STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

PROGRAM AUDIT

OFFICE OF THE INSPECTOR GENERAL

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

DECEMBER 1996

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AUDITOR GENERAL

STATE OF ILLINOIS
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DEPUTY AUDITOR GENERAL

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our report of the Program Audit of the Office of the Inspector General, Department of Mental Health and Developmental Disabilities.

We conducted the audit pursuant to Section 30/6.8 of the Abused and Neglected Long Term Care Facility Residents Reporting Act. This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

The audit report is transmitted in conformance with Section 3-14 of the Illinois State Auditing Act.

JOHN W. KUNZEMAN
Deputy Auditor General

Springfield, Illinois
December 1996

REPORT DIGEST

ILLINOIS DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

PROGRAM AUDIT: OFFICE OF THE INSPECTOR GENERAL

Release Date: December 1996

State of Illinois
Office of the Auditor General

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SYNOPSIS

This is our fourth audit of the Office of the Inspector General's (OIG's) effectiveness in investigating allegations of abuse or neglect at facilities within the Department of Mental Health and Developmental Disabilities (DMHDD). In this audit we reviewed a random sample of 278 OIG investigations closed in Fiscal Year 1996. Several findings have been repeated from our prior audits:

- While overall timeliness of the investigations has improved since our December 1994 audit, further improvement is warranted. Fifty percent of the investigations reviewed took longer than the 60 days recommended by DMHDD policy.

- Forty-four percent of the case files reviewed were missing some required documentation. Examples of missing documentation included photos where visible injuries were sustained (46 of 99 cases) and medical examinations (21 of 225 cases).

- Supervisory review of case files needs to be improved. Of 236 investigations that required a supervisory review form, 19 (8 percent) did not have the form. Also, in some cases, missing documentation was not noted in supervisory case reviews.

- OIG's database contained inaccurate information due primarily to a lack of an adequate control structure. This database is used to track and record reported incidents of abuse or neglect and to prepare the OIG's statutorily required annual report to the General Assembly.

We also found that the OIG closed cases as "recantations" without conducting thorough investigations. In addition, we found that not all OIG investigators, as well as facility personnel responsible for collecting initial investigatory information, had received all the training required by OIG policy.

FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

REPORT CONCLUSIONS

The Office of the Inspector General (OIG) closed 1,077 investigations of alleged employee abuse or neglect of DMHDD facility residents in Fiscal Year 1995 and 1,001 in Fiscal Year 1996. The percentage of abuse allegations substantiated declined from 11 percent in Fiscal Year 1995 to 8 percent in Fiscal Year 1996.

While the overall investigation timeliness has improved since our December 1994 audit, further improvement is needed. Fifty percent of the investigations we reviewed took longer than the 60 days recommended by DMHDD policy. In our 1994 audit, 78 percent of the investigations took longer than 60 days to complete.

Case files continued to lack required documentation. In our 1994 audit, 26 percent of the cases reviewed were missing required documentary evidence. In this audit, we found that 44 percent (122 of 278) of the investigations reviewed were missing one or more required documents. Examples of missing documentation included photos where visible injuries were sustained (46 of 99 cases) and medical examinations (21 of 225 cases).

The OIG also improperly closed cases classified as "recantations" (where a person recanted the allegation) without conducting a thorough investigation. In 12 of the 35 recantations reviewed, the victim had a physical injury consistent with the allegation, but the case was closed as a recantation. In some cases closed as a recantation, the victim did not actually recant the allegation.

Many factors may contribute to the above identified problems. OIG investigators were not receiving the training required by OIG policy. Of the 19 OIG investigators, 11 were lacking 5 or more of the required courses. Also, contrary to OIG policy, untrained facility staff collected 14 percent (321 of 2,299) of the written statements we reviewed from the alleged perpetrators, victims, and witnesses. Similarly, in 40 percent (110 of

278) of the investigations examined, the OIG noted a problem with the facilities' collection of preliminary evidence.

Improvements in supervisory review are also warranted. Supervisory review is essential in ensuring that OIG investigations are timely and thorough. Eight percent (19 of 236) of the cases reviewed did not have the investigation review form supervisors are required to complete. In some cases, missing documentation was not noted in supervisory case reviews.

In the audit, we also found that:

- Individual facilities decide what corrective action to take in response to a substantiated case. Of the 17 substantiated abuse or neglect allegations in our sample, no action was taken against employees in two cases. According to the OIG, in some substantiated cases, the facilities disagreed with the OIG's position and identified investigative errors;

- There was no policy to ensure that investigations conducted by facility investigators were conducted in a consistent and thorough manner;

- There was no established protocol or procedure for the conduct of investigations of reported abuse or neglect at community agencies; and

- The OIG had inadequate controls over its Investigations Log Database which impacted the reliability and accuracy of information used to monitor ongoing investigations and make reports to the General Assembly.

BACKGROUND

The Office of the Inspector General was established to investigate alleged abuse or neglect at DMHDD-operated facilities.

The General Assembly established the Office of the Inspector General (OIG) (Public Act 85-223, effective August 26, 1987) to investigate alleged incidents of abuse or neglect at DMHDD-operated facilities. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The Inspector General reports

to the Director of the Department. The current Inspector General was appointed in October 1995.

The OIG closed 1,077 investigations of employee abuse or neglect in Fiscal Year 1995 and 1,001 in Fiscal Year 1996. The substantiation rate in Fiscal Year 1995 was 11 percent; in Fiscal Year 1996 it was 8 percent. When asked about the decrease in substantiation rates, OIG officials stated that they had not yet had an opportunity to study this question.

Important aspects of an investigation are: thoroughness, timeliness, and whether corrective action is taken.

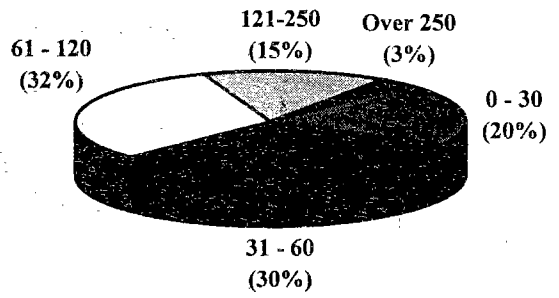
There are several aspects to an investigation which can have an impact on whether the investigation is or is not effective. These aspects include: whether the investigation is timely; whether the investigation is thorough (such as whether all relevant evidence is collected and analyzed); and whether corrective action is taken. (pp. 13, 22, & 35)

INVESTIGATION TIMELINESS

While the overall timeliness of OIG investigations of employee abuse or neglect has improved since our December 1994 audit, 50 percent of the investigations we reviewed took longer than the 60 days recommended by DMHDD policy. In our previous audit, 78 percent of investigations exceeded 60 days. In addition, the number of cases that took more than 250 days to complete decreased from 35 percent in our 1994 audit to 3 percent in this audit, as shown in **Digest Exhibit 1**. (pp. 13-15)

The overall timeliness of OIG investigations has improved since our December 1994 audit.

