2 cases were FY17);
- 9 were purged or concealed (all were FY15 cases);
- 3 were in review (one from each fiscal year);
- 2 were in a 20-day hold (both were FY17 cases); and
- 1 was pending approval (an FY17 case).

According to data provided by the Department, 25.5 percent of investigations (56,457 of 221,341) for the three-year period FY15-FY17 had a final determination or finding of indicated, meaning there was credible evidence that the allegation occurred. For 74.5 percent of all investigations the status was unfounded (164,864 of 221,341 investigations). As of July 2018, there were 20 investigations for FY16 and FY17 that were listed as pending.

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## INVESTIGATION PROCESS

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The Department of Children and Family Services (Department or DCFS) is mandated by the Abused and Neglected Child Reporting Act (ANCRA) to investigate allegations of child abuse or neglect (325 ILCS 5/2). The definitions for what constitutes abuse and neglect are established by the Act (325 ILCS 5/3), and the specific allegation types of abuse and neglect are described in the Department's Procedures 300 Appendix B.

The Department did not always follow procedures in conducting investigations. The Department has established a formal investigative protocol by promulgating administrative rules and developing written policies and procedures. These processes and protocol include establishing timelines to be followed, interviews to be conducted, forms to be completed, and documentation to be collected in completing investigations of child abuse and neglect. The Department's administrative rules govern how child abuse and neglect is reported and how such reports are handled and investigated (89 Ill. Adm. Code 300). Department procedures (Procedures 300) cover the investigation process in more detail from the point at which a report is received alleging a child may have been abused or neglected to the completion of the investigation and is more than 500 pages. The following sections discuss the investigations process and protocol, including requirements and timelines. *Exhibit 2-1* shows a basic overview of the investigation process.

### Reporting Allegations

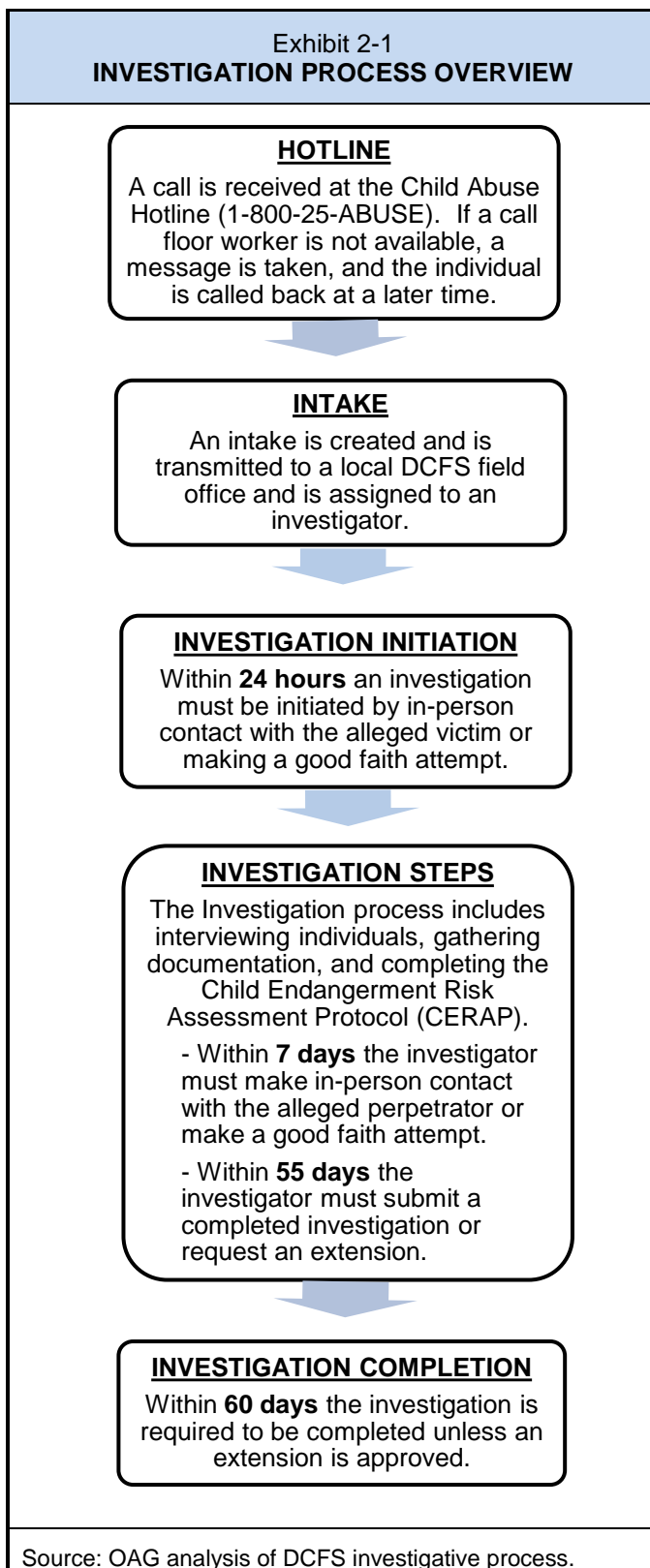
Protecting children involves a strong system of screening reported allegations, a properly assessed "front end" investigation, effective use of investigative tools, and timely service delivery. The process of investigating suspected child abuse and neglect begins at the SCR (State Central Register). Call floor workers at the SCR receive calls through the Child Abuse Hotline. All reports of suspected child abuse or neglect made under ANCRA are required to be reported immediately by telephone to the SCR's toll-free telephone number (1-800-25-ABUSE) established by the Act. Reports can also be made in person or by telephone through the nearest Department office (325 ILCS 5/7). The Department is required to be capable of receiving reports of suspected child abuse or neglect 24 hours a day, 7 days a week (325 ILCS 5/7.4).

When a report of abuse or neglect is received, call floor workers at the SCR enter information into the Statewide Automated Child Welfare Information System (SACWIS). Reports are required to include, if known, information such as the name and address of the child and his parents or other persons having custody, the child's age, and the nature of the child's condition including any evidence of previous injuries or disabilities (325 ILCS 5/7).



Call floor workers at the SCR take steps to gather information and to determine whether the alleged abuse or neglect is “reportable” and the proper response. To be reportable and sent on for investigation, three criteria must be met. There must be: (1) an eligible perpetrator, (2) an eligible victim, and (3) a specific incident or set of circumstances. Victims must be under 18 years of age or between the ages of 18 and 22 if living in a Department licensed facility. For abuse, eligible perpetrators include the victim’s parent, immediate family member, someone who resides in the same household, anyone who is responsible for the child’s welfare when the incident occurred, a parent’s significant other, or any person who knows the child through an official capacity or is in a position of trust. For neglect allegations, perpetrators must be a parent or any other person who is responsible for the care of the child when the neglect occurred.

If the call is determined to be reportable, it is sent to a local field office for investigation. Before the report is sent to the field office, the call floor worker has to establish what type of response the report will receive, which determines how quickly an investigator will respond to the report. If the call is deemed to be out of jurisdiction, the call is entered into SACWIS and is available for use as related information for concurrent active investigations or if a later call prompts an investigation. These reports may also be referred to other agencies or law enforcement.

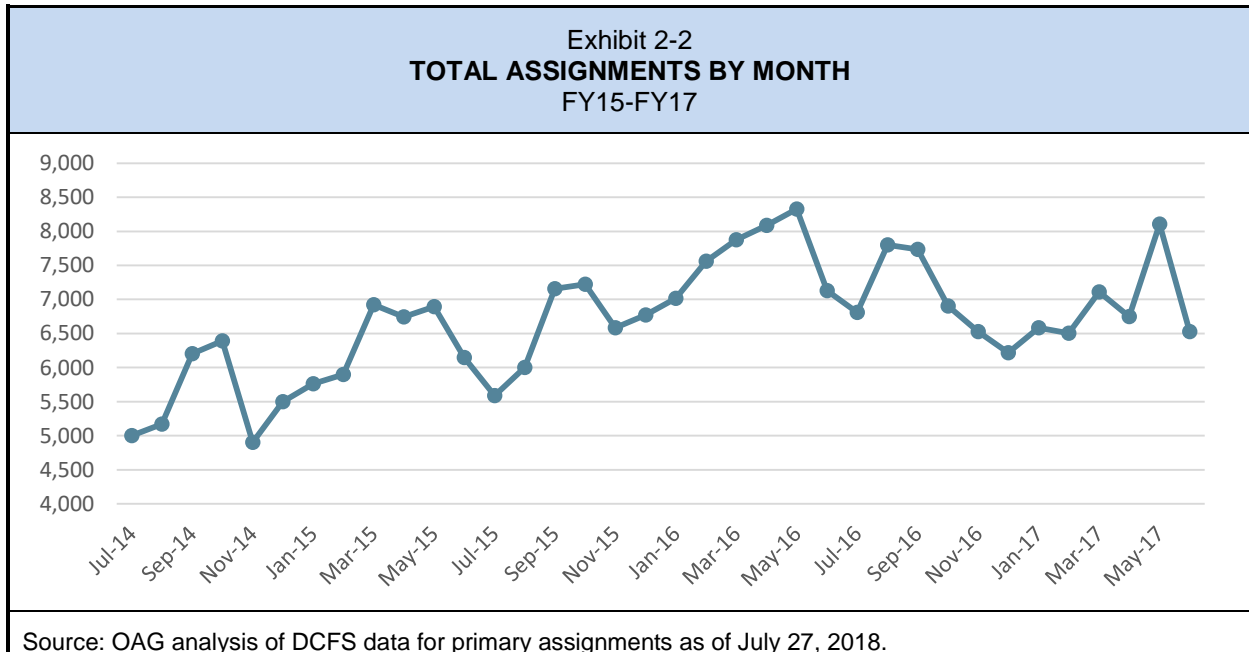


### Investigator Assignments and Caseloads

The Department should take steps to decrease the number of investigations assigned to each investigator in order to comply with the requirements of the B.H. Consent Decree. Allegations that are determined to be reportable are assigned geographically, based on the child’s address, to a local field office. Once the Hotline staff determines the allegation is reportable, it must be sent to the local field office within one hour of receipt of the report (Procedures 300.40(a)).

The field offices receive the investigation assignment electronically via a local mailbox in SACWIS. The investigation is assigned to an investigator (Child Protection Specialist or Advanced Specialist) by a supervisor at the field office. According to Department procedures, the supervisor should assign reports based on rotation, with due consideration given to the experience, expertise, and availability of staff (Procedures 300.70(c)(1)). Investigators given the primary assignment have the responsibility to complete the investigation within 60 days. For case load analysis purposes, the Department tracks primary assignments lasting more than 24 hours.

We analyzed investigator assignment data provided by the Department for the period FY15-FY17 for primary assignments lasting more than 24 hours and found that total monthly investigator assignments increased from 5,001 in July 2014 to 6,527 in June 2017 or 30.5 percent. Of particular note is the dramatic increase between July 2014 and May 2016 from 5,001 monthly assignments to 8,326 monthly assignments. This represents a 66.5 percent increase over a 23 month period (see *Exhibit 2-2*). During the same period the number of investigators with assignments dropped from 544 in July 2014 to 497 in May 2016.



Case assignments were extremely high during FY15-FY17 for certain field offices. *Exhibit 2-3* shows the ten investigators with the most total assignments during the period. As can be seen in the exhibit, the top ten investigator assignments are dominated by the Northern area of the State. Specifically, they include field offices in Joliet, Rockford, and Waukegan.

Exhibit 2-3 TOP 10 INVESTIGATORS WITH THE MOST ASSIGNMENTS BY FISCAL YEAR FY15-FY17						
Investigator	Field Office(s)	Region	FY15	FY16	FY17	Total
1	Joliet/Waukegan	Northern	242	364	237	843
2	Rockford/Joliet	Northern	163	433	212	808
3	Rockford	Northern	176	299	252	727
4	Rockford/Joliet/Waukegan	Northern	152	384	182	718
5	Waukegan	Northern	149	252	309	710
6	Rockford	Northern	157	275	266	698
7	Various	Central	183	251	246	680
8	Rockford	Northern	155	260	259	674
9	Joliet	Northern	163	392	108	663
10	Joliet/Cook South	Northern/Cook	187	288	176	651

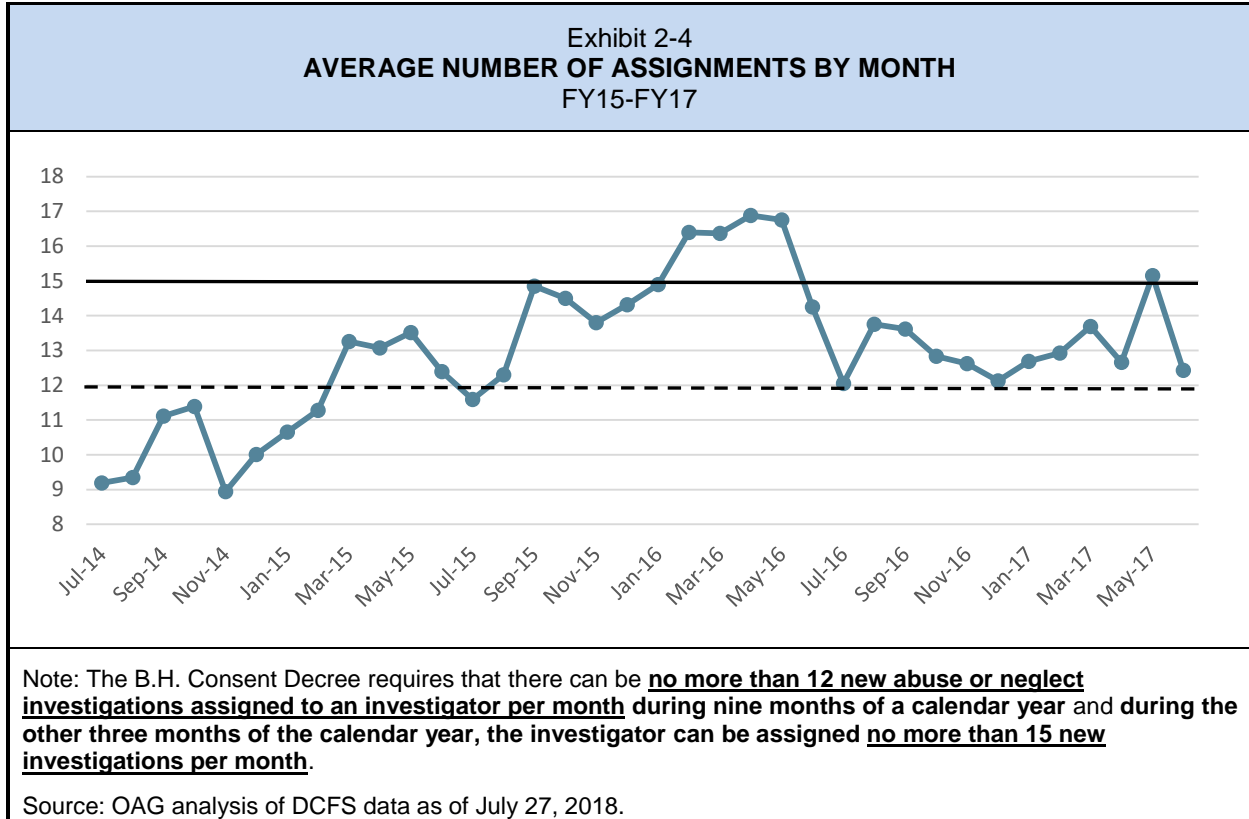
Source: OAG analysis of DCFS data for primary assignments as of July 27, 2018.

### B.H. Consent Decree Investigation Assignment Requirements

The Department is not complying with investigator assignment requirements delineated in the B.H. Consent Decree. In 1988, a class action lawsuit was filed against the Department alleging that it failed to provide adequate services to children in its custody. In 1991, the parties entered into a consent decree known as the B.H. Consent Decree (88 C 5599 (N.D. Ill.)). The parties filed a restated consent decree in 1997 and have continued to modify the Consent Decree as needed. As part of our review of Department protocols for investigating reports of child abuse and neglect, we reviewed the B.H. Consent Decree. The Consent Decree included a provision that states:

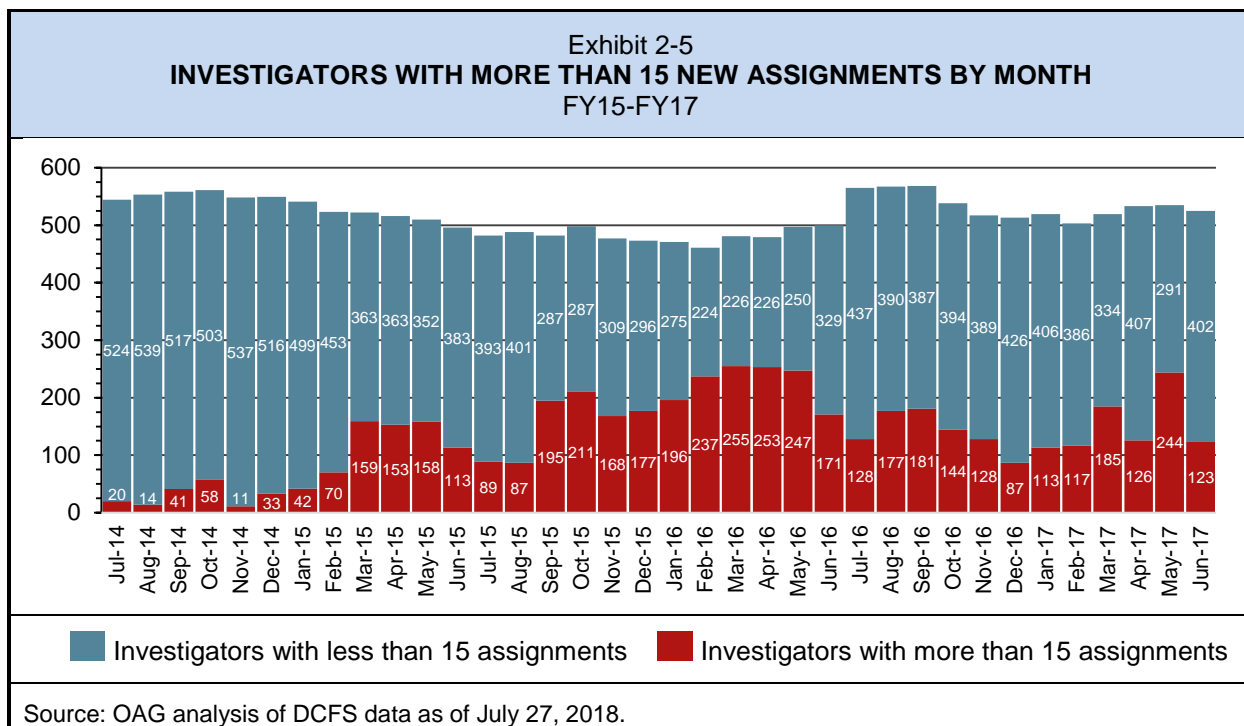
*By July 1, 1993, each DCFS child protective services investigator will be assigned no more than 12 new abuse or neglect investigations per month during nine months of a calendar year. During the other three months of the calendar year, the investigator will be assigned no more than 15 new abuse or neglect investigations per month.*

Our analysis of primary assignments showed that 926 different investigators received at least one assignment during the period. Of these, 729 or 78.7 percent had at least 1 month during the period in which they received more than 15 primary assignments. In June 2016, an investigator received 113 primary assignments in a single month. *Exhibit 2-4* shows the average number of assignments by month for the three fiscal years. Our analysis showed that 32 investigators averaged more than 15 case assignments per month for the entire three-year period. Further, an additional 114 investigators who did not receive assignments for all 36 months averaged more than 15 assignments per month for the months worked during the period.



Using the criteria for assignments contained in the B.H. Consent Decree, a child protective services investigator should not receive more than 153 new assignments annually. Because the B.H. Consent Decree investigation assignment requirement is based on a calendar year, we also reviewed calendar year 2015 and calendar year 2016. These were the only years for which we had complete calendar year information. For calendar years 2015 and 2016, 36.8 percent and 36.1 percent of investigators respectively were assigned more than 153 primary assignments and were therefore in violation of the B.H. Consent Decree.

*Exhibit 2-5* shows that as the total number of investigators decreased during FY16, the higher the percent of investigators who were out of compliance with the B.H. Consent Decree’s maximum allowable new assignments of 15 new assignments. The exhibit also shows that for February through April 2016 over half of all investigators were out of compliance.



Investigators who are overloaded with new assignments may be more prone to make mistakes and put children involved in their investigations at serious risk. It may also lead to investigator burnout and high turnover. Ensuring more reasonable caseloads would benefit the Department in achieving positive outcomes for children and families.

<b>INVESTIGATOR ASSIGNMENTS</b>	
<b>RECOMMENDATION 2</b>	<i>The Department of Children and Family Services should take steps to ensure investigator assignments are in compliance with the requirements of the B.H. Consent Decree.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	The Department of Children and Family Services (“Department”) has taken steps to ensure that investigator assignments are in compliance with the requirements of B.H. Consent Decree. The Department has established internal monthly meetings with the Regional Administrators from the Operations Division and the Office of Legal Services to review caseloads in order to maintain compliance with the B.H. Consent Decree. The Department meets with the plaintiff’s in the B.H. case monthly to discuss caseloads. The Department provides a monthly report to the B.H. plaintiffs on caseloads. The Department has created DAI positions to assure adequate staffing for investigations.

### Child Endangerment Risk Assessment Protocol

Child Endangerment Risk Assessment Protocols (CERAPs) were not always completed by investigators and private agency staff providing services. Further, for those cases in which

the CERAP was completed, it was not always completed in a timely manner. The Department could not provide documentation to show that the reliability and validity of the protocol had been evaluated during the audit period as required by statute. The Department also could not provide written procedures for training related to the CERAP as required by statute.

The CERAP is a six-page safety assessment protocol used through all stages of involvement with the Department, including child protection investigations (Form CFS 1441). This “life-of-the case” protocol is designed to provide investigators with a mechanism for quickly assessing the potential for moderate to severe harm to children in the immediate or near future and for taking quick action to protect them. Department employees as well as service providers utilize the protocol at specified milestones throughout an investigation or child welfare case to help them determine whether a child is safe or unsafe, and if unsafe, decide what actions must be taken to assure their safety. When immediate risk to a child’s safety is identified, the protocol requires that action be taken, such as the implementation of a safety plan or protective custody. Any child safety threats identified as the result of the CERAP must be incorporated into the SACWIS Family Service Plan.

**CERAPs Completed During Investigations**

**Investigators are required to complete at least one CERAP for every non-facility investigation.** The CERAP is required to be completed:

- Within 24 hours after the investigator first sees the child.
- Whenever evidence or circumstances suggest that a child’s safety may be in jeopardy.
- Every 5 working days following the determination that a child is unsafe and a safety plan is implemented.
- At the conclusion of the formal investigation, unless temporary custody is granted or there is an open intact case or assigned caseworker. The safety of all children in the home, including alleged victims and non-involved children, must be assessed.

Any child safety threats identified as the result of the CERAP are required to be incorporated into a Family Service Plan. The supervisor or designee is required to approve the CERAP within 24 hours after the worker has completed it, if a safety threat has been marked “unsafe” (Procedures 300 Appendix G).

We reviewed investigations data provided by the Department for FY15-FY17 to determine if initial CERAPs were being completed and whether it was within the required timeframes. There were 130 investigations where a CERAP was not completed after contact with the victim as required. The number remained steady for all three fiscal years, with 43 in FY15, 45 in FY16 and 42 in FY17.

A CERAP must be completed within 24 hours after the investigator first sees the alleged victim. We reviewed the time from contact with the victim to the time the first CERAP was approved and found that a CERAP is not always completed in a timely

Exhibit 2-6 INITIAL CERAP TIMELINESS FY15-FY17			
	FY15	FY16	FY17
Not Timely	13.9%	10.1%	6.4%
Timely	79.8%	81.7%	85.1%
Unknown/Other <sup>1</sup>	6.3%	8.2%	8.5%
<sup>1</sup> Unknown/Other includes investigations in which information needed to calculate timeliness was blank or returned a negative value, such as when a CERAP was not required. Source: OAG analysis of DCFS data as of July 27, 2018.			

manner. However, as shown in *Exhibit 2-6* CERAP timeliness of completion appeared to improve during the audit period from 79.8 percent in FY15 to 85.1 percent in FY17.

As part of our sample of 150 indicated investigations we also reviewed whether the final CERAPs were being conducted at the completion of the investigation. For 35 of 150 investigations (23.3%) we determined that the investigation did not have a final CERAP conducted and there was no valid exception (i.e., a services case was opened or the supervisor waived the requirement).

### **CERAP Completed During Intact Family Services**

Intact Family Services (IFS) and other services are discussed in Chapter Four. If the case involves IFS, a CERAP is required to be completed by the Department or the private agency:

- Within 5 working days after initial case assignment and upon any and all subsequent case transfers.
- Every 90 calendar days from the case opening date.
- Whenever evidence or circumstances suggest that a child’s safety may be in jeopardy.
- Every 5 working days following the determination that a child is unsafe and a safety plan is implemented.
- Within 5 working days of a supervisory approved case closure.

