



**OFFICE OF EXECUTIVE INSPECTOR GENERAL
FOR THE AGENCIES OF THE ILLINOIS GOVERNOR**

Statement of Executive Inspector General
Ricardo Meza Regarding:

**Grant Fraud at the
Illinois Department of Children and
Family Services and Other State Agencies**

Illinois House of Representatives

Human Services & State Government Administration Committee

January 27, 2012, 10:00 a.m., Chicago, IL

Thank you, Chairman Franks, Chairman Harris, members of the House Human Services Committee and House State Government Administration Committee. It is an honor to be here today.

I want to begin my presentation by providing you with a very brief overview of the Office of Executive Inspector General and then discuss the subject matter of this hearing, the investigation of grant fraud at the Illinois Department of Children and Family Services (DCFS), and other State agencies.

Overview of the OEIG

The Office of Executive Inspector General for the Agencies of the Illinois Governor (OEIG) is an independent and non-partisan agency. The OEIG is responsible for conducting investigations involving allegations of fraud, waste, abuse, mismanagement, misconduct, nonfeasance, misfeasance, malfeasance, or violations of the State Officials and Employees Ethics Act (Ethics Act) or other related laws and rules. Our Office seeks to accomplish its mission of ensuring accountability in State government, and to foster, enhance, and improve public trust in State government.

Our jurisdiction includes more than 175,000 individuals employed by 40 State agencies and departments, 9 public universities, over 300 boards and commissions, and after July 1, 2011, the Chicago-area Regional Transit Boards, as well as vendors and others doing business with those entities.

Illinois Grants

At the outset, I would like to note that the efforts of Illinois government to help its citizens through the award of State grants to community-based service providers are laudable. There are thousands of Illinois citizens who benefit from and need State assistance. In addition, there are hundreds if not thousands of organizations who receive State grants and apparently use the funds in a fiscally appropriate manner. Thus, my testimony today is not intended to deter the State's efforts to help those in need, nor is it intended to disparage or denigrate the good work that many well-intentioned and capable organizations perform every day.

That being said, the discovery that millions in State dollars earmarked and intended for the benefit of the most vulnerable citizens (many of which were children) went not to those citizens, but rather were unaccounted for and went into the pockets of Dr. George E. Smith, a personal friend and mentor of former DCFS Director Erwin McEwen, was nothing less than shocking, disappointing, and unacceptable. Therefore, I would like to alert you to some of the systemic failures we discovered that allowed such large-scale grant fraud to occur at DCFS, and other State agencies.

Grant Fraud at DCFS

In September 2010, my Office was contacted by DCFS Inspector General Denise Kane regarding an allegation of fraud involving DCFS grants awarded to Dr. George E. Smith and his business entities. Inspector General Kane and her staff discovered that Dr. Smith had not only been

awarded DCFS grants but had also been awarded grants by other State agencies under the jurisdiction of our Office.

After receiving the information regarding Dr. Smith and his entities, our Office along with the OIG—DCFS conducted a joint investigation involving what turned out to be the discovery of large-scale fraud and DCFS mismanagement, among other things. I am pleased to be here today to discuss lessons learned, to provide your committees with insight into what may have gone wrong at DCFS, and to respond to questions you may have.

There are three “big picture” issues at play in this investigation, each of which our Office believes played a significant role in allowing this misconduct to go on for years. First, and foremost, was the failure to adequately monitor grants. Second were the failures of former DCFS Director McEwen. Third was the failure to coordinate grants awarded by various State agencies.

1. Failure to Appropriately Monitor Grants

As members of these committees know, grants must be monitored to ensure that taxpayer money is used for its intended purpose in an efficient manner. Unfortunately, our investigation revealed that despite being entrusted with millions of dollars of State grant funds, DCFS and the staff of other State agencies repeatedly failed to monitor grants. Without adequate monitoring, there was no way for the State to determine that it was receiving the services for which it bargained. The grant monitoring failures were two-fold: staff failed to monitor financial expenditures by the grantee, and failed to conduct pre-award investigations of the grantee.

