FOR IMMEDIATE RELEASE

Egyptian Regional Human Rights Authority
Report of Findings
13-110-9033
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 allegations are as follows:

1. Lack of patient involvement in treatment planning.
2. Inadequate investigation of patient-on-patient abuse claims and inappropriate restriction.
3. Breach of confidentiality.

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 Ill. Adm. Code 110).

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. With the recipient's written authorization, copies of information from the recipient's clinical chart were reviewed by the Authority. Facility Policies relevant to the complaints were also reviewed. And, contact was made with the Illinois Department of Human Services' Office of Inspector General.

Allegation 1: Lack of patient involvement in treatment planning alleges that the recipient was moved from module 1 to module 2 after another recipient made claims against him but staff would not provide specifics as to what the claims involved.

Allegation 2: Inadequate investigation of patient-on-patient abuse claims and inappropriate restriction alleges that the recipient repeatedly requested to have an investigation regarding another recipient's claims against him without result. Also, the recipient was inappropriately restricted when he was put on 1:1 observation due to being "sexually aggressive" after a claim was made by a second peer.

Allegation 3: Breach of Confidentiality alleges that when the recipient was moved from one module to another, staff and recipients on the new module were aware of another recipient's allegations against him and as a result, he was "teased and taunted" by staff and other peers.

I. Interviews:

A. Recipient: The Recipient informed the Team that another recipient (recipient 2) had told his therapist that he and this recipient had engaged in consensual sexual activities, which this recipient denies. Directly following that recipient's claim, he was moved from module 1 to module 2. No one, including his own therapist, would give him specifics as to why. He was also examined by a doctor for "trauma" to his genitalia and rectum, none was found. The recipient claims he repeatedly asked for a proper investigation into the other recipient's allegations such as video recordings. He was told that the cameras are not used for such reasons. The recipient could not recall which staff person told him this. The recipient stated that this peer had made "improper solicitations" of him and he rejected him due to recipient 2 being HIV positive. After he was moved to module 2, he learned that the allegations of recipient 2 had "made their way to the other staff and patients." The recipient stated that because of these rumors, he was "fighting off teases and taunts and was even beat about the head and neck twice by another recipient while staff sat in the TV room watching TV." On another occasion he stated that recipient 2 came into his room and "hit and kicked me for 50-60 seconds until he was finally instructed to leave my room, all the while, being laughed at by staff." He also alleged that Security Therapy Aides (STA) have called him a "fag and child molester" and told him to "just kill yourself already." He reported all of the abuse allegations to OIG but said all complaints came back as unfounded.

The recipient also stated that recipient 2 wrote him 4 letters claiming that staff had put him up to making false accusations against him. He immediately turned those letters over to his therapist but he is unaware of where those letters are currently. The HRA checked with the therapist regarding the letters. The therapist did find 3 letters "allegedly written by [recipient 2.]" He said the recipient being accused handed the letters to him and "alleged that his peer wrote them to him." The recipient dated each letter when he received them; the therapist also dated and initialed when he received the letters from the recipient. The first was marked as received by the recipient on 2/14/13 and the therapist on 4/15/13 and included a statement "I'm sorry I put threw hell I was conded by the staff to lie on you….I didn't want to they used me to get you in trouble." (sic). The second letter was received by the recipient 3/22/13 and by the therapist on 4/1/13 and included a statement "[initials] pulled me into [initials] office then asked me if I knew anything bout the dip or pills coming in I said I don't know. Then [initials] said he must be having sex with you I said [explicit] then they called for the STAs they put me in FLR [full leather restraints]…" The last was received 3/30/13 and by the therapist on 4/1/13 and included a statement "I apologize for all the [explicit] that I put you threw. I was just listening to the STAs telling me you are using me for sex, so I started beliving them and making statements to [initials] felling unease around you and they start asking me have I sex with you. I said no then they said if I had they said I will no be in touble. So I said yes. Then OIG talked to me..." (sic) The handwriting on the letters appears different than the handwriting of the recipient accused and the grammar is not as fluent as the recipient's. The therapist stated he knew this incident was reported to OIG and he had completed an injury report and the recipient had completed a "rebuttal to the injury report" which was placed in his file stating the allegations were false. The

therapist passed the information on to his supervisor. He did not know what happened with the investigation from there. He did not give these letters to anyone because the other recipient was not his patient and it would have been inappropriate for him to approach him about the letters.

