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Egyptian Regional Human Rights Authority
Report of Findings
Case #12-110-9017
Chester Mental Health Center

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Chester Mental Health Center:

1. A recipient was placed in handcuffs and then assaulted by staff in the "stem" of a unit where there are no security cameras.

2. A recipient's request for documentation of the incident and copies of pictures taken of his injuries has been denied.

3. The internal abuse investigation process is inadequate in that there is a conflict of interest and lack of objectivity when security therapy aides (STAs) investigate the actions of other security therapy aides. Also, the recipient did not receive acknowledgement of his complaint until he requested it.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/100 et seq.) and regulations and protocol governing abuse protections (59 Ill. Admin. Code 50).

Chester Mental Health Center is a secure, inpatient mental health facility operated by the Illinois Department of Human Services. The facility has 240 beds.

To investigate the complaints, the HRA interviewed service recipients, a representative of the Office of Inspector General and facility staff, examined a recipient's record, with consent, examined pertinent agency policies, toured a facility unit and reviewed the Office of Inspector General (OIG) for the Illinois Department of Human Services file on the case, including the final report and supporting evidence.

COMPLAINT STATEMENT

According to the complaint, a recipient who was admitted to the facility on December 22, 2011 had an incident in the facility dining room in which he reportedly stood up to obtain a carton of milk that he forgot; he was ordered to sit down and was approached by several STAs who placed him in handcuffs. He was escorted from the dining room to the "stem" of his unit where there are no security cameras. While in the stem, he was reportedly choked, pulled down to the

ground, struck in the face and taken to the restraint room while being told to "shut the fuck up" and "I'll kill you" by the Security Therapy Aides (STAs). The recipient and a family member contacted the OIG and an investigator met with the recipient and took pictures of the recipient's injuries. The staff involved were allegedly not removed from the unit but recipients who witnessed the incident were moved to another unit. Later, the recipient attempted to secure copies of the report and pictures but was denied access to these records. And, the recipient observed the investigator interacting with other STAs at the facility and learned that the investigator is actually an internal facility investigator although this was not disclosed to the recipient; the recipient questioned the adequacy of an abuse investigation when the investigator works with STAs who are being investigated. The complaint also indicated that the recipient did not receive notice of the OIG's intent to conduct an investigation until he requested the notice.

Upon receiving the complaint, the HRA contacted the OIG to report the complaint and was informed that the OIG had already been notified. The HRA specified the portion of the complaint in which it was alleged that the internal abuse investigators have a conflict of interest. The OIG representative indicated that the external OIG office interacts weekly with the internal investigators who are responsible for conducting an in-house investigation, obtaining statements and securing photos if warranted.

FINDINGS

Interview with Staff

The HRA spoke to the chair of Chester's internal human rights committee and the facility director at the time of the incident. Both referenced facility documentation on the incident and indicated that the OIG was involved. Both confirmed that an internal investigator, employed by the facility, was involved in collecting information about the complaints. They stated that the system is set up so that a local investigator can immediately gather evidence and then submits it to the OIG for a determination of abuse or neglect. The chair and director confirmed that there are no cameras on the unit "stems" which were described as the unit areas that staff primarily use; however, recipients may walk through the stems from time to time. The stem is comprised of the nurses' station and perhaps a staff desk and doors to and from other areas of the unit or facility. The chair provided a floor plan of the unit and gathered other policy and incident information pertinent to the complaint. The chair stated that cameras are primarily used for security purposes.

At a later date, the HRA inquired about the position held by the Chester employee who services as the OIG investigator/liaison. The HRA was informed that the internal OIG Liaison/Investigator is an STA IV and part of the same bargaining unit as other STAs at the facility. The employee also has some supervisory responsibilities over certain STAs.

Tours of the Unit

The HRA toured the facility and observed the area described as the stem which was centrally located and consisted of the nursing station as well as staff work areas. Several staff were congregated in the area of the stem at the time of the HRA's visit.

