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HUMAN RIGHTS AUTHORITY - EGYPTIAN REGION
REPORT OF FINDINGS

Case # 12-110-9037
Chester Mental Health Center

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving a complaint of possible rights violations at Chester Mental Health Center. The complaints alleged the following:

1. A staff person assaulted a recipient until he became unconscious and ended up in the infirmary.
2. The internal Office of Inspector General investigation of the incident was inadequate.
3. Assessments of the recipient's injuries were inadequate in that no x-rays were taken.
4. After the recipient's release from the infirmary, he was returned to the same unit with the same staff person who was alleged to have assaulted the recipient and against the recipient's wishes. The recipient remained on the unit until another incident occurred involving the same recipient after which the staff person was moved to another unit.

If found substantiated, the allegations would violate the Mental Health and Developmental Disabilities Code (MHDDC) (405 ILCS 5/2).

Chester Mental Health Center is a secure state-operated mental health facility located in Chester, IL which provides services for around 300 male residents. The HRA investigated the above complaints by speaking with staff, reviewing relevant facility policies, and examining recipient records with consent from the individual. The complaint was also referred to the Illinois Department of Human Services, Office of Inspector General.

To investigate the allegations, HRA team members reviewed documentation that is pertinent to the investigation. The allegations in this report were brought to the attention of the Chester Human Rights Committee chairperson.

COMPLAINT STATEMENT

The complaint states that a recipient was harassed by a Security Therapy Aide (STA) because of where the recipient was eating and how long it was taking the recipient to eat. The complaint alleges the STA began pushing and provoking the recipient. When the recipient verbally retaliated, the STA hit the recipient and told him that he would be assaulted if he did not

quiet down. The next night, the STAs assaulted the recipient while calling him names until the recipient passed out and woke up in the hospital. The recipient filed a complaint with the Office of Inspector General (OIG) and pictures where taken and an OIG representative spoke to a physician. There was an order for x-rays but they were not completed the next day because the patient was too sick and sore to move. The x-rays were reportedly never completed.

The recipient requested not to be sent back to the same wing with the STA that assaulted him and even requested this from the OIG representative but the recipient was sent back to the same wing where he ended up being tied down and forced medicated to calm down. Eventually, the STA was sent to another wing. The recipient was once again assaulted by STAs.

FINDINGS (Including record review, mandates, and conclusion)
Record Review

The HRA reviewed copies of the recipient's records and compiled the following timeline of events that are pertinent to the allegations in this report:

- 12/4/11 - A rights restriction form on this date with a time of 2055 states that the recipient was placed in a physical hold and the reason for the restriction reads "Rec was highly agitated and moved to A3 due to declining behavior. Rec refused his meds and PRN when on A3 Rec began punching himself in the face multiple times." A rights restriction form for restraint on the same date at 2100 uses the same verbiage to describe the reason for restraint.
- 12/4/11 - An order for restraint on this date with a timestamp of 2100 reads "Initially recip refused HS meds. He has missed 4 meals. Staff was initiating failure to eat protocol. He [illegible word] to A3 to rm 317 where he was to be housed. Staff was talking with him, reassuring, redirecting, distracting attempted verbal support when recip began hitting himself in the face. Staff intervened and Recip escalated hitting staff. Physical hold applied to no avail 5 pt. restraint initiated and recip highly agitated and thrashing in bed."
- 12/4/11 - documents used to determine restraint release criteria on this date indicate that the recipient was released from full leather restraints at 2300 due to high blood pressure and a nurse debriefing also states that the patient was released from restraint due to high blood pressure and unresponsiveness. 15 minute checks where completed accordingly for the patient's time in restraints.
- 12/5/11 - the HRA reviewed an injury report which indicates the recipient had an injury to the wrist and head and that there was alleged abuse. Per the patient, the description of what happened was "They beat me up." The description of the injury said there was mild redness to the top of the head and then pain in the left forearm and wrist.
- 12/5/11 - On a special observation record for suicide prevention, it is indicated that there was an Office of Inspector General (OIG) investigation at 1100, 1115, and 1200.
- 12/6/11 - 12/7/11 - According to rights restrictions, orders, and assessments, beginning on 12/6/11 the patient was put into a physical hold and then restraints. The restraints

lasted until 12/7/11. The recipient was in restraints a total of 12 hours with checks every 15 minutes and offers of food, water and using the toilet.

