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**Egyptian Regional Human Rights Authority  
Report of Findings  
16-110-9017  
Chester Mental Health Center  
July 20, 2017**

The Egyptian Regional Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission has completed its investigation concerning Chester Mental Health Center, a state-operated mental health facility located in Chester. The facility provides services for approximately 240 recipients serving both forensics and civil commitments. The specific allegations are as follows:

- 1. Inhumane care due to negative staff interactions which violates staff Code of Conduct policies.**
- 2. Lack of active mental health treatment.**

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7)

To investigate the allegation, the HRA Investigation team, consisting of two members and the HRA Coordinator and HRA Director conducted a site visit at the facility. During the visit, the team spoke with Hospital Administrator and Assistant Administrator. With the recipients' written authorizations, copies of information from the recipients' clinical chart were reviewed by the Authority. Facility policies relevant to the complaints were also reviewed and staff persons were interviewed.

**I. Interviews:**

**A. Recipient 1 F Unit:** When interviewed, this recipient told the HRA that a Security Therapy Aide (STA) was giving him a hard time and said that he couldn't go to the cafeteria because he talked during TV time. It was documented that he refused breakfast but he said that he did not because he is diabetic and does not skip meals. The recipient said breakfast was not offered to him on the unit and alleged that the STA stated "we're going to put shit in his food." The recipient stated that he had filed a complaint with staff which should have been given to the Office of Inspector General (OIG) but he has not received an acknowledgement of the complaint and no one has come to speak with him about it. His complaint was turned into another STA on the unit, but he did not know that STA's name. He was told that the originals would be given to his therapist. The HRA followed up with the OIG who acknowledged that they had one

complaint that was determined not to be an OIG reportable complaint but it was filed in December and the issue with meal being refused occurred in October. The HRA also spoke with his therapist who was not aware of any complaint relating to meal refusal or staff making the above comment.

B. Recipient 2 C Unit: This recipient was questioned regarding a complaint the HRA received alleging lack of active treatment. The recipient was admitted in September, 2015 and interviewed in March, 2016. He said that he was admitted to Chester as Unfit to Stand Trial (UST) and had taken the fitness test and passed. He was told that the Psychiatrist would be recommending him as fit to stand trial but he did not know when. He never received any fitness classes, just took the test. He stated that he goes to the library but has not been enrolled in classes because he was to be recommended as fit to stand trial. The recipient said he requested horticulture and janitorial classes but was never enrolled in either class. The HRA questioned the recipient as to what his typical day consisted of and the following schedule was reported:

7:00 a.m. Wake up, Shower between 8:00-10:00 a.m.  
Watch TV or play Chess  
12:00 Eat Lunch  
1:00 Go to gym or yard  
2:00 Go to game room to play video games, watch TV or listen to the radio  
5:00 Eat Supper  
Watch TV or listen to the radio until 8:00-9:00 p.m. when he goes to sleep.

The recipient was discharged as fit to stand trial in April, 2016.

C. Recipient 3 B Unit: This recipient was interviewed regarding allegations of negative staff interactions on his unit that had been brought to the HRA's attention. This recipient told the HRA that he had witnessed negative interactions between staff and patients and said that one staff person had spit in his food and the STA IV told the staff person to stay away from him but the staff refuses to do so and continually tells him that he had better behave or the staff would spit in his food again. The recipient said that he did not eat for almost 2 weeks because of that staff person's statements to him. An OIG report of abuse was also filed regarding that allegation. He also told the HRA that when patients come to meet with the HRA in the conference room, staff escorting patients try to discourage them from speaking with the HRA by saying things such as "they're not going to be able to do anything anyway, you're wasting your time." The recipient also stated that sometimes staff "jump on them and find a reason to put them in restraints" after they return from speaking with the HRA. The HRA reviewed the OIG report regarding the allegation of staff spitting in his food and also interviewed the staff person who was accused. The OIG report was unsubstantiated due to the accused and three other staff persons providing "*consistent and corroborated accounts indicating no abuse occurred.*" The report also stated that there was one witness to the alleged incident who reported that he did see the STA spit on the recipient's tray. The report concluded by stating that the progress notes revealed that the recipient had been exhibiting severe agitation and self-injurious behavior over the duration of the alleged abuse time period, however, there was no indication that this was a direct result of the alleged incident and therefore, it was unsubstantiated.

D. Recipient 4 A Unit: This recipient was interviewed regarding allegations of negative staff interactions on his unit. This recipient stated that the staff on his unit have refused to let him see a physician for medical issues he has had and tell him that he does not need to see the physician and refuse to put him on the list and tell him he is just delusional. He also said that staff on the unit talk down to patients by telling them to shut up and that staff “give patients attitude.” He said that STAs on the unit have punched him in the stomach causing him to vomit or defecate. The OIG has been called twice on these instances but no one ever came to interview him on the complaints. This recipient also said that staff on the unit retaliate against patients for filing complaints with the OIG or HRA by “messing with clothes” and personal belongings from the room turn up missing. He also stated that staff on the unit call him a “spick” and “fag” and tell him he is a bad influence on his peers and won’t let his peers sit next to him. The recipient also stated that staff falsify behavior reports and documentation to make patients look worse than they are or to impose restrictions on them or to cover up what staff has done. One example given to the HRA was that staff documented that he refused to see the physician when actually they refused to let him go. He said that he only refused to go to the physician one time because he wanted to finish his eye medication before he saw the physician again for a follow up. When requesting to see the physician, staff would tell him that he did not need to go and that it was “all in his head.” The HRA found one OIG report regarding this recipient. The allegation was that staff made threatening comments to the recipient, but this report did not mention an allegation of him being punched in the stomach. The allegation was unsubstantiated against five staff members due to staff “*providing consistent and corroborated accounts denying the allegation*” and no witnesses being identified to verify the allegation. The HRA also checked with the OIG to ensure that no other reports were in their database regarding this recipient and was told that there were two non-reportable complaints one alleged that staff yelled and cursed at him and the other alleged that sediments were put in his shampoo. There were also three short forms where cases were referred to Chester to speak to the recipient but the date of those three forms did not match up with the date provided regarding the allegation of being punched in the stomach.