A second tour was conducted to observe the restraint rooms on the unit in question. There was a camera at the end of the hallway where the restraint rooms were located and there were cameras in the seclusion rooms. However, there were no cameras in the restraint rooms at the time of the visit although the HRA team noted a darkened panel behind which some wires could be seen. Staff interviewed reported that it has been some time since cameras were in place in the restraint room as the facility is required to have a staff attendant outside the door of the restraint room at all times. Inside the restraint room, the HRA examined a stationary table on which 4 plastic straps were attached, two straps for the wrists and two for the ankles. Staff reported that a Posey vest is used if a 5 point restraint is ordered. Staff indicated that the restraint room door is left open although, when asked, the door is reportedly closed for privacy if the recipient uses the bedpan or urinal. Although there was a toilet in one of the restraint rooms observed, recipients in restraints are to use a urinal or bedpan as per staff. Restraints are released at least every two hours for circulation, to use the urinal, or to eat or drink according to staff. Staff also reported that the cameras on the units are fixed and stationary. Also, unit cameras are not monitored in real time; instead, recordings are reviewed if there is an incident. The HRA also observed the monitoring room where seclusion rooms can be viewed via the cameras; these cameras are monitored at all times that a recipient is in seclusion. They were all in working order. Staff were also asked about the number of staff needed to employ restraints; the HRA was informed that the need varies depending on the behaviors exhibited.

Interviews with Recipients

The HRA interviewed other recipients who were identified by the recipient in the case as being witnesses to the incident in question. One recipient stated that he did not actually observe the incident but did observe the recipient in handcuffs being led out of the dining room and then saw the recipient with bloodshot, red eyes as well as scrapes, scratches and bruises on arms and elbows. This recipient confirmed that the stem is the area that patients walk through and from which staff work. Another recipient stated that he did not see the incident but did see the recipient with "blood clots" in his eyes and a swollen face. This recipient stated that the stem is where staff are located and the area through which recipients travel when being escorted to and from the unit. A third recipient who had no knowledge of the incident provided information about the stem and stated that the charge aide and nurses are located on the stem; he indicated that paperwork is kept on the stem. He also reported that recipients pass through the stem but are not allowed to stay in it. He confirmed that there are no cameras on the stem and stated that staff talk about recipients while in the stem.

Record Review

With consent, the HRA examined the record of the recipient in this case starting with his treatment plan dated 02-07-12. The recipient was admitted to Chester on 12-23-11 after having been found Unfit to Stand Trial on 11-17-11 for the charges of First Degree Murder, Armed Violence, Armed Robbery and Aggravated Battery with a Firearm. The plan noted that the recipient refused to attend the treatment plan meeting but indicated that he was not ready to return to jail and had no incidents of aggression during the reporting period. Two "problems" were noted for the recipient: his fitness to stand trial and his aggression, noting his disruptions during court proceedings. He has no Axis I diagnosis but has an Axis II Diagnosis of Personality Disorder, Not Otherwise Specified. The treatment plan references the incident that prompted the HRA case as follows: "On 12-26-11 he was put in FLR [full leather restraints]

because he stood up to get some food which he was not supposed to and got into angry arguments in the dining room and approached the staff in a threatening manner." Additional incidents were documented as well. "On 01-03-12 he had angry argument over the food and became extremely agitated in the dining room and threatened to bash STA's face with his tray. When instructed he agreed to walk to the seclusion room." The treatment plan later stated that "He learned to control his aggression however he continued to be oppositional." The recipient's emergency treatment preferences were listed as seclusion first, then restraints and then emergency medication. The treatment plan lists the treatment objectives of taking prescribed medication, cooperating with fitness evaluation/education, participating in unit activities, following unit rules, having no incidents of verbal/physical aggression, and displaying appropriate social behaviors through the facility level system. With regard to the recipient's progress on objectives, the plan noted that the recipient refused medication but actively participated and was cooperative in all other objectives. The treatment plan noted that "On 2/1/12, [the recipient] demanded documentation regarding an investigation over the [sic] on 12-26-11 which was informed he would be provided with his requested documentation as soon as it was received from administration. [The recipient] also made threats of retaliation against staff because of the incident on 12-26-11."

