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

REPORT DIGEST

PERFORMANCE AUDIT

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Office of the Auditor General
Iles Park Plaza
740 E. Ash Street
Springfield, IL 62703

Phone: (217) 782-6046
TTY: (888) 261-2887

The full audit report is available on our website: www.auditor.illinois.gov

EXECUTIVE SUMMARY

Department of Human Services' Forensic Patient Transport Procedures

On May 14, 2015, the Illinois House of Representatives adopted Resolution Number 199 directing the Office of the Auditor General to conduct an investigation into circumstances surrounding the July 2014 escape during transport of an Elgin Mental Health Center forensic patient and to evaluate whether prisoner transport procedures need to be improved at Elgin Mental Health Center (MHC) or other State facilities. Subsequently, on July 29, 2015, the Legislative Audit Commission adopted Resolution Number 147 changing the language of House Resolution Number 199 from requiring an "investigation" to requiring an "audit."

Prior to the July 2014 escape, Elgin MHC had few procedures with few specific instructions for handling a forensic patient during transport. **Following the July 2014 escape, the Department of Human Services (DHS) and Elgin MHC improved the forensic patient transport process significantly.** These improvements were made by strengthening policies, upgrading the security of vehicles, implementing a process to identify elopement (escape) risk before the transport, and conducting more training for employees.

The audit found:

- Six trip information packets, which contain patient information, could not be located and various documents were missing from these packets, including the Trip Log Progress Note, the Pre and Post Trip checklist, the Vehicle Maintenance checklist, and the Sally Port Officer Checklist.
- The patient transport checklist was, on occasion, missing important pieces of information, such as the patient's elopement risk assessment, the charge against the patient, or a clothing description.
- Security Device Authorization forms were not always filled out adequately (for example, did not have all required signatures).
- The patients and transport team were not always seated in accordance with Elgin MHC policy and the DHS Statewide Transportation Directive.
- Security Officers were not receiving all annual training as required by DHS policies.
- The policies for the other DHS State-operated facilities with adult forensic units were generally at least as strict as DHS' Statewide Transportation Directive, with some exceptions. Upon auditor inquiry, DHS promptly revised the policies to be in compliance with the Statewide Transportation Directive.
- The auditors also requested the transportation guidelines in use by the private community hospital providing juvenile forensic services and received a policy noted as "Draft 3/29/16." The hospital indicated to DHS that the 3/29/16 draft was the effective date of the policy and that it operated on this policy prior to actually drafting a written policy.

AUDIT SUMMARY AND RESULTS

On May 14, 2015, the Illinois House of Representatives adopted Resolution Number 199 directing the Office of the Auditor General to conduct an investigation into circumstances surrounding the July 2014 escape during transport of an Elgin Mental Health Center patient and to evaluate whether prisoner transport procedures need to be improved at Elgin Mental Health Center (MHC) or other State facilities. Subsequently, on July 29, 2015, the Legislative Audit Commission adopted Resolution Number 147 changing the language of House Resolution Number 199 from requiring an "investigation" to requiring an "audit."

Individuals found Unfit to Stand Trial (UST) or Not Guilty by Reason of Insanity (NGRI) are involved with both the criminal justice and mental health systems (Department of Human Services, or DHS) and are known by DHS as forensic patients. House Resolution Number 199 references "prisoner;" however, based on the status of the patient that escaped (UST), the term "forensic patient" is used throughout the audit as opposed to "prisoner." (page 2)

The Code of Criminal Procedure of 1963 requires individuals, placed in the custody of DHS (forensic patients), to be placed in a secure setting (725 ILCS 5/104-17(b)). DHS Forensic Services has three general security levels for forensic inpatients:

- Minimum security: A minimum security unit is typically used for civil inpatients, although it can also be used for forensic patients. Forensic patients placed in a minimum security unit are generally non-violent, low elopement risk offenders. This type of unit is secured with locked doors, 24/7 staff supervision, security services, and controlled access.
- Medium security: A medium security unit has fenced recreation areas, controlled access, and limitations on allowed personal items. There is a medium security unit that serves each area of the State.
- Maximum security: A maximum security unit has the highest level of security. There is only one State-operated hospital with maximum security units in the State: Chester Mental Health Center. This unit type has substantially restricted movement with nearly continuous observation. It allows for the more physically dangerous forensic patients to be treated.

Forensic patients are placed in one of DHS' secure units based on the clinical results of a placement evaluation. Elgin Mental Health Center has minimum and medium security units. (page 5)

CIRCUMSTANCES SURROUNDING THE ESCAPE

On Wednesday, July 16, 2014, a forensic patient at Elgin Mental Health Center (MHC) escaped DHS custody while being transported from the Elgin MHC to the Lake County Courthouse in Waukegan. Several months earlier, on April 28, 2014, a Lake County judge had declared the individual "Unfit to Stand Trial" (UST) and had remanded him to DHS for evaluation and

treatment. On the day of the escape, the forensic patient was scheduled for a court hearing to determine his fitness for trial on felony charges including aggravated domestic battery.