E. Recipient 5 A unit: This recipient was also interviewed regarding allegations of negative staff interactions on his unit. He explained that he had hit a peer for stealing his property and one of the Nurses was “antagonizing him” by saying that he was stupid for hitting a peer and the nurse allegedly told other staff to “tie him up like he’s in a zoo” referring to the use of ambulatory restraints. Another incident that was described was when a unit director questioned the recipient about a telephone hearing he had. When the recipient explained that it was regarding a lawsuit against the facility, later that evening his room was shaken down and the STAs appeared to be looking for something specific as they were referring to case numbers typically used for the OIG investigations. He alleged that the STAs also took complaint forms and court documents and ripped them up, tore up photographs of his daughter and took his sheets and pillows out of his room. Staff tried to move this recipient to another room but he refused to leave until someone took photographs of his room to document what a mess the STAs left his room in. He also said that later that evening approximately 10-12 STAs came to his room demanding that he clean it or they would “beat his ass and tie him to his bed and clean it for him.” The STAs allegedly told him that no pictures were going to be taken of his [expletive] room. The next day, after his room was cleaned, the OIG investigator came to speak with him regarding the allegations. Another incident occurred when the recipient was sitting in his room

and a staff person provoked him by saying he needed to “shut his [expletive] mouth or he would shut it for him.” That staff person then said that the recipient was making threats against staff and kept him back from lunch. Staff placed him in restraints and abused him while he was in restraints. Another peer on the unit called this recipient’s mother to notify her of what had happened and the OIG inspector came to speak with him that same night. Staff later moved the peer to another unit. This recipient also voiced concern over several internal complaint forms that he had written but did not file because unit staff refused to make copies of them so that he would have a copy for his records. The HRA agreed to make copies for the recipient and send them to the internal human rights chairperson. The complaints involved both OIG reportable allegations, all of which had been previously reported, as well as non-OIG reportable allegations. All were forwarded to the human rights chairperson at the facility and copies returned to the recipient. The issues involved complaints regarding commissary policies and practices and several involved comments that one staff person in particular made to the recipient. The following are some examples given:

- Staff stating “I’m going to put you on a bed if you don’t close your room door” and when the recipient stated that staff could not place him in forced seclusion, the staff person said “watch me” and called other staff and placed him in restraints and documented that he was being verbally aggressive. However, the recipient contended that his emergency preferences weren’t followed for verbal aggression.
- Complaints regarding the unit director not doing her job of properly monitoring staff and living conditions on the units to ensure a sanitary environment.
- Another STA not performing work duties in a professional manner by using gloves to make a popping sound similar to a balloon popping in order to intimidate/agitate patients or to get a reaction out of them. The recipient contributed recent fights in the dining area to this STA’s behavior.
- Staff eating extra snacks left after they have been given to patients.

G. Administration: The HRA team met with the Facility Administrator and Assistant Administrator to discuss the allegations of negative staff interactions so that those complaints could be addressed immediately due to the severity of some allegations. The HRA also discussed concern over complaints of how OIG complaints are handled and how OIG reportable allegations are reported during the hours when the telephones on the units are turned off. The HRA was informed that during those times, complaints are reported to the STA IV who is also the OIG liaison. The liaison takes the initial information and contacts the OIG. Staff document when the OIG was called and patients that are involved receive a paper notification that a complaint was filed and within 2 days they are also notified that the OIG received the complaint. After the investigation is complete, usually 3-4 months later, the OIG sends a report determination. Next, the HRA discussed allegations that staff were not immediately removed when abuse allegations are made, particularly surrounding restraint episodes where cameras are not present. The allegation is that this allows staff to corroborate their stories before the OIG investigator arrives. The response was that staff are to write separate restraint reports immediately following a restraint episode which makes it hard to corroborate stories. The HRA

questioned whether or not the administration tracks OIG and internal human rights complaints to monitor names of staff who have repeated complaints against them. The response was that yes they do look for patterns and if there is credible evidence against them, they are reassigned to non-patient care areas such as the control room and/or kitchen. The HRA was also informed that if staff violate the Code of Conduct policy, they can either be moved to a non-patient care area or removed. However, Central Management System has to approve any suspensions and determine if it is with pay or not etc.,. The HRA then questioned what ongoing training is offered regarding staff interactions with patients. Staff are trained on the Code of Conduct policy initially upon hire and then are required to have refresher trainings online annually. Administration is also looking at new staff training on the recovery process and the recovery model which places more emphasis on interaction with patients.

H. STA 1: The HRA interviewed a STA who works on one of the units about staff interactions with patients. This STA denied that staff cuss at patients and stated that she has only witnessed professional interactions. The STA denied making any direct threats against recipients or hearing other staff make any threats or “punishing” patients for speaking with the HRA or OIG. Her opinion was that the “suits and ties” do not handle staff issues appropriately but that staff “does the best they can with what they have.” The STA asked why her name came up in this investigation and if there was a direct complaint against her made to us. The HRA explained that she was named as a witness to negative staff interactions on her unit. She became escalated and expressed frustration to the HRA and stated that she was “tired of dealing with all of the false allegations against her.”

I. STA 2: This STA was also interviewed regarding staff interactions with patients on a different unit. He was named as a staff person who had been identified as having negative interactions at times with recipient 6. This STA denied any inappropriate interactions from himself or other staff members and stated that he had worked several years in the infirmary and only works on the units occasionally and denied knowing who the recipient was that was involved in the alleged inappropriate interaction.

J. STA 3: This STA was questioned regarding the allegations that involved recipient 5 having his room “shook down.” The STA explained that a room “shake down” was to be conducted due to an allegation that the recipient had staff information in his room. He was given papers that may have contained what they were looking for but stated that items were placed back neatly and he denied witnessing any staff members tearing up the recipient’s property or taking anything that was not contraband. The STA said that if it makes things go easier, he will use a STA that does not have a conflict with the recipient when a room needs to be shaken down. This recipient frequently complains about several staff, not just one in particular so it is almost impossible to use a staff with whom he hasn’t had a conflict. The STA denied any knowledge that a request was made to have photographs taken of the recipient’s room but stated that would be something the OIG liaison would have handled not him.

K. STA 4: This STA was also involved in the room shake down of recipient 5. He stated that shake downs occur monthly or sometimes twice a month where they shake down the whole unit consisting of 3 modules. They also shake down a specific room if there is a reason to believe there is contraband or if they suspect that a recipient who has left the unit has returned with

contraband. They complete a form documenting anything that is taken from the room, the room number it was taken from and what was found goes with the recipient's name to the therapist and then is placed in property for storage. Recipients are allowed to have 1 toothbrush and toothpaste however, when they shook down recipient 5's room, the toothbrush edges were filed down as if to be used for a weapon, that is why it was taken and given to the charge aide and a restriction of rights form was completed. A replacement toothbrush was given to the nurses to give to the recipient to use when needed. This recipient contended that the shake down was conducted according to policies and did not recall anything being left in a mess or destroyed during the shake down.