Digest Exhibit 1
DAYS TO COMPLETE AN ABUSE OR NEGLECT INVESTIGATION

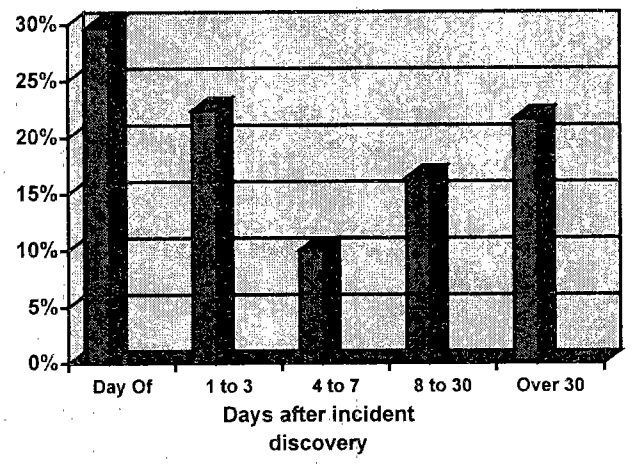


Source: OAG analysis of 278 investigations closed in Fiscal Year 1996

There were certain aspects of investigations where improvements in timeliness were also warranted. Initial written statements were not completed in a timely manner. OIG requires that an initial written statement be taken from each facility staff and resident who may have witnessed the incident within three working days of the reported incident. We reviewed 2,299 initial written statements. As shown in **Digest Exhibit 2**, 52 percent of the written statements were taken within the required three day period.

Initial witness statements were not always completed in a timely manner.

Digest Exhibit 2
Days to Take Initial Written Statements



Source: OAG analysis of 2,299 initial written statements in 278 OIG investigations

The OIG did not always initiate investigations of employee abuse or neglect in a timely manner. In one-third (95 of 278) of investigations reviewed, the first OIG interview was not conducted for more than one month after the incident was reported to the OIG.

We recommended that the OIG continue to improve the timeliness of its investigations.

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. With the passage of time, injuries heal, memories fade, and witnesses may not be located. We recommended that the OIG continue to improve the timeliness of employee abuse or neglect investigations and ensure that preliminary evidence, such as written witness statements, is collected in a timely manner. (p. 15 - 18)

INVESTIGATION THOROUGHNESS

Forty-four percent of the case files reviewed were missing one or more pieces of required documentary evidence.

Collection of all relevant evidence is an essential component of an effective abuse or neglect investigation. Many case files continued to lack required documentary evidence. Of the case files reviewed in this audit, 122 (44 percent) were missing one or more pieces of required documentary evidence. Photographs were missing in 46 cases, diagrams were missing in 30 cases, and medical exams were missing in 21 cases. **Digest Exhibit 3** summarizes the missing documentation. In our December 1994 audit, we found that 26 percent of case files reviewed were missing required documentary evidence.

Digest Exhibit 3
EXAMPLES OF MISSING DOCUMENTATION

Document	Percent Missing	*Number Missing
Medical Exam	9%	21 of 225
Photos	46%	46 of 99
Diagrams	12%	30 of 255
Time Sheets	13%	33 of 257
Visitor's Log	15%	32 of 217
Progress Notes	7%	19 of 264
Restraint/Seclusion Monitoring Record	7%	4 of 60

Source: OAG analysis of 278 OIG abuse or neglect investigations closed in FY96

Note: * Total does not equal 278 because documentation was not applicable in all cases.

We also found that in 18 percent (50 of 278) of the cases sampled, not all persons listed on the incident report completed the required initial written statement. In 11 percent of the investigations, the OIG investigator did not interview either the victim, the alleged perpetrator, or other eyewitnesses. We recommended that the Inspector General should ensure that all required documentation is collected during the investigation process. (pp. 22-27)

The OIG closed some cases without conducting a thorough investigation. Forty percent (14 of 35) of

Cases were improperly closed as "recantations".

investigations sampled which were closed as recantations (where a person recanted the allegation made) did not follow OIG procedures for closing such cases. In some cases, the victim did not actually recant the allegation. In 12 of the 35 cases (34 percent), the victim had an actual physical injury consistent with the initial allegation.

The use of recantations was more prevalent at some facilities than others in the cases we sampled. Kiley Developmental Center accounted for 10 (29 percent) of the 35. Choate Mental Health and Developmental Center had 6 (17 percent), and Howe Developmental Center and Jacksonville Developmental Center each had 5 (14 percent).

According to OIG officials, the policies concerning recantations were discontinued in Fiscal Year 1997, which occurred after our testing period. We plan to follow up on this in our subsequent audit. (pp. 27-30)

CASE REVIEW AND MONITORING

We continued to note areas where supervisory review of case files and monitoring of open investigations could be improved.

We continued to note areas where supervisory review of case files and monitoring of open investigations could be improved. The reviewer is to complete a standardized case review form for each case indicating irregularities or issues that were noted during the review.

Of the 236 investigations that required a supervisory case review form, 19 (8 percent) did not have the review form. We could therefore not determine to what extent the cases had been reviewed. Also in some cases, missing documentation was not noted in supervisory case reviews.

Fifty-four percent of the cases (74 of 138) that required status reports did not contain all the required reports. These reports are required in all cases over 60 days old in order to document the reason for the investigation delay. We recommended that the Inspector General ensure that adequate supervisory review occurs on OIG investigations, including the completion of supervisory case review forms and status reports which document reasons for investigation delays and require documentation of supervisory review. (pp. 31-33)

CORRECTIVE ACTION

Facilities decide what action to take, if any, in response to findings from the OIG investigation.

An investigation is far less likely to have an impact if corrective action is warranted, but none is recommended or taken. After an investigation is completed, the OIG sends a recommendation memo to the facility concerning the findings of the case. The OIG does not make specific recommendations to facilities concerning corrective actions. The recommendation memos generally describe the incident and state the finding, but leave it to the facility to determine what, if any, corrective actions are taken. In the 278 cases reviewed, at least 34 employees were either reprimanded, suspended, discharged, or resigned due to findings of abuse, neglect, or other employee misconduct.

Of the 278 cases sampled, OIG substantiated abuse or neglect in 17 cases. In two of the substantiated cases of abuse or neglect, no corrective action was taken against the employees. In some substantiated cases the facilities disagreed with the OIG's position and identified investigative errors, according to the OIG.