Another incident occurred when a nurse asked him to wake up another recipient (recipient 3) for his morning medicine. He said it is not uncommon for staff to ask for assistance in these manners. He first knocked on recipient 3's door and did not receive a response. He then opened his door and attempted to wake him by calling out his name, still no response. That is when the nurse told him to go into his room and awaken him. He did so and pulled the sheet from covering his eyes only. At that time, recipient 3 woke up and this recipient left his room. He said he was in recipient 3's room less than 5 seconds. Later that same day, recipient 3 had been using the staff's phone to make prank calls to other units. He made staff aware of the actions of recipient 3 and when he did so, recipient 3 "verbally threatened him and poked him in the chest and punched him in the face." Recipient 3 was escorted to the restraint room. Shortly after that, he was approached by his therapist claiming that while he was in recipient 3's room earlier that day, recipient 3 claimed that he touched his genitalia and stated "without due process I was placed on 1:1 observation for being sexually aggressive." He felt recipient 3 accused him falsely as retaliation for "ratting him out" for using the staff phone otherwise, he would have made the allegations immediately that morning and not waited until 7-8 hours later.

The recipient believed that the letters written by recipient 2 denying anything happened and also the fact that recipient 3 waited 7-8 hours to make a complaint instead of immediately after the incident allegedly occurred, prove that they were false allegations. However, the recipient claimed that these allegations were mentioned in at least one of his 90 day evaluations that were sent to the court and "hurt his case."

II. Clinical Chart Review:

A. Admission Summary: The admission summary from December, 2011 stated that the recipient was admitted to Chester as unfit to stand trial (UST). He was convicted of 5 counts of aggravated criminal sexual abuse and was serving a 26 year sentence in Illinois Department of Corrections (DOC) when another victim filed charges against him. This is the current charge for which he was found UST. He was given a diagnosis of "Personality Disorder, Narcissistic, Histrionic, etc." He also had a prior history of Attention Deficit/Hyperactivity Disorder (ADHD), Major Depressive Disorder and Anxiety. The summary also stated that the recipient was "above average intellectual functioning" and was described by unit staff as "someone who ruminates over the small stuff." It also noted that "at times he becomes tearful for no reason and other times he is socially active with peers or staff…he has required a PRN [as needed] medication when he begins to ruminate or dwell without being redirected and speaks of hopelessness and despair." Staff noted that when he speaks to his mother he appears "solid and strong" but when speaking about her he becomes "tearful, emotional and sobs 'if it weren't for her I would have already done it.' He has validated he is referring to suicide." The recipient had completed the fitness exam with a score of 100%. The summary also stated "there is no reason to doubt that he is capable of understanding the court process….but has little insight and poor judgment toward real outcomes. As noted in previous case(s) in which he plead guilty with no trial and received 26 years. He has a childhood history of mental illness dated as far back as age

6. He was inpatient at age 9 and received testing as well as treatment which was not considered when he was sentenced." The summary concluded by saying "Chester may not be the appropriate facility to address his needs, however, Chester could have an input on making the suggestion to the court as a referral to the treatment program." It was recommended "to proceed with trial and recommend for sex offender treatment."