K. Nurse 1: This nurse was questioned regarding the allegations involving recipient 4 that referrals to physicians were not given when requested. This nurse said that if there is an urgent issue, the physician on duty is contacted immediately. If the issue is not an urgent issue, recipients are placed on a list to see the physician the next day when he makes rounds on the units. When questioned directly about recipient 4 not being allowed to see the physician, she stated that she was unaware of him ever being denied access to the physician and if she was recalling the correct recipient, he had a lot of sinus issues and saw the physician regularly. She explained that sometimes patients get frustrated during the night shift because there is no physician at the facility during night time hours but she felt that patients who asked had every opportunity to see the physicians. The HRA then questioned the nurse about staff interactions with patients on the units. This nurse stated that she believes staff interacts appropriately with patients and gave examples of staff playing cards with patients and reporting back to the nurses when there is an issue of safety involving a patient; also, security staff "seems to be on top of things" and controls the environment very well considering all they have to deal with.

## **II. Clinical Chart Review:**

Recipient 1: The chart was reviewed for any documentation of meal refusals. There was documentation that the recipient regularly refused accu-checks for his blood sugar levels and he regularly refused medications. However, the HRA found no documentation of meal refusal or any documentation that he missed breakfast for any reason. There were several case notes indicating that regular snacks were given to him due to his diabetes.

Recipient 2: Upon review of the chart, the HRA found two clinical group progress notes relating to the recipient's participation in groups. One was dated 3/10/16 and the topic was Eight Dimensions of wellness and the treatment plan problem addressed was psychosis. It was documented that the recipient refused the class and went to the library instead. The second was dated 4/14/16 on the topic of recovering your mental health. The recipient also refused to attend this group. It was noted that he chose to go to the game room instead of group. No other documentation of class enrollment was found in the recipient's chart. The Master Treatment Plan dated 12/23/15 listed diagnoses of Psychosis with a history of aggression, Unfit to Stand Trial and Substance Abuse. The intervention to address his UST diagnosis is listed as "therapist will provide fitness education 1 time weekly during 1:1 therapy sessions for the purpose of assisting [recipient] on learning the rules and proceedings of the court along with the roles of court room personnel. Therapist will administer the fitness examination 1 time per month to assess [recipient's] readiness to return to court to address his legal charges." The HRA found

documentation in the case notes of regular visits with his therapist, first being seen every week then gradually decreasing to approximately once per month. The monthly treatment plan review (TPR) dated 3/2/16 documented that the recipient was on crush and observe psychotropic medication and the barriers to transfer section documented none at that time stating the recipient *“has stabilized, his aggression is under control and he has been recommended to return to court as fit to stand trial at this time.”*

C. Recipient 3: The HRA reviewed a comprehensive treatment plan dated 6/7/16 listing diagnoses of Schizoaffective Disorder, Bipolar Type, Substance Dependence in Remission in a Controlled Environment, Personality Disorder (Antisocial Traits) History of Diagnosis of Mild Intellectual Disability, Seizure Disorder and Hypertension, Hypothyroidism. Problems being addressed include Psychosis with verbal/physical aggression, self-injurious behavior and sexually inappropriate behavior. These issues were being treated with medication to reduce auditory hallucinations, meeting with therapist once per week, journaling and redirection of maladaptive behavior. The recipient’s Monthly TPR dated 6/7/16 documented increased agitation, verbal and physical aggression towards peers and staff and an increase in sexually inappropriate behavior. The recipient was moved from one module to another due to medical issues and sexually inappropriate behavior which was noted to have decreased slightly after the move. The recipient had as needed medication 5 times in May, refused medication once, required a physical hold and full leather restraints once, made sexually inappropriate comments to female staff members, was verbally threatening to hurt a peer twice and went to the quiet room once. It also noted that he was medication compliant, attended medication education and was seizure free that reporting period. The HRA found documentation that between June 27<sup>th</sup> and June 30<sup>th</sup>, the recipient refused two meals. On July 21<sup>st</sup> he refused breakfast and dinner. The allegation of refusing meals due to a staff member spitting in his food was reported to the OIG on June 6, 2016. The treatment plan dated June 7, 2016 did not mention any meal refusals or interventions due to meal refusals. There was also several notes where he refused his Lactulose medication for constipation saying that someone “spit in it.” A Utilization Review form dated 7/14/16 was also reviewed by the HRA. It documented that the recipient continued to be a danger to himself and exhibit verbal aggression towards staff and peers. He had refused medications 8 times and exhibited self-injurious behavior once for an hour and a half that month. The Psychiatrist reviewed his medication and made some changes. A recent restriction of rights form was reviewed in his chart dated May 5, 2017 that restricted pencil, toothbrush and utensil use to supervised due to the recipient throwing a chair at staff, threatening staff with “shanks” and a “shank” being found in his room made out of a pencil.

D. Recipient 4: The recipient’s diagnoses are listed as Delusional Disorder, Antisocial Personality Disorder, Unfit to Stand Trial, Mental Illness, Criminal History and History of Incarceration. It was also documented that he was serving a 12 year sentence for attempted murder by stabbing his ex-boyfriend in the chest. The HRA reviewed chart information which documented physician referrals that were made. The recipient saw the eye physician on October 9<sup>th</sup>, 21<sup>st</sup>, 30<sup>th</sup> and November 20<sup>th</sup>. The regular physician saw the recipient on November 6<sup>th</sup>, 24<sup>th</sup>, 30<sup>th</sup>, December 14<sup>th</sup>, 22<sup>nd</sup>, January 5<sup>th</sup> and 21<sup>st</sup>. There was documentation in the chart of the recipient being placed in restraints on October 6<sup>th</sup> for “assaulting” the physician during an interview by punching his left cheek and on November 4<sup>th</sup> and 5<sup>th</sup> for hitting staff. A September 15<sup>th</sup> case note documented that the patient refuses ear medication and documented that he