As part of our sample of 150 indicated investigations, we also reviewed whether CERAPs were being completed at the beginning and end of services and whether it was within the required timeframes for applicable cases. One IFS case did not have a required CERAP at the end of the services. Three of 19 IFS cases (15.8%) did not have the initial CERAP completed within 5 business days of case opening, and two IFS cases (10.5%) did not have the final CERAP completed within 5 business days of case closing.

The University of Illinois Children & Family Research Center prepares a report for the Department annually regarding the CERAP. The FY18 CERAP Annual Evaluation utilized FY14-FY17 data to assess whether those providing Intact Family Services (IFS) were completing the CERAP as required. Overall the report concluded that:

- No CERAP was completed for some IFS cases. This ranged from 16.2 percent for FY15 to 12 percent for FY17.
- CERAPs were not always completed timely for IFS cases. This ranged from 26.2 percent for FY15 to 20 percent for FY17 that were not completed within 15 days of the case open date (a CERAP is required to be completed within 5 working days after initial assignment).
- For IFS cases open more than 90 days, CERAPs were not always completed as required. For 33.5 percent in FY15, 30.0 percent in FY16, and 37.2 percent in FY17, CERAPs were not completed as required.
- For IFS cases that had a CERAP that determined the child to be unsafe, another CERAP was not always completed as required within 5 days. This ranged from 36.5 percent in FY15 to 31.2 percent in FY17.

### **Compliance With Statutory CERAP Requirements**

The Department did not comply with provisions of the Children and Family Services Act that require the Department to evaluate the reliability and validity of the CERAP. The Department also could not provide CERAP training procedures as is required by statute.

The Children and Family Services Act (20 ILCS 505/21(e)) requires that the Department shall develop and implement the following:

- (1) A standardized child endangerment risk assessment protocol.
- (2) Related training procedures.
- (3) A standardized method for demonstration of proficiency in application of the protocol.
- (4) An evaluation of the reliability and validity of the protocol.

The Act also requires the Department to report to the Illinois General Assembly annually on the evaluation of the reliability and validity of the CERAP. Although, the Department provided documentation to show it had completed and submitted CERAP annual evaluation reports to the General Assembly, **these reports did not contain conclusions regarding the reliability and validity of the Protocol.**

The Department could not provide CERAP training procedures that were also required to be implemented by the Act. Department officials provided auditors with CERAP training materials as well as general training procedures. However, they could not provide specific training procedures for CERAPs.

When auditors inquired about the annual evaluations, officials replied that the evaluation does assess the reliability and validity of the CERAP. Testing to see if a CERAP has been completed is an aspect of the protocol's reliability. However, if the only way the reliability of the CERAP is assessed is by completion rates, there's no measure of whether the CERAP was completed correctly. Department investigators deal with heavy workloads and there could be pressure to make sure the CERAP is completed on time, without necessarily ensuring it was properly or fully completed.

Because the Department is not evaluating the reliability and validity of the CERAP, it cannot ensure that the protocol is effective and ensures the safety of children. Written training procedures for investigators would help ensure consistent use of the protocol.



<b>CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL</b>	
<p><b>RECOMMENDATION</b></p> <p><b>3</b></p>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Ensure that CERAPs are completed for investigations and that they are completed in a timely manner;</i></li> <li>• <i>Ensure that CERAPs are completed and that they are completed in a timely manner when Intact Family Services are provided; and</i></li> <li>• <i>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.</i></li> </ul>
<p><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The Department has management reports in place for both intact and investigations that identify activity regarding CERAP completion. Supervisors will be trained on the reports and reminded of the need to ensure CERAPS are completed within procedure timeframes. This will be completed within the next 90 days. The CERAP Citizen Advisory group will ensure their ongoing research projects address validity and reliability as defined by the auditors; the next project is due by May 2020. Written procedures related to CERAP training will be enhanced to reflect the requirements of the Children and Family Services Act by October 2019. A random selection of cases will be reviewed quarterly by the Compliance Administrator to address timely completion.</p>

## STATUS OF ABUSE AND NEGLECT INVESTIGATIONS

House Resolution Number 418 asks the Auditor General to review the status of abuse and neglect investigations for FY15, FY16, and FY17. The status of abuse and neglect investigations may be classified as Closed, Expunged, Undetermined, In Appeal, In Review, 20-Day Hold, Purged/Concealed, and Pending Approval.

The status codes used in SACWIS are generally not defined in either the statutes, administrative rules, or in the Department’s investigative procedures. Therefore, auditors developed the definitions for each status code, and Department officials reviewed and commented on the descriptions.

- **Expunged** - An unfounded investigation where the records are unviewable or an indicated investigation in which the retention period has lapsed. According to ANCRA, all information identifying the subjects of an unfounded report shall be expunged from the register, except as provided by statute. Examples of exceptions included are for an intentional false report or the death of a child.
- **Closed** - An investigation has been completed, a decision has been rendered on the case, and it has been approved and closed.
- **Undetermined** – The investigation could not be completed within the required 60 days. These investigations are usually waiting for additional information; the finding may or may not be determined based on what information is pending.

- **In Appeal** – An investigation that has been appealed and is currently going through the appeal process.
- **Purged or Concealed** – The investigation retention period is up for a specific individual, but there may be more perpetrators listed, or the subjects of the report are involved with another report/case in the system; the person for whom the retention period is up will be purged/concealed within the investigation. This is an automatic function set up within SACWIS.

Exhibit 2-7 STATUS OF INVESTIGATION FY15-FY17				
Case Status	FY15	FY16	FY17	Total
Expunged	46,570	51,024	45,172	142,766
Closed	21,137	27,543	29,840	78,520
Undetermined	-	3	19	22
In Appeal	15	1	2	18
Purged or Concealed	9	-	-	9
In Review	1	1	1	3
20-Day Hold	-	-	2	2
Pending Approval	-	-	1	1
<b>Total</b>	<b>67,732</b>	<b>78,572</b>	<b>75,037</b>	<b>221,341</b>
Source: OAG analysis of DCFS investigations data as of July 27, 2018.				

- **In Review** – An investigation that is awaiting a mandated reporter’s second review. These are performed by the Department Compliance Manager or Area Administrators.
- **20-Day Hold** - An investigation that is waiting for a response from the mandated reporter. If an investigation is unfounded the mandated reporter has the right to request a review. If the mandated reporter does not respond, the investigation reverts to closed at the end of 20 days.
- **Pending Approval** – An investigation that is currently awaiting supervisory approval in order to be completed.

The Department provided auditors with investigations data for all intakes completed during FY15, FY16 and FY17, as of July 27, 2018. Our analysis for the three-year period showed that a majority of cases (142,766 investigations or 64.5%) were classified as expunged (see *Exhibit 2-7*). Expunged investigations for the period were unfounded investigations in which most information, including the name of the alleged perpetrator, had been hidden or removed from the investigation information. An additional 78,520 (35.5%) investigations were classified as closed. For the remaining investigations:

- 22 were undetermined (3 cases were FY16 and 19 cases were FY17);
- 18 were in appeal (15 cases were FY15, 1 case was FY16, and 2 cases were FY17);
- 9 were purged or concealed (all were FY15 cases);
- 3 were in review (one from each fiscal year);
- 2 were in a 20-day hold (both were FY17 cases); and
- 1 was pending approval (an FY17 case).

## FINAL DETERMINATIONS AND FINDINGS

House Resolution Number 418 asks the Auditor General to review the final determination or finding of abuse and neglect investigations for FY15, FY16, and FY17. A determination is the final Department decision about whether there was credible evidence that child abuse or neglect occurred.

The final determination or finding of abuse and neglect investigations may include indicated, undetermined, or unfounded. Below is a description of each type of determination.

- **Indicated** – Credible evidence of abuse or neglect has been obtained pertinent to the allegation.
- **Unfounded** – Credible evidence of abuse or neglect has not been obtained.
- **Undetermined (Pending)** – Investigative staff have been unable, for good cause, to gather sufficient facts to support a decision within 60 days of the date the report was received. Additional periods of 30 days may be permitted to complete the investigation, after which a determination is made.

According to data provided by the Department, 25.5 percent of investigations (56,457 of 221,341) for the three-year period FY15-FY17 had a final determination or finding of indicated, meaning there was credible evidence that the allegation occurred. For 74.5 percent of all investigations the status was unfounded (164,864 of 221,341 investigations) (see *Exhibit 2-8*).

Exhibit 2-8 FINAL DETERMINATION (FINDING) FY15-FY17				
Finding	FY15	FY16	FY17	Total
Indicated	19,156	18,710	18,591	56,457
Unfounded	48,576	59,860	56,428	164,864
Pending	0	2	18	20
<b>Total</b>	<b>67,732</b>	<b>78,572</b>	<b>75,037</b>	<b>221,341</b>
Source: OAG analysis of DCFS investigations data as of July 27, 2018.				

As of July 2018, there were 20 investigations for FY16 and FY17 that were listed as pending, which we interpreted to mean undetermined, and therefore a final determination had not been made. Of these 20 investigations, 2 were from FY16 and 18 were from FY17. These investigations generally involved allegations of death or sexual abuse and/or an investigation in which law enforcement is involved. These investigations may take a considerable amount of time because investigators may be waiting for medical reports from a medical examiner or coroner and may involve criminal prosecution.



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## Chapter Three

# INVESTIGATION TIMEFRAMES

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## CHAPTER CONCLUSIONS

We found that the Department needs to improve timeliness in several areas. The Department is not timely in completing intakes from callers reporting allegations of abuse and neglect. The hotline did not meet targets and call backs increased substantially during FY15-FY17, from 39.6 percent to 55.7 percent of total calls. The Department also does not have written procedures regarding the process for calling back individuals who report allegations of abuse or neglect that do not complete the intake process at the time of their initial call. Further, the Department does not maintain call back information electronically in SACWIS for more than 90 days, which makes any long-term analysis of call back timeliness difficult.

According to investigations data provided, the Department was timely in initiating investigations for approximately 99 percent of investigations. However, required interviews with the alleged victim and perpetrator were not always completed in a timely manner. With data provided by the Department, we reviewed the timeliness of interviews with the alleged victim(s) based on whether actual contact was made and found that the alleged victim was not interviewed within 24 hours in 29.1 percent of cases for the audit period FY15-FY17. The alleged perpetrator was not interviewed within 7 days in 24.5 percent of cases for the audit period.

The overall timeliness of completion for investigations declined significantly over the three-year period FY15-FY17. In FY15, 7.6 percent of investigations were not completed within 60 days. For FY16, the percentage of investigations not completed within 60 days increased to 16.0 percent. It remained elevated in FY17 at 12.4 percent of investigations not completed within 60 days.

We reviewed the timeliness of submission of the completed investigation to the supervisor and found that for the audit period FY15-FY17, 44.2 percent of all reports without extensions were not submitted within 55 days. The highest rate of noncompliance was for FY16, in which 51.2 percent of reports did not meet the 55 day requirement for submission to the supervisor, according to data provided by the Department.

The Department's difficulty in completing investigations in a timely manner during the audit period is further demonstrated by the number and percentage of investigations that received a 30-day extension. The percentage of cases receiving one or more extensions increased from 7.5 percent in FY15 to 16.1 percent in FY16 and 12.7 percent in FY17. Further, the number of investigations receiving multiple extensions also increased significantly. For instance, the number of investigations that received three extensions (an additional 90 days) increased from 274 investigations in FY15 to 1,263 investigations in FY16 and 719 investigations in FY17. In our review of cases involving an extension, it was also not always clear what the cause for the extension was or whether it rose to the level of "good cause."

## INVESTIGATION TIMELINESS

We found that the Department needs to improve timeliness in several areas. We reviewed the timeliness of completing intakes, initial assignment, conducting interviews with the alleged victim and perpetrator, and overall completion and closure of allegations that were investigated during FY15, FY16, and FY17.

DCFS rules (89 Ill. Adm. Code 300.90) require that within **24 hours** investigators must:

- Begin or make a good faith attempt to begin the initial investigation.
- Make in-person contact with the alleged victim or examine the environment for inadequate shelter and environmental neglect.
- If applicable, contact the mother of an infant hospitalized with a controlled substance in its system.

The investigation will begin immediately (the DCFS investigator has to respond within 15 minutes of receiving the report) if the child is in immediate danger or if the family may flee with the child. A report can also receive an “action needed” response which means that the assigned investigator and supervisor have to review the report within 60 minutes of receiving the report and determine what action is necessary (Procedures 300.50(f)).

### Hotline Timeliness and Callbacks

The Department is not timely in completing intakes from callers reporting allegations of abuse and neglect. For approximately half of all calls during the audit period an intake could not be initiated because a call floor worker was not available resulting in a message being taken. The Department also does not have written procedures regarding the process for calling back individuals who report allegations of abuse or neglect that do not begin the intake process at the time of their initial call. Finally, the Department does not maintain call back information electronically in SACWIS for more than 90 days, which makes any long-term analysis of performance and call back timeliness difficult.

The Department is required by statute to be capable of receiving reports of suspected child abuse or neglect 24 hours a day, 7 days a week (325 ILCS 5/7.4a). This is accomplished through a hotline at the State Central Register (SCR). According to Department administrative rules the time the report was received at the State Central Register begins the investigative process (89 Ill. Adm. Code 300.90).

#### Required Timeframes

- **1 Hour** – If the Hotline determines the allegation is reportable, it must be sent to the local field office within one hour of receipt of the call.
- **24 Hours** – In-person contact with alleged victim or examination of the environment for inadequate shelter and environmental neglect. Begin or make a good faith effort to begin the initial investigation.
- **7 Days** – In-person contact with the alleged perpetrator. Contact with caretaker and alleged victim if not completed sooner.
- **55 Days** – Investigator must submit the completed investigation to supervisor.
- **60 Days** – Final Investigation Report or the Preliminary Investigation Report if a 30-day extension is necessary.

During certain times at the hotline there are more incoming calls than there are call floor workers to take them. When this occurs, a message is taken and the reporter is called back when a call floor worker becomes available. Auditors visited the SCR Hotline and observed the operations on February 6, 2018. According to officials, the hotline at that time had 89 call floor workers and 21 current vacancies. On the day of our visit to the hotline we noted that there were 579 calls that were in the queue waiting to be returned. According to the SCR Administrator at the time, when messages are taken the calls are triaged and called back. Those with safety concerns go to the top of the list.

The Department could not provide electronic call back information for the audit period. We requested call back information for the audit period and were informed that the Department only maintains call back information in SACWIS for the most recent 90-day period. After that the information is rolled off the system and deleted.

Although electronic call back information was limited, we were able to review hardcopy summary reports at the SCR in order to gather some general information about FY15-FY17 hotline operations and call backs. The SCR Hotline has an established target goal of answering 75 percent of all calls with no more than 25 percent call backs. **Auditors requested any policies or procedures for call backs; however the Department did not provide any.**

The SCR summary reports we reviewed showed that the hotline did not meet targets and that call backs had in fact increased substantially during FY15-FY17, from 39.6 percent to 55.7 percent of total calls (*see Exhibit 3-1*).

During the course of the audit, we were able to obtain a 90-Day Call Back report for the period April 4, 2018, to July 2, 2018. The report contained a total of 43,775 messages taken. The number of attempts to call back ranged from 0 to 6 calls. We analyzed the time from the initial call to the first attempted call back and found that on average it took approximately 23.3 hours to the first attempt to call back the individual reporting the allegation. Call back times ranged from 0 minutes to 6 days 22 hours from the initial call. Of particular note is that for 35.4 percent of the call backs in the 90 day report an intake was never created.

Further, we analyzed the call back information by the type of priority (Normal, Urgent, or Emergency) and found that it can potentially take days for DCFS to call back reporters of child

**Call Back Priority**

**Emergency** – If it’s an emergency child safety issue, the call back is labeled as Emergency and a worker either takes the call right then or calls back within 15 minutes.

**Urgent** – An urgent call back is a call back that is labeled Urgent in order to demonstrate that there is a reporter who is available now but may not be available for long (i.e., getting ready to go off shift, etc.).

**Normal** – A normal call back means that it is not an emergency child safety issue and the caller is making him/herself available even after their work shift (cell phone etc.) and can be called back at any time.

Source: DCFS officials.

Exhibit 3-1 PERCENTAGE OF CALLS TAKEN AS MESSAGE FY15-FY17			
FY	Call Volume	Messages Taken	Percent
2015	222,719	88,291	39.6%
2016	245,388	129,211	52.7%
2017	252,568	140,773	55.7%
<b>Total</b>	<b>720,675</b>	<b>358,275</b>	<b>49.7%</b>
Source: OAG analysis of DCFS hardcopy hotline reports.			

abuse and neglect. *Exhibit 3-2* shows that for calls with a “Normal” response code, 58.3 percent took more than 24 hours until the first attempt to call back the reporter with 37.4 percent taking more than 2 days. Even more concerning is that approximately 35 percent of “Urgent” calls took more than 24 hours and 10.1 percent of “Emergency” calls took more than an hour to the first attempted call back. It should be noted that our analysis is to the first attempted call back, which does not necessarily mean that contact was made with the reporter to complete the intake so that the investigation could begin.

Exhibit 3-2 TIME TO FIRST CALL BACK ATTEMPT BY PRIORITY April 4, 2018 through July 2, 2018								
Timeframe	Normal	%	Urgent	%	Emergency	%	Total	Total %
0 to 15 minutes	466	3.4%	2,687	14.2%	6,838	65.1%	9,991	23.2%
15 to 30 minutes	263	1.9%	1,512	8.0%	1,720	16.4%	3,495	8.1%
30 to 60 minutes	352	2.6%	1,640	8.7%	889	8.5%	2,881	6.7%
60 minutes to 24 hours	4,599	33.8%	6,433	34.0%	770	7.3%	11,802	27.4%
24 hour to 48 hours	2,852	20.9%	2,433	12.9%	145	1.4%	5,430	12.6%
More than 48 hours	5,088	37.4%	4,188	22.2%	147	1.4%	9,423	21.9%
<b>Total</b>	<b>13,620</b>	<b>100%</b>	<b>18,893</b>	<b>100%</b>	<b>10,509</b>	<b>100%</b>	<b>43,022</b>	<b>100%</b>
Note: Totals may not add due to rounding. The table excludes messages where an attempt was not made, and call backs that occurred before the message was taken.								
Source: OAG analysis of DCFS provided 90-Day Call Back Report for April 4, 2018-July 2, 2018.								

Within the data provided, there were 747 messages taken for which there was no call back attempt listed. Of those 747, 237 had no call back listed and no intake created. Of the 237, 101 were more than 7 days old as of July 3, 2018. The oldest was an emergency priority message taken on April 5th, or 89 days from the date the report was run.

During the audit, the SCR was working to develop an online reporting system. According to a Department official, the online reporting system went live June 19, 2018, and it can be accessed through the Department’s website. Reports are submitted through an online form. Submissions are monitored by call floor supervisors and assigned to call floor workers. A worker reviews the report and assesses the information to determine if there is enough information to make a determination regarding the intake. If there is enough information the report is moved to SACWIS by the call floor worker and an email is automatically sent to the reporter to inform them of the disposition of the report. If there is not enough information to make a determination, the call floor worker will call the reporter to obtain any needed information. According to a Department official, as of February 4, 2019, the Department had assessed 5,792 online submissions. Increasing the number of individuals utilizing online reporting may reduce the number calling the hotline and therefore the number of messages taken.

The hotline serves a critical function in obtaining intake information about allegations of child abuse and neglect as well as establishing each investigation in SACWIS. If children are in danger of harm, it is important to begin investigations quickly. Seeing children as soon as possible is also critical because perishable evidence such as bruises may fade rapidly, or the willingness of the alleged victim to talk about the incident may be affected. If the hotline does



not establish intakes in a timely manner, investigations are not able to be assigned and initiated in a timely manner. This may leave children in dangerous situations for a longer period of time. Further, delays in initiating investigations could hinder an investigator’s ability to gather critical information and interview witnesses and may affect the final outcome of the investigation.

<b>HOTLINE AND INTAKE</b>	
<p><b>RECOMMENDATION</b></p> <p><b>4</b></p>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Develop formal written procedures for call backs including required timeframes for creating intakes;</i></li> <li>• <i>Ensure that the process for completing call backs is in accordance with written procedures by answering and returning hotline calls in a timely manner;</i></li> <li>• <i>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</i></li> <li>• <i>Continue to increase the utilization of online reporting as appropriate.</i></li> </ul>
<p><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The Department has recently developed written procedures for call backs and training is provided to all call floor staff during new hire training. April 2019 all staff were provided an in -service training on managing call backs. The intake is created through call back once the caller is confirmed available to talk by the hotline worker. If the call is an in call the intake is created at the time the call begins. A specialized Call Back Attempts Response Time report is received daily and weekly. The specialized report is monitored by the SCR administrator and Assistant SCR administrator for call back response times which exceed the weekly average response time. The call backs are reviewed to determine the reason for longer than average response time. The hotline currently tracks daily, weekly, monthly and yearly the message taking rate and the call back response time. The State Central Register implemented approximately 18 months ago shift strategies which are communicated to call floor staff about the managing call backs and in calls. Approximately 12 months ago an additional category “Urgent”, was added to the call back log to assist supervisors and call floor worker to prioritize the call backs by “Emergency”, “Urgent” or “Normal” response call backs. The hotline also tracks and gathers data regarding individual hotline workers and overall -team performance.</p> <p>A strategy is in development to publicize and educate potential on line users by region on the ON LINE REPORTING option and how to access the on-line reporting system.</p>

### Investigation Initiation

The Department could not verify the accuracy of intake start and end times (when the phone call with the reporter began and ended) or the assignment start time (when the report was transmitted to the field office), which hinders the Department’s ability to monitor compliance with statutory requirements. 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. Adm. Code 300.90).

Auditors reviewed the timeliness of reports being transmitted from the SCR to a field office for FY15-FY17 and found that 85,866 of 221,341 (38.8%) first assignments to field offices were transmitted prior to the intake end time. Additionally, of those 85,866 assignments, 191 were transmitted prior to the intake start time.

Auditors followed up with agency officials on October 2, 2018, to ensure we were using the correct fields for our calculations and **to ask why reports would be transmitted prior to the end of the intake, but officials did not respond.** Therefore, it is not known if there are accuracy problems with the intake times, the assignment transmittal times, or both. Because auditors are unable to confirm the accuracy of the intake start and end times, which is the start of the investigative process, the investigation initiation and victim contact timeliness may not be completely accurate.

Because of the Department’s lack of response and limitations in the data provided by the Department, we were unable to determine whether assignments were timely. There are certain types of responses that require investigators to initiate the investigation in less than 24 hours. Emergency responses require investigators to be responding within 15 minutes of the SCR transmitting the report and Action Needed responses require the investigator and supervisor to review the report within 60 minutes of the SCR transmitting the report. For Emergency and Action Needed responses, the timeliness of assigning an investigator is critical to initiation and any delay in transmitting the report to the field can hinder the investigator’s ability to respond in a timely manner.

Investigations are required to be initiated by in-person contact with the alleged child victim or victims within 24 hours of the receipt of the report, or by a good faith attempt to contact the alleged child victim or victims. Based on whether there was a good faith attempt to contact the alleged victim, our analysis of investigation initiation data showed that the percentage not initiated in a timely manner was less than one percent each year (0.7% for FY15, 0.8% for FY16, and 0.9% for FY17) (*see Exhibit 3-3*).

#### Good Faith Attempt

The following constitute good faith attempts to begin the investigation:

- 1) when investigative staff learns, upon proceeding to the location given for the children alleged to have been abused or neglected, that the children have disappeared, the family has fled, the address does not exist, no one is at the location, or not all of the children alleged as abused or neglected are at the location; or
- 2) when the involved child subjects are not accessible; or
- 3) when the adult caretaker refuses to let child protective service staff see or speak with the involved child subject.

Source: 89 Ill. Adm. Code 300.100

Exhibit 3-3 CRITICAL TIMEFRAMES ANALYSIS FY15-FY17				
FY15				
	Investigation Initiation (24 Hours)	Victim Contact (24 Hours)	Perpetrator Contact (7 Days)	Submission to Supervisor (55 Days)
Not Timely	0.7%	28.2%	23.5%	40.7%
Timely	99.0%	70.9%	63.7%	59.3%
Unknown/Other <sup>1</sup>	0.3%	0.9%	12.9%	0.0%
Total <sup>2</sup>	100%	100%	100%	100%
FY16				
Not Timely	0.8%	30.5%	26.2%	51.2%
Timely	98.9%	68.3%	59.0%	48.8%
Unknown/Other <sup>1</sup>	0.4%	1.3%	14.8%	0.0%
Total <sup>2</sup>	100%	100%	100%	100%
FY17				
Not Timely	0.9%	28.6%	23.6%	40.4%
Timely	98.8%	70.3%	62.0%	59.6%
Unknown/Other <sup>1</sup>	0.3%	1.2%	14.4%	0.0%
Total <sup>2</sup>	100%	100%	100%	100%
Total FY15-FY17				
Not Timely	0.8%	29.1%	24.5%	44.2%
Timely	98.9%	69.8%	61.4%	55.8%
Unknown/Other <sup>1</sup>	0.3%	1.1%	14.1%	0.0%
Total <sup>2</sup>	100%	100%	100%	100%
<sup>1</sup> Unknown/Other includes investigations in which information needed to calculate timeliness was blank or returned a negative value.				
<sup>2</sup> Totals may not add due to rounding.				
Source: OAG analysis of DCFS data as of July 27, 2018.				