We also noted instances where facilities took different actions against staff for similar types of misconduct. We recommended that the Inspector General monitor action taken by facilities for consistency and refer cases to the Director of DMHDD when appropriate corrective action is not taken. (pp. 35-40)

OIG INVESTIGATOR TRAINING

OIG investigators lacked required training.

OIG investigators are not receiving the training required by The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) and OIG policy. The Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations receives training on an on-going basis concerning investigative techniques, communication skills, and the appropriate means of contact with persons admitted or committed to the facilities under the jurisdiction of the Department.

As of June 30, 1996, only two of the nineteen investigators had received all the training required by OIG policy. The other 17 investigators were missing between 1 and 12 of the required courses. We recommended that the Inspector General ensure that every person employed or

newly hired to conduct investigations receive the required investigatory training courses established by OIG policy. (pp. 44-45)

TRAINING OF FACILITY STAFF

Untrained facility staff are collecting preliminary investigation evidence, contrary to OIG policy. OIG policy requires that at the scene of an alleged incident of abuse or neglect, a trained facility designee should secure the scene and collect relevant physical evidence and take initial written statements. If staff have not been trained in basic investigations, OIG field investigators are responsible for ensuring that initial written statements are obtained.

In 110 of the 278 cases sampled (40 percent), the OIG noted a problem with the facilities' collection of preliminary evidence.

In our review of 2,299 written statements, we found that 321, or 14 percent, were taken by facility staff not trained in the Basic Investigations Course. The remaining statements were taken by either OIG investigators, trained facility staff, or it could not be determined who took the statements. Furthermore, in 110 of the 278 cases sampled (40 percent), the OIG noted a problem with the facilities' collection of preliminary evidence. Our April 1996 audit of facilities' reporting of abuse or neglect also concluded that additional training of facility staff on the reporting of abuse or neglect was needed.

The proper collection of evidence is a critical component of an abuse investigation. Having facility staff who are untrained in the proper methods of evidence collection could impair the overall effectiveness of the OIG investigation. We recommended that the Inspector General ensure that all facility employees involved in reporting and collecting initial evidence of resident abuse or neglect receive required training. (pp. 45-47)

FACILITY ABUSE INVESTIGATIONS

The OIG is not ensuring that all investigations of abuse or neglect are being conducted in a thorough and consistent manner. The OIG investigates allegations of abuse of residents by employees. Investigations of other types of abuse, as defined by the Abused and Neglected Long Term Care Facility Residents Reporting Act, such as injuries

caused by another resident, are conducted by facility staff. The OIG reviews these facility investigations.

There is no policy or control to ensure that facility investigations of abuse are conducted in a consistent manner. DMHDD policy does not specify how facility investigations should be conducted and there were no uniform training requirements for facility investigators.

There is no policy to ensure that facility investigations of abuse are conducted in a consistent manner.

Our review of 25 facility investigations found a wide variance in the content of the case files submitted to the OIG for review at the conclusion of the investigation. Some case files contained only the incident report and injury report; others had additional documentation.

The Act gives the OIG the responsibility to conduct investigations of all abuse allegations. Without ensuring that all investigations of abuse are conducted by appropriately trained staff and meet basic investigation requirements, the OIG cannot assure that it is meeting its statutory mandate. We recommended that the Inspector General ensure that all investigations of abuse or neglect allegations: are conducted by trained investigators, follow established investigation protocols, adequately document the investigation procedures used and conclusions reached, and are adequately reviewed by supervisory personnel. (pp. 47-49)

OIG INVESTIGATIONS LOG COMPUTER SYSTEM

The OIG Investigations Log computer system contains inaccurate information. This condition was primarily due to a lack of an adequate control structure. These control weaknesses affect the reliability and accuracy of the information used to record and track reported incidents of abuse or neglect.

In several instances, information concerning number and types of allegations, case findings, and closed cases requested and received from the OIG was inconsistent with prior information received from the OIG or that which is contained in the OIG's Annual Reports. The changes to the data are not documented and it is often unclear why and how the data changed. Documentation of changes made to the database would allow for a clear audit trail.

The OIG has inadequate controls over its investigations database which affects the reliability and accuracy of data.

Incorrect data was input into OIG's database in over a third of the cases in our sample. In 104 of the 278 (37 percent) OIG investigations reviewed, at least one piece of information in the Investigations Log database did not agree with that in the case file. Errors ranged from differences in times or dates to incorrect investigation finding codes.

This finding is expanded and repeated from our 1994 audit report in which we also found a lack of controls related to the OIG's Investigations Log computer system. We recommended that the OIG strengthen its controls over its database and ensure that data is consistent and valid from year to year. (pp. 52-57)

AGENCY RECOMMENDATIONS

The audit report contains 15 recommendations related to the Office of the Inspector General. The Inspector General provided responses to the recommendations, as well as other comments to the report. Appendix E to the audit report contains the Inspector General's complete response.

JOHN W. KUNZEMAN
Deputy Auditor General

JK:JT:vh

December 1996

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INTRODUCTION AND BACKGROUND

Chapter One

REPORT CONCLUSIONS

The Office of the Inspector General (OIG) closed 1,077 investigations of alleged employee abuse or neglect of Department of Mental Health and Developmental Disabilities (DMHDD) facility residents in Fiscal Year 1995 and 1,001 in Fiscal Year 1996. The percentage of abuse allegations substantiated declined from 11 percent in Fiscal Year 1995 to 8 percent in Fiscal Year 1996. In a random sample of 278 employee abuse or neglect investigations we reviewed, at least 34 employees were either reprimanded, suspended, discharged, or resigned.

While the overall timeliness of OIG investigations has improved since our December 1994 audit, 50 percent of the investigations still took longer than the 60 days recommended by DMHDD policy. In 1994, 78 percent of the investigations reviewed took longer than 60 days to complete. Timely completion of investigations is critical for an effective investigation, because with the passage of time injuries heal, memories fade, or witnesses may not be located.

Case files lack required documentation and certain basic evidence is still not being collected. We found that 44 percent (122 of 278) of investigations were missing one or more required documents. In our prior audit, 26 percent of case files were missing required case file documentation. Some of the documentation problems noted in this audit include: photos were not taken in 46 percent of cases in which there was a visible injury; and in 18 percent of the cases, not all persons identified as being present when an incident occurred completed the required initial written statements.

The OIG also improperly closed cases classified as "recantations" (where a person recanted the allegation) without conducting a thorough investigation. In 12 of the 35 recantations reviewed, the victim actually had a physical injury consistent with the allegation. Therefore, these cases should not have been closed as recantations and should have been fully investigated. In some cases closed as recantations, the victim did not actually recant the allegation. According to OIG officials, the practice of closing cases as recantations ended in Fiscal Year 1997.