continues to complain of ear pain but refuses to complete treatment as order by the physician. It was documented on September 19th that the recipient was still refusing the ear medication stating that it did not work. The restraint flow sheet for November 6<sup>th</sup> from 11:00 a.m. through 2:45 p.m. documented the recipient cursing, not showing remorse or accepting responsibility for his actions, blaming staff for his actions, displaying aggressive body language and refusing to take part in the review. The HRA also reviewed a Forensic Psychiatric Evaluation that was requested by the recipient's public defender in September for a second opinion on the recipient's current fitness to stand trial. The evaluation began with the paragraph which stated "*I apologize to the court for the cost of this report. I would like to have done it much more briefly, but given that the Chester MHC appears to feel pretty strongly that [recipient] is fit; some of their specific observations of [recipient]; and the somewhat inconsistent nature of the Chester MHC information, it seemed necessary for me to be thorough and to clearly outline the rationale for my opinion (which conflicts with the Chester MHC opinion).*" The evaluation continued by pointing out inconsistencies in Chester's documentation which included stating that the recipient was delusional and psychotic at the time of admission in April but was not as of the June 25<sup>th</sup> report to the court; however no supporting information was given. It also pointed out that Chester documentation listed his diagnosis as paranoid schizophrenia in remission and diagnosed him as having antisocial personality disorder, but did not provide any description to support that impression/opinion. The evaluator also pointed out inconsistencies in court reports as to whether or not Chester staff believed he was delusional and if so why his delusions were not interfering with his fitness to stand trial. This evaluator's opinion was that the recipient was experiencing "prominent and pervasive delusions" not "isolated delusions" as Chester staff had reported. The staff had reported to the evaluator that their opinion was that he was fit to stand trial, possibly malingering but certainly very manipulative and not willing to accept responsibility for things he had done. The evaluator concurred that the recipient understood court proceedings but, due to his persistent delusions, did not meet criteria to become fit as he could not rationally assist in his own defense. A November 5<sup>th</sup> case note documented that he hit a staff member and exhibited persecutory delusions that staff is playing mind games against him and poisoning him. Several case notes followed documenting aggressive behaviors towards staff and peers through November 9<sup>th</sup>. The TPR dated September 8<sup>th</sup> stated that the recipient scored a 58% on the fitness test in May but then scored a 100% in June. The treatment listed for attaining fitness was for the therapist to refer him to group fitness education. The therapist's progress note for that month stated that he "knows his charge and has some understanding of the legal system. He is very articulate and has always been rational when discussing the court system. At this time he chooses to cooperate and has been recommended as fit." The HRA also found several case notes of sessions with his therapist documenting that they occurred regularly. At first he was seen every 2 weeks then it tapered to monthly sessions with his therapist. The October 28<sup>th</sup> TPR documented that the independent evaluator felt that the recipient was still unfit to stand trial and the treatment team and psychiatrist feel that he is fit to stand trial. The treatment plan noted that the therapist would evaluate to determine what is needed to achieve fitness and again stated that the therapist would refer him to group fitness education. His therapist noted that the recipient had shown a decompensation in his presentation and level of cooperation, that his report to the court would reflect him as unfit and a petition would be submitted for court enforced medication. This TPR also documented increased verbal altercations and confrontations with peers, pushing peers and the STA documented that the recipient calls peers the "N" word, turns their lights on and off and hoards clothes under his bed. The case notes reflected an increase in aggressive



behavior documenting instances of the recipient punching his psychiatrist, fighting STAs and making statements such as “staff needs to die, they put me here and they all need to die.” It was also documented that his supervision level was increased to 2:1 for a period of time due to his aggressive behaviors. It was also noted that the recipient was experiencing “grandiose delusions, episodic agitation and persecutory delusions of staff playing mind games against him and poisoning him.” During a room shake down, staff found a Spork, extra pencil and a rope made out of a blanket in his room; ~~and~~ his property was restricted as a result and he was placed on 2:1 supervision and court enforced medications due to his extreme aggression towards staff. The last few case notes reviewed by the HRA from July through September, 2016 just prior to the recipient’s discharge, documented that in July the recipient no longer presented as delusional and had not been aggressive. In August the social worker noted that the recipient was still UST, was in restraints at the end of July and that he “*continues to exhibit poor anger control. Patient was informed he needs to show a longer period of aggression free behaviors. Will continue to encourage patient to engage in treatment and therapy.*” In September a nursing note documented that he was leaving for court. The recipient was transferred as Fit to Stand Trial the end of September.

E. Recipient 5: This recipient’s TPR from December documented that the recipient was admitted as UST. His diagnoses are listed as mood disorder NOS (not otherwise specified); Antisocial Personality Disorder; and Hypertension and Asthma (by history). He also has verbal and physical aggression which is addressed in his TPR and a behavioral intervention plan (BIP) was developed. His TPR stated that the therapist would meet with the recipient one time weekly to help him gain insight into his illness and his need for treatment and to work on ways to cope with any aggressive impulses he may have. His TPR also required the therapist to meet with him once weekly to provide fitness education to help him attain competency to stand trial. The TPR documented that the recipient refuses to meet with his therapist once a week to discuss fitness education and refuses to take his UST Fitness test. However, it was noted that he was able to identify individuals and their roles in the courtroom, verbalize his crime and possible penalties and that he “appears able to appropriately cooperate with his attorney at this time” evidenced by multiple calls daily to his attorney. However, it was noted that his motivation to attain fitness is questionable as evidenced by refusal to cooperate with fitness education and his therapist. This TPR documented that at that time, his treatment team believed he was fit to stand trial.

**G. OIG Reports:** The HRA reviewed 23 reports ranging in dates from late 2014 to early 2017 most being from the year 2016 when the complaint was filed with the HRA. The sample reviewed was based on a search of staff names that were reported to the HRA throughout this investigation. Some of these reports were directly related to the allegations involving recipients in this case; others just involved those same staff persons with other recipients' allegations. Of the 23 reports, 3 were substantiated by the OIG; of the remaining 20 that were either unsubstantiated or unfounded, 6 had recommendations issued. The HRA also reviewed these 23 reports for patterns of complaints to determine if the same recipient is filing multiple complaints and also if the same staff are repeatedly being accused. Staff 1 below had 2 OIG complaints filed against him by the same recipient. All other staff listed below had complaints filed against them from different recipients. In these 23 reports, there was 13 different staff persons listed as the accused. The following is a summary of the OIG reports reviewed:

Name	Year of Hire	Total OIG Reports found in database	# of OIG reports reviewed for this case staff was named in	# Substantiated OIG reports found in database	# unsubstantiated but with recommendations
Staff 1	2016	18	2	1 in 2014	
Staff 2	2007	13	1	1 in 2016	*
Staff 3	2007	5	3		1
Staff 4	1996	37	1	1 in 2013	
Staff 5	2011	7	1		
Staff 6	2010	20	2		* 1
Staff 7	2014	9	9		2
Staff 8	2013	3	1		
Staff 9	2015	2	1		
Staff 10	2014	2	1		2
Staff 11	2007	30	1	1 in 2015	
Staff 12	2013	10	1	1 in 2015	
Staff 13	2015	1	1	1 in 2016	

\* OIG findings stated: *“There was some evidence to support the allegation but not to the level of preponderance.”*

Staff persons 8, 11 and 13 are no longer employed at the facility. The HRA is unaware if their separation from employment was related to the OIG investigations or not.