B. Treatment Plan Reviews (TPRs): A 3 day TPR listed his reason for admission as "ordered by the Judge to undergo evaluation to assess his fitness to stand trial." It noted that he had been serving a 26 year sentence in DOC for pleading guilty to aggravated criminal sexual abuse and that he had a history of suicide attempt. The TPR stated that the recipient "expressed concern that if convicted of his current charge, he will not get out of prison and suggested he might end up being civilly committed after he serves his time. During the evaluation concerning competency to stand trial, [recipient name] made attempts to suggest he did not really know what happens in court with a trial. On the questionnaire, [recipient name] attempted to portray himself as ignorant and even referred to himself as not very bright." The discussion section said he attended and participated in his meeting and stated that his original charge was on appeal because he felt like he was sentenced without the court taking into account his past history of mental illness. The problem areas to be addressed are listed as unfit to stand trial, aggression and psychotic symptoms. His diagnosis is listed as "Axis I: H/O [history of] Pedophilia, Dysthymic Disorder, H/O Polysubstance Abuse; Axis II: Personality Disorder NOS [not otherwise specified] (Dependent); Axis III: H/O Ulcer; Axis IV: H/O sex assault, incarceration, sexual abuse; Axis V: GAF 40." His current medication was listed as Sertraline for depressed mood and Lorazepam BID PRN PO [twice daily, as needed, orally] for anxiety. His emergency intervention preference is listed as 1) seclusion 2) medication and 3) restraints. The recipient signed this TPR and marked that he was in agreement with his treatment plan.

On April 10, 2012 a Clinical Care Monitoring (CCM) meeting was held because "a diagnosis for the patient is requested for review as well as need for subsequent medication. Patient's mother feels the patient suffers from PTSD [post traumatic stress disorder] with psychotic features which inhibit his ability to attain fitness to stand trial. Patient, himself, claims to experience voices 60% of the time. Client feels he cannot be fit to stand trial given his 'mental illness'. Direct care staff has not observed behaviors congruent with these claims and dismiss the need for psychotropic medications." The recipient and his mother both expressed dissatisfaction with his treatment, exclusively his diagnosis and medication regimen which is why the CCM was held. The summary noted that the recipient consistently asked for Vistaril but once prescribed, he began making requests for other medications to address psychosis. The summary additionally noted that he was very active in his living environment and engaged in all activities offered. He did have periods of "sadness with crying" but noted that intervention seems to bring effective relief. It was also stated that "anxiety has surfaced on occasion wherein client will pace and perspire profusely" but again the recipient responded to interventions of either counsel or medication. The doctor offered to investigate the formulary of DOC and adjust his medication with those that would effectively address his symptoms and "translate with DOC" when the recipient returned there. His mother argued that this should delay a recommendation of fitness but the team concurred that his "current mental status is currently not playing an active role in his ability to attain fitness."

The June 29, 2012 TPR mentioned in the discussion section that the recipient attended but did not participate actively in discussion, appeared "groggy" and "answered questions with yes or what do you care?" He denied any sleep or appetite issues and expressed no other concerns. He re-took the fitness test and "scored 100% with rephrasing of questions." The recipient was noted to have "demanded treatment for the voices" but a review of his mental condition and function did not show any serious mental disorder. His diagnosis had been changed by this time to "Axis I Pedophilia, Exclusive Type, Major Depressive Disorder Recurrent Type, no Psychotic Features, Mild in Partial Remission with treatment; Axis II Antisocial Personality Disorder; Axis III Acid Reflux Disease as he reported; Axis IV Long history of crimes including sex with young boys, diagnosed and convicted as a pedophile; he also has a long history of substance abuse and alcohol abuse; served time in prison; Axis V GAF 50"

The recipient was transferred from Chester in July, 2012 to a less secure facility, but was transferred back to Chester in September, 2012 due to a "pattern of escalating threats, refusal to follow unit expectations and unwanted sexual act to a male patient in his room and unwanted sexual advances at least three incidents within 4-6 weeks…"