A. Failure to Monitor Financial Expenditures by the Grantee

Our investigation uncovered that from 2008 to 2011, Dr. Smith and his business entities received over \$18 million in grants from multiple State agencies, the majority of which were issued by DCFS.¹ Disturbingly, much of these millions in taxpayer dollars came with little or no effort to determine whether services were actually provided. For example, Dr. Smith received \$450,000 annually from a DCFS grant for at-risk students that went virtually unmonitored for years.² Even when the grant was finally assigned a monitor years later that raised “red flags,” DCFS management ignored those warnings.³

The failure to adequately monitor this and other grants awarded by DCFS and other State agencies allowed Dr. Smith to:

- Submit misleading documentation, including documents containing forged signatures, for services which were never provided, for example:
 - *He submitted bills totaling \$22,348 for allegedly providing substance abuse prevention services at a community center.⁴ We know the bills were fraudulent because when the Executive Director for the community center was asked about the*

¹ See page 7 of OEIG Final Report (Redacted).

² See page 34, § IX(A) of OEIG Final Report (Redacted).

³ See pages 37-39, §§ 3(a)-(f) of OEIG Final Report (Redacted). “Red flags” included: absence of a prior monitoring file, no prior cost or program reports, the repeated failure of the grant recipient to comply with a monitor’s requests for additional documentation, and insufficient verification of which services had been provided.

⁴ See page 15, § B(1)(a) of the OEIG Final Report (Redacted).

*authenticity of certain documents, after he reviewed the documents he noted that the center was not even open at the time the services were supposedly rendered.*⁵

- Charge the State for services that could not be verified, for example:
 - *He billed the Illinois Department of Commerce and Economic Opportunity for a student trip to Washington D.C. where only 4 of the supposed 80 attending students could be identified.*⁶
- Bill multiple State agencies for the same service, for example:
 - *He submitted identical invoices for charter buses to DCFS under a student counseling grant and to the Illinois Department of Public Health under a grant for HIV and AIDS awareness programs and received payment (for the same event) from both agencies.*⁷
- Engage in numerous fiscal improprieties, for example:
 - *He engaged in ghost payrolling by charging the State \$50,000 for a therapist who did not exist.*⁸
 - *He charged in excess of 20% for so-called “administrative fees,” an amount that exceeds that allowed under Illinois law. In fact, one of his companies spent over 75% of the State grant on “administrative expenses.”*⁹
 - *He commingled funds between his for-profit and not-for-profit business entities.*¹⁰
 - *He obtained rental reimbursements from two State agencies and the City of Chicago for the same property in the same fiscal year (FY2009).*¹¹

In addition to the failures in monitoring grants, we believe the extremely broad and vague language contained in the multi-year million dollar grants awarded to Dr. Smith allowed him to spend State money without adequate accountability.

So what did Dr. Smith actually do with grant money earmarked for abused, neglected, and at-risk children if he was not providing the children these services? Unfortunately, our investigation revealed that, among other things, Dr. Smith and his business entities used State grant money:

- To spend nearly \$100,000 on sporting events, namely: Chicago Cubs, Chicago White Sox, and Chicago Bulls tickets, as well as tickets to an NBA All-Star game,¹² and,

⁵ See page 16, § b of the OEIG Final Report (Redacted).

⁶ See page 60, paragraph 4 of the OEIG Final Report (Redacted).

⁷ See page 72, § 2(a) of the OEIG Final Report (Redacted).

⁸ See pages 31-32 of the OEIG Final Report (Redacted).

⁹ See page 30, paragraph 6 of the OEIG Final Report (Redacted).

¹⁰ See page 77, § 5 of the OEIG Final Report (Redacted).

¹¹ See page 75, § 4(a) of the OEIG Final Report (Redacted).

¹² See page 19, footnote 10, and page 77, § 5(c) of the OEIG Final Report (Redacted).

- Used grant money on inappropriate expenditures including alcohol and cable bills.¹³

In short, the absence of appropriate grant monitoring allowed Dr. Smith to use State grant money meant for at-risk children and others as if it was money from his personal piggy bank. In doing so, Dr. Smith may have not only fleeced the taxpayers out of millions of dollars, but also prevented care from reaching children.