### **III. Policies:**

**A. EC.04.09.00.08 Code of Conduct** policy states *“At Chester Mental Health Center (CMHC) we strive to promote the welfare of those with whom we have contact and to prevent mental or physical harm. All patients, employees and visitors shall be treated with dignity, respect and courtesy. The rights, views, and positions of all, will be respected regardless of their job title. This will be upheld via a code of conduct which is a set of rules which outline the responsibilities*

*of / or proper practices for an individual or organization. Chester Mental Health Center has zero tolerance for workplace violence and intimidating and disruptive behaviors. In accordance with AD .01.02.03.040 Rules of Employee Conduct and AD .01.02.03.170 Reporting Misconduct...Staff will receive training on the CMHC Code of Conduct. It is the belief of CMHC that we must develop awareness of the ways in which our individual beliefs, values, needs and limitations affects our work with others, and take reasonable steps to increase the focus on safety and quality for all individuals.” This policy lists the following as unacceptable employee conduct:*

*“On Duty Conduct-*

- *Harassment (verbal or physical conduct that denigrates or shows hostility or aversion toward an individual) this includes: epithets, slurs, teasing, ridicule, making someone the brunt of pranks or practical jokes, negative stereotyping, threatening, intimidating, bullying or hostile acts, radical jokes, stalking, malicious or mischievous gossip, written or graphic material showing hostility or aversion toward a group or individual.*
- *Improper Language – this includes vulgar, profane or loud/disruptive language*
- *Threats-this includes direct, indirect and/or conditional threats of bodily harm. They may be electronic, written or verbal.*
- *Insubordination-refusing to follow supervisory instruction*
- *Physical aggression-this includes aggression toward patients, visitors, other staff and property*
- *Being under the influence of illicit drugs or impaired by alcohol.*
- *Viewing inappropriate images or pornography in hard copy or electronically*
- *Unwelcome physical contact including that of a sexual, intimate or threatening nature. No sexual harassment. No sexual activity while on facility grounds.*
- *Withholding approval for or denial of requests maliciously, discriminatorily, unfairly or without basis.*
- *Unsafe work practices or behavior which may harm the staff member or others.*
- *Excluding or isolating individuals.*
- *Undermining performance, reputation or professionalism of others by deliberately withholding information, resources or authorization or supplying incorrect information.*
- *Stealing or misuse of facility resources.*
- *All other rules as outlined in Administrative Directive .01.02.03.040 Rules of Employee conduct...*

*III. Process for managing behaviors that undermine a culture of safety and quality. All DHS employees are required to expose without fear or favor, illegal or unethical conduct of others.*

*A. Employee Expectations: 1. All DHS employees who are victims of, witness of, or who become aware of any incident/behavior that undermines a culture of safety and the facility Code of Conduct policy, must report it immediately to his/her immediate supervisor and write an incident report CMHC 207 concerning the incident. 2. Staff is required to report any potential conflicts to their supervisors. Documentation of such is to be made on a CMHC 207 information report form...The employee [found guilty of violating the Code of Conduct Policy] may be subject to disciplinary action up to and including discharge, and/or may be subject to criminal charges, where so provided by statute.”*

B. AD.01.02.03.040 Rules of Employee Conduct policy requires all DHS (Department of Human Services) employees to abide by the following rules:

- “1. An employee shall not participate in or condone fraud; dishonesty, or misrepresentation in the performance of duties;*
- 2. An employee shall provide full cooperation with the Office of Inspector General of the Department or any official investigative entity and shall testify truthfully and completely in all court proceedings;*
- 3. An employee shall refrain from socializing with clients, client's family members, or individuals closely associated with the client or client's family when such a relationship may constitute a conflict of interest;*
- 4. An employee shall show respect for cultural styles and values of different groups and individuals within those groups;*
- 5. An employee shall not use vulgar, profane or loud/disruptive language in the workplace or while on work status in a manner directed at or which could disturb clients and/or other staff;*
- 6. An employee's conduct while off-duty may subject the employee to discipline up to and including discharge. In order to invoke discipline or to discharge an employee, the conduct must raise reasonable doubt concerning the employee's suitability for continued state employment. Acts of domestic or interpersonal violence, sexual abuse, child/elder neglect or abuse may raise reasonable doubt concerning an employee's suitability for continued employment;*
- 7. An employee shall not make direct or indirect threat of bodily harm to another employee, client, recipient, student or any other person covered by the services of the Department;*
- 8. An employee shall not demonstrate inappropriate behavior and/or discourteous treatment of the public, co-workers, clients, and/or applicants;*
- 9. An employee shall not disclose confidential information or records on recipients, vendors or employees in violation of Department directives, state law or federal law.*
- 10. An employee shall not use state equipment for inappropriate purposes or for personal gain.*
- 11. An employee shall not refuse to follow supervisory instructions; and*
- 12. An employee shall not violate local regulations regarding matters such as eating in the office, outside visitors, use of radios, etc.*

*Procedures: Any violation of these provisions should be immediately reported by the observing employee to his/her immediate supervisor. The observing employee's immediate supervisor should report the infraction to the alleged violator's immediate supervisor. Employees found to have violated these policies shall be subject to disciplinary action up to and including discharge. Any employee conduct which is considered alleged criminal conduct must be reported through the appropriate administrative chain to the Illinois State Police.”*

C. State of Illinois Code of Personal Conduct Policy says the following about employees conduct while serving in his or her official capacity *“Each state employee has a responsibility to the people of the State of Illinois to act with integrity and to treat the people we serve, our colleagues, and other parties with dignity and respect...State Employees should avoid any action that creates the appearance of a violation of the law or the ethical standards set forth in this Code...There must be no unlawful discrimination, harassment, intimidation or retaliation in any employment practice based on race, color, national origin, religion, age, sex, marital status, disability, ancestry, sexual orientation, military service, political affiliation or any other protected status or non-merit based factor...A State Employee may not engage in disruptive*

*conduct or activities or horseplay that interrupts work or impedes the work of others or use abusive or offensive language, gestures or similar conduct...A State Employee who witnesses, is a victim of, or becomes aware of any threatening words or actions must immediately report the incident to his or her supervisor or to the appropriate law enforcement entity...A State Employee may not hit or push another person or have hostile or unwelcomed contact with another person, unless otherwise authorized by State or State Agency policy or procedure...A State Employee may not interfere with or obstruct an investigation by refusing to testify or cooperate in a properly authorized inquiry or investigation, without legal justification interfering with or improperly influencing or attempting to interfere with or improperly influence the testimony of any witness or participant in an investigation or improperly influencing or attempting to improperly influence any investigatory official...A State Employee may not...knowingly make any deliberate misrepresentation or omission of a material fact including perjury, making any false sworn statement and lying to a supervisor or falsify or knowingly fail to correct false information contained in official documentation or in an official record related to the performance of such state employee's job duties...A State Employee may not be under the unauthorized influence of alcohol, drugs or other controlled substances to a degree that would interfere with proper performance of his or her job duties, would be a menace to safety or would be prejudicial to the maintenance of discipline or be under the unauthorized influence of alcohol, drugs or other controlled substances to a degree that results in injury to another individual or damage to State property."*