An April 23, 2013 TPR stated in the discussion section that he attended and participated in his meeting. He was involved in verbal altercations due to "interpersonal conflict with his peers." It was reiterated that there "does not appear to be any signs or symptoms of mental illness at this time which would affect his fitness for trial." The team agreed that he was "fit to stand trial" but returned from his February hearing with a court order for an independent psychiatric evaluation. His Diagnosis is listed as "Axis I Bipolar I Disorder mixed with Psychotic Features; Pedophilia; history of ADHD; Axis II Personality Disorder NOS [not otherwise specified] (Borderline); Axis III Hyperlipidemia; GERD; Constipation; Axis IV Since 2008 serving 26 year sentence for the crime of pedophilia; currently UST for an additional charge of aggravated sexual abuse …Axis V GAF 70."
This TPR cited specific examples of the recipient's reports of voices in his head and what they said to him and also mentioned delusions about "the lawyer and judge belonging to the satanic cult and they are out to kill me." The TPR notes however, that the recipient is "pleasant, polite, cooperative, greets staff with a smile and overly compliments male and female staff members most of the time. He laughs and jokes with peers and gets along well with them. No behavior disorder reports (BDR) have been written." The TPR did state that from 2/18/13-2/27/13 he had been on 1:1 observation to "monitor for sexual aggression. This step was taken because of alleged unwanted sexual advances on two lower functioning psychiatric patients at Chester MHC. Patient [name] is able to argue forcibly and defend himself that he did not engage in unwanted sexual advances. This behavior requiring close monitoring is related to the sexual disorder and does not interfere in his understanding of his legal charges and his ability to cooperate and assist his attorney in his own defense." The recipient signed this TPR and marked that he was in agreement with his treatment plan.

B. Progress Notes: On 2/11/13 a nursing note said the recipient was seen by a doctor for "reporting he had sex with a peer…injury report completed no injuries [name] **STA IV notified - stated not OIG reportable.** [name] RN PSA notified. Labs ordered per policy per Dr. [name]" The doctor's note stated that he was asked to evaluate the recipient for possible consensual sex. The recipient denied any sexual activity. The doctor ordered labs for "potential body fluid

exchange due to sexual activity." Twenty minutes later the recipient requested and received a PRN medication for agitation. A social worker's note an hour and a half later stated that he allowed the recipient to make a phone call to his lawyer from his office. The next day a nursing note indicated that the recipient was agitated because he found out that he is on red level, which is a restriction that is used at Chester when behavioral problems occur. He calmed down by talking with the nurse and agreed to take his supper tray in his room that night to avoid "losing his cool" in the dining room. The HRA reviewed an injury report dated 2/11/13 which indicated that the recipient "reported that he had sexual intercourse with peer and performed oral sex also." The recipient was assessed and the doctor was notified and labs were ordered. Under the Physician's examination, comments and disposition section the doctor's note said "please see the progress note in the chart dated 2/11/13 2:30 p.m." The case note referred to was also reviewed and it said "I have been asked to evaluate pt. [patient] for possible consensual sex. **Pt. denies any sexual activity of sexual penetration or sexual fluid exchange. [illegible] pt. denies sexual activity,** no acute pathology [illegible] will order labs for [illegible] body fluid exchange due to sexual activity." The recipient also requested that a note he wrote be placed in his permanent chart. The HRA reviewed this note entitled "Injury report rebuttal for 2/11/13." This note repeated verbatim what was written on the injury report by the nurse regarding the recipient admitting to engaging in sexual activities and the recipient said in this rebuttal "this report and accusations can't be any further from the truth. I wish to contest the validity of this injury report. The accusation from my peer and the comments from nurse [name] are false and without merit. It is my opinion that nurse [name] falsified this report…the overseeing medical doctor noted that I denied any sexual activity…" Later this day, a social worker note stated that the recipient requested and was allowed to make a phone call to his lawyer in the social worker's office.

A 2/15/13 nursing note at 2:00 p.m. indicated that the recipient was agitated over another recipient attacking him and was given a PRN medication. The note also stated "recipient was attacked by peer [identification] to right neck/back. He has denied any injury at this time." At 3:20 p.m. a case note stated he had been "placed on 1:1 for attempted sexual assault on [illegible]."

On 2/16/13 a psychiatry note stated that when asked how the recipient felt, he became "loud and angry" and stated "how am I supposed to feel? They accused me of having sex, they are lying." They psychiatry note continued to state "most probably he manipulates and takes advantage of lower functioning peers and has sex with them. He had consensual sex with one peer [name] and most probably engaged in touching [illegible] sexual part due to which peer [name] attacked him. Plan: continue 1:1 observation to monitor for sexual aggression."

