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Egyptian Regional Human Rights Authority
Report of Findings
13-110-9025
Chester Mental Health Center

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 allegation is as follows:

Chester Mental Health's internal OIG liaison was contacted regarding an incident of peer to peer sexual assault due to inadequate staff supervision but an investigation was not conducted.

If substantiated, the allegations would be violations of the Mental Health and Developmental Disabilities Code (405 ILCS 5/2) and the Illinois Administrative Code (59 IL ADC 50).

Statutes

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) 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 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."

The Code (405 ILCS 5/3-211) also states "When an investigation of a report of suspected abuse of a recipient of services indicates, based upon credible evidence, that another recipient of services in a mental health or developmental disability facility is the perpetrator of the abuse, the condition of the recipient suspected of being the perpetrator shall be immediately evaluated to determine the most suitable therapy and placement, considering the safety of that recipient as well as the safety of other recipients of services and employees of the facility."

The Illinois Administrative Code (59 IL ADC 50.20) states "1) If an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline according to the community agency's or facility's procedures. The employee, community agency or facility shall report the allegation immediately,

but no later than the time frames specified in subsections (a)(2) and (3) of this Section. Such an employee or representative of a community agency or facility shall be deemed the "required reporter" for purposes of this Part. Such reporting will additionally meet any requirements of 59 Ill. Adm. Code 115, 119 and 132 and Department administrative directives, as applicable.

2) Within four hours after the initial discovery of an incident of alleged physical abuse, sexual abuse, mental abuse, financial exploitation or neglect, the required reporter shall report the following allegations by phone to the OIG hotline: A) Any allegation of physical, sexual or mental abuse by an employee; B) Any allegation of neglect by an employee, community agency or facility…"

Investigation Information

To investigate the allegation, the HRA Investigation Team (Team), consisting of two members and the HRA Coordinator conducted a site visit at the facility. During the visit, the Team spoke with the Recipient whose rights were alleged to have been violated and the Chairman of the facility's Human Rights Committee (Chairman). With the Recipient's written authorizations, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility Policies relevant to the complaint were also reviewed as well as the Office of the Inspector General's (OIG) investigative report information.

I. Interviews:

The HRA initially became aware of this incident as the result of a phone call from a concerned recipient at Chester who wanted to alert someone that his friend had been sexually coerced and that an OIG report was filed. However, the concerned recipient said the internal OIG liaison claimed he met with the recipient and indicated that the recipient did not have any concerns. This recipient had reported to the caller that the internal OIG liaison never came to talk with him. Another OIG complaint was called into the hotline and an external investigator was requested.

A. Recipient 1: This recipient contacted the HRA regarding a concern he had for another recipient. He said the recipient was raped by another peer on Lincoln's Birthday holiday (February 12th). He contacted the OIG hotline and said the OIG investigator (not the internal OIG liaison) came and spoke with him on March 26. The inspector told him he was going to talk to the recipient of concern and look at a video tape recording from the date of the incident if it was still available. Three days later, the internal OIG liaison came to speak with him and said that the recipient of concern did not have a complaint. However, when this recipient spoke directly to the recipient of concern, he was told that the internal OIG liaison never came to speak with him. This recipient then contacted the Springfield OIG and filed a complaint about Chester's internal OIG process.

B. Recipient 2: This Team met with this recipient on March 1, 2013. He informed the Team that he was raped by another peer around 10:00 p.m. on Lincoln's Birthday holiday (February 12th). He told recipient 1 about it and asked that he contact the HRA and the OIG for him because he was afraid of repercussions from the peer that assaulted him and staff if he called from his unit. He also told the Team that he was raped a second time on February 27th and that

he had not yet reported that incident to the OIG because he had not seen the peer who helped him report it previously and he was afraid to report it himself from his unit. He said the first rape occurred in the day room next to the corner bookcase and no one else was in the day room at that time. He said the peer who assaulted him approached him with magazines and told him if he would perform sexual acts with him, then he could have the magazines. The recipient said "no thanks" to the peer but he responded "Do it or I'll beat your ass and re-open your scar or I'll sick my pit bull on you." According to this recipient the peer's "pit bull" is another recipient that this peer uses to "do his dirty work" which the recipient said means that he has him beat up people for him. The recipient said there were no staff in the dayroom when this incident occurred, but later he tried to tell a Security Therapy Aide (STA) whose response was "I wasn't there so I don't care, it ain't my problem." He gave the HRA a description of this staff person and his first name. He said he had recipient 1 call the internal OIG liaison, but no one ever came to speak with him.