### Interviewing the Alleged Victim

The Department's administrative rules require in-person contact with the alleged victim be made **within 24 hours** (89 Ill. Adm. Code 300.90). With data provided by the Department we reviewed the timeliness of interviews with the alleged victim(s) based on whether actual contact was made, and as seen in *Exhibit 3-3*, found that the alleged victim was not contacted within 24 hours in 28.2 percent of cases for FY15, 30.5 percent of cases in FY16, and 28.6 percent of cases in FY17. The alleged victim was not interviewed at all in 415 cases in FY15, 726 cases in FY16, and 678 cases in FY17.

If an in-person contact with the alleged victim is not made within 24 hours, according to the Department's rules it must be completed within 7 days. According to data provided, the percentage of alleged victims in which contact was not made within 7 days ranged from 9.2 percent to 13.0 percent for the three years FY15-FY17.

### Interviewing the Alleged Perpetrator

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

timeliness of interviews with the alleged perpetrator and found that the alleged perpetrator was not contacted within 7 days in 23.5 percent of cases for FY15, 26.2 percent of cases in FY16, and 23.6 percent of cases in FY17, as seen in *Exhibit 3-3*. In addition, the alleged perpetrator was not interviewed at all in 8,591 cases in FY15, 11,441 cases in FY16, and 10,688 cases in FY17.

### **Submission of Investigation to Supervisor**

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).

With data provided by the Department, we reviewed the timeliness of submission of the completed investigation to the supervisors and found that for the audit period FY15-FY17, 44.2 percent of all reports **without extensions** were not submitted within 55 days. The highest rate of noncompliance was for FY16, in which 51.2 percent of reports did not meet the 55 day requirement for submission to the supervisor, as seen in *Exhibit 3-3*.

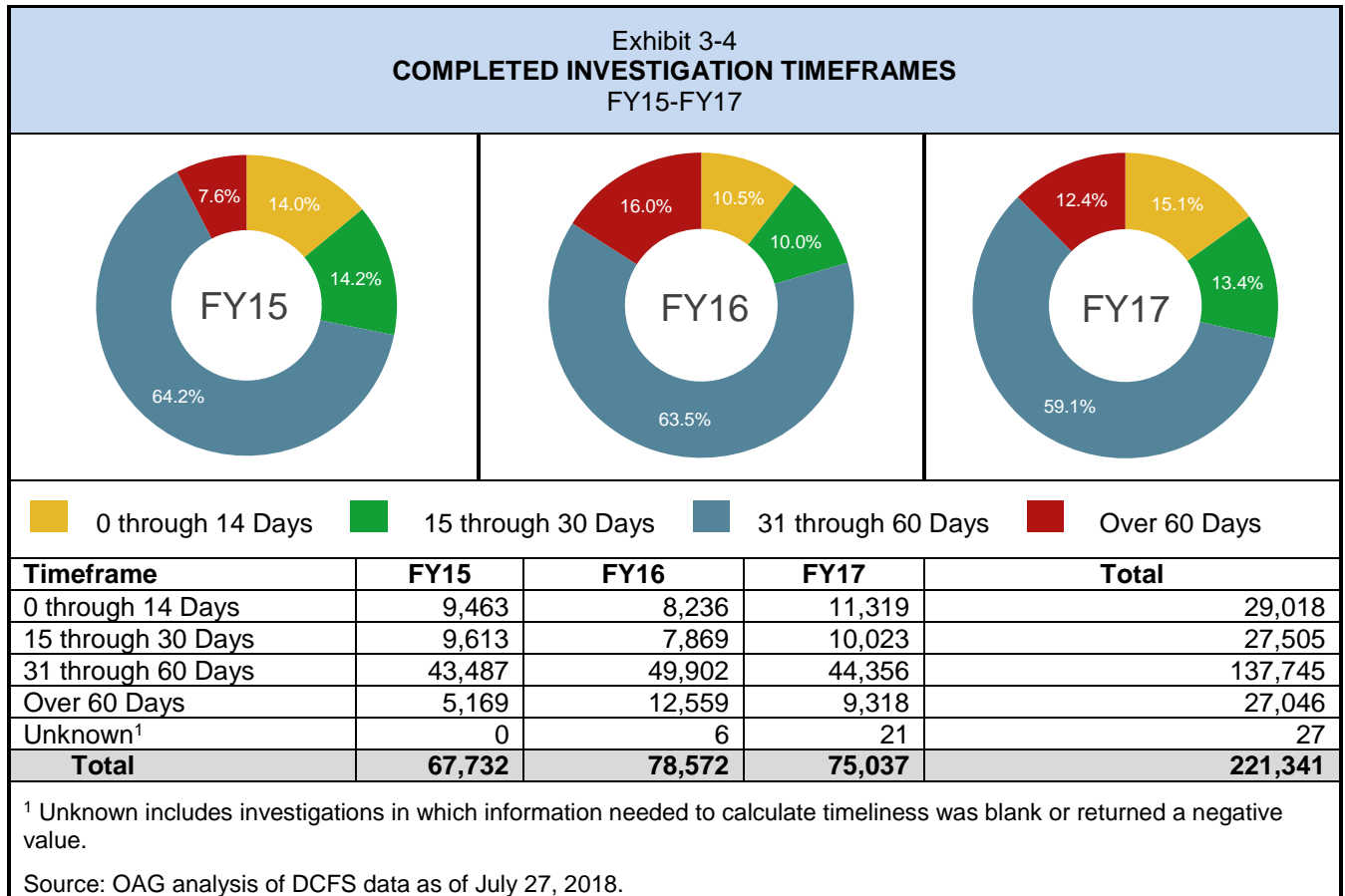
### **Overall Time to Complete an Investigation**

An investigator has **14 days** to make a good faith determination that the alleged abuse or neglect exists. If a good faith report exists, the investigation continues. If a good faith report does not exist, the investigation is terminated (Procedures 300.50(a)).

ANCRA requires the Child Protective Service Unit to determine, within **60 days**, whether the reported allegation is “indicated” or “unfounded” and report the finding to the SCR (325 ILCS 5/7.12). “Indicated” means that it was determined that the abuse or neglect is likely to have occurred based on heightened credible evidence. “Unfounded” means that there was not enough evidence to indicate that the abuse or neglect occurred. Once the investigator has made a determination, the supervisor has to review and approve the report. In addition to supervisory approval, certain types of reports also require approval of the Area Administrator. Examples of reports that require an Area Administrator’s approval include death investigations, serious injury investigations, or reports involving DCFS wards (Procedures 300.75(a)).

With data provided by the Department, we reviewed the timeliness of completing the investigations and found that, **with extensions**, 0.3 percent of all investigations were not completed in a timely manner, going from 0.3 percent in FY15 to 0.4 percent in FY16 and 0.2 percent in FY17. Although this analysis took into account those investigations that received an extension, it does not accurately reflect the actual time it took to complete investigations for the audit period.

The time it took to complete an investigation increased during the audit period. We found that the percentage of investigations that were not completed within 60 days doubled from FY15 to FY16. With investigations data provided by the Department, we reviewed the overall time to complete investigations from intake to supervisory approval. As is shown in *Exhibit 3-4*, in FY15, 7.6 percent of investigations were not completed within 60 days. For FY16, the percentage of investigations not completed within 60 days increased to 16.0 percent. It remained elevated in FY17 at 12.4 percent of investigations not completed within 60 days. Additionally, the number of investigations completed in fourteen days or less dropped from 14.0 percent in FY15 to 10.5 percent in FY16 before increasing to 15.1 percent in FY17.



The purpose of investigative timeframes is to establish protocols for responding to allegations of abuse and neglect. By not meeting these timeframes, not only is the Department not in compliance with statutes, rules, and policies, but more importantly the Department is not responding in the best interest of the alleged victims and providing for the protection of those children.

<b>INVESTIGATION TIMELINESS</b>	
<b>RECOMMENDATION 5</b>	<i>The Department of Children and Family Services 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.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	The Department currently tracks for compliance with initiation and is at 99% compliance. Since March 1, 2019 report completion and extension is now being monitored weekly through reports and staffings with Regional Administrators. Supervisors have access to a worker activity report and will be trained on how to access and utilize this report. This will be completed by September 2019. The Compliance Administrator will review a random selection of cases quarterly to ensure staff are meeting timeframes.

## EXTENSIONS

The Department’s struggle to complete investigations in a timely manner during the audit period is further demonstrated by the number and percentage of investigations that received a 30-day extension during the audit period. Where it is not possible to initiate or complete an investigation within **60 days**, the report may be deemed “undetermined” provided every effort has been made to undertake a complete investigation. The Department may extend the period in which such determinations must be made in individual cases for additional periods of up to **30 days** each for good cause (325 ILCS 5/7.12). Both the Supervisor and Area Administrator are responsible for reviewing and approving extensions every 30 days after the initial 60 day investigative period.

ANCRA requires that the Department shall by rule establish what shall constitute good cause (325 ILCS 5/7.12). Department rules state that good cause for extending the period for making a determination an additional 30 days may include, but is not limited to, the following reasons:

- State's attorneys or law enforcement officials have requested that the Department delay making a determination due to a pending criminal investigation;
- Medical or autopsy reports needed to make a determination are still pending after the initial 60 day period;
- The report involves an out-of-state investigation and the delay is beyond the Department's control; or
- Multiple alleged perpetrators or victims are involved necessitating more time in gathering evidence and conducting interviews (89 Ill. Adm. Code 300.110 (i)(3)(D)).

Exhibit 3-5  
30-DAY EXTENSIONS  
FY15-FY17

Extensions	FY15 Investigations		FY16 Investigations		FY17 Investigations	
	Count	Percent	Count	Percent	Count	Percent
0	62,626	92.46%	65,958	83.95%	65,474	87.26%
1	3,626	5.35%	7,336	9.34%	6,243	8.32%
2	925	1.37%	2,762	3.52%	1,839	2.45%
3	274	0.40%	1,263	1.61%	719	0.96%
4	122	0.18%	587	0.75%	320	0.43%
5	52	0.08%	283	0.36%	175	0.23%
6	35	0.05%	125	0.16%	79	0.11%
7	20	0.03%	90	0.11%	62	0.08%
8	10	0.01%	54	0.07%	38	0.05%
9	7	0.01%	33	0.04%	26	0.03%
10+	35	0.05%	81	0.10%	62	0.08%
<b>Total</b>	<b>67,732</b>	<b>100 %</b>	<b>78,572</b>	<b>100%</b>	<b>75,037</b>	<b>100%</b>

Source: OAG analysis of DCFS data as of July 27, 2018.

We reviewed the number of investigations that received an extension and found that it increased significantly during the audit period as is shown in *Exhibit 3-5*. The percentage of cases receiving at least one extension increased from 7.5 percent in FY15 to 16.1 percent in FY16 and 12.7 percent in FY17. Further, the number of investigation receiving multiple extensions also increased significantly. For instance, the number of investigations that received three extensions (an additional 90 days) increased from 274 investigations in FY15 to 1,263 investigations in FY16 and 719 investigations in FY17.

We reviewed a random sample of 50 investigations that received extensions to review the timeliness of the submission and approval of the first extension. Department rules require that extensions be submitted prior to the 55th day of the investigation. Of the 50 extensions sampled, only 1 (2.0%) was submitted prior to the 55th day. This extension was submitted on the 50th day for a prearranged leave.

### Good Cause

In some investigations there are legitimate reasons why there are multiple extensions. For instance, in one case an investigation received 33 extensions (990 days). This case involved the death of a child and an ongoing criminal case. However, in our review of cases involving an extension, it was not always clear what the cause for the extension was or whether it rose to the level of “good cause.”

Auditors judgmentally sampled an additional 20 investigations that received a total of 99 extensions. These extensions were reviewed to determine the “Reason for Extension,” a uniform drop down option in SACWIS, and other pertinent extension data. Of the 99 extensions, 44 had a Reason for Extension of “Other.” Auditors reviewed the Worker, Supervisor, and Manager Explanations which summarize the rationale for the extension. Often “Other” extensions had been requested and approved due to a need to finish investigative tasks such as entering notes, writing reports, or submitting the case for supervisor review.

Extensions often had identical information for the explanations for the extension. For instance, for one investigation sampled that had 12 total extensions, the worker explanation for 11 of those extensions was that it was a human trafficking case.

Of the 99 extensions, 22 Worker Explanations were identical to the previous extension, 17 Supervisor Explanations were identical to the previous extension, and 17 Manager Explanations were identical to the previous extension. Further, 36 extensions had identical explanations from the worker and either the supervisor or manager.

Auditors identified 22 extensions in which a staff member had both submitted and approved the extension. For instance, one investigation which received 17 extensions had 11 extensions where the supervisor both requested and approved these extensions on the same day. Further, the first extension was requested 462 days after the start of the intake (408 days after the extension should have been requested). Auditors asked Department officials why this might occur; **however Department officials did not respond.**

Department procedures require that an extension request contain four criteria:

- the reason the investigation cannot be completed by the 55<sup>th</sup> day,
- activities to be completed,
- who is responsible for completing each activity, and
- the expected date of completion.

For the 99 extensions sampled, only six (6.1%) extensions contained all four criteria in the Worker Explanation.

<b>INVESTIGATION EXTENSIONS</b>	
<b>RECOMMENDATION 6</b>	<p><i>The Department of Children and Family Services should comply with rules and procedures and ensure:</i></p> <ul style="list-style-type: none"> <li>• <i>Extensions are requested prior to the 55<sup>th</sup> day of the investigation;</i></li> <li>• <i>That extensions are given only for good cause;</i></li> <li>• <i>Extensions are requested and approved by appropriate staff;</i> <i>and</i></li> <li>• <i>Extension requests contain all required information.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department is monitoring extensions and ensuring cases are extended for good cause. Since March 1, 2019 there is a weekly report completed by the regions to identify all teams with more than 10 cases over 60 days, actions needed and anticipated closure date. Also instituted is a weekly staffing with all Regional Administrators regarding extensions more than 90 days to address the appropriateness of the request and actions to complete the investigation. This process has already resulted in a reduction of cases over 60 days. All staff will be reminded of the need to extended cases within the timeframe set forth in procedures.</p>



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## Chapter Four

# SERVICES

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## CHAPTER CONCLUSIONS

Conducting an analysis of all recommendations for services and services provided by the Department was not possible for the audit period because of inherent limitations in the data provided by the Department as well as other data reliability and consistency issues. In order to assess the services recommended and services provided, we selected a sample of 150 indicated investigations (50 each year for FY15, FY16, and FY17) and reviewed the investigations for recommended services and any services received.

### Recommendations for Services

The Department's policies and procedures require that during an investigation the need for services for the family involved in the investigation be assessed by the Child Protection Specialist (investigator) and the Child Protection Supervisor. Our review of 150 indicated investigations found that investigators did not always document that they assessed the need for services by completing the Level of Intervention field in the Department's information system known as SACWIS. Of the 150 indicated investigations sampled, 16 investigations (10.7%) had no Level of Intervention listed (services recommended). Further, 39 investigations (26.0%) had "No Service Needed" as the Level of Intervention. For most of these cases there was no rationale regarding why no services were being recommended even though the case had been indicated. Additionally, of the investigations sampled, for 64 (42.7%) we found that the Level of Intervention was inaccurate.

For Intact Family Services (IFS) provided through the Department, investigators have the responsibility to discuss and offer these services if the final investigation finding of indicated has been recommended. The Department did not document that Intact Family Services were discussed and offered to all families with indicated investigation findings as is required by Department procedures. Only 20 of 150 (13.3%) indicated investigations reviewed contained documentation of a recommendation for Intact Family Services (IFS). An additional 3 investigations had recommendations for multiple services, which included IFS; therefore 23 of 150 indicated investigations had a recommendation of IFS. For 33 of 150 investigations (22.0%), community services were recommended. We could not determine whether any services were recommended or what the specific services were for 67 of 150 (44.7%) indicated investigations reviewed. The remaining 27 investigations included recommendations for placement, already receiving services, no services needed, multiple services, Intact Family Recovery, and Norman Cash Assistance.

### Services Provided

We sampled 150 indicated cases for the audit period and found that for 98 cases (65.3%), there was a lack of documentation regarding whether any services were received by the families involved and the duration of those services. The Department could not provide basic information for Intact Family Service cases, such as referral forms, to document that a formal referral for services was made. The Department also could not provide auditors with the number of families served by each IFS contractor each year for the audit period. For investigations

involving the Norman Cash Assistance program, the Department could not provide all approval forms. For community services, there are no formal forms for referrals to community based services and the Department is not documenting these services as required by procedures. Therefore, it is difficult to determine if the families actually received services from community providers.

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## SERVICES

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According to the Abused and Neglected Child Reporting Act (ANCRA), if the Child Protective Service Unit determines, following an investigation of child abuse or neglect, that there is credible evidence that a child has been abused or neglected, the Department is required to assess the family's need for services, and, as necessary, develop, with the family, an appropriate service plan for the family's voluntary acceptance or refusal (325 ILCS 5/8.2). Even if there is no credible evidence that the child was abused or neglected, if it appears that the child or family could benefit from other social services, the Department may suggest services, for the family's voluntary acceptance or refusal (325 ILCS 5/8.1). Possible services that may be provided to families through the Department include programs such as Intact Family Services (IFS), Intact Family Recovery Program (IFR), placement, or Norman Cash Assistance. Families may also receive services through community based providers.

The Department and its social service partners provide services that allow children to remain in their homes. The largest of those programs is the **Intact Family Services (IFS)** program. The Intact Family Services program is designed to work with families on a voluntary basis when they have come to the attention of the Department as a result of a referral from a child abuse or neglect investigation or involuntarily when ordered by the court to provide services. Intact Family Services are meant to provide reasonable efforts to preserve families, to enable children to remain safely at home, and to avoid separation and/or placement of the children. The requirements for the Intact Family Services program are established by Department Procedures 302.388.

**Norman Cash Assistance** services assist families who lack food, clothing, housing or other basic human needs that place children's safety at risk and would otherwise necessitate removal from the family or would be a barrier to reunification. The program provides cash assistance to purchase needed items, assistance in locating housing, and expedited enrollment in Temporary Assistance for Needy Families (TANF).

According to Department procedures, **community services** are appropriate when children have been assessed to be at low to medium risk and the family is capable of using support services provided through community resources without further Department intervention. Because the Department's rules and procedures do not include a definition of what constitutes community services, we asked the Department what would be defined as community services. Officials responded that community services would include any services that are not provided as contracted services. According to a Department official, community services may include food pantries, mental health service referrals, and medical and dental information. It may also include providing the locations of other agency offices such as the Department of Human Services, the Social Security Office, or where to apply for unemployment. Transportation information may also be provided. Some communities may also have various cultural and language service providers.

### **Limitations of Services Data**

Conducting an analysis of all recommendations for services and services provided by the Department was not possible for the audit period because of inherent limitations in the data provided by the Department as well as other data reliability and consistency issues. The Department's information system for abuse and neglect investigations, known as SACWIS, contains a field entitled "Level of Intervention" which contains the recommended services for each investigation. The Department provided auditors with a download of investigations for FY15-FY17, as of July 27, 2018, including the Level of Intervention and whether a service case was created for IFS, Norman Cash Assistance, or placement as a result of investigations. We reviewed the recommended services and cases created (services case ID) for accuracy and found that:

- Investigators did not always complete the Level of Intervention field in SACWIS. According to data provided by the Department, for 11,607 investigations (5.2%) the Level of Intervention field was blank. This included 11,435 investigations with an associated service case created for Intact Family Services (IFS), IFR, placement, or Norman Cash Assistance (Norman).
- The Level of Intervention field was not always accurate or there was no support in SACWIS for the recommended Level of Intervention. For example, for 6,203 investigations (2.8%) the Level of Intervention field was listed as "Referral for Community Based Services" but there was a Department service case associated with the investigation (IFS, IFR, Norman, or placement).
- We reviewed a sample of Department service cases that were created as a result of an investigation, and found that for 17 of 36 (47.2%) of these investigations, the services information was not accurate.
- There were service cases that were created in error. In our sample, we identified 4 cases, 3 placement and 1 IFS, (11.1%) that were created in error. For example, for IFS cases, according to Department officials, this can happen when an IFS case is created in SACWIS before the possibility of receiving services is discussed with a family due to the investigation getting close to the 60 day deadline. If the family refuses services, the case cannot be deleted from SACWIS, so "Opened in Error" is selected as the option for closing the case. According to Department procedures, IFS cases must be created in SACWIS before the investigation is completed and closed.
- The population of placement cases created could not be calculated accurately because services include a family case ID as well as a case ID for each child, artificially inflating the number of services cases.
- Cases that transition from IFS to placement keep the same case ID making it difficult to determine the type of service case created. According to Department officials, this provides continuity and allows for all the historical documentation to remain in place. However, in the data provided, the case type is only listed as IFS and does not show the transition to placement; therefore, a placement case may appear to be an IFS case. Further, some cases that transition to placement may not be linked to any specific investigation.

- Sometimes IFS cases are created in order to provide Norman Cash Assistance and do not include IFS services. For one of the four investigations sampled in which we determined Norman Cash Assistance was involved, an IFS case was created only to provide the Norman Cash Assistance. According to a policy guide provided by the Department, a new IFS case may be opened in order to make a Norman Cash Assistance payment. Therefore, when reviewing the population of services, the number of IFS cases would be overstated while the number of Norman Cash Assistance cases would be understated.

Through FY17, the Department had published statistics on services in its annual Executive Statistical Summaries. However, services data was not included in these summaries when the Department reissued investigation statistics for the past five years in April 2018. The Department does provide some services data to the federal government for inclusion in the Child Maltreatment reports issued by the US Department of Health & Human Services. When asked about the data presented in the federal report, Department officials stated that the numbers might not match other data. **We requested field definitions for the federal reports but the Department failed to provide auditors with those definitions.**

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## RECOMMENDATIONS FOR SERVICES

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House Resolution Number 418 asks the Auditor General to determine for FY15, FY16, and FY17, for sampled cases, recommendations made by the Department to families who were the subject of an abuse or neglect investigation.

Our review of 150 indicated investigations found that investigators did not always document that they assessed the need for services by completing the Level of Intervention field in SACWIS. Further, the recommendations that were shown in SACWIS were not always supported by case notes. For indicated investigations sampled in which the recommended service was “No Service Needed,” there was no rationale for the decision to not offer services in most cases.

### Assessing the Need for Services

The Department’s policies and procedures require that during an investigation the need for services for the family involved in the investigation be assessed by the Child Protection Specialist (investigator) and the Child Protection Supervisor. The policies specifically require that the Child Protection Supervisor ensure that a reported family is provided an appropriate service referral or that the need for preventive services is assessed, which may include, but is not limited to the following:

- Educational services, including early education;
- Substance abuse assessment and treatment;
- Domestic violence services;
- Housing assistance;
- Mental Health services;
- Nursing referrals; or
- Other community services (e.g., Family Advocacy Center services, Safe Families, etc.) (Procedure 300.70 (h)).

SACWIS contains a field entitled “Level of Intervention” which contains the recommended services for each investigation. The different levels of intervention listed in the data received from the Department included: Currently Open Case, No Service Needed, Open and Assign for Permanency Services, Open and Assign for Regular POS (Purchase of Service), Other Services-Facility Report, Referral for Community Based Services, and Services Offered/Refused. Despite the procedural requirement to assess the need for services, the Level of Intervention field in SACWIS does not need to be completed in order to close an investigation.

Data provided by the Department for FY15-FY17 investigations showed that over half (120,071 or 54.2%) of all investigations had a recommendation of no services needed. For another 11,607 (5.2%), the Level of Intervention field was blank in SACWIS.

We selected a sample of 150 indicated investigations (50 each year for FY15, FY16, and FY17) and reviewed the recommended Level of Intervention. Of the investigations sampled, for 64 (42.7%) we found that the Level of Intervention was inaccurate. For 16 investigations there was no Level of Intervention listed even though the Department’s procedures require the investigator and the supervisor to assess the need for services (*see Exhibit 4-1*).

Exhibit 4-1 LEVEL OF INTERVENTION For FY15-FY17 Investigations Sampled		
Level of Intervention	Count	Percent
Community Based Services	57	38.0%
No Service Needed	39	26.0%
Services Offered/Refused	20	13.3%
Blank – No Recommendation	16	10.7%
Currently Open Case	15	10.0%
Other Services – Facility Report	3	2.0%
<b>Total</b>	<b>150</b>	<b>100%</b>
Source: OAG sample of 150 indicated investigations for FY15-FY17.		

Of the investigations sampled, 39 (26.0%) had “No Service Needed” as the recommended Level of Intervention. We followed up with the Department to determine why the Level of Intervention for these investigations was no services. After reviewing Department responses we determined that for 24 investigations there was no rationale in the SACWIS case notes regarding why no services were being recommended even though the cases had been indicated.

Of the investigations sampled, 20 investigations (13.3%) had “Services Offered/Refused” as the Level of Intervention. For most of these cases (15 of 20) we could not determine by reviewing the case notes what services were offered or that the services had been refused. **The Department does not complete any formal documentation when offering services or when services are refused.**

Because of the limited number of options available to investigators in SACWIS for Level of Intervention it is difficult to accurately reflect the investigator’s decision made to recommend services or not recommend services. For instance, the Level of Intervention field does not have an option to select Intact Family Services or whether the family is already receiving community services.