D. RI .05.00.00.01 Code of Ethics states that *"Chester Mental Health Center employees and the day-to-day operations of the facility as a whole will be guided by a code of ethics designed to safeguard the best interest of those who live and work here... All facility operations and employee conduct will be focused on fulfilling the mission, vision and values of the facility in a consistently ethical manner.*

*A. Mission: Our mission is to assist individuals requiring a maximum secure forensic mental health setting to recover to their maximum potential in order to return to a less restrictive setting, or to court, and eventually to society as a productive citizen. We will accomplish our mission in a safe, violent free, patient centered and culturally sensitive environment.*

*B. Vision: It is our vision to be recognized and respected as one of the premier maximum secure forensic mental health hospitals in the nation.*

*C. Values: We hold these values in high esteem, as an essential component of our organization, and crucial to our success in achieving our mission and vision. Respect, honesty, good work ethics, dependability, responsibility, teamwork, hope, integrity.*

#### **EMPLOYEES**

*A. General Ethical Concepts for Guiding Employee Conduct: It is expected that all Chester Mental Health Center employees will serve as ethical role models for each other and for patients being served. Every employee, at every level of the organization, must continually evaluate the potential outcomes of the decisions he/she makes since action or inaction may affect the well-being of others. The employee must accept responsibility for any consequence resulting from his/her behavior.*

*Chester Mental Health Center employees will act to safeguard and perpetuate the rights and interests of patients. Employees shall act as advocates for patients and strive to promote their well-being. Employees will speak out to promote the rights, interests, and prerogatives of patients.*

*Employees will assure that patients will be involved in decisions regarding the care they receive to the extent that is possible. They will inform patients about the therapeutic alternatives and risks associated with care provided and will provide care with respect for patients' background, gender, religion and heritage. Every task performed by a Chester Mental Health Center employee must have, as its ultimate goal, to serve in a positive way, those patients in our care. Ongoing self-awareness and continued self-evaluation of adherence to standards of ethical behavior, as well as support, encouragement, and positive recognition for compliance with those standards, directly enhance employee morale, job performance, public relations, and Chester Mental Health Center's reputation for assuring clinical outcomes..."*

EC.04.01.01.03 Physical Plant Security Searches states that all units will be thoroughly searched for contraband at a minimum of twice per month. It also provides for "Spot Searches" to be conducted to address missing property, suspected dangerous contraband etc. A unit director, shift supervisor or coordinating therapist shall be present during a spot search. The policy continues by saying "*Caution should be used when searching patient's clothing and personal effects to avoid damage or unduly upsetting the patient, the room and its contents...common search areas include but are not limited to: personal items...folders, envelopes, all papers including legal documents..."*

### **Statutes**

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-101) states "*Any adult under guardianship may request and receive counseling services or psychotherapy. The consent of the guardian shall not be necessary to authorize counseling or psychotherapy..."*

The Code (405 ILCS 5/2-102) also states "*A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan. The Plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient. The facility shall advise the recipient of his or her right to designate a family member or other individual to participate in the formulation and review of the treatment plan. In determining whether care and services are being provided in the least restrictive environment, the facility shall consider the views of the recipient, if any, concerning the treatment being provided. The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan.*" Adequate and humane care and services is defined as "*services reasonably calculated to result in a significant improvement of the condition of a recipient of services confined in an inpatient mental health facility so that he or she may be released or services reasonably calculated to prevent further decline in the clinical condition of a recipient of services so that he or she does not present an imminent danger to self or others"* (405 ILCS 5/1-101.2)."

The Mental Health and Developmental Disabilities Administrative Act (20 ILCS 1705/7) states that Department facilities are to "*provide the highest possible quality of humane and rehabilitative care and treatment to all persons admitted or committed or transferred in*

*accordance with law to the facilities, divisions, programs, and services under the jurisdiction of the Department....”*

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-112) states *"Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."* Section 5/1-101.1 defines abuse as *"any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means."* Section 5/1-117.1 defines neglect as *"...the failure to provide adequate medical or personal care or maintenance to a recipient of services, which failure results in physical or mental injury to a recipient or in the deterioration of a recipient's physical or mental condition."*

The Administrative Code (59 IL ADC 50.10) pertaining to Office of Inspector General investigations defines neglect as *"An employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance, and that, as a consequence, causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death."*

## **Conclusion**

**I. The first allegation was inhumane care due to negative staff interactions.** Five recipients from four different units at the facility were interviewed regarding staff interactions with patients. Four of the five described negative staff interactions that ranged from false documentation in the charts to mental, physical and verbal abuse as well as staff retaliating against patients for speaking with the HRA or OIG.

Recipient 1 said that a Security Therapy Aid (STA) was giving him a hard time and would not allow him to go to the cafeteria because he talked during television time and that it was documented in his chart that he refused breakfast but he said that he did not because he is diabetic and does not skip meals. The recipient said breakfast was not offered to him on the unit and alleged that the STA stated “we’re going to put shit in his food.” The recipient stated that he filed a complaint and gave it to another STA on the unit and he was told that it was given to his therapist. However, when questioned, the therapist told the HRA that she was unaware of any complaint relating to meal refusal or staff making the above comment. When reviewing the chart, the HRA found no documentation of meal refusal or any documentation that he missed breakfast for any reason. There were several case notes indicating that regular snacks were given to him due to his diabetes. The STA was not identified and could not be interviewed regarding the complaint that was allegedly filed. Therefore the allegation regarding recipient 1 is **unsubstantiated**.