- According to the discharge summary, the patient was discharged on 12/15/11 to a county jail as being fit to stand trial.

The HRA reviewed other records and policy that relate to the allegations. In reviewing the rights restriction document dated 12/6/11 at 1330, the reasons for the identified restrictions, reads "Pt. became violent with staff upon [Illegible Word]. Is A3 requiring use of restraints to prevent harm to self others." An order for seclusion on 12/6 reads "Pt. upset upon return from infirmary; became very upset wanting to be placed in restraints." There is no statement as to why the patient became upset. On another restraint order, under the reason for restraint or seclusion, it reads "Threatening harm to others when released" and "Immediate [illegible word] of harm to others."

The HRA reviewed two rights restriction notices for the administration of emergency medication on 12/6 at 1935 and 2150. Both occurred while the patient was still in restraints. The reason written for the 1935 forced medication reads "Aggressive agitated behavior in 4 pt. restraints for uncontrolled behavior" and the reason give for the 2150 administration reads "Emergency enforced medication due to agitation."

According to the rights restriction notices, one from 12/4 and then one from 12/6, the individual was in unit A and this did not change after returning from the infirmary after the 12/4 incident.

The HRA reviewed a report by the OIG, dated 2/10/12, regarding the abuse allegations which stated that the complaints of physical abuse were unfounded. The report reads "He [recipient] told the medical staff that unnamed staff members had struck him on top of the head during the restraint episode. [Recipient] also admitted to striking himself in the face several times. A medical examination revealed [Recipient] to have redness and swelling to the top of the head, swelling to the face and the presence of fingernail marks at the base of his neck. During an interview with the Facility Investigator (FI), [recipient] admitted to being in his room and being upset with staff members on December 4, 2011 around shift change at 3:00 p.m. He claimed that he raised his fist at the staff members and challenged them to fight him. Five staff members rushed into his room and started hitting him on the head and choking him as per the recipient. The facility's progress notes and restraint packet revealed that [recipient] was placed into restraints on December 4, 2011 at approximately 8:55 p.m. This action followed two separate incidents where he was observed striking himself in the face with his fist. The progress notes revealed that [recipient] denied any injury during the restraint episode. He was released from restraints on December 4, 2011 at approximately 11:55 p.m., and transferred to the infirmary due to high blood pressure and a low level of responsiveness." The HRA did not receive progress notes regarding patient injuries. The OIG report proceeds to name the staff members who acknowledge being involved in the incident. In the incident findings, there is a statement that allegations of abuse against the staff members named are unfounded. The OIG report also indicates that video evidence shows that there was no abuse. The report reads "The facility's video recording of the alleged incident revealed that STA [staff name] and [staff name] were observed standing at [recipient] room door talking with him before suddenly rushing into his

room along with STA [staff name]. STAs [staff name] and [staff name] entered the room a short time later and [recipient] was observed being escorted from his room in a proper physical hold. The video recording showed [recipient] walking to the restraint room under his own physical power and not resisting the physical hold. [Recipient] claim that STA [staff name] was standing at the door chastising him was refuted by the video recording."

The HRA requested incident Reports, Internal abuse investigations by the OIG Liaison and the OIG report related to any abuse investigation and was told by the facility to contact OIG for information pertaining to any active or closed OIG cases for Chester.

The HRA also reviewed assessments taken while the recipient was being restrained the second time, after returning from the infirmary, and at least one individual named in the OIG report was present during an assessment (12/6/11 at 1730) indicating that after the OIG complaint, accused staff remained on the same unit as the recipient. This occurred after the OIG inspector spoke with the recipient on 12/5.

The HRA reviewed the facility policy on reporting and investigating incidents or allegations which reads "The Chester Mental Health Center has established procedures to ensure that all allegations of abuse and neglect of patients and certain other incidents are reported and investigated in accordance with Department of Human Services Act [20 ILCS 1305], Department of Human Services Policy and Procedure 02.01.06.010 Prevention of Abuse and/or Neglect of Individuals; 02.01.06.020 Reporting and Investigating Incidents and Allegations of Abuse and Neglect." The policy proceeds to define terms, define what is to be reported, explain reporting requirements and how to conduct an investigation. In the section titled "Conducting an Investigation" it reads "The Facility Director or designee will ensure that evidence is preserved and the safety of patient, employees, and property is maintained. This includes: ordering immediate medical examination on all patient alleged to be victims of physical or sexual abuse, impounding records and other appropriate documentation, securing all relevant physical evidence such as clothing, and preserving and photographing the scene of the incident and the patient's injury when appropriate."