Assessing the need for services, including the rationale for the decision, may help ensure the safety and well-being of children as well as help provide stability for children and families. Formally documenting the offer and refusal of services can also help in the decision making process if there are additional allegations and investigations in the future.

<b>ASSESSING THE NEED FOR SERVICES</b>	
<b>RECOMMENDATION</b>  <b>7</b>	<i>The Department of Children and Family Services should:</i> <ul style="list-style-type: none"> <li>• <i>Make the Level of Intervention a required field in SACWIS and revise the Level of Intervention options to more accurately reflect current practices, and</i></li> <li>• <i>Include a rationale for indicated investigations in which there is a Level of Intervention of “No Service Needed.”</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	Procedure 300 will be updated to include the expectation the investigator documents the reason no services are necessary. This will be completed by September 2019. Creating a special “services” note in the SACWIS file will be explored.

### Recommended Services

The Department did not document that Intact Family Services (IFS) were discussed and offered to all families with indicated investigation findings as is required by Department procedures.

An indicated investigation is an investigation of suspected child abuse/neglect that has revealed credible evidence that the abuse/neglect occurred. 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)). The IFS provider contracts we reviewed stated that all families who are the subject of an indicated abuse/neglect investigation must be offered the opportunity to participate in Intact Family Services.

An **indicated investigation** is an investigation of suspected child abuse/neglect that has revealed credible evidence that the abuse/neglect occurred.

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.

We reviewed the sampled investigations to determine the actual services recommended. Although Intact Family Services are required to be discussed and offered to all families that are the subject of an indicated investigation, only 20 of 150 (13.3%) indicated investigations reviewed contained documentation of a recommendation for Intact Family Services. An additional 3 investigations had recommendations for multiple services, which included IFS; therefore 23 of 150 indicated investigations had a recommendation of IFS.

As is shown in *Exhibit 4-2*, for 67 (44.7%) indicated investigations reviewed, we could not determine whether services were recommended or what specific services were recommended. For 33 investigations (22.0%), community based services were recommended. An additional three investigations had recommendations for multiple services, including community services.

Department officials provided auditors with a memo to all child protection staff dated February 27, 2018 (five weeks after the audit entrance conference), regarding the review of indicated reports with no service recommendations or the family refuses services. The memo states:

*“Over the past several months, many cases which have resulted in poor outcomes for our children (death or serious harm) have had prior DCFS contact and at least one indicated report in which no services were recommended or the family refused services and the investigations were closed with no follow up action or discussion to assure the child was safe under those circumstances.*

*Effective immediately, any indicated investigation in which services have not been recommended or the family has refused to participate in services, shall be staffed with the Area Administrator before closing. This consultation should include a discussion around the family dynamics and support systems, prior reports both indicated and unfounded, overall family cooperation and the possible need to consult with States attorney [sic], screen with court, or take protective custody in an effort to ensure the safety of the child(ren).”*

There is also a lack of consistency in what services are recommended and ultimately received among similar cases. For example, for two different indicated sexual abuse investigations sampled, one case had an open Intact Family Services case for counseling for the victim and another case had no services recommended for multiple victims abused by a family member. Another example involved two indicated Environmental Neglect investigations where homes were deemed to pose a risk to the safety of the children. One investigation involved piles of garbage, rotting food and animal feces in the home yet the recommendation was no services needed. The other investigation was for a home with cleanliness issues and a cockroach infestation. That investigation had an Intact Family Services case opened to clean the home. The Intact Family Services case was open for 6 months with a Purchase of Service (POS) provider.

Making effective recommendations for services may help prevent future abuse and neglect. Although the Department recognized in its February 2018 memo that not providing

Exhibit 4-2 SERVICES RECOMMENDED For FY15-FY17 Investigations Sampled		
Services Recommended	Count	Percent
Could Not Determine	67	44.7%
Community Based Services	33	22.0%
Intact Family Services	20	13.3%
Placement	12	8.0%
Already Receiving Services	8	5.3%
Multiple Services <sup>1</sup>	4	2.7%
No Services Needed	4	2.7%
Intact Family Recovery	1	0.7%
Norman Cash Assistance	1	0.7%
<b>Total</b>	<b>150</b>	<b>100%</b>
<sup>1</sup> Multiple Services includes three cases that were recommended for Intact Family Services. Source: OAG sample of 150 indicated investigations for FY15-FY17.		

services for certain types of investigations can lead to bad outcomes, there is little or no guidance for investigators or their supervisors regarding the recommendations that should be considered.

<b>RECOMMENDATIONS FOR SERVICES</b>	
<b>RECOMMENDATION</b>  <b>8</b>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Formally document when services are offered and whether those services are refused; and</i></li> <li>• <i>Consider establishing guidelines or policies to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>Individual offices maintain a list of resources for their area. Procedures 300 will be enhanced to ensure the supervisor and investigator have a discussion regarding services available to assist families and document services offered and the outcome-i.e. accepted or refused and the reason for refusal. The core practice model which is in the process of implementation also addresses identification of services with the family and allowing them to identify services which will best benefit them. Procedures will be updated by September 2019. Creation of a special “services” note within SACWIS will be explored.</p>

## **SERVICES PROVIDED**

House Resolution Number 418 asks the Auditor General to determine for FY15, FY16, and FY17, for sampled cases, any services provided by the Department to the child or family.

The Department could not provide basic information for Intact Family Service cases such as referral forms to document that a formal referral for services was made. We sampled 150 indicated investigations for the audit period and found that for 98 investigations (65.3%), there was a lack of documentation regarding whether any services were received by the families involved and the duration of those services. The Department also could not provide auditors with the number of families served by each IFS contract each year for the audit period. For investigations involving the Norman Cash Assistance program, the Department could not provide approval forms or documentation to show what the funds were used to purchase. Because of the lack of basic formal documentation for most cases, auditors could only assess the services provided for investigations sampled by reviewing case notes in SACWIS. Although there are required forms for some services, the Department utilizes case notes in SACWIS to document services.

### **Services Provided Testing**

We selected 150 indicated investigations from FY15, FY16, and FY17 to determine the services provided including the type and duration of the services. Department procedures state that the Child Protection Specialist (investigator) has the responsibility to discuss and offer the family intact family services if the final finding of indicated has been recommended. Additionally the family should be informed of community services (Procedures 300.130(a)(2)(A)). If a family does not meet the criteria for Intact Family Services (i.e.



unfounded investigations) it is expected that the investigator will refer the family to appropriate community services as applicable to the needs of the family (Procedures 302.388(c)(1)).

As is shown in *Exhibit 4-3*, there was no documentation in SACWIS or provided by the Department to support that 65.3 percent (98 of 150) of the indicated investigations reviewed received any services. Due to the lack of documentation, it was difficult to determine why services were not received in most cases. We determined that 8.7 percent (13 of 150) of the investigations reviewed were already receiving some form of services either through the Department or community based services.

Thirteen or 8.7 percent of investigations sampled received Intact Family Services (12 Intact Family Services and 1 Intact Family Recovery). Families who were served by IFS received a variety of services, which included parenting classes, counseling, and substance abuse assessment among others.

Another 8.7 percent (13 of 150) resulted in the Department taking the children into care (placement services). For 2.7 percent of cases reviewed (4 of 150) multiple services were received (3 of the 4 involved IFS and Norman Cash Assistance). Additionally there was one other case that received Norman funds.

**Intact Family Services (IFS)**

The Department and its social service partners provide services that allow children to remain in their homes. The largest of these programs is the Intact Family Services (IFS) program. The Intact Family Services program is designed to work with families on a voluntary basis when they have come to the attention of the Department as a result of a referral from a child abuse or neglect investigation or involuntarily when ordered by the court to provide services. Intact Family Services are meant to provide reasonable efforts to preserve families, to enable children to remain safely at home, and to avoid separation and/or placement of the children. The requirements for the Intact Family Services program are established by Department Procedures 302.388.

According to Department officials, beginning in 2012, the Department privatized the provision of most Intact Family Services. For the audit period FY15-FY17, Intact Family Services were provided by private and not-for-profit Purchase of Service (POS) agencies through service contract agreements. According to officials, in 2018 some cases were being shifted back to Department Intact caseworkers. The Department’s goal is to achieve about 90 percent of Intact cases served by the private agency providers and have approximately 10 percent of Intact cases remain with the Department Intact caseworkers.

Exhibit 4-3 <b>SERVICES RECEIVED</b> For FY15-FY17 Investigations Sampled		
<b>Services Received</b>	<b>Count</b>	<b>Percent</b>
No Service Received	98	65.3%
Placement Services	13	8.7%
Already Receiving Services	13	8.7%
Intact Family Services/Recovery	13	8.7%
Multiple Services Received <sup>1</sup>	4	2.7%
Community Based Services	3	2.0%
No Service Received – Withdrew	3	2.0%
Not Applicable <sup>2</sup>	2	1.3%
Norman Cash Assistance	1	0.7%
<b>Total</b>	<b>150</b>	<b>100%</b>

Notes:  
<sup>1</sup> Multiple services includes three cases that involved IFS and Norman Cash Assistance.  
<sup>2</sup> Not Applicable includes Facility and Foster Care cases.  
 Source: OAG sample of 150 indicated investigations for FY15-FY17.

A POS agency is responsible for providing the actual intact services, either through the agency or through other subcontracted entities. Examples of services that might be provided include mental health counseling, parenting classes, substance abuse treatment, or domestic violence counseling.

When an investigation shows a need for services and the family agrees to receive services, a request form is sent by the Child Protection Supervisor to the Area Administrator who then forwards the case to the Intact Utilization Unit Supervisor for assignment to a POS agency or Department worker. The child protection worker and supervisor, and the Intact worker and the Intact supervisor have a “hand-off” conference call to determine the needs of the family and schedule a transitional visit. After the hand-off call, the case worker and Intact worker meet with the family at the family’s home for the transitional visit to review the plan and explain the process. The Intact worker from the POS agency takes over the case services, and has five days to complete a Child Endangerment Risk Assessment Protocol.

Intact services are billed to the Department by the POS agency at a per family rate. For FY15-FY17, the rate was \$1,206 per month for the first six months. After six months the rate dropped to \$639 per month for FY15-FY16 and to \$671 per month for FY17. In 2014 the Department instituted a tier two approach which allows for a rate of \$1,106 per month after the first six months for some cases. There is no limit on the length of time an IFS case may remain open.

A total of 29 POS agencies provided IFS services during FY15-FY17. Some agencies have multiple contracts that cover different regions of the state. While the number of contracts dropped each year, the total capacity fluctuated, dropping between FY15 and FY16 before slightly rising in FY17. The IFS agency capacity is the maximum number of open cases at any one time. This allows for agencies to plan for the number of caseworkers needed to serve IFS cases. *Exhibit 4-4* shows the number of contracts, the capacity and the expenditures for IFS by fiscal year.

Due to limitations in the service data provided by the Department, we could not determine the number of IFS cases for the audit period. On August 1, 2018, we requested the number of intact family services cases served by POS agency contracts for FY15-FY17. The Department could not readily provide data to show the number served by each IFS contract or

Exhibit 4-4 INTACT FAMILY SERVICES CONTRACTS, CAPACITY, AND EXPENSE FY15-FY17			
	FY15	FY16	FY17
Contracts	42	38	37
Capacity	2,380	2,250	2,330
Expense	\$27,895,182	\$26,808,690	\$30,710,472
Source: OAG analysis of Department data.			

agency and officials stated it would require a special data run from its systems. **Information regarding the number served by each IFS contract each fiscal year for the audit period was never provided.** According to an official, there is no database with this information in it.

Without having IFS case data readily available it is difficult for the Department to conduct budgetary or strategic planning for its IFS program. It is also unclear how the Department is determining the contracted capacities in the POS agency contracts without knowing the actual number that received services. Further, it makes it difficult for the Department to know if POS caseworkers are maintaining caseloads in compliance with the B.H. consent decree (88 C 5599 (N.D. Ill.)), which limits the caseload to 20 families per caseworker.

<b>INTACT FAMILY SERVICES MONITORING</b>	
<b>RECOMMENDATION</b>  <b>9</b>	<i>The Department of Children and Family Services should track the number of Intact Family Services cases that are opened annually including which POS agency provided the services.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	The Department currently tracks Intact Family Services cases using payment data for both POS agency (contract) utilization and for budgeting purposes. While these fiscal reports will continue, the Department in addition will be developing monthly production reports from DoIT to ensure DCFS management staff receives timely reporting of agency caseloads.

### Intact Family Services County Coverage

For Intact Family Services, the Department POS contracts did not cover all counties in the State during the audit period. During our review of IFS POS agency contracts, auditors found 10 counties that were not covered by any provider for at least one fiscal year. Auditors followed up with the Department and an official explained that the lack of coverage was due to an oversight on the contract. The official stated that they asked the POS agencies to review the coverage section of the contract to ensure its accuracy and it often got overlooked. According to the official there is at least one agency for every county in the State even though it may not be reflected in the contracts. However, because the Department could not provide a list of those served by each POS contract, we could not determine whether services were provided to families in all counties of the State.

<b>Counties Without Contract Coverage</b>	
<b><u>FY15</u></b>	<b><u>FY17</u></b>
Hancock	Henderson
Kane	Logan
Kendall	Mason
Moultrie	Warren
Schuyler	
Shelby	

Not ensuring that the contracts are accurately completed and inclusive of all counties increases the risk that families in the overlooked counties may not be provided needed services due to the lack of agencies having a contractual obligation to serve those counties.

<b>INTACT FAMILY SERVICES COVERAGE</b>	
<b>RECOMMENDATION 10</b>	<i>The Department of Children and Family Services should ensure that POS agency contracts are accurate and specify coverage for all assigned counties.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	The Department’s Office of Contract Administration reviews all contracts annually, each Spring, in preparation for July 1 <sup>st</sup> services. Beginning in FY19, the Department has included as part of that review process to ensure a careful review with Intact Family Services management staff that all counties are reported accurately for every contract. While no families were denied services due to specific counties not being listed, the Department’s expectation is that all assigned counties are reflected in the POS agency contracts in a complete and accurate manner.

### **IFS Referrals**

According to Department procedures, once a Child Protection Specialist (investigator) recommends that an investigation be indicated and that a family will need Intact Family Services, the Child Protection Supervisor is required to review the recommendations with the investigator during a supervisory conference. The Child Protection Supervisor is required to document the decision to refer the case to Intact Family Services in a Supervisory note. If the Child Protection Supervisor approves the recommendation an Intact Family Services Case Referral and Assignment Form (CFS 2040) is required to be completed with the investigator and approved by the Child Protection Supervisor. The Child Protection Supervisor then submits the CFS 2040 form to the appropriate Area Administrator via Department email (Procedures 302.388).

We requested the CFS 2040 IFS referral forms for 25 investigations that we sampled that had an IFS case ID number. The Department could only provide 1 of 25 (4.0%) requested referral forms. The form that was provided did not show evidence of Department approval for the services.

According to officials, because of computer modifications and folders being archived, the CFS 2040 forms may no longer exist. Often these documents, which are only shared by email between the supervisor and Area Administrators, are no longer in their folders. It is very likely most of these existed only in electronic format.

The CFS 2040 forms show information about the investigation including family composition, paramours involved, CERAP information, prior abuse and neglect history, criminal history, case opening history, investigation history, and services already initiated all in one place. If maintained, these forms would allow investigators to quickly review any previous issues and services.

<b>INTACT FAMILY SERVICES REFERRALS</b>	
<p><b>RECOMMENDATION</b></p> <p><b>11</b></p>	<p><i>The Department of Children and Family Services should complete a CFS 2040 form for Intact Family Service referrals as is required by procedures. These forms should also be maintained in an accessible location.</i></p>
<p><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The CFS 2040 has been used as an Intact referral document from the Investigation supervisors to the Area Administrators. The document’s development can be tracked back to 9/09. Until May 2015, the Area Administrators statewide referred to the Intact agencies directly. May 1, 2015 the Intact referrals began to come to the Intact Utilization Unit for Cook County referrals only. The Intact PSA assigned the cases to the respective POS agencies, sent the assignment information back to the DCP AA, the assigned private agency Intact contact and the DCP supervisor for the handoff to be scheduled.</p> <p>The Intact Utilization PSA housed in Cook, has hard copies of 2015 2040’s. As of December 2017, the Intact Utilization Unit took over case assignment from the Area Administrators statewide. Prior to December 2017 all of the Downstate referrals were managed by the AA’s.</p> <p>The PSA in Springfield and the PSA in Cook divide the 4 regions, each taking two regions, to be responsible for case assignment.</p> <p>Currently, all Intact referrals are logged and maintained electronically by the Intact Utilization Unit.</p> <p>The log of referrals is statewide. Historically, regions were required to submit their Intact referral logs to the Chief Deputy monthly.</p> <p>This demonstrates there has been tracking of Intact referrals, and it continues to be refined and enhanced. All 2040s are managed electronically from AA to the Intact Unit PSA and electronic folders. The Intact Utilization clerical’s document each referral in the respective Regional log.</p>

### **Norman Cash Assistance**

Norman Cash Assistance services assist families who lack food, clothing, housing or other basic human needs that place children’s safety at risk and would otherwise necessitate removal from the family or would be a barrier to reunification. The program provides cash assistance to purchase needed items, assistance in locating housing, and expedited enrollment in TANF (Temporary Assistance for Needy Families).

When cash assistance is needed to purchase an item to keep a child from being placed in, or to return a child home from Department care, the Child Protection Specialist (investigator) or permanency worker shall submit a CFS 370-5 form, Request for Cash and/or Housing Assistance, to the permanency supervisor. This request for cash assistance should be made promptly upon the Child Protection Specialist (investigator) or permanency worker learning of the subsistence needs. If other types of assistance are inappropriate or unavailable and the client

cannot afford to purchase the item, the worker shall apply for Norman funds. The Child Protection Specialist (investigator) or permanency worker shall indicate on the form the purpose for which cash assistance is being requested, the amount, and the type of cash assistance requested. The final decision regarding the types and amounts of cash assistance rests with the Department supervisor or Department Norman Liaison.

Depending on the need, an authorized Department supervisor may approve up to \$800 in cash assistance in a 12-month period for a family who is certified as a member of the Norman Class. This may be provided in addition to funds from the Illinois Department of Human Services, other cash funds available from the Department, or other local community resources. There is no limit on the number of times cash assistance can be provided in a 12-month period. In situations where higher amounts are necessary, a Department Norman Liaison may approve up to \$1,200. A Department Regional Norman Liaison may approve up to \$2,000. The Norman Program Coordinator or designee may approve requests up to \$2,400. Any request over \$2,400 must have the approval of the Deputy Director of the Division of Service Intervention or designee (Procedures 302.385(g)). We could not identify the position of Deputy Director of the Division of Service Intervention in any Department organizational charts that were provided. According to Department officials, the position of Deputy Director of the Division of Service Intervention no longer exists. The policies for approving Norman Cash Assistance were last updated in 2005.

Of the 150 investigations we reviewed, we identified 4 that received Norman Cash Assistance. On November 16, 2018, auditors requested any documentation from the Department for these expenditures. On November 19, 2018, the Department provided notes and a one page printout for one expenditure, but did provide any approval forms. **On April 5, 2019, after the exit conference was held, the Department provided approval forms for three expenditures.** The Department could not provide an approval form for one expenditure for \$1,400.

<b>NORMAN CASH ASSISTANCE</b>	
<b>RECOMMENDATION 12</b>	<i>The Department of Children and Family Services 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.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department agrees that Procedures and Organization charts should reflect the current process. The Department also agrees that purchases made using Norman Cash Assistance Funds should not only be well documented but, that documents should be readily available for review/audit.</p> <ul style="list-style-type: none"> <li>• The Agency shall update their written procedures to reflect how Norman Cash Assistant funds are currently processed, including who approves assistance.</li> <li>• The Agency shall update the Organization Chart, reflecting the removal of the Deputy Director of the Division of Service Intervention position.</li> <li>• The Agency shall include in their update of written procedures the process of properly retaining CFS 370-5 forms to ensure they are readily available for review/audit.</li> </ul> <p>In completing the corrective actions above, the Department expects to develop a system that; (A) properly reflects the current process and organizational structure of the Norman Cash Assistance program and (B) ensures proper document retention of purchases made.</p>

### **Community Services**

The Department could not provide documentation of referrals to community services or whether the services were received. Department investigators rely on contact notes in SACWIS to document any verbal discussions with families. Although Department procedures require investigators to be actively involved in the referral/linkage process and to document this involvement in a contact note, our review of cases in SACWIS showed that these procedures are not being followed. There are no formal forms for referrals to community based services. Therefore, it was difficult to document if the families actually received referrals or followed up with any referrals and received services from community providers.

According to Department procedures, it is expected that a Child Protection Specialist (investigator) shall refer a family that does not meet the eligibility criteria for Intact Family Services (i.e., unfounded investigations) to appropriate community services as applicable to the needs of the family. Such referrals should be documented in a case note in SACWIS (Procedures 302.388(c)(1)).

Because the Department’s rules and procedures do not include a definition of what constitutes community services, we asked the Department what would be defined as community services. Officials responded that community services would include any services that are not provided as contracted services. According to a Department official, community services may include food pantries, mental health service referrals, and medical and dental information. It

may also include providing the locations of other agency offices such as the Department of Human Services, the Social Security Office, or where to apply for unemployment. Transportation information may also be provided. Some communities may also have various cultural and language service providers. Available services may vary by community.

According to Department procedures, community services are appropriate when children have been assessed to be at low to medium risk and the family is capable of using support services provided through community resources without further Department intervention. The purpose of Department involvement is to actively link the family with those services and resources that effectively address their needs. **The Child Protection Specialist (investigator) shall actively be involved in the referral/linkage process and shall document this involvement in a contact note.** Referral/linkage activities include, but are not limited to:

- Initiating contact with providers;
- Advocating on the family’s behalf;
- Documentation of the frequency of and duration of services recommended for the specific members of the family and the conditions/circumstances that the services are designed to mitigate;
- Documentation of the date and time of the intake session;
- Assistance with the family’s transportation issues;
- Participation in the intake process when necessary; and
- Verification that the family is following through and utilizing the services provided (Procedures 300.130(b)).

We reviewed information in SACWIS for 150 investigations and requested information from the Department regarding 60 investigations that may have received community services. For 45 of 60 investigations (75.0%), the Department could not provide documentation that any services were received. Further, in our review of investigation case notes in SACWIS, we found little documentation of the required referral/linkage activities covered in Procedure 300.130(b).

<b>COMMUNITY BASED SERVICES</b>	
<b>RECOMMENDATION 13</b>	<p><i>The Department of Children and Family Services should follow existing Department procedures including:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Verifying whether the family is following through with the community services.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department will ensure staff are reminded of current procedures regarding community referrals, what the service mitigates, time frames and verification the family has linked with the service. This will be completed by July 2019. The Creation of a specific “services” note within SACWIS will be explored.</p>



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## Chapter Five

# DEMOGRAPHIC INFORMATION

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## CHAPTER CONCLUSIONS

During the audit period, the number of indicated children decreased every year while the total number of alleged victims increased. According to data provided by the Department as of July 27, 2018, for the three-year period FY15-FY17 there were 221,341 investigations involving a total of 358,545 children, 96,576 of whom had at least one indicated allegation.

Auditors could not obtain a reliable count of the number of unique victims because of limitations with the data provided by the Department. Each person in the SACWIS system is assigned a unique PersonID. However, auditors found that there were over 8,000 instances where the same child had been assigned multiple PersonIDs. Therefore, auditors could not obtain a reliable count of the number of unique child victims over the audit period because of data limitations.

For the 221,341 investigations for FY15-FY17, there were 450,483 total allegations, with an overall indication rate of 25.5 percent. The most common allegations were “Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect” and “Inadequate Supervision.” A total of 52,502 children were the alleged victims of sexual abuse during FY15-FY17 and 32,439 children were the alleged victims of serious harm.

### Age

Children under the age of one were the most frequent alleged victims of abuse or neglect (8.1% of all victims) and also the most likely to be indicated victims (13.3% of all indicated victims). After the age of one, the number of indicated allegations of abuse or neglect trends downward.

### Race and Ethnicity

For race, children who were identified as White or Black/African-American made up 96.4 percent of all alleged victims (62.5% White and 33.9% Black/African-American) and 97.1 percent of all indicated victims (62.4% White and 34.7% Black/African-American). Data provided by the Department showed that 2.3 percent of alleged victims did not have a race recorded. For ethnicity, children with a Hispanic ethnicity comprised 15.6 percent of all victims and 16.7 percent of indicated victims.

### Gender

For gender, there was an even split between male and female victims. Males accounted for 49.7 percent of all alleged victims and females were 49.6 percent. For indicated victims, males accounted for 49.4 percent and females were 50.3 percent.