The HRA reviewed 11 different Chester "Information Reports" regarding the 12-26-11 incident. They were all dated 12-26-11. The reports concerned events that occurred in the dining room beginning at 7:35 am. One report stated that the recipient "…was non-compliant during breakfast. He jumped up and lunged toward staff and was placed in PH [physical hold] at 0735. Due to combativeness placed in cuff #T36 at 0740 and returned to [unit]. I was notified that [the recipient] was placed in FLR [full leather restraint] at 0745. I am also placing [the recipient on dining room restriction due to violet [sic] and unpredictable behavior." Another account provided by an STA stated "Recipient was being agitated and complaining at breakfast. He was asked to calm down. He stood from his table and approached staff in threatening manner. He was placed in cuffs while bringing him back from dining room he struggled and threatened staff. Upon entering stem he kicked staff and struggled. It was necessary to take him to floor where he continued to threaten and struggle. Code Red was initiated. He was taken to Room 902-C-3. Placed in 4 Pt. Rest." Six individuals were listed as being involved and 2 were listed as being witnesses. Similar accounts were documented by 6 other Security Therapy Aides (STAs) noting that the recipient became disruptive and threatening in the dining room resulting in a physical hold, then the placement of cuffs after which he was taken to a specific room and placed in full leather restraints because of physical aggression, "lunging at staff," "headbutting at staff" and struggling with staff. Most reports documented that there were 6 STAs involved in the incident and 1 to 2 witnesses.

Additional "Information Reports" were completed on 12-27-11 in response to abuse allegations. At 9:40 a.m. on 12-27-11, the recipient complained of injuries from the 12-26-11 incident and it was documented that he appeared to have redness in his left eye; he complained of swelling in the face but most reports noted that there was no swelling noticed. The internal OIG investigator who is also referred to as an STA IV was notified and a referral was to be made to medical staff. Similar accounts of the allegation were also noted as the complaint was made during a treatment plan meeting at which the recipient attended. One report documented that the recipient complained of a knot on the back of his neck. Another report noted that the recipient stated he

was hit in the eyes. The physician in attendance at the meeting documented in an Information Report that the recipient "…reports that he was struck by staff who he believes were angry with him from the evening before…He reports that on the morning of 12/26/11, he stood up in the dining room to get a milk. Staff surrounded him. He took off his shirt and took an aggressive stance. Per pt, staff put him in handcuffs and he cooperated. He was taken back to the unit and when cuffs were removed, he reports staff hit him on his head causing a hematoma. Pt has L eye hematoma. His complaints of swelling on his face, esp on his R side and a 'knot' on the L side back of head."

The order for physical hold, dated 12-26-11 at 0735, stated that the recipient became very disruptive in the dining room and was asked to calm down. He reportedly stood up quickly and then was told he was returning to the unit but when he moved toward staff he was placed in a physical hold and then cuffs due to aggression. A separate order for metal cuffs was completed at 0736 to allow for the recipient to be taken back to the unit safely due to continued escalation. A third order was completed for restraints for up to 4 hours beginning at 0745 due to struggling with and kicking at staff. Release criteria included the following: when the recipient is calm, cooperative and no longer being angry, cursing and threatening for 60 minutes; and, being able to discuss incident and the triggers.

A restriction of rights form was completed for the physical hold due to the recipient becoming "loud and threatening in dining room - cont to escalate." His preferred emergency treatment was not used due to an increasing level of violence. A separate restriction of rights notice was completed for the metal cuffs due to threats and increased level of violence. A third restriction notice was completed for the application of restraints at 0745.

A restraint flow sheet began noting 15 minute observations starting at 8 a.m. It appeared that toileting and fluids were offered. The recipient was released at 11:45 when he agreed to follow unit rules and staff direction.

The HRA examined a complaint form completed by the recipient and dated 12-27-11 which stated the following: "I was physically abused and the abuse caused me very severe pain and bruises and I now have blood clogs [sic] in both of my eyes." The abuse was documented as occurring "in the stem of Unit 'C'" The statement further documented: " was placed in handcuffs in the dining room, while being escorted back and being resistable [sic] I was pulled and chocked [sic] slammed to the ground while still in handcuffs. I was then punched in the face, kneed in the face and chocked [sic] I wasn't even resisting and if I were how much could I have while in handcuffs? There should be a proper restraint procedure in a step 1, 2, 3 format if so someone was resisting and I'm positive punching and kicking is <u>not involved</u>!"