Many factors may contribute to the above identified problems. OIG investigators have not received the training required by OIG policy. Of the 19 OIG investigators, 11 lacked 5 or more of the required courses. Also, untrained facility staff collected

preliminary investigatory evidence, contrary to OIG policy. Fourteen percent of the written statements we reviewed (321 of 2,299) were taken by staff untrained in the Basic Investigations Course. Similarly, in 40 percent (110 of 278) of the investigations examined, the OIG noted a problem with the facilities' collection of preliminary evidence.

We continue to find problems with supervisory review of case files and monitoring of open investigations similar to those noted in our prior audits. Supervisory review is essential in ensuring that OIG investigations are timely and thorough. In some cases, missing documentation was not noted in supervisory case reviews. Eight percent (19 of 236 cases) did not have the investigation review form supervisors are required to complete. In addition, 54 percent of the cases did not contain all required case status reports which are submitted to and reviewed by supervisors.

In the audit, we also found that:

- **The Office of the Inspector General does not recommend corrective actions in substantiated cases. The individual facilities decide what corrective action to take in response to a substantiated case. Of the 17 substantiated abuse or neglect allegations in our sample, no action was taken against employees in two cases. According to the OIG, in some substantiated cases, the facilities disagreed with the OIG's position and identified investigative errors;**

- **The OIG did not ensure that investigations conducted by facility investigators were conducted in a consistent and thorough manner;**

- **There was no established protocol or procedure for the conduct of investigations of reported abuse or neglect at community agencies; and**

- **The OIG had inadequate controls over its Investigations Log Database which impacted the reliability and accuracy of information used to monitor ongoing investigations and make reports to the General Assembly.**

BACKGROUND

The General Assembly established the Office of the Inspector General (OIG) (Public Act 85-223, effective August 26, 1987) to investigate alleged incidents of abuse or neglect at DMHDD-operated facilities. The Inspector General is appointed by the Governor and confirmed by the Senate for a four-year term. The current Inspector General was appointed in October 1995.

The primary purpose of the OIG is to investigate alleged incidents of abuse or neglect reported at facilities operated, licensed or funded by DMHDD. The OIG may recommend sanctions against facilities to DMHDD or the Department of Public Health. These sanctions,

intended to protect the residents at the facilities, include the appointment of on-site monitors or receivers, the transfer or relocation of residents, and the closure of units.

Prior to establishing the Office of Inspector General, all cases of abuse or neglect were reported to the Department of State Police Division of Internal Investigations (DII). If DII elected not to investigate, it was referred back to DMHDD to investigate the case. Abuse or neglect facility investigations were reviewed by the DMHDD Office of Internal Review.

In August 1987, the Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) (210 ILCS 30/6.2) created the Office of the Inspector General. The Act was amended most recently in December 1995.

In 1995, the role of the Office of Inspector General was clarified and expanded, as shown in **Exhibit 1-1.** The Inspector General function is now clearly within DMHDD and the Inspector General reports to the Director of the Department. Previously, it was unclear to whom the Inspector General reported, the Director of DMHDD or the Governor. The OIG is still required by the Act to provide an annual report to the General Assembly and the Governor. The annual report includes a summary of reports and investigations for the prior fiscal year with respect to residents of institutions under the jurisdiction of DMHDD. The report is to be released no later than January 1 of each year.

Exhibit 1-1
CHANGES IN THE
ABUSED AND NEGLECTED LONG TERM CARE FACILITY RESIDENTS REPORTING ACT
Effective 12-7-95

- Inspector General reports to the Director of DMHDD;
- Inspector General has authority to investigate reports of abuse or neglect at any facility or program licensed or certified by DMHDD or that is funded by DMHDD and is not licensed or certified by any agency of the State;
- Inspector General no longer is involved in programmatic, licensure, or certification operations of DMHDD;
- Inspector General shall promulgate rules establishing minimum requirements for initiating, conducting and completing investigations;
- Inspector General shall provide a report on each substantiated case to the Director of DMHDD within 10 calendar days of completing the investigation.

Source: Public Act 89-0427

As seen in **Exhibit 1-1**, the recent amendment also gives the Inspector General the authority to investigate reports of abuse or neglect at facilities or programs not only operated by DMHDD, but also licensed, certified or funded by DMHDD. This, in effect, gives the OIG the authority to conduct investigations at community agencies.

According to the new amendments to the Act, the OIG is required to promulgate rules which will establish guidelines and requirements for investigations. The Act requires the OIG to promulgate rules that govern the conduct of investigations and how the OIG will interact with the licensing unit of DMHDD. The Act does not specify a deadline for the rules.

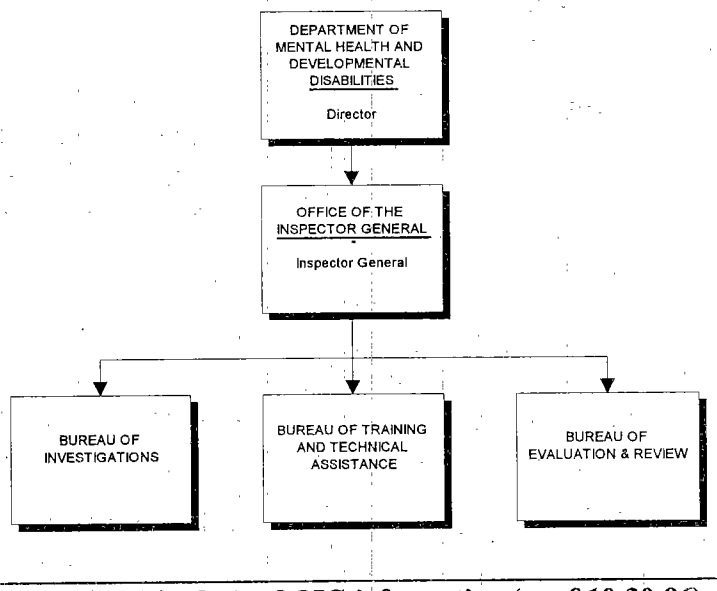
The OIG is currently in the process of promulgating rules for conducting investigations at State-operated facilities and community agencies. There is a task force of 45 people, which consists of parents, advocacy groups, Quality Care Board members and legislators who are currently working to formulate the rules. The task force met in January, February, and April of 1996 and, as of September 1996, has developed a working draft of the rules.

The OIG has been in a state of reorganization during each of the past several audits. The last OIG organizational chart approved through the Department of Central Management Services was dated December 1994 and since that time there have been significant changes in OIG's structure and function.