The forensic patient reportedly jumped out of the back door of an Elgin MHC van at approximately 7:45 a.m. on July 16, 2014, while stopped at a gas station. He was being transported by two Security Officers and a Maintenance Equipment Operator (driver). The driver and one Security Officer were in the vehicle at the time of the escape; neither noticed anything out of the ordinary until they heard the back door opening. Elgin MHC's vans could be unlocked from the inside by anyone and the patient had gotten the handcuff off one wrist. Shortly after the escape, Elgin MHC transport staff called 911 and notified Elgin MHC. About 4:00 p.m., approximately 8 hours later, the escapee was taken into custody.

DHS officials reported they had never had an escape during transport before and, as of the end of fieldwork (April 2016), there have not been any escapes since the July 2014 escape.

PROBLEMS IDENTIFIED AND CHANGES MADE

Prior to the July 2014 escape, Elgin MHC had few procedures with few specific instructions for handling a forensic patient during transport. One of those procedures required annual security device (in other words, handcuff) training for Security Officers, which was the only forensic patient transport requirement Elgin MHC was in violation of at the time of the escape.

Following the July 2014 escape, the Department of Human Services and Elgin MHC improved the forensic patient transport process significantly.

Following the July 2014 escape, DHS and Elgin MHC improved the forensic patient transport process significantly. These improvements were made by strengthening policies, upgrading the security of vehicles (disabling internal door locks and installing security partitions), implementing a process to identify elopement (escape) risk before the transport, and conducting more training for employees.

In response to the July 2014 escape, DHS issued a Statewide Transportation Directive which addressed Statewide transportation of individuals in forensic and civil legal status. Elgin MHC now also has two policies which contain a significant amount of new guidance for the transport of forensic patients. Some of the new requirements or information not previously found in DHS policies, procedures, or program directives include:

- Information related to the safety and security of transport vehicles, which includes ensuring door locks are disabled and the security partition is in place;
- Revised seating arrangements requiring a Security Officer to sit behind the patient;
- A pre-trip search of the patient;
- A pre-trip elopement risk assessment prior to each trip and changes to a risk assessment conducted upon admission;
- New pre-trip and en-route forms; and
- Pre-authorization required for unscheduled stops. (pages 10, 13, 17-21)

TESTING RESULTS

Our testing showed some instances in which new requirements had not been followed.

We tested 50 of 978 Elgin MHC forensic patient transports made during May to September 2015 to ensure the new transport process had been implemented and was being utilized. Our testing showed some instances in which these new requirements had not been followed. We found the following regarding forensic patient trip testing:

- Six trip information packets, which contain patient information, could not be located and various documents were missing from these packets, including the Trip Log Progress Note, the Pre and Post Trip checklist, the Vehicle Maintenance checklist, and the Sally Port Officer Checklist.
- The patient transport checklist was, on occasion, missing important pieces of information, such as the patient's elopement risk assessment, the charge against the patient, or a clothing description.
- Security Device Authorization forms were not always filled out adequately (for example, did not have all required signatures).
- The patients and transport team were not always seated in accordance with Elgin MHC policy and the DHS Statewide Transportation Directive.

We recommended that DHS ensure trip information packets are filled out completely and appropriately for all trips and returned to and maintained by the appropriate person(s) at the respective facility. We also recommended that DHS ensure forensic patients at Elgin MHC are seated in accordance with Elgin MHC policy and DHS' Statewide Transportation Directive.

Our testing showed that Security Officers were not receiving all annual training as required by DHS policies.

We also tested 35 of 368 Elgin MHC employees certified to transport patients to ensure they received training on the new transport policies and process. Our employee training testing showed that Security Officers were not receiving all annual training as required by DHS policies. We recommended that DHS ensure appropriate employees at Elgin MHC receive annual training on current transportation policy and the application of security devices as required by Elgin MHC policy and DHS program directives. (pages 33-38)

The auditors reviewed facility-specific forensic transport policies from the other DHS State-operated facilities with adult forensic units. The other facilities' policies were generally at least as strict as DHS' Statewide Transportation Directive; however, there were some exceptions, mainly at Choate Mental Health and Developmental Center (Choate MHDC). However, upon auditor inquiry, DHS promptly revised the policies to be in compliance with the Statewide Transportation Directive. The auditors also requested the transportation guidelines in use by the private community hospital providing juvenile forensic services on March 24, 2016, and received a policy noted as "Draft 3/29/16." The hospital indicated to DHS that the 3/29/16 draft was the effective date of the policy and that it operated on this policy prior to actually drafting a written policy. (pages 29-32)

RECOMMENDATIONS

The audit report contains five recommendations. The Department of Human Services agreed with all five of its recommendations. Appendix D to the audit report contains the agency responses.

SIGNED ORIGINAL ON FILE

FRANK J. MAUTINO
Auditor General

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