<u>Policy Review</u>

The HRA examined policies and procedures related to the complaints. The "Use of Restraint and Seclusion (Containment) In Mental Health Facilities" Procedure (TX.06.00.00.03) states that restraints and seclusion are only to be used to prevent physical harm to self or others. The procedure addresses physician exams, physician orders, release criteria, treatment team reviews, the restraint chair, sanitation and performance improvement reviews. The procedure makes no mention of cameras in restraint rooms but does reference the possible use of cameras with regard

to seclusion rooms. The number of staff involved in a restraint application is also not referenced in the procedure.

The procedure entitled, "Use and Monitoring of Video Equipment," indicates that video equipment is to "enhance the safety and security of patients and staff." According to the procedure, "The locations of video monitoring equipment will be approved by the Facility Director. A list of locations will be provided annually and/or whenever new cameras are installed to the president of each union representing direct care staff. The OIG Liaison will coordinate the use of the video monitoring equipment as well as coordinate providing copies of video as related to an investigation." The procedure states that cameras will not be placed in private areas such as restrooms, shower rooms, bedrooms, locker rooms, changing rooms or treatment rooms. Nor are cameras to be placed at nurses' stations, private offices, employee break rooms or other areas where patients are not located. The procedure states that "At this time video monitoring for patient and staff safety shall be performed on the living units, if any additions are deemed to be necessary the unions representing direct care staff shall be notified." Video recordings are to be preserved for the duration of hard drive capacity and only used for investigations as determined by the facility director, the OIG or for worker compensation investigations. Requests to preserve a particular event can be made to the OIG Liaison who keeps a master copy in a locked file. It is unclear who can or cannot request a copy of a video recording.

A procedure on "Off Module Patient Movement" states that patients are to be escorted by staff when they leave their living unit. The staff member is to maintain direct sight of the patient and within close proximity.

With regard to record requests, a procedure entitled, "Patient or Guardian Access to Clinical Records" states that a patient can make either an oral or written request to his therapist or other professional in order to view his record and professional staff are to arrange an area for the patient to view the record. A professional staff person is to make him/herself available to answer questions during the record review. The procedure also explains how a patient can dispute record contents.

The HRA also examined Facility Investigative Protocol as posted on the Illinois Department of Human Services (DHS) website. According to the website, DHS operated facilities are to identify at least one individual to assist with abuse/neglect investigations. And, an OIG Liaison is to be named; the investigator and liaison can be the same individual. The liaisons/investigators are to complete required training, be approved by the OIG and not have a position that would represent a conflict of interest. The protocol identified specific individuals who are prohibited from being investigators/liaisons, including those authorized to identify the investigator/liaison, the assistant facility director, the assistant hospital administrator, human resources staff, labor relations staff, any family members of these positions, any persons with a substantiated finding of abuse/neglect, or any other person the OIG determines to have a potential conflict of interest. The OIG makes the final decision as to the determination of the appropriate investigator/liaison and can revoke the decision at any time. When incidents occur, immediate care and protection of the victim is to be secured and the OIG is to be notified. The alleged employee perpetrators are to be removed from contact with the recipients when there is

credible evidence of abuse. The investigator is to secure the scene and physical evidence, identify and separate accused staff and potential witnesses until written statements can be obtained, copy/impound pertinent documents, lock up evidence and notify the OIG of collected evidence within one day. Photographs can be taken upon consent and are to be labeled whether or not an injury is visible. The size of any bruising is to be documented and follow-up checks should be made to determine if an injury becomes visible at a later time. **The protocol requires that there be no conflict of interest/bias by the investigator, that the investigator not be one of the "prohibited persons" and that the investigator is not a supervisor of the unit where the incident occurs nor involved in the same bargaining unit.** With regard to written statements, the protocol calls for the separation of all witnesses until an initial statement is taken. In addition, the investigator is to conduct interviews to obtain more details from any person who was present at the incident or has knowledge of the incident. "Ideally, an interview and written statement should be obtained immediately upon the report of an allegation, but no later than two working days from the report. If it is not possible for the facility investigator to immediately interview and obtain a written statement from a staff member, then the facility investigator shall require that staff member write a statement. The investigator can then utilize this statement to interview and secure a more detailed statement from the staff member later. …Every interview shall cover the elements of the offense, and the fundamental investigative questions of who, what when, where why and how from each interviewee." Interviewees can request representation.