Exhibit 1-2 shows that the OIG is currently divided into three bureaus:

- The **Bureau of Investigations** is responsible for investigating cases of abuse or neglect at State-operated DMHDD facilities and at community agencies.
- The **Bureau of Training and Technical Assistance** is responsible for coordinating and tracking training received by OIG investigators.
- The **Bureau of Evaluation and Review** conducts internal studies and unannounced site visits to facilities.

Exhibit 1-2
OFFICE OF THE INSPECTOR GENERAL
ORGANIZATIONAL CHART



Source: OAG analysis of OIG information (as of 10-30-96)

Our December 1994 program audit noted that some OIG investigators were paid from funds appropriated to DMHDD facilities, rather than from funds appropriated for OIG operations. While we found no evidence that the OIG investigators were impeded or compromised by the fact that their salaries were paid from facility funds, we recommended the OIG take steps to ensure all investigative staff were paid out of monies appropriated for the OIG. We note that as of the time of our fieldwork, the OIG investigators were all being paid from OIG appropriated monies.

INVESTIGATIONS OF ABUSE OR NEGLECT AT STATE-OPERATED FACILITIES

The Office of the Inspector General is required by the Abused and Neglected Long Term Care Facility Residents Reporting Act to investigate reports of suspected abuse or neglect (as defined in the Act) of patients or residents in DMHDD operated facilities. "Abuse" is defined by the Act to include any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. "Neglect" occurs when the failure to provide adequate medical or personal care or maintenance results in a physical or mental injury or causes the resident's physical or mental condition to deteriorate.

The Inspector General investigates all cases of alleged resident abuse or neglect by DMHDD employees, other than those investigated by the Illinois State Police. As shown in **Exhibit 1-3,** DMHDD's incident reporting policies define abuse or neglect as mistreatment of a resident by an *employee* (categories 1.a. - 1.e.). Any other type of physical injury or sexual abuse, such as that caused by another resident, is classified as another type of reportable incident. These other types of reportable incidents are typically investigated by facility investigators. Facility investigations are discussed further in Chapter Five.

Exhibit 1-3
TYPES OF INCIDENTS REPORTABLE TO THE INSPECTOR GENERAL

ABUSE OR NEGLECT	OTHER REPORTABLE INCIDENTS
1. Mistreatment of Residents by Employees: a. Physical abuse requiring emergency medical treatment b. Other physical abuse c. Sexual abuse d. Verbal/psychological abuse e. Neglect	1f. Other improper employee conduct 2. Resident Death 3. (a) Injuries requiring emergency medical treatment or (b) non-accidental injuries inflicted by another person 4. Unauthorized resident absence from a facility 5. Certain sexual incidents between residents 6. Theft of resident property 7. All other allegations of misconduct, malfeasance, misfeasance or other conduct serious enough to warrant reporting

Source: DMHDD Policy and Procedures Directive 01.05.06.03

OIG INVESTIGATION PROCESS

Facility staff are required to report all incidents of alleged employee abuse or neglect to the OIG. Once an incident is reported, an OIG investigator is assigned to the case. The facility is responsible for collecting physical evidence and interviewing staff and residents about the alleged incident. This information is then turned over to the OIG investigator. The OIG investigator reviews the facility-collected information to determine if further interviews must be conducted or additional documentation needs to be collected. When the case is completed, the investigator submits a case report to his or her supervisor for review. Substantiated cases are sent to the Inspector General for her review. The OIG then sends a recommendation memo to the facility discussing the findings in the case and whether corrective action is warranted. The facility takes corrective action, if needed, and sends a letter to the OIG documenting the action taken and requesting that the case be closed. OIG officials review the action taken and close the case. **(See Exhibit 1-4)**

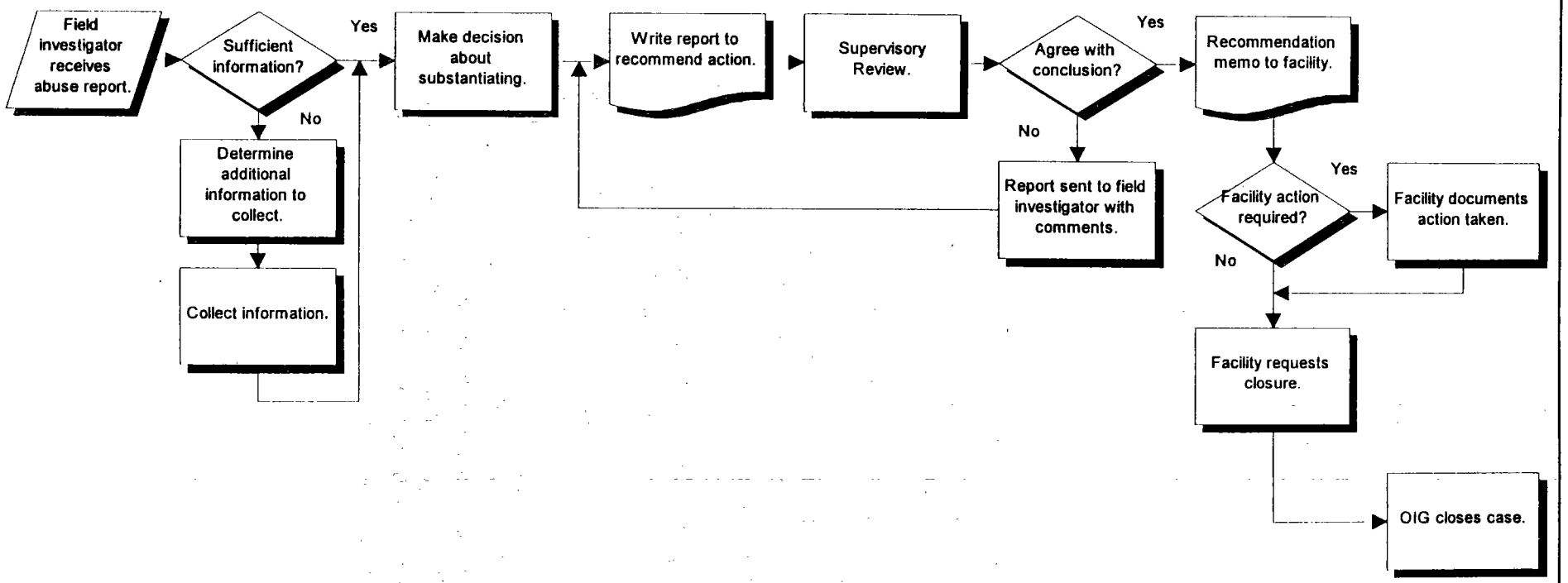
OTHER STATE AGENCIES

The Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30/1 et seq.) requires the OIG to investigate reported incidents of abuse or neglect and refer potential criminal cases to the Department of State Police for investigation. The OIG must determine within 24 hours of receiving a report of suspected abuse or neglect whether evidence indicates any possible criminal act has been committed. If it is determined a possible criminal act has occurred, the OIG must notify the State Police immediately. OIG policy requires that incidents involving physical or sexual abuse with a documented injury classified as moderate or above, employee theft, all deaths or homicides, and other incidents deemed appropriate by the lead investigator must be reported to the State Police. If the incident is deemed by State Police as a potential criminal act, State Police investigates the case. If not, State Police returns the case to the OIG to investigate.