C….STA I: The HRA interviewed this STA I as he fit the description given by recipient 2 as the staff he allegedly reported the sexual assault incident to. The HRA questioned this STA on the alleged incident and asked if he recalled the recipient ever reporting to him any alleged sexual assault on or about this timeframe. The STA could not recall any such report being made to him. He said the proper protocol on the OIG reportable offenses is to verbally report it to the Nurse and Charge Aide and fill out a written report that is placed on the STA IV's desk and the report "goes up the ladder" from there. This is usually done within 20-30 minutes of the allegation being made. He said if it had been reported to him, he would have completed a written report and it would be documented. He said all allegations of this nature are to be reported even if the STA might think it has no merit, so he would have reported it "no matter what." This STA could not identify to the HRA what staff person at Chester is responsible for reporting the allegations to the OIG. Once he verbally reports it and completes the written report and gives it to the STA IV his job is done and he does not know what happens after that. He informed the HRA that staff undergo training once a year on the OIG reporting. When asked what things are discussed in the training he said "it's just a refresher."

D. Chairman: The HRA notified the human rights committee chairman of the alleged incident when the complaint came in. The chairman contacted the recipient who reportedly told him he was assaulted several times that week (the week of April 11) and also noted that his glasses were broken making him vulnerable. The chairman then notified the unit manager and assigned therapist along with the OIG liaison and Acting Assistant Facility Administrator and notified them of the allegation and broken glasses and requested that the recipient be moved for his safety. The recipient was moved to another unit after the alleged sexual abuse happened to separate him from that peer while the investigation took place.

II. Clinical Chart Review:

A. Injury Report: The Team reviewed an injury report from the recipient's chart dated 3/4/13 at 8:30 a.m. The internal OIG liaison was listed as the person who discovered the injury. The description of the injury states "pt alleges peer had anal sex with him on 2/17/13 & 2/18/13" the what happened section states " I had sex with [peer's initials]." The recipient was referred to a doctor. The physician's examination section states "3/4/13 pt reports a peer drug him to a corner in the day room and this peer made pt give oral sex and performed anal sex on this pt. Pt. states

it happened on 2/17/113 & 2/18/13. Exam of genitalia shows 0 [zero] abnormality. 0 [zero] rectal gaping. 0 [zero] rectal tears seen." This examination was dated 3/4/13 at 10:00 a.m.

B. OIG Reports: The Team reviewed 2 investigative reports and one amended investigative report regarding the alleged rape incident from February 28, 2013 detailed below.

April 15, 2013 report: This investigation was involving the 2/28/13 incident and was alleging that the incident occurred due to the lack of supervision. This report details the investigation that took place including the video tape that was reviewed by the OIG which showed that the 2 individuals "engaged in consensual sexual activity" in the day room. The STAs listed in this report as being those on shift during the incident *includes* the STA that the recipient named to HRA as the one who he reported the incident to who did nothing and two others not named by the recipient. The report goes on to say that during an interview with the internal OIG liaison, the recipient claimed that the sexual activity was consensual and that a medical examination found no evidence to support any sexual act occurred. The report also stated "The facility's video recording revealed no evidence to suggest a lack of staff supervision, or that any force or coercion occurred." The allegation of neglect was unfounded against these 3 STAs.

April 19, 2013 report: This investigation was regarding the same 2/28/13 incident alleging neglect due to lack of supervision. However, this report, completed by the same investigator, named 3 STAs as those who were on shift during the time of the incident but 2 of the STAs were different than the April 15th report had stated. The STA that the recipient had identified to HRA as being the one he reported the incident to, *was not listed* in this report. The OIG report went on to say that these 3 staff members were "in very close proximity with each other, in conversation with each other, and with the day room completely unsupervised. Only when STA [name] casually walked into the dayroom to turn off the television, did the sexual activity cease." This report also mentioned that the recipient told the internal OIG liaison that he consented to the sexual activity and that staff did not know "we were doing this." The report also noted that it was documented in behavioral reports that the recipient had threatened staff saying he was going to "show them." This report was unsubstantiated.