Office of Inspector General Report and Evidence

The HRA examined the OIG report on the case; the allegation of physical abuse was determined to be "unfounded." The investigator's name on the report was different from the name of the internal investigator employed by the facility. According to the approximately one page report, the report stated that the recipient informed a restraint debriefing team that "…unnamed staff members had punched him in the face and eye during his restrain [sic] episode on December 26, 2011. During an interview with the Facility Investigator (FI), he changed his account of the incident to that of being choked and threatened with death, in addition to being beaten on by staff members." The OIG report stated that a nurse completed a debriefing on the day of the incident "…which noted no signs of any physical injury or complaint of any staff misconduct. A medical examination completed on December 27, 2011, following the reporting of the incident revealed [the recipient] having conjunctive redness in both eyes and complaint of tenderness around his eyes. A medical consultation with [an optometrist] suggested the cause of the conjunctive redness … was related to a vascular incident and showed no signs of trauma around the eyes. The bilateral redness also suggested a vascular etiology as opposed to trauma." The report then stated that accounts of the incident were provided by 8 STAs, a nurse, a social worker and a support service worker and all were consistent and denied abuse. "A review of the facility's video recording of the incident showed a limited view of the incident from the C/2 module stem door camera, as no cameras are present on the stem. [The recipient] was observed being escorted from the stem onto module C/3 in a proper physical hold. There was no evidence revealed during the video review to support [the recipient's] claim of abuse. A rational individual would expect some sort of visible trauma to [the recipient] from his claim of being punched by three staff members, kneed in the face by another staff member and choked by two staff members, yet none was visible. These factors greatly reduced the credibility of [the recipient] and established that no credible evidence was present to support the allegation."

The HRA examined evidence retrieved by the OIG. An admission note completed by a registered nurse upon admission on 12-22-11 makes no mention of eye issues. An injury report was completed on 12-27 upon the report of abuse allegations and the physician noted eye redness and tenderness, "…slight swelling behind left ear…and swelling of wrist." The optometry statement referencing the vascular accident was dated 03-14-12 and referenced a review of pictures on 03-14-12 versus an exam of the recipient on or around the date of the incident, December 26, 2011. The optometrist stated, "I viewed the photos today of [the recipient]. It is my opinion these photos are consistent with subconjunctival hemorrhages likely resultant from a vascular incident. I see no other signs of periorbital trauma. I would grade the subconjunctival hemorrhages Grade 1 of 4. The nature of a bilateral presentation is also suggestive of vascular etiology." **The official OIG report does not mention that the optometrist's position was based on a review of photographs 3 months after the incident**. Progress notes completed by a nurse just after restraint application on 12-26-13 indicated that the recipient denied any injuries and no injuries were noted**. The OIG statements completed by staff involved in the incident were consistent with the facility information reports although these statements were taken and dated anywhere from January 30, 2012 to February 2012 to March 2012; most statements were taken in February 2012. Statements from another Chester recipient and the unit manager were not taken until April 2012.** Some statements were taken by Chester's internal OIG liaison/investigator and others were taken by an OIG investigator. Chester information reports written by the staff to whom the recipient reported abuse were included in the OIG record; these reports, with one exception, were dated 12-27-11; the reports indicated that the OIG liaison/investigator and medical staff would be notified. The case was transferred from the internal OIG liaison to the OIG on 12-28-11. An OIG statement was taken from the recipient on 12-27-11. A collection of photos taken of the recipient on 12-27-11 at 10:40 am indicated what appeared to be blood clots in both eyes and some discoloration around the neck as well as a knot on the neck. The photo log identifies the object photographed (e.g. left wrist) but does not identify the size of any bruises or the size of the blood clots in the eyes. It was difficult to determine from the photos if the wrists were red or swollen.