The OIG has entered into an interagency agreement with the State Police (effective date April 8, 1996). Prior to April 1996, the OIG had a memo of agreement with the State Police signed in May 1993 which clarified referrals between offices. The current agreement with State Police also clarifies referrals between offices regarding reportable incidents of possible criminal activity.

The Act requires all persons who provide services or have direct contact with residents to report all incidents of suspected abuse immediately to the Illinois Department of Public Health (IDPH). Under DMHDD's Policy and Procedures Directives, employees of DMHDD State-operated facilities are to complete an OIG incident report form for all allegations of abuse or neglect and notify IDPH no later than the end of the next calendar day. Public Health has established a 1-800 hotline for reporting cases of suspected abuse or neglect. IDPH is responsible for investigating those cases that occur in DMHDD facilities participating in the

Exhibit 1-4
OIG INVESTIGATION PROCESS



Source: OAG Analysis of OIG process

Medicaid or Medicare program. The OIG conducts investigations for the Department of Public Health per an interagency agreement.

The OIG entered into an interagency agreement with the Department of Public Health which was effective February 4, 1994. The agreement with Public Health outlines the duties of each agency with regard to investigations of abuse or neglect. It requires the OIG to disseminate final case summaries to Public Health for review and to conduct additional interviews or obtain additional documentation per Public Health's request. The agreement requires Public Health to monitor and review final case summaries and provide recommendations regarding investigatory procedures or case recommendations.

The Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.) mandates that all field personnel of DMHDD, among others, immediately report incidents of suspected abuse of all persons under the age of 18 to the Department of Children and Family Services (DCFS). The OIG does not have an interagency agreement with DCFS regarding the referral and investigation of abuse or neglect allegations involving minors. Consequently, both DMHDD and DCFS may be conducting investigations of the same abuse allegation.

The recent revisions to the Abused and Neglected Long Term Care Facility Residents Reporting Act require that the OIG promulgate rules that set forth instances where two or more State agencies could investigate an allegation of abuse or neglect so that OIG investigations are not redundant to investigations conducted by other State agencies. The latest draft rules (as of September 1996) do not specifically delineate in which instances DCFS or DMHDD would investigate an abuse allegation involving a facility resident under the age of 18. In addition to not complying with the legislative mandate of not conducting duplicate investigations, having two agencies investigate the same case may result in inefficient use of investigative resources.

Case file documentation reviewed also did not show whether the abuse allegation of a resident under the age of 18 was indeed reported to DCFS, as required by the Abused and Neglected Child Reporting Act. During our testing of 278 OIG investigations, we found that 15 cases involved a victim who was under 18 years of age. In 8 of these 15 cases (53 percent), there was no documentation in the case file that the allegation had been reported to DCFS. In our April 1996 program audit of DMHDD facilities' reporting of abuse or neglect, we similarly found that there was no evidence of DCFS notification in 55 percent (92 of 166) of the abuse allegations reviewed.

Recommendation Number One:

The Inspector General should take action to ensure that duplicate investigations of abuse or neglect of individuals under the age of 18 are not being unnecessarily conducted. Consideration should be given to specifying investigatory responsibilities of DCFS and DMHDD either in an interagency agreement or in the rules being developed pursuant to 210 ILCS 30/6.2. In addition, the Department's compliance with the reporting requirements of The Abused and Neglected Child Reporting Act should be documented in case files.

Office of Inspector General's Response:

The working draft of the rules establishes that OIG would conduct an investigation only at DCFS' request. However, the Abused and Neglected Child Reporting Act requires a report, but confidentiality provisions of this Act may prohibit any indication in the file that DCFS was contacted if the case is not substantiated. The resolution of this issue must precede any final agreement. The DMHDD Legal Department has begun its review.

TRENDS IN ABUSE REPORTING AND INVESTIGATIONS

The Department of Mental Health and Developmental Disabilities provides care and treatment to Illinois citizens who are mentally ill or developmentally disabled. The population in the State-operated residential facilities has been steadily decreasing since 1989. The facility population decreased from 8,097 in Fiscal Year 1989 to 5,713 by the end of Fiscal Year 1996. This decrease is due to many factors, including the population being transferred from the State facilities to the community agencies throughout the State.

Exhibit 1-5
ALLEGATIONS OF STAFF ABUSE OR NEGLECT REPORTED FY 1994 - FY 1996

FY 1994	929
FY 1995	987
FY 1996	838

Source: OAG analysis of OIG data.

The number of allegations of employee abuse or neglect reported to the OIG rose in Fiscal Year 1995 and then decreased in 1996. The number of residents treated at these facilities declined over this period. As shown in **Exhibit 1-5,** cases of alleged employee abuse or neglect of residents reported increased from 929 in Fiscal Year 1994 to 987 in Fiscal Year 1995 and then decreased to 838 in Fiscal Year 1996.

The percentage of substantiated employee abuse or neglect cases decreased in Fiscal Year 1996, as shown in **Exhibit 1-6.** OIG closed a total of 990 investigations of abuse or neglect in Fiscal Year 1994 and 1,077 in Fiscal Year 1995, with substantiation rates at 11 percent of the total cases for both years. The substantiation rate decreased to 8 percent in Fiscal Year 1996. When asked about the decrease in substantiation rates, OIG officials stated that they have not yet had an opportunity to study this question. OIG officials commented that since the December 1994 audit found substantiation rates of 7 percent in Fiscal Year 1992 and 12 percent in Fiscal Year 1993, these current rates seem to be within normal variation.

Exhibit 1-6
INVESTIGATIONS OF STAFF ABUSE OR NEGLECT AND SUBSTANTIATED CASES FY 1994 - FY 1996

Fiscal Year	Cases Closed	Substantiated Cases	Percent Substantiation
1994	990	105	11%
1995	1,077	117	11%
1996	1,001	76	8%

Source: OAG analysis of OIG data.