Recipient 3 told the HRA that he had witnessed negative interactions between staff and patients and said that one staff person had spit in his food. The recipient said that he did not eat for almost 2 weeks because of that staff person’s statements to him that she would spit in his food again. An OIG report of abuse was filed regarding that allegation. The HRA reviewed the OIG report regarding the allegation and also interviewed the staff person who was accused. The report stated that there was one witness to the alleged incident who reported that he did see the

STA spit on the recipient's tray. However, the STA denied the allegation to the OIG and said that this witness would often seek positive attention from peers. The STA also told the HRA that she has only witnessed professional interactions on her unit and contended that any problems were a result of the "suits and ties" not handling things properly. The STA denied making any direct threats against recipients or hearing other staff make any threats. The HRA did not directly question the STA regarding the spitting allegation to protect the confidentiality of the recipient as this STA presented as guarded and defensive and became increasingly agitated/frustrated that she was being questioned and stated that she was "tired of dealing with all of the false allegations against her." The OIG report was unsubstantiated due to the accused and three other staff persons providing "consistent and corroborated accounts indicating no abuse occurred" and progress notes revealing that the recipient had been exhibiting severe agitation and self-injurious behavior over the duration of the alleged abuse time period, however, there was no indication that this was a direct result of the alleged incident. The HRA found documentation that the recipient had refused medications 8 times and meals 4 times. The STA's demeanor and defensiveness with the HRA's questioning, the recipient's history of aggression and sexually inappropriate behavior towards staff and the witness to this alleged incident, lended some credibility to this allegation. Although there were some documented meal refusals around the time of the alleged incident there was no documentation to verify that meals were refused for 2 weeks and other staff had stated that the witness to the alleged incident would often say or do things for attention which lessened the credibility of the 2 recipients and the staff denied any wrongdoing.

This recipient also told the HRA that when patients come to meet with the HRA, staff escorting patients try to discourage them from speaking with the HRA by saying things such as "they're not going to be able to do anything anyway, you're wasting your time." The recipient also stated that sometimes staff "jump on them and find a reason to put them in restraints" after they return from speaking with the HRA. The HRA asked several recipients about this allegation and most could not corroborate this specific allegation, but would instead continue with their own allegations of staff wrongdoing that had occurred to them unrelated to deterring them from speaking with HRA. Recipient 4 did corroborate this statement by saying that staff "mess with" clothing and other personal belongings if they speak with the HRA. The STAs interviewed denied any retaliatory actions against recipients and denied witnessing other staff make any threats or "punishing" patients for speaking with the HRA or OIG. Since the other recipients questioned could not state that staff had made those statements to them directly, the allegation regarding recipient 3 is **unsubstantiated**. The HRA offers the following suggestions:

1. The HRA was concerned by the demeanor of the STA interviewed regarding this allegation. She was defensive and became verbally escalated a few times during the interview and stated that she was tired of dealing with all of the false allegations against her which lead the HRA to believe that there had been several. Upon review of the OIG database, the HRA found 9 total OIG allegations of abuse and/or neglect against this STA since being hired in 2014 from 6 different individuals and 3 from this recipient. Although none were substantiated, there were 2 that included recommendations from the OIG due to false statements being given by this STA and another STA during the OIG interview and this STA "pointing a pen at and blocking egress" of a recipient which resulted in him becoming frustrated and striking her. The other recommendation was for



the STA failing to follow procedure when dealing with an aggressive and highly agitated recipient. The HRA suggests that this STA's supervisors monitor her interactions with recipients closely to determine if further action needs to be taken regarding training or other staff assistance to ensure that recipients are free from abuse and neglect and to ensure humane care and treatment as required in the Mental Health Code (405 ILCS 5/2-112 and 405 ILCS 5/2-102).

Recipient 4 said that STAs on the unit have punched him in the stomach causing him to vomit or defecate. The OIG has been called twice on these instances but no one ever came to interview him on the complaints. The HRA found a 11/17/15 case note indicating he did vomit and defecate in his room and it was noted that he said it is because he feels sick due to "polluted air coming through his room." The HRA found one OIG report unrelated to this allegation and two complaints deemed to be "non-reportable" by the OIG but those dates did not line up with the timeframe reported by the recipient. The allegation that was investigated was unsubstantiated against five staff members due to staff "providing consistent and corroborated accounts denying the allegation" and no witnesses being identified to verify the allegation. This recipient also said that staff on the unit retaliates against patients for filing complaints with the OIG or HRA by "messing with clothes" and personal belongings from the room turn up missing. He also stated that staff on the unit call him a "spick" and "fag" and tell him he is a bad influence on his peers and won't let his peers sit next to him. However no staff or witness names were given to further investigate these allegations and the HRA found case notes documenting paranoia about staff poisoning him which lessened the credibility of his statements.

Recipient 4 also stated that staff falsifies behavior reports and documentation to make patients look worse than they are, to impose restrictions on them or to cover up what staff has done. One example given was stating that he refused to see a physician when actually staff refused to let him go, that is examined in more detail in allegation II below. The HRA also reviewed an evaluation conducted by an independent psychiatrist hired by the recipient's public defender for a second opinion on the recipient's fitness noted in his evaluation a "somewhat inconsistent nature" of the Chester MHC information, pointing out inconsistencies in Chester's documentation which included stating that the recipient was delusional and psychotic at the time of admission in April but was not as of the June 25<sup>th</sup> report to the court; however no supporting information was given. It also pointed out that Chester documentation listed his diagnosis as paranoid schizophrenia in remission and diagnosed him as having antisocial personality disorder, but did not provide any description to support that impression/opinion. The evaluator also pointed out inconsistencies in court reports as to whether or not Chester staff believed he was delusional and if so why his delusions were not interfering with his fitness to stand trial status. Although these statements lend some credibility to an allegation of lack of proper documentation or supportive information, the HRA found nothing substantiating false documentation. There were several nursing notes documenting aggressive behavior and the actions that were taken to address that behavior but found nothing to indicate that any of those case notes were false. Therefore, the allegation regarding recipient 4 is **unsubstantiated**.

Recipient 5 had several complaints of negative staff interactions including a nurse allegedly telling other staff to "tie him up like he's in a zoo" referring to the use of ambulatory

restraints. When questioned, the nurse denied making or hearing other staff make that comment. No other witnesses were identified.