The HRA also examined Facility Investigative Protocol as posted on the Illinois Department of Human Services (DHS) website. According to the website, 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.

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 also reads "The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given

unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available" (405 ILCS 5/2-107). The Code also reads "(a) Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to …" (405 ILCS 5/2-201).

In accordance with Office of Inspector General regulations, a authorized representative is to "1) Ensure the immediate health and safety of involved individuals and employees, including ordering medical examinations when applicable; and 2) Remove alleged accused employees from having contact with individuals at the facility or agency when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation, prosecution or disciplinary action against the employee [405 ILCS 5/3-210];" (59 Il Admin Code 50.30).

Conclusion

Complaint #1 Conclusion - A staff person assaulted a recipient until he became unconscious and ended up in the infirmary.

In reviewing the provided documentation, including a report from the OIG, the HRA finds no evidence indicating that staff assaulted a recipient, and therefore finds this complaint **unsubstantiated** but offers the following **suggestions:**

- The reasons documented for the restraints and forced medication on the rights restrictions forms from 12/6 describe the recipient as "aggressive" and "agitated", which are very generic and do not meet the Code's standards to prevent physical harm or serious and imminent physical harm (405 ILCS 5/2-201). Ensure that the reasons for the restrictions are more detailed and specific and meet the Code's requirement of "serious and imminent physical harm."
- The Code states that forced medication can only be given when "… necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available" (405 ILCS 5/2-107). The documentation shows that the recipient was given medication while already in restraints and the HRA questions whether this is appropriate since action (restraint use) was already taken that may have prevented harm to the recipient or others.

Complaint #2 Conclusion - The internal Office of Inspector General investigation of the incident was inadequate.

The HRA does not have evidence indicating when the actual complaint was made and when the facility reacted to the complaint, but there is evidence that there was an OIG investigation the day after the incident allegedly occurred and there was an OIG report that was completed regarding the incident. Due to lack of evidence to the contrary, the HRA finds this complaint **unsubstantiated** but the HRA offers the following **suggestion:**

- Documentation seems to indicate that one of the staff who was an alleged perpetrator of abuse was not removed from the unit per DHS rules. Assure that the facility is following DHS procedure regarding employee perpetrator contact with recipients when there is evidence of abuse.

Complaint #3 Conclusion - Assessments of the recipient's injuries were inadequate in that no x-rays were taken.

The HRA reviewed a medical examination that was completed by the facility when the recipient was removed from restraints and taken to the infirmary. The examination did indicate that the patient had injuries. The HRA saw no documentation indicating that x-rays were taken. To question a physician's discretion regarding needed assessments is beyond the HRA's scope. Because of this, the HRA finds this complaint **unsubstantiated.**

Complaint #4 Conclusion - After the recipient's release from the infirmary, he was returned to the same unit with the same staff person who was alleged to have assaulted the recipient and against the recipient's wishes. The recipient remained on the unit until another incident occurred involving the same recipient after which he was moved to another unit.

The recipient had an OIG investigation on 12/5/11 which was after the incident on 12/4/11. The HRA has no evidence that the recipient directly named any individuals as his assailants; the OIG report names staff members as being innocent of the abuse allegations although the report states that staff members were "unnamed." Later documentation indicates that one of the staff members who was part of the allegation was present with the recipient on 12/6/11. The date of the OIG report was 2/10/12 which is well after the incident. If the staff member named in the allegation is present with the recipient during an OIG investigation, it is not in compliance with OIG regulations which state the investigator must "2) Remove alleged accused employees from having contact with individuals at the facility or agency when there is credible evidence supporting the allegation of abuse pending the outcome of any further investigation, prosecution or disciplinary action against the employee [405 ILCS 5/3-210];" (59 Il Admin Code 50.30). There is no evidence that states with certainty that the staff member was named by the complainant, that the investigation was not completed by 12/6/11 when the staff member was present with the recipient, or that there was credible evidence of abuse, therefore the HRA finds this complaint **unsubstantiated** but the HRA offers the following **suggestion:**

- Assure that facility and staff are in compliance with OIG regulations 59 Il Admin Code 50.30.