The percentage of employee abuse allegations substantiated at the individual DMHDD facilities varied widely in Fiscal Year 1996. Three facilities -- Mabley, Meyer, and Zeller -- had no substantiated abuse or neglect allegations during this period. Six facilities had substantiation rates of 15 percent or greater. The substantiation rates at these facilities were as follows: Fox, 25 percent (1 of 4); McFarland, 20 percent (2 of 10); Murray, 20 percent (1 of 5); Kiley, 18 percent (18 of 102); Chicago-Read, 19 percent (4 of 21); and Singer, 15 percent (8 of 53). Substantiation rates for all facilities can be found in Appendix C.

Office of Inspector General Comment:

Substantiations or lack of such are based on the facts of each case, and no conclusion can be reached by reviewing a substantiation rate without reviewing the investigative quality of each case.

AUDIT SCOPE & METHODOLOGY

This audit was conducted in accordance with generally accepted government auditing standards and the audit standards promulgated by the Office of the Auditor General at 74 Ill. Adm. Code 420.310.

Initial work on this audit began in January 1996 and fieldwork was concluded in September 1996. We interviewed representatives of DMHDD, the Inspector General's Office, the Department of Public Health, Department of State Police, and Department of Children and Family Services. We reviewed documents at the Inspector General's Office, State Police, DCFS, and Public Health, and interagency agreements with State Police and Public Health. We examined the current OIG organizational structure, policies and procedures, investigations

process, case review process, and documentation requirements. We also reviewed internal controls over the investigation process. We reviewed investigator backgrounds, caseloads and statistics. Our audit work also included follow-up on previous audit recommendations and a survey of other states to gather information related to investigation procedures, standards used to conduct investigations, and training requirements of staff.

We assessed audit risk by reviewing prior audits, OIG internal documents, agency organizational structure, management controls, and policies and procedures. Assessing the effectiveness of investigations was the primary objective of the audit. Compliance with the Act was also assessed as part of this audit.

This audit focused on the Inspector General's investigation of allegations of employee abuse or neglect of facility residents, since these cases account for most of the investigations conducted by OIG investigators. We conducted a statistically significant (95% confidence, 5% margin of error) sample of 278 OIG investigations of employee abuse or neglect cases closed during Fiscal Year 1996. In addition, we sampled cases that took over 200 days to complete, OIG and facility investigated death cases, facility investigated cases, and community investigations.

Office of Inspector General Comment:

While the sample was selected randomly over the year, the Auditor General failed to test whether progress was made throughout the year and under new leadership.

Auditor's Comment: The sampling methodology used was consistent with prior audits. Our review of the policies and management controls of the Office of the Inspector General focused on those in effect during Fiscal Year 1996.

The Auditor General has previously conducted three program audits which reviewed the Office of Inspector General's effectiveness in investigating alleged cases of abuse or neglect. In May 1990 the Auditor General released a program audit on the reporting and investigating of resident abuse or neglect which included a review of the Office of the Inspector General's effectiveness in investigating reports of suspected abuse or neglect. A second program audit of the OIG was released in April 1993 and a third audit was released in December 1994.

The Auditor General has also released three other audit reports concerning DMHDD's abuse or neglect reporting that described trends and patterns in State-operated facilities. These were released in November 1992, June 1994 and April 1996.

Government Auditing Standards require the disclosure of all matters relating to the audit work, the audit organization, and the individual auditors concerning impairment of audit independence, whether real or apparent. In accordance with these requirements, the Office of

the Auditor General reports the following matter in regard to this audit: During the audit period, the Auditor General's former wife was employed by DMHDD and under the authority of the Inspector General. All responsibilities for this audit were transferred to the Deputy Auditor General, including review of findings, conclusions, and recommendations, as well as report signature authority. The auditors submit that no impairments to independence existed that would have limited their ability to conduct a fair and objective audit. This matter is noted here to comply with full disclosure requirements of relevant auditing standards.

REPORT ORGANIZATION

Chapter Two examines the timeliness of OIG investigations.

Chapter Three discusses the thoroughness of OIG investigations and the OIG case review process.

Chapter Four reviews actions, sanctions and recommendations.

Chapter Five discusses training, community and facility investigations, death investigations, and OIG database controls.

TIMELINESS OF ABUSE OR NEGLECT INVESTIGATIONS

Chapter Two

CHAPTER CONCLUSIONS

While the overall timeliness of OIG investigations has improved since our December 1994 audit, some problems were noted with the timeliness of certain aspects of investigations. In terms of overall timeliness, 50 percent of the 278 cases we sampled took longer to complete than the 60 days recommended by DMHDD policy. Three percent (8 of 278) of the cases exceeded 250 days. In our 1994 audit, only 22 percent of the investigations were completed within 60 days; 35 percent took longer than 250 days.

Initial written statements were not completed in a timely manner. OIG policy requires that initial written statements be received within three working days of the reported incident; more than 38 percent of the written statements reviewed were prepared more than a week after the incident was discovered.

The OIG did not always initiate investigations of employee abuse or neglect in a timely manner. In one-third (95 of 278) of investigations, the first OIG interview was not conducted for more than one month after the incident was reported to the OIG.

Also, the OIG did not report all required allegations to the Illinois State Police within the required 24 hours. In one case, the allegation was not reported until 32 days had elapsed.

INVESTIGATION TIMELINESS

The effectiveness of an investigation is diminished if it is not conducted in a timely manner. We surveyed agencies in seven other states and reviewed professional journals to develop criteria to measure the effectiveness of abuse or neglect investigations in institutions serving the mentally ill or developmentally disabled. We found that most of these sources followed similar timeliness criteria, namely prompt initiation and completion of an investigation.

Timely completion of investigations is critical for an effective investigation, because with the passage of time injuries heal, memories fade, or witnesses may not be located. DMHDD policy requires that investigations should be completed as expeditiously as possible

and should not exceed 60 days absent exceptional circumstances. Exceptional circumstances include difficulty receiving a death certificate or autopsy report, vacation or extended sick leave of a suspect or witness, review by an external entity, or low priority due to high caseloads. Our survey of other states and review of professional literature found that the length of time recommended for an investigation ranged from 14 to 90 days with an average of 40 days.

The overall timeliness of the OIG's investigations of employee abuse or neglect has improved since our December 1994 audit. In our previous audit only 22 percent of investigations were completed within 60 days. Of the 278 cases examined in this audit, half (140) were completed within 60 days. In addition, the number of cases that took more than 250 days to complete decreased from 35 percent in our 1994 audit to 3 percent in this audit, as shown in **Exhibit 2-1**. Of the cases closed in Fiscal Years 1995 and 1996, the number of cases that took more than 60 days to complete decreased from 811 in Fiscal Year 1995 to 443 in Fiscal Year 1996.