Another complaint involved his room being shaken down on August 3<sup>rd</sup> around 8:30 p.m. The recipient stated that earlier that day a staff person asked him what a call was related to and he replied it was about his lawsuit against the facility. The recipient alleged that the STAs took complaint forms and court documents and ripped them up and tore up photographs of his daughter and left his room in a mess during this shakedown. In the morning of August 4<sup>th</sup> this was reported to the OIG. In the evening of August 4<sup>th</sup> STAs came to his room demanding that he clean it or they would “beat his ass and tie him to his bed and clean it for him.” The recipient refused because he wanted the OIG to see the condition his room was left in. The STAs allegedly replied that no pictures were going to be taken of his room. The morning of August 5<sup>th</sup>, after he cleaned his room, the OIG investigator came to speak with him regarding the allegations. The first STA interviewed stated that the shakedown was conducted due to an allegation that the recipient had personal staff information in his room. He was given papers that may have contained what they were looking for but stated that items were placed back neatly and he denied witnessing any staff members tearing up the recipient’s property or taking anything that was not contraband. The second STA interviewed by the HRA who was involved in the shakedown corroborated the first story that the shakedown was to look for contraband and stated that they found toothbrush edges that were filed down as if to be used for a weapon which was removed from the room and a restriction of rights form was given which the HRA reviewed. Both STAs denied that the room was left in a mess and contended that things were put back in reasonable order. The OIG report named 4 other STAs who were also interviewed and corroborated the story of these 2 STAs. There were 10 recipients also interviewed by the OIG and 5 stated they saw the after effects of the messy room and torn photograph; one saw it but accused the recipient of tearing the photo to get back at staff. Two recipients saw the STAs shake down the room; one of those recipients saw staff tearing up the photos but the other said the room was messy but no photos were torn. One recipient stated he recalled the room search but nothing was messy or torn up and the final recipient did not witness the shakedown but heard the recipient complaining that staff had torn up his photograph. Although there were mixed witness statements, there were still corroborating witness statements regarding the state of the recipient’s room and the STAs involvement. Thus, the HRA **substantiates** a violation of Chester’s search policy and **recommends** the following.

- 1. Chester policy EC.04.01.01.03 Physical Plant Security Searches requires that *“Caution should be used when searching patient’s clothing and personal effects to avoid damage or unduly upsetting the patient, the room and its contents.”* STAs conducting room shake downs should be retrained on this policy to ensure that in the future a recipients’ property is treated respectfully and not damaged.**

Furthermore, the HRA finds a related Code of Conduct violation. Upon request, the administration provided the HRA with training records showing what staff members had completed the Code of Conduct policy training. Of the 13 employees listed in the table in this report, 4 had completed the training, 6 had not completed the training and 3 are no longer employed. Of the employees with past substantiated OIG complaints 2 had completed this training 2 had not. The HRA is also concerned that of the OIG reports reviewed for the 10

currently employed STAs, 4 had substantiated OIG findings and 3 had unsubstantiated findings with recommendations in the past 3 – 4 years.

1. **The HRA recommends that administration and/or supervisors conduct a review of training records of the STAs to ensure that staff are up to date on required training and ensure that interactions with patients are positive and conducive to recovery as required by the Code of Conduct and Ethics policies at Chester and the Department of Human Services policies.**
2. **The administration also told the HRA that they were in the process of reviewing a new staff training on the recovery process and the recovery model which places more emphasis on interaction with patients. The HRA would like an update on that training being made available and if any staff have completed that training.**

**II. The second allegation was lack of active mental health treatment.** Two of the five recipients who were interviewed described lack of treatment to attain fitness and not being allowed to see a physician when needed. Recipient 2 stated that he was sent to Chester Mental Health as Unfit to Stand Trial (UST) but he never received any fitness classes, just took the fitness test which he passed and was then told he would be recommended as fit to stand trial. He stated that he was not enrolled in rehabilitation classes because he was going to be recommended as fit to stand trial; therefore he spent his days watching television, playing video games or going to the gym and/or yard. The recipient was admitted in September, 2015 and discharged as fit to stand trial in April, 2016. Upon review of the chart the HRA found clinical group progress notes documenting the recipient was enrolled in two different groups on separate occasions, but refused to attend those groups. No other documentation was found regarding clinical groups. This recipient's treatment plan listed the intervention for UST status as *“therapist will provide fitness education 1 time weekly during 1:1 therapy session for the purpose of assisting [recipient] on learning the rules and proceedings of the court along with the roles of court room personnel. Therapist will administer the fitness examination 1 time per month to assess [recipient's] readiness to return to court to address his legal charges.”* The HRA found documentation in the case notes of visits regularly with his therapist, first being seen every week then gradually decreasing to approximately once per month. Therefore, this allegation regarding recipient 2 is **unsubstantiated**.

Recipient 4 was admitted to Chester in April, 2015 and discharged in September 2016 as fit to stand trial. He told the HRA that staff documented that he refused to see the physician when actually they refused to let him go. The recipient said that when he would ask if he could see the physician, he was told by staff that he did not need to go and that it was “all in his head.” The HRA reviewed chart information which documented at least 11 physician referrals that were made between October and January which corroborates the nurse's statements that he saw the physician regularly. The nurse also said that she was unaware of the recipient ever being denied access to the physician. The HRA contends that 11 referrals over a 16 week time period was reasonable access and there was documentation that the referrals occurred and no patients were identified as witnessing staff denying access to a physician.

As for the issue of fitness, there seemed to have been some discrepancy between the treatment team and an outside psychiatrist. In May, the recipient scored a 58% on his fitness test but then in June scored 100%. He was recommended as fit to stand trial by the treatment team in June, 2015 noting that he was “well aware of court procedures in spite of isolated delusions.” His public defender requested a second opinion on fitness in August which was completed in September. That psychiatrist’s opinion differed from that of Chester Mental Health and concluded that the recipient was still unfit to stand trial because of ongoing pervasive delusions about the alleged victim in the case and prison in general. He also noted that the recipient had sufficient understanding of court proceedings but his delusions interfered significantly with his ability to rationally assist in his own defense. The case notes and October TPR reflected an increase in aggressive behavior and the recipient was deemed unfit again due to aggressive behavior and becoming more paranoid and delusional. The treatment listed in the TPR for attaining fitness was for the therapist to refer him to group fitness education. The HRA reviewed 3 clinical group progress notes the first on 10/6/15 which he refused due to being on unit restriction; and then on 10/13/15 for Court and Life Skills held Tuesdays at 9:45 a.m. which the recipient refused to attend. He was then enrolled on 11/3/15 in Understanding My Illness Tuesdays at 9:45 a.m. which he attended and finally on 12/14/15 he was enrolled in Court Terms which he attended. The HRA also found case notes from 10 therapy sessions and 3 psychiatrist notes between October, 2015 and July, 2016. In July a Social work note indicated no aggression and recipient’s motivation to return to court as fit to stand trial, but he required restraints 3 days later. The August social work note indicated poor anger control and the recipient was told he needed to show a longer period of aggression free behaviors. However, in September it was noted that he was motivated to attain fitness and no longer presented as paranoid and on September 25th he was discharged to the court as fit to stand trial. Therefore the allegation is **unsubstantiated**. The following suggestion is made:

The HRA suggests that staff should ensure documentation is consistent and that it accurately reflects a recipient’s needs and behaviors.