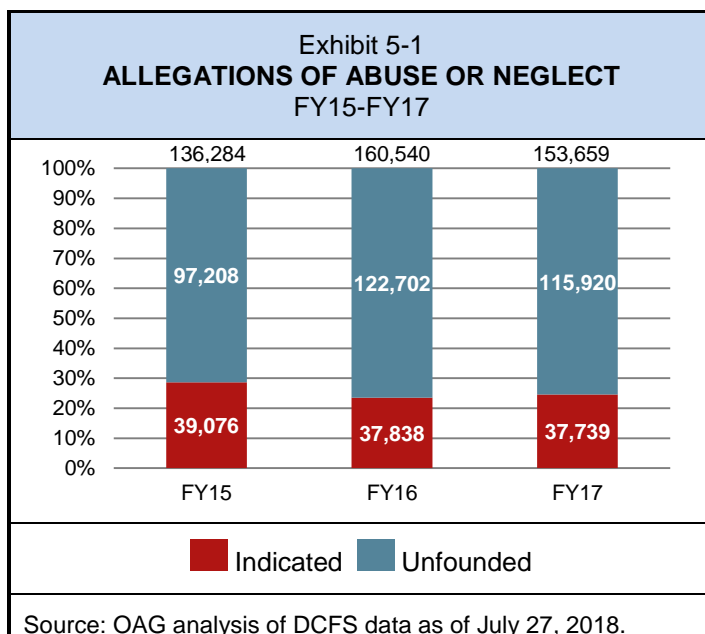
### Geographic Location

Auditors found that 25.5 percent of all investigations occurred in Cook County, followed by Lake County with 4.1 percent. There were investigations of alleged abuse or neglect in all 102 counties in Illinois.

## ALLEGATIONS

The Department utilizes an allegations system. According to Department procedures, the purpose of the allegations system is to identify and define specific types of moderate to severe harm, provide a framework for decision-making by the State Central Register (Hotline) and investigative staff, and provide an important investigation tracking and record-keeping function. Every alleged victim is assigned at least one allegation. The allegations are categorized as either abuse or neglect. All allegations coded with a number ranging from 1 to 40 are abuse and all allegations coded with a number between 51 and 90 are neglect allegations. Some allegations can fall under both abuse and neglect. For example, Allegation #1 is death by abuse and Allegation #51 is death by neglect.

During fiscal years 2015 through 2017 DCFS investigated a total of 450,483 allegations of abuse or neglect. Of the 450,483 allegations, 114,653 were indicated, for an overall indication rate of 25.5 percent. *Exhibit 5-1* shows the number of allegations and the number of allegations that were indicated and unfounded by year.



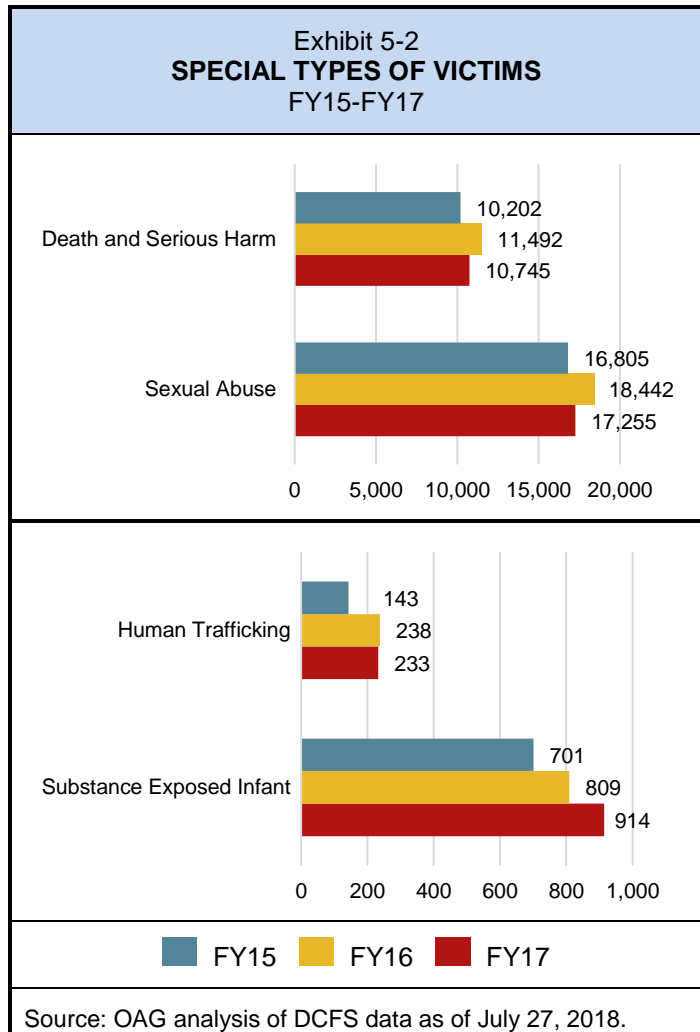
The most common alleged allegations were #60 - Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect (123,019 allegations, 27.3% of allegations) and #74 - Inadequate Supervision (74,542 allegations, 16.5% of allegations). The most common **indicated allegations** were also #60 - Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare by Neglect (44,991 allegations, 39.2% of indicated allegations) and #74 - Inadequate Supervision (18,582 allegations, 16.2% of indicated allegations). The allegation with the **highest indication rate** was #65 - Substance Misuse by Neglect at 55.6 percent and the allegation with the **lowest indication rate** was #67 - Mental Injury by Neglect at 3.9 percent. Appendix E provides a summary of all the allegations by type and fiscal year.

### Special Types of Victims

The Department classifies certain allegations together as special types. These include death & serious harm (for example head injuries, internal injuries, burns or torture), sexual abuse, human trafficking, and substance exposed infants. Substance exposed infants are defined as child victims under the age of one who have been reported for the allegation of substance

misuse (for example, a child born with exposure to a controlled substance). Appendix E lists all the special types of allegations.

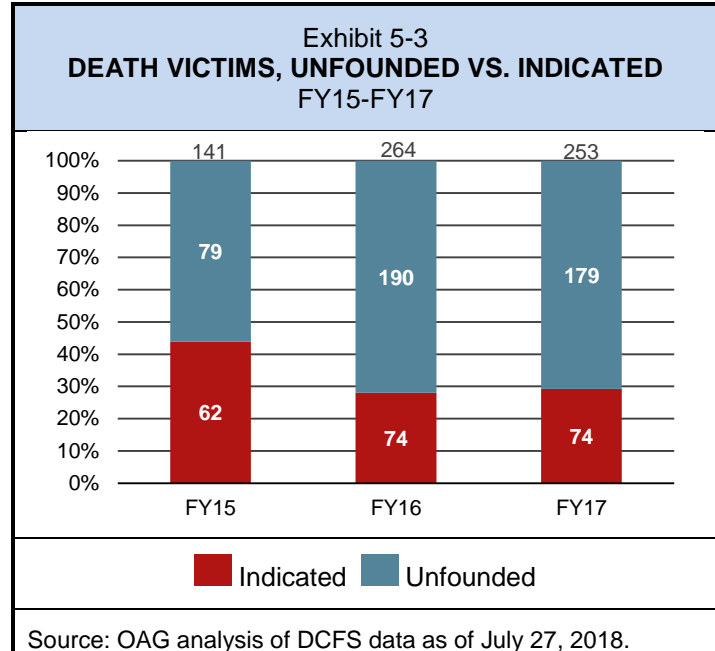
*Exhibit 5-2* shows the number of victims per year for special types of abuse and neglect. The most common special type of victim is sexual abuse victims, with a total of 52,502 alleged victims over the course of the 3 years with 13,525 indicated victims. There were 32,439 alleged death & serious harm victims and 8,135 indicated victims during FY15-17. DCFS publishes data on death & serious harm reports (investigations) but for consistency, the numbers reported here are for victims. There were 2,424 alleged substance exposed infants with 1,892 indicated victims. Human trafficking had 614 alleged victims with 112 indicated victims. Appendix E shows a breakdown by year for indicated victims for all special types of allegations.



### Deaths Analysis

There were 658 victims with a death allegation (Allegation #1 or #51) during FY15-FY17, of which 210 were indicated for death by abuse or neglect. The indication rate for death victims dropped significantly during the audit period going from 44.0 percent in FY15 to 28.0 percent in FY16 and 29.2 percent in FY17.

Auditors conducted an analysis of death victims to look for any with prior abuse/neglect investigations that were conducted during FY15-FY17; 102 victims (15.5%) had prior investigations. There were 163 prior investigations for these 102 victims. As discussed later in this chapter, because of issues with the PersonID, it is difficult to know if these are all the death victims with prior contact with DCFS. The number of prior investigations ranged from one to nine. For the child with nine prior investigations during FY15-FY17, six were indicated and there was an open Intact Family Services (IFS) case when the child passed away. There was also a victim with seven prior investigations (1 indicated) who was a DCFS youth in care when s/he died and a victim with four indicated prior investigations and an open IFS case at the time of the death. For the prior investigations, 28 of 163 involved DCFS services (1 Intact Family Recovery, 18 Intact Family Services and 9 placement). Of those 28 cases, 21 were receiving services when the child died.

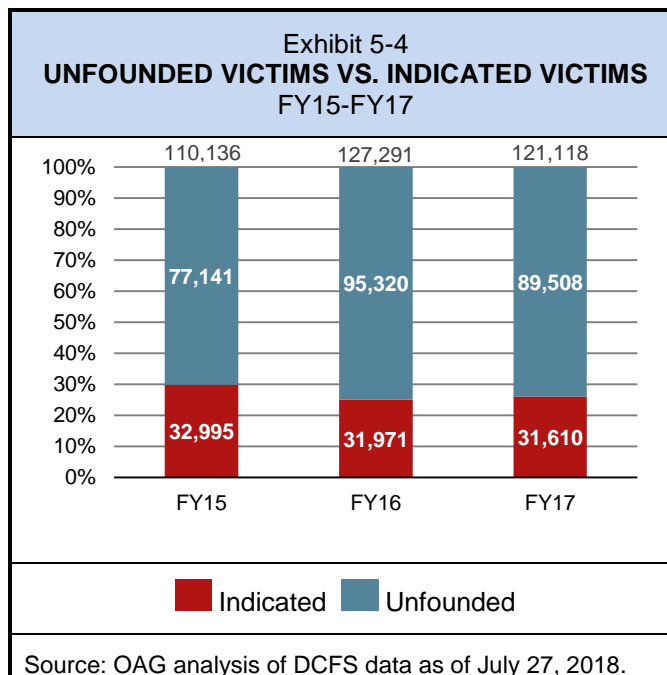


## VICTIM DEMOGRAPHICS

House Resolution Number 418 asks the Auditor General to review for FY15, FY16, and FY17 the demographic information on abuse and neglect investigations, including the age, race, and gender of children who were subjects of the abuse or neglect investigations, and, if available, the zip code and county where the abuse or neglect was alleged to have occurred.

Data provided by the Department included the total number of alleged victims involved in an investigation during the three-year audit period. Since victims can be reported multiple times this is not an unduplicated count.

According to data provided by DCFS as of July 27, 2018, for the three-year period FY15-FY17 there were a total of 221,341 investigations involving a total of 358,545 alleged victims. Of these 358,545, 96,576 victims had at least one indicated allegation over the three-year period. As shown in *Exhibit 5-4*, the number of alleged victims with investigations increased over the three-year period. However, the number of indicated victims decreased each year.



### Limitations of Provided Data

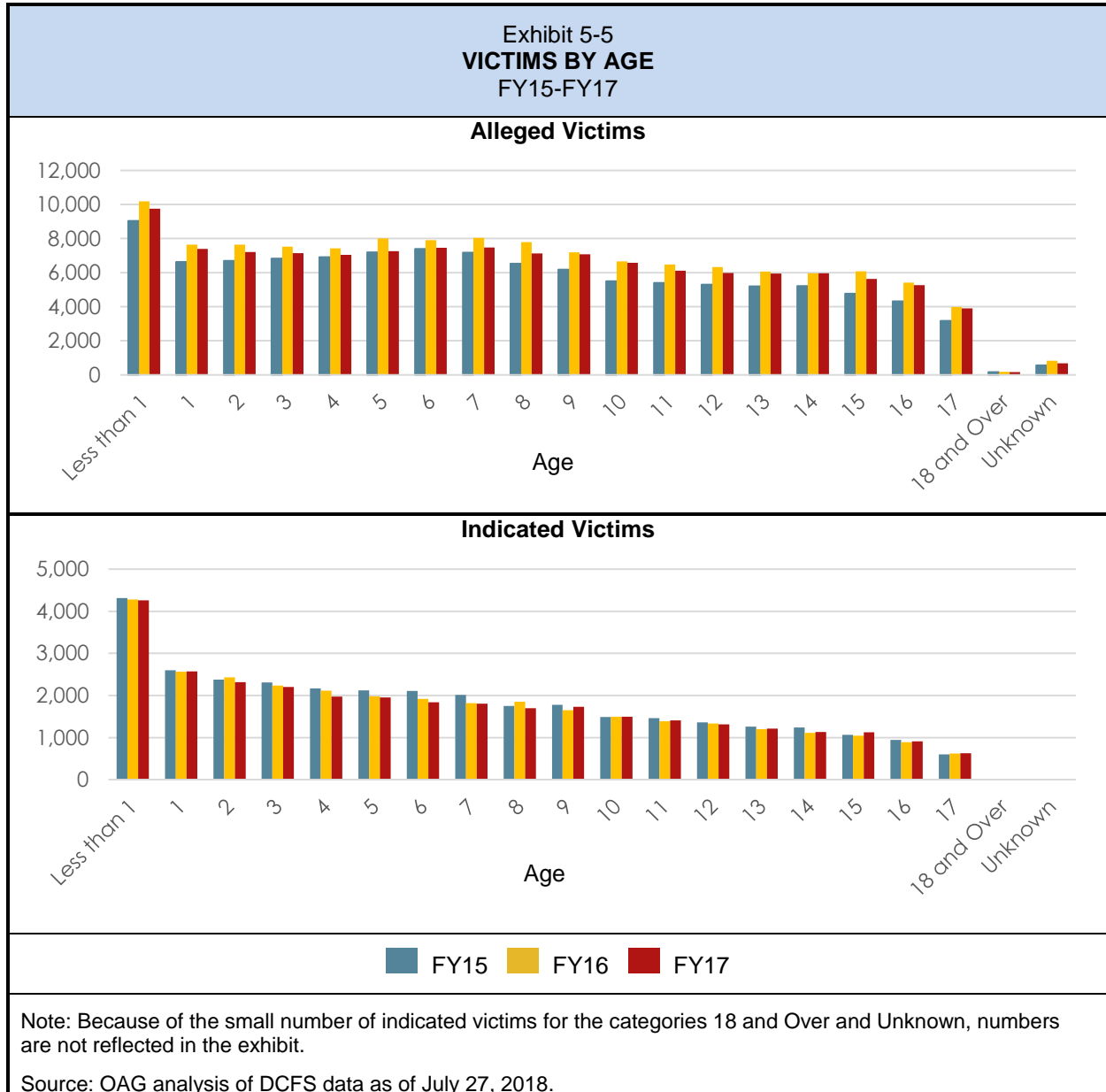
Auditors could not obtain a reliable count of the number of unique child victims over the audit period because of data limitations. Every year the federal government publishes national child abuse and neglect statistics that are submitted by the states. Due to data reliability issues it was difficult to compare Illinois to national statistics because demographics in federal reports are based on a unique count of indicated victims. Further, the data limitations could make it difficult for DCFS to accurately report data to the federal government.

DCFS assigns each person in the SACWIS system a unique PersonID that follows that person throughout different investigations. Auditors conducted an analysis of victim data based on PersonID for FY15-FY17. For the audit period, 8,061 children were identified where there was an identical name, the same date of birth and the same gender but a different PersonID. Due to input error, there may be inconsistencies in demographic fields. To attempt to control for issues such as with the misspelling of names, auditors performed the same analysis, but limited the first name to the first two letters. This identified an additional 2,570 children as possible duplicates because they shared the same date of birth, the same gender, the same last name and the same first two letters of their first name. When asked why this might occur, DCFS officials stated that possible explanations are, at intake, workers create a new PersonID in error or when a child is adopted a new post-adoption PersonID is assigned per procedure, so the child will have a separate pre-adoption and post-adoption PersonID.

Giving children multiple PersonIDs makes it difficult for the Department to search for prior reports on the children. DCFS procedures require that investigators complete a person search for all subjects of the report. DCFS Call Floor Workers also search SACWIS for any prior reports. If a child is listed under multiple PersonIDs the Call Floor Worker and investigator may not be able to identify all the prior reports involving that child. Data limitations are not confined to issues with PersonIDs. The limitations of data provided by the Department are discussed in Chapter One.

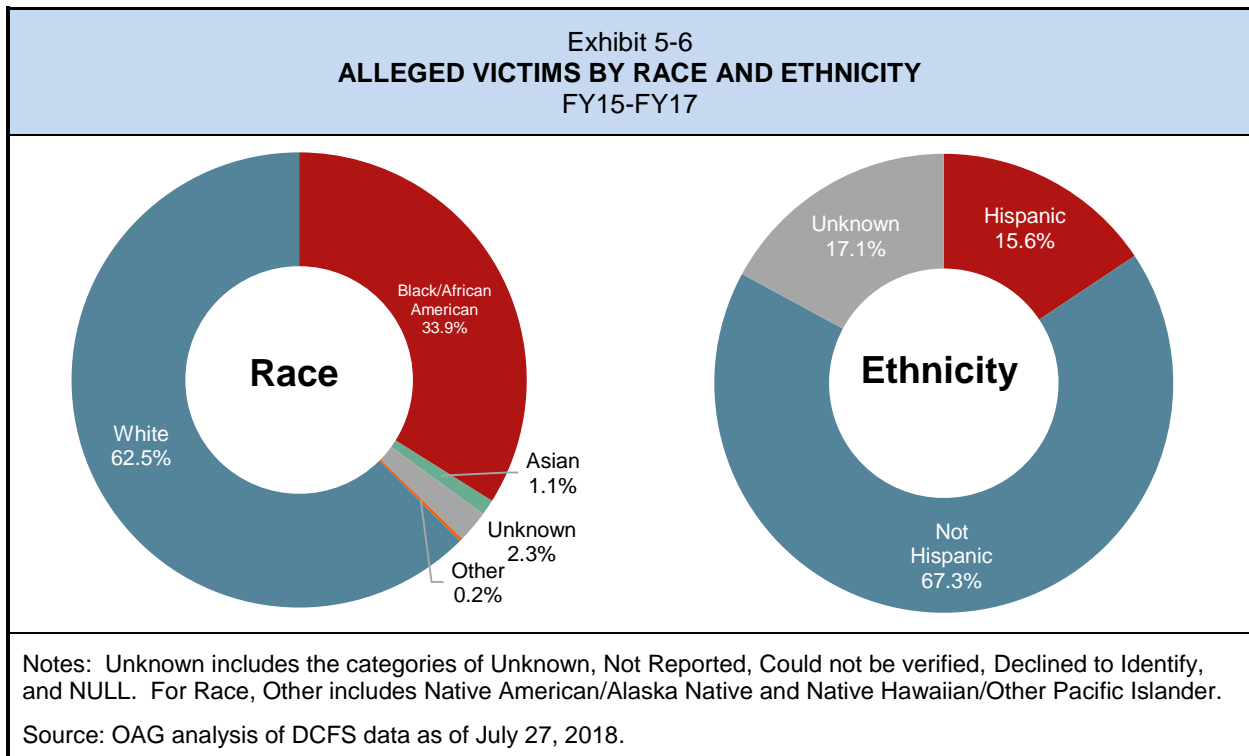
### Age

House Resolution Number 418 asks the Auditor General for the age of children who were subjects of abuse or neglect investigations during FY15-FY17. *Exhibit 5-5* shows the breakdown by year. Children under one year of age were the most frequent alleged victims. They also were the most likely to be indicated. While children under 1 year of age make up 8.1 percent of all alleged victims, they are 13.3 percent of indicated victims. Over the three fiscal years 44.4 percent of victims under the age of 1 were indicated, compared to 26.9 percent of all victims. Appendix F shows the number of victims per age.



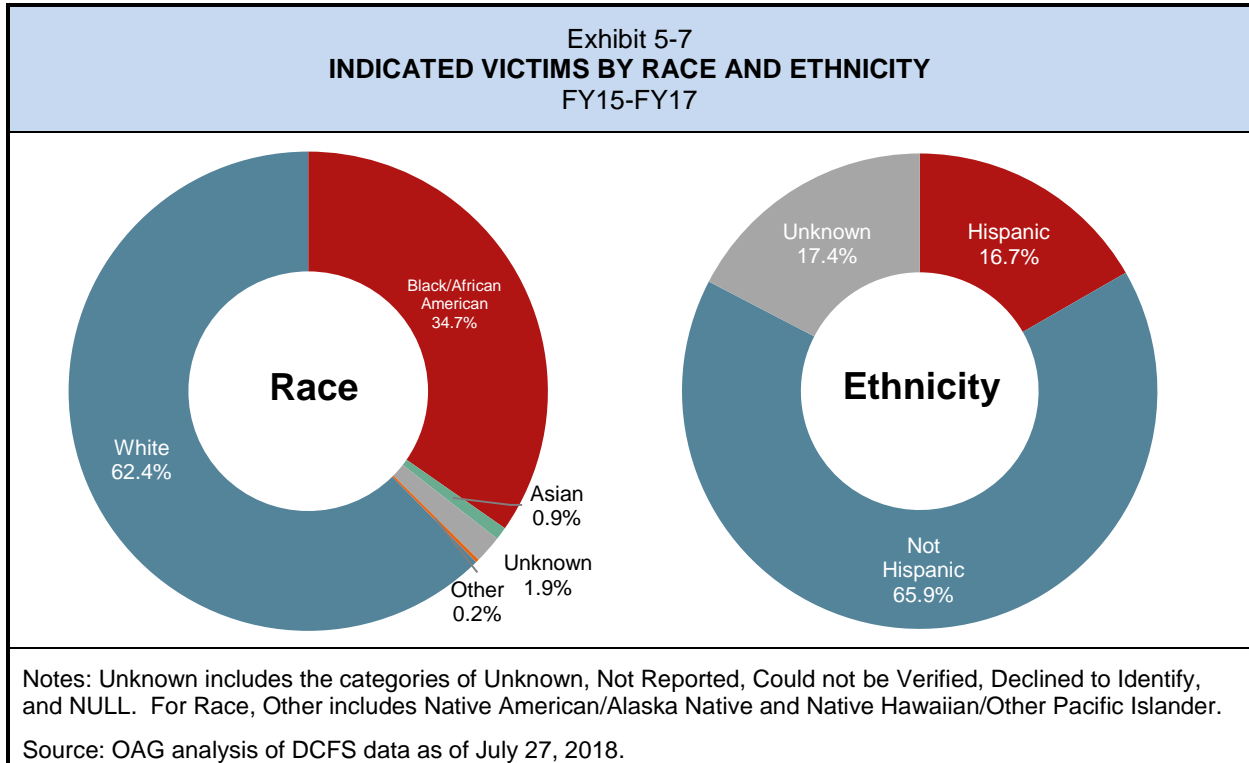
### Race and Ethnicity

House Resolution Number 418 asks the Auditor General for the race of children who were subjects of abuse or neglect investigations during FY15-FY17. DCFS captures data by race and ethnicity in separate categories. DCFS data does not record Hispanic as a race but instead categorizes it as an ethnicity. Approximately 89 percent of Hispanic alleged victims are included in the race category of White. *Exhibits 5-6 and 5-7* show the breakdown by race and ethnicity for FY15-FY17 (see Appendix F for the racial and ethnic breakdowns by fiscal year).



Children who were identified by the Department as White and Black/African-American made up 96.4 percent of all alleged victims (62.5 percent White and 33.9 percent Black/African-American). The percentage of children who were indicated by race mirrors the breakdown for all children. For 62.4 percent of indicated children their race was identified as White and 34.7 percent of children were identified as Black/African-American.