A videotape was also reviewed by the HRA. The video indicates that the camera is at the C-3 stem door on 12-26-2011 beginning at 7:49 am. At 07:51:52, the recipient, who is in handcuffs, is seen escorted down the hall and into a room (believed to be a restraint room) by 3 male staff. Besides the male staff escorting the recipient into the room, 8 additional male staff entered the room and one female staff observed from outside the room. Two more male staff and 2 female staff arrived and observed from the hallway. Staff gradually exited from the room and hallway and the situation seemed to be over by about 7:58 am; a nurse entered the room with a blood pressure cuff. Another individual came to the room shortly thereafter and then exited. There was no view of the inside of the room or what was occurring. At one point staff provided something (a Posey vest or sheet) that was taken into the room. There was no sound to the video. The HRA also examined the original OIG intake dated 12-27 at 11:12 a.m. approximately 2 hours after reported to staff. Additional calls were made by a family member in January and then the HRA in February upon receipt of the complaint; these calls named one witness whose statement was not secured. There was no documentation that the recipient received notice that OIG was investigating his allegation of abuse although he did receive notification of the investigation results as documented in correspondence. The recipient requested a reconsideration of the OIG's findings in April 2012 and the reconsideration stated that there are

no cameras in the facility dining room where the incident began and no cameras in the restraint room. Also, the reconsideration indicated that all witnesses were interviewed with the exception of recipients who had been discharged from the facility and it was determined it would not be cost effective to seek their testimony as all other accounts from staff were consistent. The reconsideration also resulted in unfounded allegations and the recipient was notified.

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) requires that recipients of mental health services "be provided with adequate and humane care and treatment in the least restrictive environment…." The Code (405 ILCS 5/2-112) guarantees the rights to "…be free from abuse and neglect." The Code (405 ILCS 5/2-108) also addresses restraint use and states that "Restraint may be used only as a therapeutic measure to prevent a recipient from causing physical harm to himself or physical abuse to others…. (f) Restraint shall be employed in a humane and therapeutic manner and the person being restrained shall be observed by a qualified person as often as is clinically appropriate but in no event less than once every 15 minutes. The qualified person shall maintain a record of the observations. Specifically, unless there is an immediate danger that the recipient will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the recipient shall be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the recipient or others. (g) Every facility that employs restraint shall provide training in the safe and humane application of each type of restraint employed. The facility shall not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each facility in which restraint is used shall maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use."

The Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/4) addresses the recipient's right to access records and states the following: "The following persons shall be entitled, upon request, to inspect and copy a recipient's record or any part thereof:….
(2) the recipient if he is 12 years of age or older…" According to the Act (740 ILCS 110/2) a record is defined as "…any record kept by a therapist or by an agency in the course of providing mental health or developmental disabilities service to a recipient concerning the recipient and the services provided. 'Records' includes all records maintained by a court that have been created in connection with, in preparation for, or as a result of the filing of any petition or certificate under Chapter II, Chapter III, or Chapter IV of the Mental Health and Developmental Disabilities Code [FN1] and includes the petitions, certificates, dispositional reports, treatment plans, and reports of diagnostic evaluations and of hearings under Article VIII of Chapter III [FN2] or under Article V of Chapter IV of that Code. [FN3] Record does not include the therapist's personal notes, if such notes are kept in the therapist's sole possession for his own personal use and are not disclosed to any other person, except the therapist's supervisor, consulting therapist or attorney. If at any time such notes are disclosed, they shall be considered part of the recipient's record for purposes of this Act."