B. Failure to Conduct Pre-Award Investigations of Grantee

Another major failure discovered in the course of our investigation related to the complete absence of any pre-award investigation into the capability of a grant recipient to provide the necessary services. For example, Dr. Smith received annual grants of approximately \$200,000 (\$199,206 in FY 2009 and \$217,100 in FY 2010) from DCFS to provide psychiatric services to at-risk youth.¹⁴ Yet it was not revealed until over a year into the grant term that psychotropic medication was being dispensed without a guardian's consent, and that the children receiving the medication were not even being weighed to determine proper dosage before being medicated.¹⁵ In addition, Dr. Smith was awarded DCFS grant funds in order to serve as the so-called "fiscal agent" for certain central Illinois not-for-profit agencies.¹⁶ Unbelievably, DCFS paid Dr. Smith and his entities to oversee as "fiscal agent" State money awarded to other agencies because the other agencies were unable to manage their fiscal house.

A proper pre-award investigation of the grant recipient, in this case Dr. Smith and his entities, may have prevented this misconduct from occurring. Requiring grant applicants to demonstrate their ability to perform the necessary work will aid in preventing further waste and abuse and will ensure that the Illinois citizenry receives the services they desperately need.

There is no doubt that the lack of proper oversight and grant monitoring by State agencies allowed Dr. Smith's misconduct to go on and on for years. While Dr. Smith's exploitation of the State and its citizens has been exposed, if robust grant monitoring procedures are not implemented and followed, the sort of large-scale fraud we discovered in this investigation will continue.

2. The Failures of DCFS Director McEwen

Our investigation also uncovered troubling examples of failings in the management of State agencies, and in particular DCFS. Our investigation suggests that former Director McEwen may have allowed his personal relationships to interfere with his professional duties as a State official and we make this conclusion based on the facts that:

- When investigators asked Director McEwen if he knew Dr. Smith, he described Dr. Smith as his "personal friend and mentor."¹⁷

¹³ See page 8, §§ B(1)(a)-(c) of the OEIG Final Report (Redacted).

¹⁴ The program was named Psychiatry for Adolescents and Children in Transition; see table on page 6 of the OEIG Final Report (Redacted).

¹⁵ See pages 45-46, §§ X(A)(1)-(3) of the OEIG Final Report (Redacted).

¹⁶ See page 3, paragraph 1, page 4, § (e), and page 8, paragraph 1 (among other references) of the OEIG Final Report (redacted).

¹⁷ See page 48, § b of the OEIG Final Report (Redacted).

- When investigators looked into Director McEwen’s role in relation to serving as grant monitor for certain Dr. Smith grants, we learned Director McEwen was the recommending authority, the grant monitor, and provided approval of Dr. Smith’s grant, thus making him the final authority for nearly every stage of the grant process.¹⁸
- When investigators learned that Director McEwen told his staff that he was personally monitoring a Dr. Smith grant and later questioned Director McEwen about how he monitored that particular grant, Director McEwen stated, he was “truly not monitoring the contract.”¹⁹
- When investigators learned that DCFS monitors attempted to obtain grant documentation from Dr. Smith, Dr. Smith responded that he did not have to answer to them, and only reported to “Mac,” the nickname for Director McEwen.²⁰

Unfortunately, Director McEwen also failed to accept responsibility for the numerous irregularities investigators found as evidenced by the facts that:

- When asked to explain irregularities, Director McEwen blamed his staff, saying, “My people did not do their job.”²¹
- When asked about the Dr. Smith grant agreement terms and what they meant, Director McEwen said, “I don’t read contracts thoroughly prior to signing them.”²²
- When asked how DCFS monitors performance on grant agreements, Director McEwen said that he “did not know” how DCFS ensured a grant recipient was following the program plan.²³

In short, Director McEwen appeared to have created a culture at DCFS where grant oversight was far from a priority.

What is interesting to note, is that when given an opportunity to respond to the investigative findings in this matter, former Director McEwen did not deny his relationship with Dr. Smith, and in fact, said:

- He “found Dr. Smith to be a highly regarded and respected human service professional in the community.”²⁴
- He “considered it an honor to be able to learn from someone like Dr. Smith.”²⁵

¹⁸ See page 49, § D of the OEIG Final Report (Redacted).

¹⁹ See page 48, § C, paragraph 3 of the OEIG Final Report (Redacted).

²⁰ See page 35, paragraph 2 of the OEIG Final Report (Redacted).

²¹ See page 50, paragraph 2 of the OEIG Final Report (Redacted).

²² See page 50, § F, paragraph 3 of the OEIG Final Report (Redacted).

²³ See page 50, § F, paragraph 2 of the OEIG Final Report (Redacted).

²⁴ See page 3, §II of McEwen’s response, appended to the OEIG Final Report (Redacted).