A 2/17/13 social work note stated the recipient "remains very upset about being placed on 1:1 observation. Patient feels he wasn't given an opportunity to clear 'his good name' pt. also feels that with his departure no real effort will be made to find out the truth. Patient would like more privacy but the writer explained we could not close his room door. The rules are the rules and we can't deviate from them."

A 2/18/13 psychologist's note stated the recipient "believes he should not be on the 1:1 observation. He indicated he was falsely accused of touching a peer inappropriately. I explained to [name] that the treatment team will continue to review his case for need for the 1:1

observation. Continue 1:1 observation until the treatment team can review this case." Another psychiatrist's note on this same date stated "continue 1:1 observation for sexual aggression. 2 patients complained about …inappropriate touching and sex. Patient engages in angry denial…."

The 1:1 observation was renewed daily through 2/20/13 when the recipient went to court, upon his return from court the next day, 1:1 observation was renewed. On 2/23/13 a social worker note indicated that the recipient denied any wrong doing and explained the events over the last week and a half and claims he is now on module 3 and the patients he supposedly aggressed against are on different modules and did not understand why the 1:1 is continued. **He also requested cameras to be reviewed**; **the social worker recommended that he discuss these issues with the treatment team and stated "he makes a logical request pertaining to being investigated further to prove his innocence**." A therapist note this same date also indicated that the patient was requesting that 1:1 observation be discontinued and stated "he has no desire to engage in any type of inappropriate sexual behavior…" The therapist noted that **"thought process was logical, coherent and goal directed.**" On 2/25/13 a psychiatry note stated that the "psych team discussed and decided to DC (discontinue) 1:1 observation and continue frequent observation for previous allegations of inappropriate sexual behaviors." On 2/27/13 frequent observation was discontinued.

The case notes on 3/23/13 indicate the recipient was upset about the phone and arguing with another patient and requested and received a PRN medication. On 3/25/13 nursing notes indicate that the recipient complained of neck stiffness from being struck by a peer on 3/23/13 and an injury report was completed. The recipient said "I was sitting down and he started hitting me in the head. I put my hands up around my face." The recipient requested to speak with his social worker and expressed frustration about the incident on 3/23/13 "due to an argument over the telephone." The recipient admitted that at times he can be antagonistic and agreed to work on interpersonal issues.

On 3/28/13 there are several case notes that indicate the recipient was refusing to follow directions, giving commissary away and trying to use the phone when it was not appropriate times to use it. A STA note this date at 10:00 p.m. indicated that the STA was called in to talk to the recipient and the recipient continued to grab his left arm and squeeze it, then asked for a PRN medication. When the nurse came in to administer the medication, the recipient alleged abuse against staff. The nursing note stated that an abuse allegation was received and reported to the medical director and the STA IV who acts as the OIG liaison at Chester. At 10:40 p.m. a case note indicated that an injury report was completed.

III...Facility Policies:

A. EC.04.01.01.07 Use and Monitoring of Video Equipment states "It is the policy of Chester Mental Health Center (CMHC) that the use of video monitoring equipment will enhance the safety and security of patients and staff." It further states under process for investigation and recording "The Facility Director or Assistant Hospital Administrator and O.I.G. Liaison, shall review stored video footage during the preservation period for recordings that have been reported to contain incidents subject for review such as but not limited to: training, investigations, serious

injuries and worker compensation cases." The policy further outlines the process for handling written requests to preserve video recordings and states "if reviewing staff are aware that the substance of any video recording is related to pending or threatened litigation, or if they determine that the recording may be relevant to future litigation, such recording(s) shall be preserved indefinitely, irrespective of whether a request for preservation was received".

The HRA also inquired with a staff person about how allegations of peer-to-peer aggression are handled. The Team was told that staff "just treats the injury unless there are 3 or more incidents between 2 patients. Then there are OIG reporting requirements. Our treatment teams usually address all aggressive acts between patients as they occur." Additionally, the HRA was told by the Administrator that generally Chester views the video recordings anytime there is a question or concern around an incident that may indicate a patient safety concern.