Office of Inspector General regulations (59 Ill. Admin. Code 50) address abuse allegations in

state-operated facilities and requires employees to report abuse allegation within four hours of initial discovery (59 Ill. Admin. Code 50.20). Upon receipt of a report, the OIG is to notify the facility within 3 days unless the notice would jeopardize the investigation and the victim within 24 hours. The OIG is also to notify the complainant within 3 days. The regulations also describe the role of the authorized representative (usually the facility director) which includes ensuring the health and safety of all individuals involved in the abuse allegation, removing "…alleged accused employees from having contact with the individuals at the facility or agency when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation...Ensure OIG is notified; and…initiate the preliminary steps of the investigation by a designated employee who has been trained in the OIG-approved methods to gather evidence and documents and for whom there is no conflict of interest. This may include the need to: A) Secure the scene of the incident and preserve evidence…**B) Identify, separate potential witnesses, and interview when applicable C) Identify and record the names of all persons at the scene at the time of the incident…** [emphasis added] D) Secure all relevant documents and physical evidence…E) Photograph the scene of the incident and the individual's injury, when applicable." Section 50.40 describes the investigation methods of OIG which includes determining who should take the lead in the investigation based on the allegation and then **notifying the authorized representative and the alleged victim and the accused "…in writing when an investigation will be opened and to whom the primary responsibility for the investigation will be assigned."**[emphasis added] Furthermore, "OIG shall assume primary responsibility for investigation the following allegations: **A) Allegations of physical abuse or sexual abuse by an employee…."**[emphasis added] This section also states that "When OIG designates primary responsibility for the investigation to the agency, OIG will provide investigative guidance and be available for assistance and shall retain the right to assume primary responsibility for the investigation at any time….OIG investigations may include, but are not limited to site visits, telephone contacts, requests for written statements and responses from the community agency or facility." Section 50.50 governs investigations and states that the investigation should ensure that the victim is not in danger, the integrity of the investigation is protected, evidence and the scene should be secured, the witnesses should be identified and separated and statements as well as related documentation should be collected. Section 50.60 states that "The investigative report shall be submitted to the Inspector General within 60 days from assignment unless there are extenuating circumstances, including but not limited to, the unavailability of witnesses or official documents." The OIG regulations do not address a recipient's right to access the OIG's record.

CONCLUSIONS

Complaint #1: A recipient was placed in handcuffs and then assaulted by staff in the "stem" of a unit where there are no security cameras

Based on the available evidence, the HRA could not substantiate this complaint. As indicated in complaint statement, there are no security cameras on the unit stem. During its investigation, the HRA found that stationary cameras are in place on unit hallways and in seclusion rooms; however, there are no cameras on the stems, in the dining room or in the restraint room even though recipients use these areas. The HRA was able to confirm that a recipient was in handcuffs when he was taken to the restraint room escorted by 3 male staff and followed by an

addition 8 staff. Three additional staff were observed on the video standing outside and looking into the restraint room. Although the HRA cannot substantiate the complaint, it has concerns about observations made during the course of its investigation. If video monitoring is to protect recipients and staff, the HRA questions why cameras are not in place in the areas frequented by residents other than just their units. Although the HRA recognizes the privacy concern for residents who may be receiving some type of treatment in the stem where nursing staff are located, the HRA notes that the monitoring is not viewed in real time and reviews are only done when there are incidents. With regard to the restraint room, it appeared and staff reported that the restraint rooms previously had cameras in place but those cameras were removed and staff are stationed outside the door to monitor a recipient's safety. While the HRA acknowledges that such monitoring is warranted and consistent with Mental Health Code protections, the HRA contends that cameras in the restraint room just as in the seclusion room provides further safety and security protections for both recipients and staff alike. Furthermore, the HRA was concerned about the number of staff involved in the incident, the number of staff who entered the restraint room and the staff who observed the restraint application from the hallway, especially when the recipient was in handcuffs. The HRA does not discount the fact that recipient behaviors can become highly aggressive but questions if the show of force could have further aggravated the situation. The number of staff involved in an incident, if not needed, also impacts the patient's privacy. There also appeared to be more staff involved in the incident than the number of reported completed. The HRA also questions the initial event in the dining room that led to the incident that escalated; there is no documentation of the chain of the events other than vague references to being non-compliant and there is no video to review an incident that occurred in the dining room. The HRA does acknowledge that restraint monitoring documentation appears consistent with Code requirements.