²⁵ Id.

- He “often turned to Dr. Smith with questions about management, agency operations, and clinical services.”²⁶

Yet, despite the above statements in response to this investigation, Director McEwen maintained that he “did not allow his relationship to impact his professional decision-making on behalf of IDCFS.”²⁷

In addition, former Director McEwen continued to blame his staff for the grant monitoring deficiencies discovered during our investigation. For example, he said that:

- His employees, DCFS Deputies, “made it clear to [him] that they did not report to [him].”²⁸
- His employees, DCFS Deputies, “clearly failed to adequately monitor the DBCC contracts and sought to shift the responsibility to [him] for monitoring by misdirecting ... staff.”²⁹

3. Failure to Coordinate Grants Awarded by Various State Agencies

Another systemic problem this investigation uncovered was the lack of grant oversight or coordination between various State agencies. This is likely attributable to the absence of any centralized database of information about grants and recipients. As noted in the report, more than one of Dr. Smith’s business entities performed the same services for different agencies and received funding for those services under multiple grants,³⁰ yet the agencies apparently did not realize that Dr. Smith was receiving grant funds from various agencies for purportedly providing nearly the same sort of services.

For example, Dr. Smith submitted identical invoices for student consulting services to DCFS, the Chicago Board of Education, and Illinois State Board of Education.³¹ The bill to each agency was for a service provided by the same person, on the same day, to the same students, and at the same time.³² As a result, each agency reimbursed Dr. Smith for the same service, unaware that he was obtaining reimbursement for providing the same service, essentially allowing Dr. Smith to double and triple dip at the taxpayer’s expense. The creation of a grant database accessible by all State and local agencies might allow grant-awarding entities to determine whether a particular individual or vendor is receiving grant funds for providing substantially the same or similar services. This would prevent dishonest grant recipients from receiving payments for duplicate or triplicate services. Additionally, it would allow intra-governmental sharing of information regarding problematic or fraudulent grantees.

²⁶ Id.

²⁷ See page 4, paragraph 1 of McEwen’s response, appended to the OEIG Final Report (Redacted).

²⁸ See page 3, paragraph 1 of McEwen’s response, appended to the OEIG Final Report (Redacted).

²⁹ See page 6, § V, paragraph 2 of McEwen’s response, appended to the OEIG Final Report (Redacted).

³⁰ See footnote 7, *supra*.

³¹ See page 73, § e of the OEIG Final Report (Redacted).

³² Id.

Closing Comments

At its core, the DCFS final summary report our Office and the OIG—DCFS produced illustrates what can happen when State agencies fail to adequately ensure that money earmarked for services reach those in need. Rather than taxpayer money going to provide for the care and education of at-risk children, the money was used to line the pockets of a self-serving individual who was, oftentimes, incapable of providing services he promised.

In closing, I hope that my testimony today has been helpful in identifying some of the systemic problems that emerged during our investigation. This investigation would not have been possible without the dedicated work of Inspector General Kane and her staff, as well as staff from our Office including Deputy Inspector General Erin Bonales and Investigator Edward Escamilla, among many others.

We hope the observations our Office made will aid in preventing further abuses of this type—but, our Office is not so naïve to believe that even the greatest internal controls can prevent fraud in every instance. We recognize that perhaps the greatest deterrent for this type of behavior is transparency. If State employees and grantees realize that their conduct or misconduct may someday be publically disclosed, they might hesitate before engaging in misconduct. The public release of the DCFS report will likely do more to prevent this type of fraud than any policy recommendation or corrective action any State agency may take. And, while the days when every OEIG report remains in a desk drawer are now behind us, it is important for the committees to recognize that nothing in Illinois law *required* the public release of this entire report. In light of the fact that Director McEwen resigned (was not terminated), under the Ethics Act, the Illinois Executive Ethics Commission was not obligated to publically release this entire report, but it did. Therefore, on behalf of our staff and members of the public, we wish to thank Executive Director Chad Fornoff and all the members of the Executive Ethics Commission for releasing this report under their discretionary authority. We hope an increased number of our reports get released by the Executive Ethics Commission because we believe the public has a right to be aware of misconduct involving State employees, grantees, or vendors who abuse the public trust.

We remain eager to work with all members of the General Assembly and State agencies and appreciate the opportunity to serve Illinois citizens.

Thank you.