B. EC .04.04.00.03 Occurrences of Patient Sexual Abuse or Sexual Conduct states "All sexual activity between persons who are patients at CMHC is prohibited. All occurrences of sexual conduct or sexual abuse as defined in Program Directive 01.05.06.03 is prohibited and shall be reported to the Facility Director. Each employee shall immediately report all incidents upon becoming aware of the incident, complete all forms as required by facility procedures and fully cooperate with any ensuing administrative investigations." The policy outlines the steps to be taken when a staff person observes or becomes aware of any sexual activity and requires that "any alleged or suspected sexual penetration **will be immediately reported to OIG**. The Facility Director, Unit Director, STA III/IV, and Unit Nurse are to be notified of the allegation of sexual penetration or sexual conduct." After reporting, the policy requires that the patients be examined by a doctor and further explains the steps to be taken from that point forward to conduct an investigation if sexual conduct has been confirmed after examination including contacting the local police department and transporting the individuals to the community hospital to have evidence collected by using the vitulo kit.

Statutes

The Illinois Administrative Code (59 IL ADC 50.10) defines Sexual abuse as "any sexual behavior, sexual contact or intimate physical contact **between an employee and an individual**, including an employee's coercion or encouragement of an individual to engage in sexual activity that results in sexual contact, intimate physical contact, sexual behavior or intimate physical behavior." Sexual contact is defined as "Inappropriate sexual contact **between an employee and an individual** involving either an employee's genital area, anus, buttocks or breasts or an individual's genital area, anus, buttocks or breasts. Sexual contact also includes sexual contact between individuals that is coerced or encouraged by an employee."

The Code (59 IL ADC 50.20) requires that " 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 Code (59 IL ADC 50.30) states " OIG staff receiving the report of the allegation are responsible for assessing, based on the information received at intake, whether the allegation

could constitute abuse, neglect, or financial exploitation and whether OIG has the authority to investigate in accordance with the Act. OIG shall make these assessments within one day after receiving the call… The Inspector General shall, within 24 hours after determining that there is credible evidence indicating that a criminal act may have been committed in connection with an allegation of abuse, neglect, financial exploitation or death of an individual served by a facility or agency, or that law enforcement expertise is required, refer those allegations to the Department of State Police or ensure that notification is made to the respective local law enforcement entity for investigation in accordance with Section 1-17(l) of the Act"

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 Plan shall be formulated and periodically reviewed with the participation of the recipient…"

The Code (405 ILCS 5/2-112) guarantees freedom from abuse and neglect. "Every recipient of services in a mental health or developmental disability facility shall be free from abuse and neglect."

The Code (405 ILCS 5/2-201) requires that "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 therefore to: (1) the recipient… "

The Code (405 ILCS 5/3-211) also makes provision regarding recipients who are perpetrators of abuse by stating: "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."

Finally, the Code (405 ILCS 5/2-100) guarantees that: "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services."

Conclusion

Allegation 1: Lack of patient involvement in treatment planning alleges that the recipient was moved from module 1 to module 2 after another recipient made claims against him but staff would not provide specifics as to what the claims involved. After a review of the chart, the HRA determined that the recipient was not moved to module 2 until after he returned from his fitness hearing which was approximately 12 days after the alleged incident. Although no specific reasons for the move were documented in the chart, the HRA concluded that the move was

unrelated to the incident due to the time lapse. The TPRs that were reviewed documented that the recipient attended and participated in his meeting. He signed the TPRs and indicated agreement with the treatment plan which included discussion regarding the recipient being on 1:1 observation to monitor for sexual aggression and further explained that this step was taken because of alleged unwanted sexual advances on two lower functioning psychiatric patients at Chester MHC. Therefore, the allegation is **unsubstantiated**.