May 14, 2013 amended report: This investigation was also regarding the 2/28/13 allegation of neglect due to lack of supervision and amended the April 15th report. This report listed the same 3 STAs as the April 15th report did which *includes* the STA the recipient had identified to HRA. The synopsis section of this report removed a sentence stating that a review of email correspondence revealed that another staff person (not the STA named by the recipient) became aware of the allegation on the evening of 2/27/13 but failed to report the incident to the OIG intake until the following morning. HRA reviewed this correspondence and found that the email time stamp was 4:36 pm which is after this staff person's shift is over. No other differences were noted between the April 15th report and this one. It was noted that this report did not have the detailed case summary that the April 19th report had in it.

The HRA contacted the external OIG office to see if there were any investigations regarding this type of incident involving this particular recipient. The OIG searched back to 2011 cases (including those that were "non-reportable") and found no other investigations other than the one involving the February 28th incident.

The Team found no OIG investigative reports involving the first incident on Lincoln's Birthday holiday (February 12th).

C...Progress Notes: Progress notes for the month of February were reviewed. There were no case notes indicating that he complained to staff that he was sexually assaulted by a peer. There is one case note on 2/9/13 documenting that patient was released from restraints. Another case note dated 2/14/13 documenting his bowel movement. The next entry was dated 2/18/13 at 9:25 a.m. indicating the recipient was upset, argumentative and refused to get in line for breakfast. He asked for a PRN medication and it was given to him. The next entry was an hour later indicating the PRN was effective. A psychologist note at 1:20 pm summarized his significant behavioral problems including physical aggression directed towards both peers and staff especially when he is told he cannot have something. At 4:50 pm there is a nursing note documenting that he was hit with a trash can by a peer, however the patient identification number is different than the peer's identification number who allegedly sexually assaulted him. The next entry is dated 2/20/13. The case notes from then through 2/24/13 document a few altercations with peers, however none indicate any sexual abuse occurred. After 2/24/13, the next case note is 3/2/13. No case notes were made during the time of the second alleged sexual assault dated 2/27/13.

There was a nursing case note dated 4/19/13 at 8:30 p.m. stating "recipient came to nurses' station and stated 'I made a deal with [peer initials who allegedly assaulted him sexually] to have sex with him and I could look at his magazines. When questioned when this happened he stated 'I was raped' I notified [STA II]. Recipient was escorted to room 628 by [STA II]. When [another STA II] questioned recipient about incident he stated 'it didn't happen I wanted to get [peer name] in trouble.' [STA II] then asked this writer to come to room 628 when recipient again stated 'it didn't happen, I just wanted to get him into trouble.' A 207 [behavioral report] was completed by this writer. I notified [RN] of alleged incident and of denial." The HRA found no other case notes referring to either incident.

D. Treatment Plan Reviews (TPRs): TPRs for February through May were reviewed, they all list "inappropriate sexual behaviors" as one of his problem areas along with "psychiatric symptoms including mood instability" and "verbal and physical aggression". The "evidence for problem" for "inappropriate sexual behaviors" is listed as "[recipient] occasionally touches others in a sexual manner. He also makes inappropriate sexual gestures and statements directed to, and about, both peers and staff.

The 2/20/13 TPR notes in the response to medication section that "patient has not been reported to have engaged in sexually inappropriate behavior lately." This TPR also notes in the problem area for inappropriate sexual behavior that his goal is to be "free of inappropriate sexual behavior for six consecutive months by 12/2013." The assigned psychologist said he "has occasionally been prompted to discontinue touching peers in an inappropriate manner." The STA stated that he "requires prompting to discontinue touching others." The intervention listed is that "STAs will monitor [recipient] and on those occasions when he exhibits inappropriate behaviors, they will document these behaviors on a behavior data report (BDR). [Recipient] will be redirected from the maladaptive behavior, and prompted to engage in more appropriate alternatives."

The 3/19/13 TPR again noted in the response to medication section that the "patient has not been reported to have engaged in sexually inappropriate behavior lately." The problem/goal section was verbatim what the 2/20/13 TPR listed.

The 4/16/13 TPR also noted in the response to medication section that the "patient has not been reported to have engaged in sexually inappropriate behavior lately" and also noted verbatim in the problem/goal section what was in the previous TPRs.

The 5/14/13 TPR's response to medication section only stated "[Recipient] was in FLR (full leather restraints) 3 times this time period. He continues to attack peers and staff. He has no disregard for others. Patient has had some medication refusals." The problem/goal section stated verbatim what was in the previous TPRs.