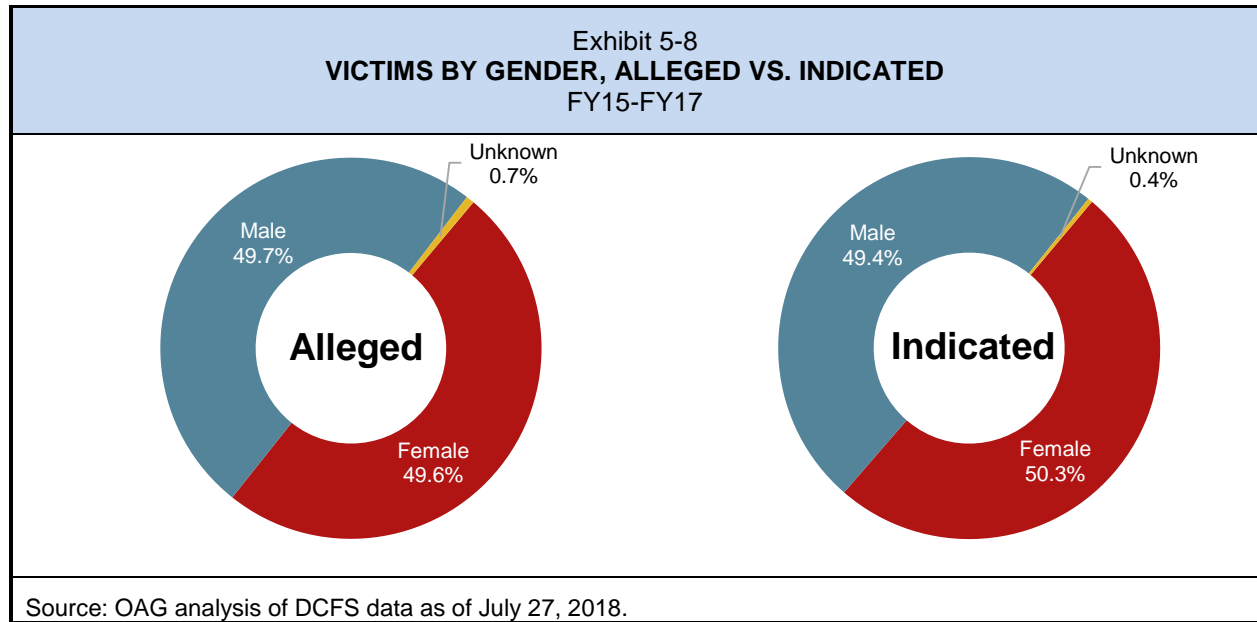


The largest group for ethnicity for all children was Not Hispanic at 67.3 percent followed by Hispanic at 15.6 percent. The percentage for children indicated by ethnicity is similar to the numbers for all children. Some 65.9 percent of children who were indicated were Not Hispanic children and 16.7 percent were Hispanic.

### Gender

House Resolution Number 418 asks the Auditor General for the gender of children who were the subjects of abuse or neglect investigations during FY15-FY17. According to data provided by DCFS there was an even split between the number of males and the number of females (see **Exhibit 5-8**). Overall males made up 49.7 percent of the victims while females were 49.6 percent of the victims.

For victims where the allegations were indicated, the breakdown remained evenly split. Males were 49.4 percent of all indicated victims and females were 50.3 percent. **Exhibit 5-8** shows the comparison between the overall number of alleged victims and the number of indicated victims.



### Zip Code and County of Occurrence

House Resolution Number 418 asks the Auditor General for the zip code and county where the abuse or neglect was alleged to have occurred. DCFS records the occurrence address, which includes the zip code and county. Occurrence data is based on the number of investigations instead of the number of victims. While zip code is captured, auditors found issues with the reliability of the data. For incidents that took place in Illinois, over 1,000 did not have valid Illinois zip codes. Additionally, even though addresses can be verified through the United States Postal Service, 19.5 percent of addresses were not verified or were blank. Therefore, only county-level data will be presented. For county data, there were 916 investigations in which the state is Illinois but there was no county provided.

**Exhibit 5-9  
OCCURRENCE TOP 10 COUNTIES  
FY15-FY17**

County	FY15		FY16		FY17		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Cook	18,015	26.6%	20,048	25.5%	18,479	24.6%	56,542	25.5%
Lake	2,679	4.0%	3,290	4.2%	3,109	4.1%	9,078	4.1%
Winnebago	2,565	3.8%	2,776	3.5%	2,478	3.3%	7,819	3.5%
Will	2,351	3.5%	2,794	3.6%	2,486	3.3%	7,631	3.4%
DuPage	2,235	3.3%	2,677	3.4%	2,414	3.2%	7,326	3.3%
Kane	2,170	3.2%	2,573	3.3%	2,474	3.3%	7,217	3.3%
Sangamon	1,907	2.8%	2,108	2.7%	1,954	2.6%	5,969	2.7%
St. Clair	1,750	2.6%	2,008	2.6%	1,980	2.6%	5,738	2.6%
Peoria	1,607	2.4%	1,809	2.3%	1,629	2.2%	5,045	2.3%
Madison	1,434	2.1%	1,581	2.0%	1,756	2.3%	4,771	2.2%

Source: OAG analysis of DCFS data as of July 27, 2018.

There were allegations of abuse or neglect in all 102 counties in Illinois, ranging from 42 investigations in Calhoun County to 56,542 in Cook County. *Exhibit 5-9* shows the top 10 counties with the highest number of abuse and neglect investigations. Appendix G lists the number of investigations for all counties.



# **APPENDICES**



**APPENDIX A**

**HOUSE RESOLUTION NUMBER 418**





STATE OF ILLINOIS  
HOUSE OF REPRESENTATIVES  
100TH GENERAL ASSEMBLY

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HOUSE RESOLUTION NO. 0418

OFFERED BY REPRESENTATIVES LA SHAWN K. FORD-MARY E. FLOWERS-STEPHANIE A. KIFOWIT-LOU LANG-LAWRENCE WALSH,  
JR., PATRICIA R. BELLOCK AND LATOYA GREENWOOD

**WHEREAS**, The Department of Children and Family Services ("DCFS" or "Department") is responsible for providing child protective services and programs to abused, neglected, and dependent children and their families; and

**WHEREAS**, The shooting death of 17 year-old Laquan McDonald by a Chicago police officer on October 20, 2014 shed light on the inefficiencies that plague the DCFS foster care program as media reports revealed the instability and abuse Laquan McDonald experienced throughout his youth as he moved through the foster care system; and

**WHEREAS**, Last month's suspicious death of 16 month-old Semaj Crosby, whose body was found in her family's Joliet home a day and a half after DCFS case workers visited the home to investigate an allegation of child neglect, has elicited sharp criticism on how DCFS investigates reports of child abuse and neglect; and

**WHEREAS**, Illinois has an interest in ensuring that all reports of child abuse and neglect are thoroughly investigated and that the children of this State have access to adequate and efficient protective services and programs; therefore, be it

**RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE ONE HUNDREDTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS**, that the Auditor General is directed in accordance with Section 3-2 of the Illinois State Auditing Act to conduct a performance audit on the Department of Children and Family Services to review and assess the Department's protocols for investigating reports of child abuse and neglect; and be it further

**RESOLVED**, That the audit include a review of abuse and neglect investigations conducted by the Department of Children and Family Services in Fiscal Year 2015, Fiscal Year 2016, and Fiscal Year 2017, including, but not limited to, a review of:

- (1) the status of abuse and neglect investigations;
- (2) the final determination or findings made by the Department for abuse and neglect investigations;
- (3) the time frame within which the Department completed or closed abuse and neglect investigations;
- (4) for sampled cases, recommendations made by the Department to families who were the subject of an abuse or neglect investigation, including any services provided by the Department to the child or family; and
- (5) demographic information on abuse and neglect investigations, including the age, race, and gender of children who were subjects of the abuse or neglect investigations, and, if available, the zip code and county where the abuse or neglect was alleged to have occurred; and be it further

**RESOLVED**, That the Auditor General compile a detailed report that includes a full summary on the number of lawsuits or other legal actions filed against the Department within the past 3 fiscal years that concern an abuse or neglect investigation and the number of lawsuits the Department settled within the past 3 fiscal years that concern an abuse or neglect investigation; and be it further


**RESOLVED**, That the Department of Children and Family Services cooperate fully and promptly with the Auditor General in the conduct of this audit; and be it further

**RESOLVED**, That the Auditor General is not allowed or authorized to release or disclose in his report any information that is prohibited from public disclosure under the Abused and Neglected Child Reporting Act or under any other State or federal law; and be it further

**RESOLVED**, That the Auditor General commence this audit as soon as possible and submit his report, including his findings and recommendations, upon completion in accordance with the provisions of Section 3-14 of the Illinois State Auditing Act; and be it further

**RESOLVED**, That a copy of this resolution be delivered to the Auditor General and the Department of Children and Family Services.

Adopted by the House of Representatives on June 25, 2017.

  
TIMOTHY D. MAPES  
CLERK OF THE HOUSE



  
MICHAEL J. MADIGAN  
SPEAKER OF THE HOUSE

## **APPENDIX B**

# **AUDIT SCOPE AND METHODOLOGY**



# **Audit Scope and Methodology**

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This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

House Resolution Number 418, adopted June 25, 2017, directed the Auditor General to conduct a performance audit of the Department of Children and Family Services (DCFS) to review and assess the Department's protocols for investigating reports of child abuse and neglect. The resolution required the audit to include a review of abuse and neglect investigations conducted by DCFS in Fiscal Year 2015, Fiscal Year 2016, and Fiscal Year 2017 (see Appendix A).

During the audit, we examined the DCFS organizational structure, headcount, and the investigation process. We specifically examined the processes for reporting allegations of child abuse and neglect, assigning and conducting investigations, timeliness and documentation requirements, and supervisory review. We also reviewed the investigative protocols used and related internal controls over the investigation process.

As part of reviewing and assessing DCFS investigation protocol, we reviewed statutes, administrative rules, and agency policies and procedures related to the conduct of investigations and the provision of services. Any instances of noncompliance are included in the audit report as recommendations. During the audit we also assessed the risk of fraud occurring as related to the audit objective and discussed these risks in an audit team meeting.

## **Data Limitations**

The Department of Children and Family Services had significant issues producing accurate child abuse and neglect investigation statistical reports during the audit period and while we were conducting the audit. We also identified concerns with the quality of the data contained in the Department's Statewide Automated Child Welfare Information System (SACWIS) as well as data provided to us for the audit. These concerns are discussed in Chapter One. Although the data is not always complete and accurate, it is the only source that exists for analyzing child abuse and neglect investigations. While recognizing the shortcomings of the data provided, in our opinion, the data was reliable enough to use in the general context of addressing the audit's objectives including sampling services.

## **Investigation and Demographic Data**

On July 27, 2018, DCFS provided auditors with a download of the population of intakes received by DCFS for FY15, FY16, and FY17 and the investigations related to those intakes. With the data provided, we conducted analyses to identify trends and made comparisons between years for investigations of child abuse and neglect. In accordance with the audit objectives in House Resolution Number 418, with the data provided by DCFS we determined:

- The status of abuse and neglect investigations for each year;
- The final determination or findings for investigations;
- The timeframes in which abuse and neglect investigations were completed or closed; and
- Demographic information related to the children involved, including their age, race, and gender. We also reviewed the county in which the abuse or neglect was alleged to have occurred.

We assessed the sufficiency and appropriateness of investigations data provided by DCFS. This included:

- Performing walkthroughs for intakes at the State Central Registry, investigations, and services at DCFS in order to determine what data was collected and how it was utilized;
- Developing field definitions for requested data to ensure the validity of data being provided;
- Gaining access to SACWIS in order to test the reliability and validity of data provided; and
- Comparing data provided to published available reports.

### Sampling of Services

For the period FY15-FY17 there were a total of 221,341 investigations. Because of the number of unfounded cases that were expunged, and are therefore not accessible in DCFS' computer system, we focused our sampling of services on indicated cases (founded).

According to data provided by the Department, for the three years FY15-FY17 there were 56,457 indicated investigations. We conducted a random sample of 50 indicated investigations for each fiscal year for a total of 150 cases. Because the majority of investigations were expunged and were therefore unviewable, they could not be included in our sample. Testing results cannot be extrapolated to the overall population. Using a data collection instrument, we gathered information from the investigation and case files in SACWIS related to:

- Whether a specific recommendation for services was made by the Child Protection Specialist (investigator) and the types of service(s) recommended;
- Whether the family received services from DCFS or a private Purchase of Service (POS) agency and the duration of those services;
- Whether the recommended services (which are voluntary) were waived by the child's family; and

CHILD ABUSE AND NEGLECT STATISTICS FY15-FY17				
	FY15	FY16	FY17	Total
Investigations	67,732	78,572	75,037	221,341
Indicated Reports <sup>1</sup>	19,156	18,710	18,591	56,457
Percent Indicated	28.3%	23.8%	24.8%	25.5%
<sup>1</sup> Indicated reports include those that were indicated due to review. Source: OAG analysis of DCFS data as of July 27, 2018.				

- Whether the services received matched the recommendation made by the Child Protection Specialist (investigator).

We also reviewed these cases to determine whether they followed the investigative protocol for Child Endangerment Risk Assessment Protocols (CERAPs) and whether cases met requirements related to timeliness.

We also conducted a judgmental sample of cases that took longer than 60 days to complete to review whether extensions were completed and the reason given for the extension.

### **Audit Risk**

We provided the Department with exceptions from our sample of services. However, the Department's responses did not always include a response or documentation to support statements made in regard to audit exceptions and questions. Because the Department was not always responsive to our requests, in some individual cases auditors were forced to use their best judgement to determine if services were provided without additional input or documentation from the Department. Without full cooperation and input from the Department, there is some risk that auditors could reach an invalid conclusion in individual cases. However, this would not affect our overall conclusions presented in the audit.

### **Lawsuits, Settlements, and Other Legal Actions**

We worked with DCFS legal counsel officials to determine the number of lawsuits or other legal actions filed against the Department within the past three fiscal years that concern abuse or neglect investigations and the number of lawsuits that DCFS has settled within the past three fiscal years that concern an abuse or neglect investigation. We reviewed and summarized the documentation provided by DCFS legal staff. Appendix C is a summary of the lawsuits or other legal actions and settlements for FY15-FY17.

The date of the exit conference, along with principal attendees, are noted below:

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*Date: April 1, 2019*

**Agency**

Department of Children and Family Services

- Debra Dyer-Webster, Interim Director
- Royce Kirkpatrick, Acting CFO
- Kenneth Hovey, Chief Internal Auditor
- Nora Harms-Pavelski, Deputy Director, Child Protection
- Anne Gold, Associate Deputy Director, Child Protection

Office of the Auditor General

- Mike Paoni, Audit Manager
  - Paul Skonberg, Audit Supervisor
  - Brian Bratton, Audit Staff
-



**APPENDIX C**

**LAWSUITS FILED OR SETTLED  
FY15-FY17**

Appendix C  
**LAWSUITS FILED OR SETTLED**  
 FY15-FY17

Count	Case Name	Case Number	Date Filed	Court
1	A.B. v Holliman et al	14CV07897	10/9/2014	U.S. District Court, Northern District, Eastern Division
2	A.N. et al v Bolanos-Ayala	17CV1033	2/8/2017	U.S. District Court, Northern District, Eastern Division
3	Allen v City of Chicago et al	14CV09359	11/20/2014	U.S. District Court, Northern District, Eastern Division
4	Ashley M. v DCFS et al	13CH20278	9/3/2013	Circuit Court of Cook County, County Department, Chancery Division
5	Cole v Meeks	15CV01292	7/15/2015	U.S. District Court, Central District, Peoria Division
6	Dickman v Cook County State's Attorney	16CV9448	10/3/2016	U.S. District Court, Northern District, Eastern Division
7	Fountas v Oak Forest and DCFS	14CV03174	3/25/2014	U.S. District Court, Northern District, Eastern Division

Appendix C  
**LAWSUITS FILED OR SETTLED**  
 FY15-FY17 (Continued)

<b>Summary</b>	<b>Date Disposed</b>	<b>Final Disposition</b>	<b>Settlement Terms</b>
Plaintiff alleged the Department violated her civil rights to unreasonable seizure, to substantive due process, and procedural due process when her children were removed.	6/23/2016	Settled	\$75,000, amend policies
Plaintiff alleged violation of the personal integrity, associational, and property rights of the mother; due process rights as to familial association; and deprivation of her liberty interest in directing medical and psychological care for children and herself.	3/22/2018	Settled	\$100,000, amend policies
Plaintiff alleged malicious prosecution, unlawful detention, unlawful search and seizure, and excessive detention by the Chicago Police and failure to intervene by DCFS investigator who looked into allegations made against plaintiff.	4/5/2018	Dismissed	N/A
Class action suit alleging DCFS violated the Administrative Procedure Act by using Allegation 60 to indicate abuse after Supreme Court invalidated that rule and before it was re-promulgated as a rule (between July 13, 2012, and December 31, 2013).	1/8/2015	Settled	\$50,000; expunge Allegation 60 findings between 7/13/12 and 12/31/13
Plaintiff alleged Department investigator and Peoria Police violated his civil due process rights by withholding exculpatory evidence; fabricating evidence; and failing to intervene to protect his civil rights, and alleged violation of state law including malicious prosecution; false imprisonment; conspiracy; and intentional infliction of emotional distress.		Pending but DCFS no longer defendant	N/A
Plaintiffs alleged intentional infliction of emotional distress, invasion of privacy, defamation, malicious prosecution, conspiracy, violations of substantive and procedural due process rights, the Fourth Amendment right against unreasonable seizures and searches, and equal protection rights against a hospital, doctors, Cook County employees, and a Department employee.	3/16/2018	Dismissed	N/A
Plaintiff sued the Department and City of Oak Forest for wrongful death.		Pending but DCFS no longer defendant	N/A

Appendix C  
**LAWSUITS FILED OR SETTLED**  
FY15-FY17

Count	Case Name	Case Number	Date Filed	Court
8	Harris v Association House of Chicago et al	14L13330	12/29/2014	Circuit Court of Cook County, County Department, Law Division
9	Hughes v Jones et al	12CV09494	12/12/2012	U.S. District Court, Northern District, Eastern Division
10	Juan G v Wilson	15CV02452	3/23/2015	U.S. District Court, Northern District, Eastern Division
11	Kelly K. v DCFS	17CV04703	6/22/2017	U.S. District Court, Northern District, Eastern Division
12	L.W. v DCFS	13CV08463	11/22/2013	U.S. District Court, Northern District, Eastern Division
13	Manier v DCFS	14CH20237	12/18/2014	Circuit Court of Cook County, County Department, Chancery Division
14	Oleszcak v DCFS	17CV00933	2/8/2017	U.S. District Court, Northern District, Eastern Division
15	Nicole P et al v DCFS	16CH12809	9/28/2016	Circuit Court of Cook County, County Department, Chancery Division

Appendix C  
**LAWSUITS FILED OR SETTLED**  
 FY15-FY17 (Continued)

Summary	Date Disposed	Final Disposition	Settlement Terms
Public Guardian sued DCFS contractor and relative caregiver for wrongful death and negligence. DCFS is legally required to represent providers.		Pending	
Plaintiff alleged Department deprived her of her liberty interest and violated both her substantive and procedural due process rights.	9/29/2014	Settled	\$63,000
Plaintiff alleged Department violated his protected liberty interest in chosen career without due process and violated due process rights in its investigatory and hearing processes.	4/25/2017	Settled	\$85,000
Plaintiff alleged Department and contractor violated her fundamental right to familial association as well as her substantive and procedural due process rights. She also alleged violation of the A.B. v. Holliman settlement agreement regarding victims of domestic violence.		Pending	
Plaintiff alleged violations of the Fourth Amendment right not to be subject to unreasonable seizure, her procedural and substantive due process rights related to familial association, rights related to liberty interest in career opportunity, and Title II of the Americans with Disabilities Act for discrimination based on perceived disability.	6/27/2016	Settled	\$150,000, amend policies
This case challenged Allegation 74 (inadequate supervision). Plaintiff was indicated after investigation and sued for reversal of decision to indicate.	8/28/2015	DCFS Decision Reversed - Court ruled Allegation 74 was unlawful as it is outside the scope of ANCRA.	
Plaintiff alleged violation of liberty interests of custodial care and due process rights.		Pending	
This is a class action suit brought by plaintiffs who had been indicated under Allegation 74 (inadequate supervision), which had been declared void by the court in Manier v. DCFS on 8/28/15, that DCFS had not expunged its records or re-promulgate rules for Allegation 74.	6/4/2018	Settled	DCFS to allow special reviews of Allegation 74 findings indicated between 8/28/15 and 5/9/17.

Appendix C  
**LAWSUITS FILED OR SETTLED**  
FY15-FY17

<b>Count</b>	<b>Case Name</b>	<b>Case Number</b>	<b>Date Filed</b>	<b>Court</b>
16	Jessica R and Claudia G v Department of Children and Family Services et al	15CH4487	5/29/2015	Circuit Court of Cook County, County Department, Chancery Division
17	Roberson v Village of Sauk Village	14CV08174	10/17/2014	U.S. District Court, Northern District, Eastern Division
18	S.B.T v Miller et al	15CV00162	2/13/2015	U.S. District Court, Southern District, East St. Louis Division
19	Sebesta v Davis, et al	12CV07834	9/28/2012	U.S. District Court, Northern District, Eastern Division
20	Traharne et al v DCFS et al	15CV11133	12/10/2015	U.S. District Court, Northern District, Eastern Division
21	Tyagi et al v Sheldon et al	16CV11236	12/9/2016	U.S. District Court, Northern District, Eastern Division
22	Van Dyke v DCFS et al	13CV05971	8/22/2013	U.S. District Court, Northern District, Eastern Division

Appendix C  
**LAWSUITS FILED OR SETTLED**  
 FY15-FY17 (Continued)

Summary	Date Disposed	Final Disposition	Settlement Terms
Case was originally Etonia C. v DCFS, but other plaintiffs were added. Plaintiffs challenged the Allegation 60 (environment injurious) emergency rule made 1/1/14 and expiring 5/31/14 claiming DCFS improperly invoked emergency rulemaking authority because there was no emergency.	11/22/2016	Settled	DCFS agreed to expunge all persons indicated between January 1, 2014, and May 31, 2014.
Plaintiff alleged Department and Sauk Village officials violated her protected liberty interest of chosen career, substantive and procedural due process rights, and her Fourth Amendment right to be free from unreasonable seizure, as well as malicious prosecution, intentional infliction of emotional distress, and conspiracy.	3/30/2016	Dismissed	N/A
Plaintiff alleged Department violated her liberty interest in pursuing her career and rights to due process. She also alleged that the allegation indicated (Allegation 60) was void.	8/21/2017	Settled	\$60,000
Plaintiff alleged violation of substantive due process, invasion of privacy, and intentional infliction of emotional distress.	1/20/2016	Dismissed	N/A
Plaintiffs alleged violation of Fourth Amendment right against unlawful seizure, substantive due process rights to familial rights and association, and procedural due process rights for removing children.		Pending	
Plaintiffs alleged violation of First Amendment rights to free exercise of religion, Fourth Amendment rights to unlawful search and seizure, and due process and equal protection rights guaranteed by the Fourteenth Amendment among others.		Pending	
Plaintiff alleged violation of First Amendment right to free speech, Fourth Amendment right to be free from unlawful search, and Fourteenth Amendment regarding due process.		Pending but DCFS defendant dismissed	N/A

Appendix C  
**LAWSUITS FILED OR SETTLED**  
FY15-FY17

<b>Count</b>	<b>Case Name</b>	<b>Case Number</b>	<b>Date Filed</b>	<b>Court</b>
23	W.M. v Giscombe et al	15CV00305	1/13/2015	U.S. District Court, Northern District, Eastern Division

Source: OAG analysis of information provided by DCFS legal counsel.



Appendix C  
**LAWSUITS FILED OR SETTLED**  
 FY15-FY17 (Continued)

Summary	Date Disposed	Final Disposition	Settlement Terms
Plaintiff alleged violation of Fourth Amendment right against unreasonable seizure, substantive due process rights to familial association, and procedural due process rights.	6/20/2016	Settled	\$93,000, amend policies

Source: OAG analysis of information provided by DCFS legal counsel.



**APPENDIX D**

**INTACT FAMILY SERVICES  
PROVIDER CONTRACTS  
FY15-FY17**



**APPENDIX D  
INTACT FAMILY SERVICES PROVIDER CONTRACTS  
FY15**

<b>Provider</b>	<b>Contract Number</b>	<b>Capacity</b>	<b>Expenditures</b>
Arden Shore Child And Family Services	0015243135	60	\$841,162.16
Association House Of Chicago	0280514295	90	\$913,067.19
Aunt Marthas Youth Svc Ctr Inc.	0016673145	60	\$742,627.45
Baby Fold	0203296105	20	\$137,600.26
Bethany For Children And Families	3105102195	30	\$357,099.36
Casa Central Social Services	0039064125	140	\$1,784,340.83
Catholic Charities Diocese SPF	0039735105	85	\$991,194.66
Catholic Charities/The Arch Of Chicago	0039714315	140	\$1,808,769.22
Center For Youth & Family Solutions	5129612095	40	\$586,162.70
Center For Youth & Family Solutions	5129615015	20	\$327,771.57
Center For Youth & Family Solutions	5129616055	120	\$969,752.39
Childrens Home And Aid Soc Of Illinois	0042361055	60	\$569,594.14
Childrens Home And Aid Soc Of Illinois	0042364245	30	\$370,919.40
Childrens Home And Aid Soc Of Illinois	0042366095	20	\$126,497.88
Childrens Home And Aid Soc Of Illinois	0042367095	90	\$919,308.51
Childrens Home And Aid Soc Of Illinois	1463033025	140	\$1,224,437.59
Childrens Home Association Of Illinois	0042592165	60	\$773,991.49
Community Youth Network Inc.	0002923065	20	\$247,113.42
Evangelical Child And Family Agency	0067263035	50	\$799,363.45
Hephzibah Children's Association	0094104175	10	\$215,515.27
Kaleidoscope, Inc.	0111264255	70	\$885,719.25
Lutheran Child And Family Services IL	0129988085	50	\$443,403.94
Lutheran Social Services Of Illinois	0130051155	10	\$137,633.35
Lutheran Social Services Of Illinois	0130051165	20	\$196,389.73
Lutheran Social Services Of Illinois	0130052045	40	\$531,848.68
Lutheran Social Services Of Illinois	0130054225	80	\$798,973.76
Lutheran Social Services Of Illinois	0130058055	80	\$1,025,890.79
Omni Youth Services	0005654055	180	\$2,219,473.01
One Hope United-Hudelson Region	0100538055	70	\$1,040,655.77
One Hope United-Hudelson Region	0100535025	85	\$672,723.79
One Hope United-Northern Region	0040193155	30	\$392,528.25
One Hope United-Northern Region	0040194285	110	\$1,271,658.32
Pioneer Center	1656493095	50	\$623,116.75
Rutledge Youth Foundation, Inc.	0178229025	10	\$211,736.59
Sinnissippi Centers, Inc.	0968021175	30	\$378,127.16
Universal Family Connection Inc.	0935184165	50	\$633,670.63
Webster Cantrell Hall	0217466015	30	\$578,811.14
Youth Outreach Services Inc.	0698844225	20	\$356,743.06
Youth Service Bureau Of Illinois Valley	2808991025	10	\$121,640.25
Youth Service Bureau Of Illinois Valley	2808992235	20	\$147,805.99
Youth Service Bureau Of Illinois Valley	2808993015	30	\$310,441.13
Youth Services Network, Inc.	0775759045	20	\$209,901.41
<b>Total</b>		<b>2,380</b>	<b>\$27,895,181.69</b>

Note: Capacity represents the number of families that can be served, not individuals.