Allegation 2: Inadequate investigation of patient on patient abuse claims and inappropriate restriction alleges that the recipient repeatedly requested to have an investigation, including reviewing video footage, regarding another recipient's claims against him without result. It also alleged the recipient was inappropriately restricted when he was put on 1:1 observation due to being "sexually aggressive" after a claim was made by a second peer. Chester policy EC.04.01.01.07 states that video footage will be reviewed for recordings that have been reported to contain "incidents subject for review such as but not limited to: training, investigations, **serious injuries** and worker compensation cases." This policy further states that "if reviewing staff are aware that the substance of any video recording is **related to pending or threatened litigation,** or if they determine that the recording may be relevant to future litigation, such recording(s) shall be preserved indefinitely, irrespective of whether a request for preservation was received." The recipient asked to have the video tapes reviewed to prove his innocence and was allegedly told that videos aren't used for such purposes. The case notes indicated that the recipient requested a private phone call with his attorney and told the HRA that his attorney was looking into the allegations and also felt that these allegations "hurt his case." Since the recipient had pending charges for sexual aggression the HRA concluded that allegations such as this would be relevant for pending litigation and thus subject to videotape review as per policy.

Chester policy EC .04.04.00.03 states that "any alleged or suspected sexual penetration **will be immediately reported to OIG**." When the alleged incident occurred, case notes documented that the nurse contacted a STA IV to report it, but was told that it was not OIG reportable which contradicts what Chester's policy states.

Although 1:1 supervision could be an appropriate restriction if substantiated in order to protect the safety of individuals involved, the recipient stated to multiple staff persons that this allegation was false and included a statement in his chart explaining his side of the story. The HRA found no documentation in the chart to indicate that an investigation took place or that the recipient's concerns were addressed in his TPR meetings even though there were unverified letters suggesting false allegations. Therefore, the allegation regarding an inadequate investigation and in appropriate restriction is **substantiated** and the HRA **recommends** the following:

1. The Illinois Administrative Code's definitions are clear with regard to sexual abuse and sexual contact in that these acts must occur between an employee and individual and not between recipients. However, the OIG informed the HRA in a follow-up contact made by the HRA that patient-on-patient abuse claims **can** be investigated if it is alleged that the incident was a result of lack of staff supervision. Chester policy EC .04.04.00.03 states that incidents between individuals should be **immediately** reported to OIG. Staff should be reminded that they are

required to report **all** incidents to the OIG and it is the OIG's responsibility to determine if the allegation is "reportable" or not.

2. The recipient requested an investigation to "prove his innocence" and had a written statement placed in his chart stating his side of the story. In addition, unverified letters suggested that the allegations against the recipient were not valid. None of the TPRs indicated his written statement or his concern of being falsely accused was discussed in any of his treatment meetings. There was also no indication that this issue was investigated further, including no videotape review, only that he was placed on 1:1 observation for sexual aggression. The Code (405 ILCS 5/2-102) requires that treatment should be formulated with participation of the individual. The treatment team should have addressed his concerns and should do so in the future when conflicting statements arise regarding a behavioral incident, especially one that would result in restrictions on the individual. Given the seriousness of the allegations and the impact on this recipient's restrictions as well as pending court activity, the HRA recommends that a videotape review of similar incidents be conducted.

3. The HRA did not find restriction of rights forms in this recipient's chart when he was placed on 1:1 observation. The restriction was noted in the case notes and the restriction was reviewed regularly; however Chester staff should indicate in case notes when restriction of rights forms are given to a recipient and keep a copy of the form in the chart as required by the Mental Health Code (405 ILCS 5/2-201).

4. The HRA notes that the Chester policy prohibits sexual relations. The HRA contends that such a prohibition is inconsistent with Mental Health Code and basic Constitutional rights. To reiterate, the Code states that "No recipient of services shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of the receipt of such services." Chester administration should review this policy with the Department of Human Services (DHS) to address the discrepancy between the Code and Chester Policy and clarify the final policy with staff.

Allegation 3: Breach of Confidentiality alleges that when the recipient was moved from one module to another, staff and recipients on the new module were aware of another recipient's allegations against him and as a result, he was "teased and taunted" by staff and other peers and was "beat about his head and neck" by a peer. There was documentation in the chart to corroborate that the recipient had a head injury from a peer but case notes indicated that it was due to a disagreement over telephone use. Case notes also indicated that the recipient admitted to being antagonistic at times and agreed to work on interpersonal relationships. There was insufficient information to prove that his altercations with other recipients were a result of them knowing about the allegations of another peer. Therefore, the allegation is **unsubstantiated.**