III...Facility Policies:

A. RI.03.03.00.01 Reporting and Resolving Complaints/Concerns Involving Patients: This policy states that "any complaint alleging any of the following will be reported to the OIG following established OIG reporting protocol: A. Any physical or mental abuse; B. Any neglect; C. Any financial exploitation or D. Any sexual abuse." The policy also says that any person who feels their concerns haven't been addressed can fill out Chester form 424 (complaint form). This form is forwarded to the Quality Assessment and Improvement office for review. If the complaint involves abuse, weapons, rape, deaths unauthorized absences of an UST or NGRI patient or patient injury, then it should be forwarded to the OIG liaison or the hospital administrator. If the complaint does not involve the above, it is referred to the Human Rights and Ethics Committee.

B. EC.04.01.01.01 Routine Observation-Patient Visual Observation Checks: This policy states that "In order to ensure the continued safety and security of a patient, Security Therapy Aide (STA) staffs assigned to each module are required to visually observe and account for each patient assigned to that module at least every 15 minutes. Any unusual behavior and/or situations noted requiring intervention shall be promptly responded to in accordance with facility procedures and documented as required."

Summary

Although both recipients told the Team that the OIG was contacted regarding the February 12th incident of alleged peer to peer sexual assault due to lack of staff supervision, the HRA could find nothing in the clinical chart indicating that a complaint had been filed or that staff was notified. When the Team checked with both the internal liaison and the external OIG, there was no investigation, either reportable or non-reportable, that involved the February 12th incident. The only OIG investigation that occurred was regarding the February 28th incident which was unfounded. When reviewing the video tape from the February 28th incident, the OIG found the two recipients engaging in "consensual sexual activities" which ceased when a STA came into the room. The first indication in the chart that the recipient mentioned the alleged assault to staff was on 4/19/13, 2 months after the incident was to have occurred. However, there was a case note indicating that the recipient retracted his statement the same day saying he was

only trying to get the peer into trouble. There was also a note in the OIG report indicating that the recipient had made threats to "show staff." Once staff learned of the alleged assault, proper protocol was followed in that it was reported to the appropriate chain of command and the recipient saw a medical doctor for an examination.

Conclusion

Although recipient 1 informed the HRA that he reported the alleged February 12th incident, the HRA was unable to find any documentation either in the recipient's chart, with the internal OIG liaison or in an OIG report for this date, only the February 28th incident had resulted in an OIG investigation. Therefore, the HRA was unable to prove that a report was filed regarding the February 12th incident. The only documentation that an alleged sexual assault had been reported to staff was in April when the recipient reported it to a nurse who documented it in the case progress notes. At that time, Chester staff did follow protocol of reporting and referring the recipient to the facility doctor. Documentation indicated that the recipient had made threats to "get staff." There was also documentation that the recipient retracted his original statement when interviewed by the OIG liaison as well as other staff. Therefore, the allegation is **unsubstantiated.**

Suggestions

Although no rights violation occurred, a videotape recording reviewed by the OIG revealed that the STAs were in conversation with each other, and left the day room "completely unsupervised" for approximately 13 minutes, however staff did not violate Chester's 15 minute visual observations policy. The Authority **suggests** the following:

1. The facility review the visual observations policy with direct care staff ensuring they understand this policy is in place to keep individuals safe in their living units. Although it seems this incident was a consensual one, leaving an area unsupervised for this length of time could leave recipients vulnerable to abuse in the future. The recipients seemed to know that they had a 15 minute window before staff would be checking on them which they appeared to use to their advantage.

The HRA was also concerned that the STA I interviewed by the HRA did not seem to have a grasp of the entire OIG reporting process. He knew what his obligations were, but did not understand what happened after his part was completed. There also seems to be no follow up once a report is filed to ensure that the OIG report actually makes it to the OIG. The HRA was concerned that if written reports are just being placed on the desk of a STA IV and verbally reported to the nurse and charge aide, that this might leave room for error and important abuse and neglect reports might possibly get lost or not be reported within the 4 hour timeframe as required by the Illinois Administrative Code (59 IL ADC 50.20) and the initial person reporting would be held responsible for this violation. **The HRA suggests that Chester re-evaluate how their OIG training is implemented and explore other training methods that might be more effective. The facility should also consider making it the responsibility of the person**

receiving the complaint to report directly to the OIG along with reporting to the nurse, charge aide and STA IV.

The HRA acknowledges and appreciates the full cooperation of the facility throughout the course of this investigation.