To help ensure that provision of adequate and humane care and treatment and the humane application of restraint, the HRA strongly encourages the facility to:

1. Place cameras in the dining room, unit stems and unit restraint rooms.
2. Review the number of staff needed to deescalate the situation and the subsequent impact.
3. Train staff to clearly document the chain of events that lead to the use of restraints, seclusion, or other restrictions.
4. Review initial approaches use by staff to address and deescalate recipient behaviors to ensure the principal of least restriction.
5. Ensure that all staff involved in an incident complete required reports.

Complaint #2: A recipient's request for documentation of the incident and copies of pictures taken of his injuries has been denied.

The HRA found no evidence of a resident's request for, provision of or denial of his records although the HRA informed staff of the recipient interest in viewing photographs and other documentation. There was some discussion that the pictures, even though taken by the Chester internal OIG liaison, were part of the Chester record or part of the OIG's record. Chester policy guarantees access to Chester records for recipients who request them either verbally or orally and then requires staff documentation of the process for providing record access. The Confidentiality

Act requires that a recipient have access to his facility records. The OIG regulations do not guarantee recipient access to the OIG records although it was unclear to the recipient whether or not the photographs were part of the facility or the OIG records.

Due to the lack of documentation regarding the record request, HRA substantiates a violation of its policy and recommends the following:

1. **Follow policy with regard to record requests and document the process. If certain documents are denied because they are not considered part of the facility's records on the patient, document this in the record as well and notify the recipient.**

Complaint #3: The internal abuse investigation process is inadequate in that there is a conflict of interest and lack of objectivity when security therapy aides (STAs) investigate the actions of other security therapy aides. Also, the recipient did not receive acknowledgement of his complaint until he requested it.

The HRA was particularly concerned about this complaint based on the following:

- The HRA found no OIG correspondence notifying the recipient that his complaint was under investigation after he reported abuse on 12-27-13.

- OIG regulations specify that the facility investigator is not to investigate when there are reports of employee abuse; however, the internal investigator in this case conducted most of the investigation.

- The internal investigator/OIG liaison has supervisory responsibilities over STAs at Chester which could represent a conflict of interest and his position is in the same bargaining unit as the STAs involved in this incident which conflicts with OIG protocol.

- Pictures taken do not document the sizes of the blood clots in the eyes or the sizes of any bruises or knots identified by the recipient as required in OIG protocol.

- There was no apparent optical exam after the incident to review the blood clots in the eyes as required in the OIG regulations. An optometrist examined pictures of the recipient 3 months later.

- Although Chester information reports were completed after the incident, OIG interviews and statements were not done until a month to 4 months after the incident.

- The OIG final report that was issued does not include specifics as to when the interviews occurred.

- There were inconsistencies in documentation regarding the presence of injuries or swelling.

Based on the comments above, the HRA substantiates the complaint that the internal abuse investigation process is inadequate in that there is a conflict of interest and lack of objectivity when security therapy aides investigate the actions of other security therapy aides and when the recipient did not receive acknowledgement of his complaint. The HRA recommends the following:

1. **As required in regulations, immediately turn over complaints involving staff abuse to the OIG for investigation.**

2. **Ensure that the alleged victim receives notification of the abuse investigation and in a timely manner consistent with OIG mandates.**

3. **Secure staff statements in a timely manner and ensure that staff are separated until statements are taken and interviews are held.**

4. **As per OIG protocol and to ensure that there is not a conflict of interest as required by OIG regulations, ensure that the OIG liaison/investigator is not from the same bargaining unit as those being investigated nor should the liaison/investigator have supervisory responsibilities over those investigated.**

5. **Ensure that examinations pertaining to abuse reports are timely.**

6. **Document bruises and injuries consistent with OIG-DHS protocol. Ensure there are follow-up visits to the alleged victim to check for bruising.**

7. **Ensure that staff are removed from contact with the recipient when there is credible evidence of abuse and until the investigation outcome is determined.**

The HRA also suggests the following:

1. Inform recipients who have filed abuse complaints of the investigation process, the role and identification of the OIG representative and the role and identity of the internal investigator/liaison.