Source: OAG analysis of DCFS data.

**APPENDIX D  
INTACT FAMILY SERVICES PROVIDER CONTRACTS  
FY16**

<b>Provider</b>	<b>Contract Number</b>	<b>Capacity</b>	<b>Expenditures</b>
Arden Shore Child And Family Services	0015243136	70	\$908,195.46
Association House Of Chicago	0280514296	70	\$808,960.72
Aunt Marthas Youth Svc Ctr, Inc.	0016673146	60	\$519,305.65
Baby Fold	0203296106	30	\$118,606.03
Bethany For Children And Families	3105102196	30	\$351,415.33
Casa Central Social Services	0039064126	130	\$1,542,923.58
Catholic Charities Diocese SPF	0039735106	90	\$1,350,569.30
Catholic Charities/The Arch Of Chicago	0039714316	120	\$1,324,850.96
Center For Youth & Family Solutions	5129616056	160	\$1,810,026.90
Childrens Home And Aid Soc Of Illinois	0042364246	30	\$330,975.30
Childrens Home And Aid Soc Of Illinois	0042366096	10	\$104,797.21
Childrens Home And Aid Soc Of Illinois	0042367096	70	\$1,093,904.74
Childrens Home And Aid Soc Of Illinois	1463033026	150	\$1,918,772.77
Childrens Home Association Of Illinois	0042592166	60	\$763,059.90
Community Youth Network Inc.	0002923066	20	\$304,507.62
Evangelical Child And Family Agency	0067263036	50	\$682,537.99
Hephzibah Children's Association	0094104176	30	\$393,329.14
Kaleidoscope, Inc.	0111264256	60	\$437,347.56
Lutheran Child And Family Services IL	0129988086	50	\$443,663.44
Lutheran Social Services Of Illinois	0130051166	30	\$320,687.93
Lutheran Social Services Of Illinois	0130052046	40	\$666,860.60
Lutheran Social Services Of Illinois	0130054226	60	\$719,232.12
Lutheran Social Services Of Illinois	0130058056	70	\$1,303,917.82
Omni Youth Services	0005654056	170	\$1,882,871.07
One Hope United-Northern Region	0040193156	30	\$520,880.94
One Hope United-Northern Region	0040194286	90	\$1,230,979.59
One Hope United-Hudelson Region	0100535026	50	\$561,070.75
One Hope United-Hudelson Region	0100538056	90	\$1,267,728.74
Pioneer Center	1656493096	50	\$466,211.05
Rutledge Youth Foundation, Inc.	0178229026	10	\$189,201.08
Sinnissippi Centers, Inc.	0968021176	30	\$501,011.79
Universal Family Connection Inc.	0935184166	50	\$555,468.37
Webster Cantrell Hall	0217466016	20	\$202,074.38
Youth Advocate Program Inc.	0007292016	10	\$39,262.85
Youth Outreach Services Inc.	0698844226	30	\$282,297.87
Youth Service Bureau Of Illinois Valley	2808992236	20	\$143,559.02
Youth Service Bureau Of Illinois Valley	2808993016	90	\$526,968.79
Youth Services Network, Inc.	0775759046	20	\$220,655.93
<b>Total</b>		<b>2,250</b>	<b>\$26,808,690.29</b>

Note: Capacity represents the number of families that can be served, not individuals.

Source: OAG analysis of DCFS data.

**APPENDIX D  
INTACT FAMILY SERVICES PROVIDER CONTRACTS  
FY17**

<b>Provider</b>	<b>Contract Number</b>	<b>Capacity</b>	<b>Expenditures</b>
Arden Shore Child And Family Services	0015243137	80	\$959,074.62
Association House Of Chicago	0280514297	70	\$787,228.92
Aunt Marthas Youth Svc Ctr Inc.	0016673147	80	\$881,402.67
Baby Fold	0203296107	30	\$151,989.89
Bethany For Children And Families	3105102197	30	\$388,750.45
Casa Central Social Services	0039064127	130	\$1,534,656.50
Catholic Charities Diocese SPF	0039735107	90	\$1,335,909.44
Catholic Charities/ The Arch Of Chicago	0039714317	110	\$1,408,652.00
Center For Youth & Family Solutions	5129616057	150	\$1,722,270.61
Childrens Home And Aid Society Of Illinois	0042364247	30	\$372,407.77
Childrens Home And Aid Society Of Illinois	0042366097	30	\$356,595.13
Childrens Home And Aid Society Of Illinois	0042367097	80	\$1,707,684.22
Childrens Home And Aid Society Of Illinois	1463033027	150	\$2,063,974.42
Childrens Home Association Of Illinois	0042592167	60	\$934,300.76
Community Youth Network Inc.	0002923067	20	\$388,561.95
Evangelical Child And Family Agency	0067263037	50	\$733,114.45
Hephzibah Children's Association	0094104177	30	\$399,557.00
Kaleidoscope, Inc.	0111264257	60	\$572,684.53
Lutheran Child And Family Services IL	0129988087	50	\$532,849.76
Lutheran Social Services Of Illinois	0130051167	30	\$558,717.14
Lutheran Social Services Of Illinois	0130052047	60	\$1,002,984.52
Lutheran Social Services Of Illinois	0130054227	60	\$741,028.67
Lutheran Social Services Of Illinois	0130058057	100	\$1,672,598.95
Omni Youth Services	0005654057	160	\$1,698,655.52
One Hope United-Hudelson Region	0100535027	55	\$792,764.25
One Hope United-Hudelson Region	0100538057	105	\$1,530,461.21
One Hope United-Northern Region	0040193157	40	\$491,561.82
One Hope United-Northern Region	0040194287	90	\$1,166,216.17
Rutledge Youth Foundation, Inc.	0178229027	10	\$143,892.58
Sinnissippi Centers, Inc.	0968021177	50	\$488,682.44
Universal Family Connection Inc.	0935184167	50	\$592,064.32
Webster Cantrell Hall	0217466017	20	\$322,916.56
Youth Advocate Program Inc.	0007292017	10	\$235,709.93
Youth Outreach Services Inc.	0698844227	30	\$330,411.91
Youth Service Bureau Of Illinois Valley	2808992237	20	\$187,514.03
Youth Service Bureau Of Illinois Valley	2808993017	90	\$1,257,272.46
Youth Services Network, Inc.	0775759047	20	\$265,354.48
<b>Total</b>		<b>2,330</b>	<b>\$30,710,472.05</b>

Note: Capacity represents the number of families that can be served, not individuals.

Source: OAG analysis of DCFS data.





**APPENDIX E**

**ABUSE AND NEGLECT  
ALLEGATIONS  
FY15-FY17**



Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATION CLASSIFICATIONS**

Abuse Allegations	Neglect Allegations
#1 – Death	#51 – Death
#2 – Head Injuries	#52 – Head Injuries
#4 – Internal Injuries	#54 – Internal Injuries
#5 – Burns	#55 – Burns
#6 – Poison/Noxious Substances	#56 – Poison/Noxious Substances
#7 – Wounds	#57 – Wounds
#9 – Bone Fractures	#59 – Bone Fractures
#10 – Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare <ul style="list-style-type: none"> <li>• 10a – Incidents of Violence or Intimidation</li> <li>• 10b – Medical Child Abuse (Factitious Disorder by Proxy or Munchausen by Proxy Syndrome)</li> </ul>	#60 – Substantial Risk of Physical Injury/Environment Injurious to Health and Welfare
#11 – Cuts, Bruises, Welts, Abrasions and Oral Injuries	#61 – Cuts, Bruises, Welts, Abrasions, and Oral Injuries
#12 – Human Bites	#62 – Human Bites
#13 – Sprains/Dislocations	#63 – Sprains/Dislocations
#14 – Tying/Close Confinement	#65 – Substance Misuse
#15 – Substance Misuse	#67 – Mental and Emotional Impairment
#16 – Torture	#74 – Inadequate Supervision
#17 – Mental and Emotional Impairment	#75 – Abandonment/Desertion
#18 – Sexually Transmitted Diseases	#76 – Inadequate Food
#19 – Sexual Penetration	#77 – Inadequate Shelter
#20 – Sexual Exploitation	#78 – Inadequate Clothing
#21 – Sexual Molestation	#79 – Medical Neglect
#22 – Substantial Risk of Sexual Injury <ul style="list-style-type: none"> <li>• 22a – Sex offender has access</li> <li>• 22b – Sibling of sex abuse victim</li> <li>• 22c – Sexualized behavior of young child</li> <li>• 22d – Child Pornography</li> <li>• 22e – Suggestive Behavior</li> </ul>	#81 – Failure to Thrive (Non-Organic)
	#82 – Environmental Neglect
	#83 – Malnutrition (Non-Organic)
	#84 – Lock-out <ul style="list-style-type: none"> <li>• 84a – Community Location</li> <li>• 84b – Psychiatrically Hospitalized</li> <li>• 84c – Correctional Facility</li> </ul>
	#85 – Medical Neglect of Disabled Infants
#40 – Human Trafficking of Children	#86 – Neglect by Agency
	#90 – Human Trafficking of Children

Note: Death & Serious Harm allegations are highlighted in red.

Source: DCFS Procedures 300 Appendix B & DCFS Child Protective Services Statistics.



Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
FY15

<b>Allegations</b>	<b>Indicated</b>	<b>Unfounded</b>	<b>Total</b>	<b>Percent Indicated</b>
60- Substantial Risk of Physical Injury by Neglect	14,934	20,390	35,324	42.3%
74- Inadequate Supervision	6,497	16,814	23,311	27.9%
10- Substantial Risk of Physical Injury by Abuse	3,962	13,577	17,539	22.6%
11- Cuts, Bruises, Welts, Abrasions, and Oral Injuries	2,423	9,824	12,247	19.8%
82- Environmental Neglect	1,948	8,244	10,192	19.1%
22b- Substantial Risk of Sexual Abuse- Sibling of sex abuse victim	1,709	3,798	5,507	31.0%
21- Sexual Molestation	1,230	2,988	4,218	29.2%
79- Medical Neglect	681	3,128	3,809	17.9%
22a- Substantial Risk of Sexual Abuse- Sex offender has access	1,018	2,758	3,776	27.0%
19- Sexual Penetration	1,172	2,108	3,280	35.7%
77- Inadequate Shelter	469	2,173	2,642	17.8%
76- Inadequate Food	169	2,433	2,602	6.5%
61- Cuts, Bruises, Welts, Abrasions, and Oral Injuries by Neglect	314	1,084	1,398	22.5%
20- Sexual Exploitation	359	1,010	1,369	26.2%
15- Substance Misuse	195	1,026	1,221	16.0%
84- Lock-Out	133	1,050	1,183	11.2%
65- Substance Misuse by Neglect	567	445	1,012	56.0%
78- Inadequate Clothing	34	480	514	6.6%
55- Burns by Neglect	105	392	497	21.1%
22c- Substantial Risk of Sexual Abuse- Sexualized behavior of young child	36	442	478	7.5%
5- Burns	55	416	471	11.7%
9- Bone Fractures	149	278	427	34.9%
14- Tying/Close Confinement	52	288	340	15.3%
17- Mental and Emotional Impairment by Abuse	23	302	325	7.1%
59- Bone Fractures by Neglect	76	182	258	29.5%
12- Human Bites	75	179	254	29.5%
2- Head Injuries	93	108	201	46.3%
22d- Substantial Risk of Sexual Abuse- Child Pornography	96	99	195	49.2%
67- Mental Injury by Neglect	6	183	189	3.2%
52- Head Injuries by Neglect	47	123	170	27.6%
75- Abandonment/Desertion	74	93	167	44.3%
81- Failure to Thrive	87	59	146	59.6%
16- Torture	27	98	125	21.6%
40- Human Trafficking of Children	26	97	123	21.1%
51- Death by Neglect	46	74	120	38.3%
6- Poison/Noxious Substances	4	110	114	3.5%
18- Sexually Transmitted Diseases	44	53	97	45.4%
56- Poison/Noxious Substances by Neglect	18	71	89	20.2%
62- Human Bites by Neglect	12	62	74	16.2%
4- Internal Injuries	18	22	40	45.0%
13- Sprains/Dislocations	9	29	38	23.7%
1- Death	19	16	35	54.3%

Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
 FY15 (Continued)

Allegations	Indicated	Unfounded	Total	Percent Indicated
7- Wounds	16	19	35	45.7%
83- Malnutrition	22	13	35	62.9%
57- Wounds by Neglect	11	20	31	35.5%
54- Internal Injuries by Neglect	9	18	27	33.3%
90- Human Trafficking of Children by Neglect	1	22	23	4.3%
85- Medical Neglect of Disabled Infants	4	6	10	40.0%
63- Sprains/Dislocations by Neglect	2	4	6	33.3%
22e- Substantial Risk of Sexual Abuse- Suggestive Behavior	0	0	0	0.0%
86- Neglect by Agency	0	0	0	0.0%
<b>Total</b>	<b>39,076</b>	<b>97,208</b>	<b>136,284</b>	<b>28.7%</b>

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
FY16

<b>Allegation</b>	<b>Indicated</b>	<b>Unfounded</b>	<b>Total</b>	<b>Percent Indicated</b>
60- Substantial Risk of Physical Injury by Neglect	14,549	28,981	43,530	33.4%
74- Inadequate Supervision	6,249	20,402	26,651	23.4%
10- Substantial Risk of Physical Injury by Abuse	4,233	19,509	23,742	17.8%
11- Cuts, Bruises, Welts, Abrasions, and Oral Injuries	2,212	10,827	13,039	17.0%
82- Environmental Neglect	1,819	9,160	10,979	16.6%
22b- Substantial Risk of Sexual Abuse- Sibling of sex abuse victim	1,600	4,474	6,074	26.3%
21- Sexual Molestation	1,245	3,497	4,742	26.3%
79- Medical Neglect	637	3,991	4,628	13.8%
22a- Substantial Risk of Sexual Abuse- Sex offender has access	863	3,023	3,886	22.2%
19- Sexual Penetration	1,047	2,324	3,371	31.1%
76- Inadequate Food	108	2,701	2,809	3.8%
77- Inadequate Shelter	420	2,154	2,574	16.3%
20- Sexual Exploitation	399	1,348	1,747	22.8%
61- Cuts, Bruises, Welts, Abrasions, and Oral Injuries by Neglect	249	1,383	1,632	15.3%
15- Substance Misuse	183	1,295	1,478	12.4%
84- Lock-Out	125	1,181	1,306	9.6%
65- Substance Misuse by Neglect	644	596	1,240	51.9%
17- Mental Injury	18	861	879	2.0%
55- Burns by Neglect	85	458	543	15.7%
22c- Substantial Risk of Sexual Abuse- Sexualized behavior of young child	19	517	536	3.5%
78- Inadequate Clothing	33	464	497	6.6%
14- Tying/Close Confinement	51	413	464	11.0%
5- Burns	54	391	445	12.1%
9- Bone Fractures	145	244	389	37.3%
59- Bone Fractures by Neglect	42	229	271	15.5%
12- Human Bites	66	202	268	24.6%
22d- Substantial Risk of Sexual Abuse- Child Pornography	99	164	263	37.6%
51- Death by Neglect	50	174	224	22.3%
2- Head Injuries	95	122	217	43.8%
75- Abandonment/Desertion	73	143	216	33.8%
40- Human Trafficking of Children	37	175	212	17.5%
16- Torture	20	183	203	9.9%
52- Head Injuries by Neglect	42	145	187	22.5%
81- Failure to Thrive	89	97	186	47.8%
67- Mental Injury by Neglect	10	166	176	5.7%

Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
 FY16 (Continued)

Allegation	Indicated	Unfounded	Total	Percent Indicated
6- Poison/Noxious Substances	24	148	172	14.0%
22e- Substantial Risk of Sexual Abuse- Suggestive Behavior	37	80	117	31.6%
56- Poison/Noxious Substances by Neglect	12	90	102	11.8%
18- Sexually Transmitted Diseases	33	59	92	35.9%
62- Human Bites by Neglect	17	49	66	25.8%
83- Malnutrition	11	48	59	18.6%
1- Death	26	29	55	47.3%
13- Sprains/Dislocations	5	48	53	9.4%
7- Wounds	19	30	49	38.8%
57- Wounds by Neglect	12	26	38	31.6%
4- Internal Injuries	17	18	35	48.6%
90- Human Trafficking of Children by Neglect	2	27	29	6.9%
54- Internal Injuries by Neglect	6	14	20	30.0%
63- Sprains/Dislocations by Neglect	2	16	18	11.1%
86- Neglect by Agency	1	15	16	6.3%
85- Medical Neglect of Disabled Infants	4	11	15	26.7%
<b>Total</b>	<b>37,838</b>	<b>122,702</b>	<b>160,540</b>	<b>23.6%</b>

Source: OAG analysis of DCFS data as of July 27, 2018.



Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
FY17

<b>Allegation</b>	<b>Indicated</b>	<b>Unfounded</b>	<b>Total</b>	<b>Percent Indicated</b>
60- Substantial Risk of Physical Injury by Neglect	15,508	28,657	44,165	35.1%
74- Inadequate Supervision	5,836	18,744	24,580	23.7%
10- Substantial Risk of Physical Injury by Abuse	3,414	17,502	20,916	16.3%
11- Cuts, Bruises, Welts, Abrasions, and Oral Injuries	2,213	10,277	12,490	17.7%
82- Environmental Neglect	1,880	9,071	10,951	17.2%
22b- Substantial Risk of Sexual Abuse- Sibling of sex abuse victim	1,568	4,459	6,027	26.0%
21- Sexual Molestation	1,220	3,345	4,565	26.7%
79- Medical Neglect	647	3,777	4,424	14.6%
22a- Substantial Risk of Sexual Abuse- Sex offender has access	763	2,543	3,306	23.1%
19- Sexual Penetration	998	2,112	3,110	32.1%
76- Inadequate Food	161	2,566	2,727	5.9%
77- Inadequate Shelter	430	1,945	2,375	18.1%
20- Sexual Exploitation	373	1,174	1,547	24.1%
61- Cuts, Bruises, Welts, Abrasions, and Oral Injuries by Neglect	240	1,178	1,418	16.9%
84- Lock-Out	147	1,208	1,355	10.8%
65- Substance Misuse by Neglect	786	554	1,340	58.7%
15- Substance Misuse	178	1,160	1,338	13.3%
17- Mental Injury	47	899	946	5.0%
78- Inadequate Clothing	33	488	521	6.3%
55- Burns by Neglect	77	397	474	16.2%
14- Tying/Close Confinement	67	404	471	14.2%
5- Burns	47	407	454	10.4%
22c- Substantial Risk of Sexual Abuse- Sexualized behavior of young child	35	377	412	8.5%
9- Bone Fractures	133	271	404	32.9%
22e- Substantial Risk of Sexual Abuse- Suggestive Behavior	89	302	391	22.8%
75- Abandonment/Desertion	90	157	247	36.4%
12- Human Bites	75	171	246	30.5%
59- Bone Fractures by Neglect	60	176	236	25.4%
2- Head Injuries	98	126	224	43.8%
51- Death by Neglect	63	158	221	28.5%
40- Human Trafficking of Children	45	171	216	20.8%
81- Failure to Thrive	94	99	193	48.7%
52- Head Injuries by Neglect	40	149	189	21.2%
22d- Substantial Risk of Sexual Abuse- Child Pornography	76	81	157	48.4%
16- Torture	13	143	156	8.3%
6- Poison/Noxious Substances	17	112	129	13.2%

Appendix E  
**DCFS ABUSE AND NEGLECT ALLEGATIONS BY TYPE**  
 FY17 (Continued)

Allegation	Indicated	Unfounded	Total	Percent Indicated
67- Mental Injury by Neglect	3	114	117	2.6%
56- Poison/Noxious Substances by Neglect	21	82	103	20.4%
18- Sexually Transmitted Diseases	35	43	78	44.9%
83- Malnutrition	21	47	68	30.9%
86- Neglect by Agency	15	47	62	24.2%
62- Human Bites by Neglect	8	50	58	13.8%
1- Death	18	33	51	35.3%
13- Sprains/Dislocations	9	41	50	18.0%
7- Wounds	14	32	46	30.4%
57- Wounds by Neglect	13	20	33	39.4%
4- Internal Injuries	16	11	27	59.3%
90- Human Trafficking of Children by Neglect	1	21	22	4.5%
54- Internal Injuries by Neglect	2	8	10	20.0%
63- Sprains/Dislocations by Neglect	1	7	8	12.5%
85- Medical Neglect of Disabled Infants	1	4	5	20.0%
<b>Total</b>	<b>37,739</b>	<b>115,920</b>	<b>153,659</b>	<b>24.6%</b>

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix E  
**SPECIAL TYPES OF VICTIMS**  
 FY15-FY17

Special Type	FY15		FY16		FY17		Total	
	All	Indicated	All	Indicated	All	Indicated	All	Indicated
Sexual Abuse	16,805	4,779	18,442	4,473	17,255	4,273	52,502	13,525
Death & Serious Harm	10,202	2,810	11,492	2,702	10,745	2,623	32,439	8,135
Substance Exposed Infants	701	540	809	619	914	733	2,424	1,892
Human Trafficking	143	27	238	39	233	46	614	112
Human Trafficking Involving Sexual Abuse	32	12	50	17	43	18	125	47

Source: OAG analysis of DCFS data as of July 27, 2018.

**APPENDIX F**

**VICTIM DEMOGRAPHIC  
INFORMATION**

**AGE, RACE, ETHNICITY, AND GENDER**

**FY15-FY17**

Auditor Note:

Data provided by the Department included the total number of alleged victims involved in an investigation during the three-year audit period. Since victims can be reported multiple times, numbers presented are not an unduplicated count.



Appendix F  
**ALLEGED VICTIMS BY AGE**  
 FY15-FY17

Age	FY15		FY16		FY17		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
0	9,032	8.20%	10,174	7.99%	9,755	8.05%	28,961	8.08%
1	6,620	6.01%	7,640	6.00%	7,393	6.10%	21,653	6.04%
2	6,699	6.08%	7,643	6.00%	7,204	5.95%	21,546	6.01%
3	6,829	6.20%	7,524	5.91%	7,144	5.90%	21,497	6.00%
4	6,910	6.27%	7,419	5.83%	7,035	5.81%	21,364	5.96%
5	7,186	6.52%	7,999	6.28%	7,252	5.99%	22,437	6.26%
6	7,396	6.72%	7,911	6.21%	7,460	6.16%	22,767	6.35%
7	7,181	6.52%	8,034	6.31%	7,472	6.17%	22,687	6.33%
8	6,518	5.92%	7,793	6.12%	7,125	5.88%	21,436	5.98%
9	6,181	5.61%	7,189	5.65%	7,069	5.84%	20,439	5.70%
10	5,500	4.99%	6,652	5.23%	6,575	5.43%	18,727	5.22%
11	5,388	4.89%	6,471	5.08%	6,104	5.04%	17,963	5.01%
12	5,301	4.81%	6,331	4.97%	5,980	4.94%	17,612	4.91%
13	5,191	4.71%	6,067	4.77%	5,940	4.90%	17,198	4.80%
14	5,211	4.73%	5,959	4.68%	5,966	4.93%	17,136	4.78%
15	4,772	4.33%	6,081	4.78%	5,634	4.65%	16,487	4.60%
16	4,315	3.92%	5,411	4.25%	5,257	4.34%	14,983	4.18%
17	3,177	2.88%	3,992	3.14%	3,908	3.23%	11,077	3.09%
18+	164	0.15%	175	0.14%	160	0.13%	499	0.14%
Unknown	565	0.51%	826	0.65%	685	0.57%	2,076	0.58%
<b>Total</b>	<b>110,136</b>	<b>100%</b>	<b>127,291</b>	<b>100%</b>	<b>121,118</b>	<b>100%</b>	<b>358,545</b>	<b>100%</b>

Note: Totals may not add to 100% due to rounding.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**INDICATED VICTIMS BY AGE**  
 FY15-FY17

Age	FY15		FY16		FY17		Total	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
0	4,315	13.08%	4,278	13.38%	4,260	13.48%	12,853	13.31%
1	2,600	7.88%	2,566	8.03%	2,574	8.14%	7,740	8.01%
2	2,374	7.20%	2,430	7.60%	2,319	7.34%	7,123	7.38%
3	2,310	7.00%	2,237	7.00%	2,204	6.97%	6,751	6.99%
4	2,169	6.57%	2,117	6.62%	1,974	6.24%	6,260	6.48%
5	2,124	6.44%	1,979	6.19%	1,953	6.18%	6,056	6.27%
6	2,107	6.39%	1,922	6.01%	1,838	5.81%	5,867	6.08%
7	2,010	6.09%	1,816	5.68%	1,804	5.71%	5,630	5.83%
8	1,752	5.31%	1,855	5.80%	1,698	5.37%	5,305	5.49%
9	1,777	5.39%	1,649	5.16%	1,733	5.48%	5,159	5.34%
10	1,486	4.50%	1,498	4.69%	1,495	4.73%	4,479	4.64%
11	1,460	4.42%	1,390	4.35%	1,408	4.45%	4,258	4.41%
12	1,358	4.12%	1,333	4.17%	1,317	4.17%	4,008	4.15%
13	1,262	3.82%	1,202	3.76%	1,214	3.84%	3,678	3.81%
14	1,242	3.76%	1,110	3.47%	1,134	3.59%	3,486	3.61%
15	1,062	3.22%	1,043	3.26%	1,128	3.57%	3,233	3.35%
16	947	2.87%	889	2.78%	913	2.89%	2,749	2.85%
17	604	1.83%	623	1.95%	627	1.98%	1,854	1.92%
18+	17	0.05%	14	0.04%	6	0.02%	37	0.04%
Unknown	19	0.06%	20	0.06%	11	0.03%	50	0.05%
<b>Total</b>	<b>32,995</b>	<b>100%</b>	<b>31,971</b>	<b>100%</b>	<b>31,610</b>	<b>100%</b>	<b>96,576</b>	<b>100%</b>

Note: Totals may not add to 100% due to rounding.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**ALLEGED VICTIMS BY RACE**  
 FY15-FY17

Race	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
White	67,669	61.44%	80,361	63.13%	76,050	62.79%	224,080	62.50%
Black/African-American	38,113	34.61%	42,588	33.46%	40,893	33.76%	121,594	33.91%
Asian	1,158	1.05%	1,430	1.12%	1,373	1.13%	3,961	1.10%
Native American/ Alaska Native	160	0.15%	185	0.15%	143	0.12%	488	0.14%
Native Hawaiian/ Other Pacific Islander	100	0.09%	96	0.08%	95	0.08%	291	0.08%
Unknown <sup>2</sup>	2,936	2.67%	2,631	2.07%	2,564	2.12%	8,131	2.27%
<b>Total<sup>1</sup></b>	<b>110,136</b>	<b>100%</b>	<b>127,291</b>	<b>100%</b>	<b>121,118</b>	<b>100%</b>	<b>358,545</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> Unknown includes the categories of Unknown, Not Reported, Could not be verified, Declined to Identify, and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**INDICATED VICTIMS BY RACE**  
 FY15-FY17

Race	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
White	20,023	60.68%	20,341	63.62%	19,864	62.84%	60,228	62.36%
Black/African-American	11,795	35.75%	10,789	33.75%	10,915	34.53%	33,499	34.69%
Asian	303	0.92%	262	0.82%	268	0.85%	833	0.86%
Native American/ Alaska Native	68	0.21%	40	0.13%	38	0.12%	146	0.15%
Native Hawaiian/ Other Pacific Islander	23	0.07%	21	0.07%	25	0.08%	69	0.07%
Unknown <sup>2</sup>	783	2.37%	518	1.62%	500	1.58%	1,801	1.87%
<b>Total<sup>1</sup></b>	<b>32,995</b>	<b>100%</b>	<b>31,971</b>	<b>100%</b>	<b>31,610</b>	<b>100%</b>	<b>96,576</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> Unknown includes the categories of Unknown, Not Reported, Could not be verified, Declined to Identify, and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**ALLEGED VICTIMS BY ETHNICITY**  
 FY15-FY17

Ethnicity	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Not Hispanic	66,420	60.31%	87,771	68.95%	86,959	71.80%	241,150	67.26%
Hispanic <sup>2</sup>	16,584	15.06%	20,158	15.84%	19,321	15.95%	56,063	15.64%
Not Reported	21,006	19.07%	9,516	7.48%	7,154	5.91%	37,676	10.51%
Unknown <sup>3</sup>	6,126	5.56%	9,846	7.74%	7,684	6.34%	23,656	6.60%
<b>Total<sup>1</sup></b>	<b>110,136</b>	<b>100%</b>	<b>127,291</b>	<b>100%</b>	<b>121,118</b>	<b>100%</b>	<b>358,545</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> DCFS divides Hispanic into Central American, Cuban, Dominican, Mexican, Other, Puerto Rican, South American, and Spanish Descent.

<sup>3</sup> Unknown includes the categories of Unknown, Could not be verified, Declined to Identify, and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**INDICATED VICTIMS BY ETHNICITY**  
 FY15-FY17

Ethnicity	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Not Hispanic	19,402	58.80%	21,601	67.56%	22,670	71.72%	63,673	65.93%
Hispanic <sup>2</sup>	5,484	16.62%	5,462	17.08%	5,178	16.38%	16,124	16.70%
Not Reported	6,381	19.34%	2,395	7.49%	1,856	5.87%	10,632	11.01%
Unknown <sup>3</sup>	1,728	5.24%	2,513	7.86%	1,906	6.03%	6,147	6.36%
<b>Total<sup>1</sup></b>	<b>32,995</b>	<b>100%</b>	<b>31,971</b>	<b>100%</b>	<b>31,610</b>	<b>100%</b>	<b>96,576</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> DCFS divides Hispanic into Central American, Cuban, Dominican, Mexican, Other, Puerto Rican, South American, and Spanish Descent.

<sup>3</sup> Unknown includes the categories of Unknown, Could not be verified, Declined to Identify, and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.



Appendix F  
**ALLEGED VICTIMS BY GENDER**  
 FY15-FY17

Gender	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Male	54,814	49.77%	63,100	49.57%	60,359	49.83%	178,273	49.72%
Female	54,509	49.49%	63,310	49.74%	59,961	49.51%	177,780	49.58%
Unknown <sup>2</sup>	813	0.74%	881	0.69%	798	0.66%	2,492	0.70%
<b>Total<sup>1</sup></b>	<b>110,136</b>	<b>100%</b>	<b>127,291</b>	<b>100%</b>	<b>121,118</b>	<b>100%</b>	<b>358,545</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> Unknown includes the categories of Unknown and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.

Appendix F  
**INDICATED VICTIMS BY GENDER**  
 FY15-FY17

Gender	FY15		FY16		FY17		Total <sup>1</sup>	
	Count	Percent	Count	Percent	Count	Percent	Count	Percent
Male	16,271	49.31%	15,736	49.22%	15,660	49.54%	47,667	49.36%
Female	16,590	50.28%	16,112	50.40%	15,832	50.09%	48,534	50.25%
Unknown <sup>2</sup>	134	0.41%	123	0.38%	118	0.37%	375	0.39%
<b>Total<sup>1</sup></b>	<b>32,995</b>	<b>100%</b>	<b>31,971</b>	<b>100%</b>	<b>31,610</b>	<b>100%</b>	<b>96,576</b>	<b>100%</b>

Notes:

<sup>1</sup> Totals may not add to 100% due to rounding.

<sup>2</sup> Unknown includes the categories of Unknown and NULL.

Source: OAG analysis of DCFS data as of July 27, 2018.



**APPENDIX G**

**INVESTIGATIONS BY COUNTY  
FY15-FY17**



Appendix G  
**INVESTIGATIONS BY COUNTY**  
FY15-FY17

<b>County</b>	<b>Region</b>	<b>FY15</b>	<b>FY16</b>	<b>FY17</b>	<b>Total</b>
Cook	Cook	18,015	20,048	18,479	56,542
Lake	Northern	2,679	3,290	3,109	9,078
Winnebago	Northern	2,565	2,776	2,478	7,819
Will	Northern	2,351	2,794	2,486	7,631
DuPage	Northern	2,235	2,677	2,414	7,326
Kane	Northern	2,170	2,573	2,474	7,217
Sangamon	Central	1,907	2,108	1,954	5,969
St. Clair	Southern	1,750	2,008	1,980	5,738
Peoria	Central	1,607	1,809	1,629	5,045
Madison	Southern	1,434	1,581	1,756	4,771
McHenry	Northern	1,236	1,460	1,434	4,130
Champaign	Central	1,258	1,363	1,303	3,924
Rock Island	Central	1,161	1,323	1,273	3,757
McLean	Central	958	1,135	1,078	3,171
Macon	Central	966	1,119	1,051	3,136
Vermilion	Central	874	1,041	1,007	2,922
LaSalle	Central	878	1,018	938	2,834
Tazewell	Central	820	992	1,004	2,816
Adams	Central	675	761	737	2,173
Williamson	Southern	599	617	686	1,902
Kankakee	Northern	567	659	635	1,861
DeKalb	Northern	568	681	602	1,851
Jefferson	Southern	453	565	503	1,521
Whiteside	Northern	485	509	474	1,468
Coles	Central	410	506	531	1,447
Knox	Central	407	450	440	1,297
Jackson	Southern	404	454	433	1,291
Kendall	Northern	407	460	411	1,278
Henry	Central	372	456	407	1,235
Marion	Southern	394	400	413	1,207
Macoupin	Central	387	432	385	1,204
Stephenson	Northern	302	411	452	1,165
Franklin	Southern	323	389	434	1,146
Morgan	Central	271	384	360	1,015
Ogle	Northern	315	317	297	929
Fulton	Central	314	337	271	922
Livingston	Central	252	317	296	865

Appendix G  
**INVESTIGATIONS BY COUNTY**  
 FY15-FY17 (Continued)

County	Region	FY15	FY16	FY17	Total
Saline	Southern	251	312	265	828
Christian	Central	220	281	278	779
Boone	Northern	232	258	288	778
Logan	Central	241	287	217	745
Lee	Northern	236	254	218	708
McDonough	Central	201	266	231	698
Grundy	Northern	208	238	247	693
Montgomery	Central	196	245	230	671
Randolph	Southern	182	251	201	634
Effingham	Southern	195	248	183	626
Bureau	Central	170	214	239	623
Edgar	Central	230	184	208	622
Iroquois	Central	188	192	174	554
Fayette	Southern	162	151	177	490
Crawford	Southern	173	132	172	477
Clinton	Southern	133	168	156	457
Pike	Central	141	176	140	457
Hancock	Central	125	159	171	455
Union	Southern	134	166	149	449
Woodford	Central	133	156	160	449
White	Southern	106	172	160	438
DeWitt	Central	129	175	131	435
Jersey	Central	120	146	162	428
Clark	Central	141	132	144	417
Richland	Southern	167	143	107	417
Mason	Central	126	132	142	400
Ford	Central	139	132	124	395
Warren	Central	126	129	138	393
Perry	Southern	112	130	148	390
Wabash	Southern	122	146	121	389
Jo Daviess	Northern	123	125	135	383
Shelby	Central	127	142	108	377
Lawrence	Southern	120	135	120	375
Massac	Southern	137	133	88	358
Wayne	Southern	108	118	124	350
Clay	Southern	123	108	106	337
Mercer	Central	84	112	118	314

Appendix G  
**INVESTIGATIONS BY COUNTY**  
 FY15-FY17 (Continued)

County	Region	FY15	FY16	FY17	Total
Monroe	Southern	73	126	115	314
Douglas	Central	92	127	88	307
Carroll	Northern	88	102	114	304
Cass	Central	89	92	112	293
Greene	Central	93	98	97	288
Bond	Southern	91	93	100	284
Marshall	Central	84	64	100	248
Piatt	Central	95	81	70	246
Menard	Central	68	93	84	245
Alexander	Southern	77	74	77	228
Cumberland	Central	65	63	92	220
Washington	Southern	60	60	76	196
Henderson	Central	46	62	72	180
Hamilton	Southern	62	56	59	177
Gallatin	Southern	51	63	57	171
Jasper	Southern	48	47	59	154
Johnson	Southern	59	52	41	152
Pulaski	Southern	44	59	43	146
Moultrie	Central	61	41	39	141
Edwards	Southern	35	53	52	140
Schuyler	Central	31	43	46	120
Stark	Central	31	27	45	103
Hardin	Southern	26	27	34	87
Brown	Central	18	30	39	87
Scott	Central	20	22	27	69
Putnam	Central	22	20	23	65
Pope	Southern	21	19	10	50
Calhoun	Central	14	14	14	42
NULL (Blank)	N/A	7,488	9,930	10,303	27,721
Out of State	N/A	50	66	55	171
<b>Total</b>		<b>67,732</b>	<b>78,572</b>	<b>75,037</b>	<b>221,341</b>

Source: OAG analysis of DCFS data as of July 27, 2018.





**APPENDIX H**

**AGENCY RESPONSES**



JB Pritzker  
Governor



Marc D. Smith  
Acting Director

April 23, 2019

Michael Paoni  
Audit Manager  
Illinois Office of the Auditor General  
740 E Ash Street  
Springfield, IL 62703

Dear Mr. Paoni:

Enclosed with this letter are the DCFS responses to the audit recommendations.

We hope that the recommendations meet your requirements and look forward to being of service in your future needs. If you have any questions, however, please feel free to contact us.

Sincerely,

**SIGNED ORIGINAL ON FILE**

Marc D. Smith  
Acting Director

Office of the Director  
100 West Randolph, Suite 6-100 • Chicago, Illinois 60601-3249  
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<b>CHILD ABUSE AND NEGLECT DATA</b>	
<b>RECOMMENDATION</b>  <b>1</b>	<p><i>The Department of Children and Family Services 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:</i></p> <ul style="list-style-type: none"> <li>• <i>Ensuring that proper controls are in place for SACWIS data entry, or any future child abuse and neglect information systems, in order to ensure that data is collected and is reliable; and</i></li> <li>• <i>Maintaining updated manuals including data field definitions.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department –</p> <p>The Department agrees with the recommendation. Steps to improve the quality of the Child Abuse and Neglect Data have been taken:</p> <p>Current Steps In Action:</p> <ul style="list-style-type: none"> <li>• Several SACWIS releases have release improvements to data quality.</li> <li>• Data Field definitions are being assembled into a Data Dictionary.</li> </ul> <p>Planned Steps:</p> <ul style="list-style-type: none"> <li>• Project is being sourced to execute soon to execute data cleanup on Child Abuse and Neglect Data</li> <li>• CCWIS program will replace current systems offering more advanced data validation capabilities</li> <li>• CCWIS requires a Data Quality plan which will address data quality controls throughout the lifecycle of Child Abuse and Neglect date</li> </ul>

INVESTIGATOR ASSIGNMENTS	
<b>RECOMMENDATION</b>  <b>2</b>	<i>The Department of Children and Family Services should take steps to ensure investigator assignments are in compliance with the requirements of the B.H. Consent Decree.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department of Children and Family Services (“Department”) has taken steps to ensure that investigator assignments are in compliance with the requirements of B.H. Consent Decree. The Department has established internal monthly meetings with the Regional Administrators from the Operations Division and the Office of Legal Services to review caseloads in order to maintain compliance with the B.H. Consent Decree. The Department meets with the plaintiff’s in the B.H. case monthly to discuss caseloads. The Department provides a monthly report to the B.H. plaintiffs on caseloads. The Department has created DAI positions to assure adequate staffing for investigations.</p>

**CHILD ENDANGERMENT RISK ASSESSMENT PROTOCOL**

<p align="center"><b>RECOMMENDATION</b></p> <p align="center"><b>3</b></p>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Ensure that CERAPs are completed for investigations and that they are completed in a timely manner;</i></li> <li>• <i>Ensure that CERAPs are completed and that they are completed in a timely manner when Intact Family Services are provided; and</i></li> <li>• <i>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.</i></li> </ul>
<p align="center"><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The Department has management reports in place for both intact and investigations that identify activity regarding cerap completion. Supervisors will be trained on the reports and reminded of the need to ensure CERAPS are completed within procedure timeframes. This will be completed within the next 90 days. The Cerap Citizen Advisory group will ensure their ongoing research projects address validity and reliability as defined by the auditors; the next project is due by May 2020. Written procedures related to Cerap training will be enhanced to reflect the requirements of the Children and Family Services Act by October 2019. A random selection of cases will be reviewed quarterly by the Compliance Administrator to address timely completion</p>

<b>HOTLINE AND INTAKE</b>	
<b>RECOMMENDATION</b>  <b>4</b>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Develop formal written procedures for call backs including required timeframes for creating intakes;</i></li> <li>• <i>Ensure that the process for completing call backs is in accordance with written procedures by answering and returning hotline calls in a timely manner;</i></li> <li>• <i>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</i></li> <li>• <i>Continue to increase the utilization of online reporting as appropriate.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department has recently developed written procedures for call backs and training is provided to all call floor staff during new hire training. April 2019 all staff were provided an in -service training on managing call backs. The intake is created through call back once the caller is confirmed available to talk by the hotline worker. If the call is an in call the intake is created at the time call begins. A specialized Call Back Attempts Response Time report is received daily and weekly. The specialized report is monitored by the SCR administrator and Assistant SCR administrator for call back response times which exceed the weekly average response time. The call backs are reviewed to determine the reason for longer than average response time. The hotline currently tracks daily, weekly, monthly and yearly the message taking rate and the call back response time. The State Central Register implemented approximately 18 months ago shift strategies which are communicated to call floor staff about the managing call backs and in calls. Approximately 12 months ago an additional category “Urgent”, was added to the call back log to assist supervisors and call floor worker to prioritize the call backs by “Emergency”, “Urgent” or “Normal” response call backs. The hotline also tracks and gathers data regarding individual hotline workers and overall -team performance.</p> <p>A strategy is in development to publicize and educate potential on line users by region on the ON LINE REPORTING option and how to access the on-line reporting system.</p>

<b>INVESTIGATION TIMELINESS</b>	
<b>RECOMMENDATION 5</b>	<i>The Department of Children and Family Services 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.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department currently tracks for compliance with initiation and is at 99% compliance. Since March 1, 2019 report completion and extension is now being monitored weekly through reports and staffings with Regional Administrators. Supervisors have access to a worker activity report and will be trained on how to access and utilize this report. This will be completed by September 2019. The Compliance Administrator will review a random selection of cases quarterly to ensure staff are meeting timeframes.</p>

<b>INVESTIGATION EXTENSIONS</b>	
<b>RECOMMENDATION 6</b>	<p><i>The Department of Children and Family Services should comply with rules and procedures and ensure:</i></p> <ul style="list-style-type: none"> <li>• <i>Extensions are requested prior to the 55<sup>th</sup> day of the investigation;</i></li> <li>• <i>That extensions are given only for good cause;</i></li> <li>• <i>Extensions are requested and approved by appropriate staff; and</i></li> <li>• <i>Extension requests contain all required information.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department is monitoring extensions and ensuring cases are extended for good cause. Since March 1, 2019 there is a weekly report completed by the regions to identify all teams with more than 10 cases over 60 days, actions needed and anticipated closure date. Also instituted is a weekly staffing with all Regional Administrators regarding extensions more than 90 days to address the appropriateness of the request and actions to complete the investigation. This process has already resulted in a reduction of cases over 60 days All staff will be reminded of the need to extended cases within the timeframe set forth in procedures.</p>



<b>ASSESSING THE NEED FOR SERVICES</b>	
<b>RECOMMENDATION 7</b>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Make the Level of Intervention a required field in SACWIS and revise the Level of Intervention options to more accurately reflect current practices, and</i></li> <li>• <i>Include a rationale for indicated investigations in which there is a Level of Intervention of “No Service Needed.”</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>Procedure 300 will be updated to include the expectation the investigator documents the reason no services are necessary. This will be completed by September 2019. Creating a special “services” note in the SACWIS file will be explored</p>

<b>RECOMMENDATIONS FOR SERVICES</b>	
<b>RECOMMENDATION 8</b>	<p><i>The Department of Children and Family Services should:</i></p> <ul style="list-style-type: none"> <li>• <i>Formally document when services are offered and whether those services are refused; and</i></li> <li>• <i>Consider establishing guidelines or policies to assist Child Protection Specialists and Supervisors regarding services to be offered for indicated allegations.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>Individual offices maintain a list of resources for their area. Procedures 300 will be enhanced to ensure the supervisor and investigator have a discussion regarding services available to assist families and document services offered and the outcome-i.e. accepted or refused and the reason for refusal. The core practice model which is in process of implementation also addresses identification of services with the family and allowing them to identify services which will best benefit them. Procedures will be updated by September 2019. Creation of a special “services “note within SACWIS will be explored.</p>

<b>INTACT FAMILY SERVICES MONITORING</b>	
<b>RECOMMENDATION 9</b>	<i>The Department of Children and Family Services should track the number of Intact Family Services cases that are opened annually including which POS agency provided the services.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department currently tracks Intact Family Services cases using payment data for both POS agency (contract) utilization and for budgeting purposes. While these fiscal reports will continue, the Department in addition will be developing monthly production reports from DoIT to ensure DCFS management staff receives timely reporting of agency caseloads.</p>

<b>INTACT FAMILY SERVICES COVERAGE</b>	
<b>RECOMMENDATION 10</b>	<i>The Department of Children and Family Services should ensure that POS agency contracts are accurate and specify coverage for all assigned counties.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department's Office of Contract Administration reviews all contracts annually, each Spring, in preparation for July 1<sup>st</sup> services. Beginning in FY19, the Department has included as part of that review process to ensure a careful review with Intact Family Services management staff that all counties are reported accurately for every contract. While no families were denied services due to specific counties not being listed, the Department's expectation is that all assigned counties are reflected in the POS agency contracts in a complete and accurate manner.</p>

**INTACT FAMILY SERVICES REFERRALS**

<p align="center"><b>RECOMMENDATION</b> <b>11</b></p>	<p><i>The Department of Children and Family Services should complete a CFS 2040 form for Intact Family Service referrals as is required by procedures. These forms should also be maintained in an accessible location.</i></p>
<p align="center"><b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b></p>	<p>The Department</p> <p>The CFS 2040 has been used as an Intact referral document from the Investigation supervisors to the Area Administrators. The document's development can be tracked back to 9/09. Until May 2015, the Area Administrators statewide referred to the Intact agencies directly. May 1, 2015 the Intact referrals began to come to the Intact Utilization Unit for Cook County referrals only. The Intact PSA assigned the cases to the respective POS agencies, sent the assignment information back to the DCP AA, the assigned private agency Intact contact and the DCP supervisor for the handoff to be scheduled.</p> <p>The Intact Utilization PSA housed in Cook, has hard copies of 2015 2040's. As of December 2017, the Intact Utilization Unit took over case assignment from the Area Administrators statewide. Prior to December 2017 all of the Downstate referrals were managed by the AA's.</p> <p>The PSA in Springfield and the PSA in Cook divide the 4 regions, each taking two regions, to be responsible for case assignment.</p> <p>Currently, all Intact referrals are logged and maintained electronically by the Intact Utilization Unit.</p> <p>The log of referrals is statewide. Historically, regions were required to submit their Intact referral logs to the Chief Deputy monthly.</p> <p>This demonstrates there has been tracking of Intact referrals, and it continues to be refined and enhanced. All 4020's are managed electronically from AA to the Intact Unit PSA and electronic folders. The Intact Utilization clerical's document each referral in the respective Regional log.</p>

<b>NORMAN CASH ASSISTANCE</b>	
<b>RECOMMENDATION 12</b>	<i>The Department of Children and Family Services 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.</i>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department agrees that Procedures and Organization charts should reflect the current process. The Department also agrees that purchases made using Norman Cash Assistance Funds should not only be well documented but, that documents should be readily available for review/audit.</p> <p style="padding-left: 40px;">The Agency shall update their written procedures to reflect how Norman Cash Assistant funds are currently processed, including who approves assistance.</p> <p style="padding-left: 40px;">The Agency shall update the Organization Chart, reflecting the removal of the Deputy Director of the Division of Service Intervention position.</p> <p style="padding-left: 40px;">The Agency shall include in their update of written procedures the process of properly retaining CFS 370-5 forms to ensure they are readily available for review/audit.</p> <p>In completing the corrective actions above, the Department expects to develop a system that; (A) properly reflects the current process and organizational structure of the Norman Cash Assistance program and (B) ensures proper document retention of purchases made.</p>

COMMUNITY BASED SERVICES	
<b>RECOMMENDATION 13</b>	<p><i>The Department of Children and Family Services should follow existing Department procedures including:</i></p> <ul style="list-style-type: none"> <li>• <i>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</i></li> <li>• <i>Verifying whether the family is following through with the community services.</i></li> </ul>
<b>DEPARTMENT OF CHILDREN AND FAMILY SERVICES RESPONSE</b>	<p>The Department</p> <p>The Department will ensure staff are reminded of current procedures regarding community referrals, what the service mitigates, time frames and verification family has linked with the service. This will be completed by July 2019. The Creation of a specific “services” note within SACWIS will be explored.</p>