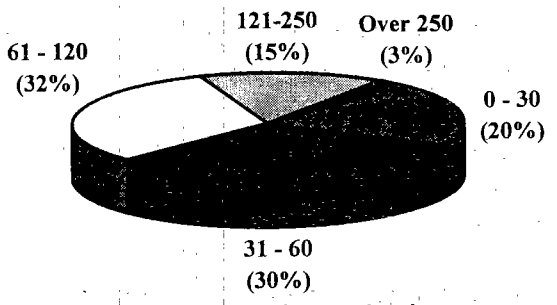
The length of time to complete an investigation was measured from the time an incident was reported to the OIG until the OIG sent a recommendation letter to the facility informing it of the investigation results. Overall it took the OIG an average of 78 days to complete investigations of employee abuse or neglect.

Office of Inspector General Comment:

All OIG investigations closed in FY96 took an average of 53 days to complete. During the first three months of FY96, the average was 66 days; during the last three months, the average was 46 days.

While the overall timeliness of OIG investigations has improved, further improvement is warranted. As shown in **Exhibit 2-1**, half of the investigations reviewed took longer than the 60 day guideline established by DMHDD. **Exhibit 2-2** contains examples of 2 of the 8 cases which took over 250 days to complete. These cases were delayed primarily because the OIG did not initiate the investigations in a timely manner or cases were reassigned to other investigators. Three facilities, Kiley (22%), Choate (20%), and Elgin (18%), accounted for 60 percent of cases that took more than 120 days to complete. The

Exhibit 2-1
DAYS TO COMPLETE AN ABUSE OR NEGLECT INVESTIGATION



Source: OAG analysis of 278 investigations closed in Fiscal Year 1996

large number of older cases for these three facilities may be caused in part because they reported some of the highest number of employee abuse or neglect allegations of all DMHDD facilities.

In our review of the OIG investigations, we examined the various time components which comprise the investigation process. In several of these areas, we noted concerns with timeliness issues. The following sections contain our conclusions.

Initial Collection of Evidence

An essential element in an effective investigation is the timely collection of preliminary evidence. The greater the delay in collecting evidence, the greater the possibility that witness accounts will be distorted and/or physical evidence will be destroyed or contaminated.

The OIG requires each facility to collect and submit investigation items within three working days of the reported incident/allegation of abuse or neglect. One item required to be collected is an initial written statement from each facility staff and resident who may have witnessed the incident. Initial written statements (preliminary interviews with incident witnesses) are to be taken immediately after the occurrence or discovery of the incident or allegation (e.g., employee written statements are required by the end of the employee's shift), unless special circumstances exist at the time of the allegation.

Exhibit 2-2
EXAMPLES OF CASES OVER 250 DAYS TO COMPLETE

338 Days to Complete - A resident alleged that several Mental Health Technicians hit her, including one who hit her with a belt. The incident was reported to OIG on 7-6-94 but the investigation was not initiated until five months later on 12-8-94. The only OIG interviews were done on 12-8-94 and 12-9-94. The victim was not interviewed because she was discharged from the facility by that time. The case was reassigned to another investigator five months after that on 5-8-95 and then finally completed on 6-9-95. It took five months before any interviews were done and then the case was not closed for six months after discovery, even though no other interviews were conducted. Eventually the case was not substantiated.

325 Days to Complete - A resident requested a sturdy rope from a staff member stating that he wanted to hang himself. The resident was placed on suicide watch but was found later with a red mark on his neck. The resident said that he tried to hang himself with the cord from his jogging shorts. The allegation, made on 8-5-94, was that staff failed to provide observation of a resident which culminated in the resident doing physical harm to himself. The resident was discharged seven months after the case was reported and was not interviewed within that time. The case was reassigned after it was 120 days old, then it took 6 more months to complete the case. The investigation did not substantiate that the staff member failed to watch the resident but it was found that the RN on duty did not properly implement the suicide watch procedure. The RN was counseled.

Source: Sample of 278 OIG abuse or neglect investigations closed in FY 1996

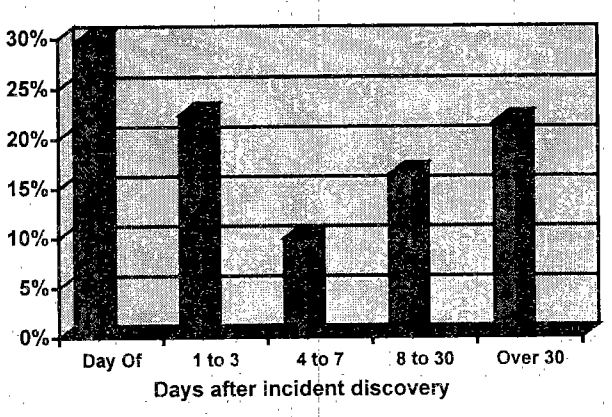
Initial written statements were not being completed in a timely manner. In our sample of investigations closed, we reviewed 2,299 initial written statements. As shown in **Exhibit 2-3**, 52 percent of the written statements were taken within 3 days after the discovery of the incident (30 percent were taken on the date of discovery; another 22 percent were taken 1 to 3 days after the discovery of the incident). More than 38 percent of the initial written statements reviewed were not taken until more than a week after the incident was discovered.

Office of Inspector General Comment:

OIG acknowledges that statements should be taken within the allotted time. However, an analysis of the number of cases, the number of other witnesses interviewed in each case, and reasons for the delay would more clearly indicate whether this had an impact on the ultimate quality of the investigation.

We examined the time taken to obtain written statements at the 12 facilities with five or more investigations in our sample. The median number of days to collect statements (i.e., the middle value of a rank ordering of days to collect statements) at 4 facilities was substantially higher than most other facilities: Metro C&A, 35 days; Singer, 15 days; Elgin, 13 days; and Chester, 11 days. In contrast, the median number of days to collect statements at the other 8 facilities was 2 days or less.

Exhibit 2-3
Days to Take Initial Written Statements



Source: OAG analysis of 2,299 initial written statements in 278 OIG investigations

We also reviewed the written statements broken out by three categories: alleged victims; alleged perpetrators; and other witnesses. In 15 cases, an initial written statement was not taken from the victim until more than a month after the date of discovery. In one of these 15 cases, it took over 200 days for the victim to give an initial written statement. In 14 cases, there were no initial statements for all the alleged victims when, according to OIG criteria, there should have been.

In 32 cases, the alleged perpetrator did not complete an initial written statement for more than a month. In four cases, it took over 200 days to get these statements. In 21 cases,

there were no initial written statements from all the alleged perpetrators in the investigative file.

Even with the delays noted above, the initial written statements of alleged victims and perpetrators were taken more quickly than those of other witnesses. Witnesses are especially critical to an investigation of abuse or neglect because their testimony is often crucial in clarifying conflicting testimonies of the victim and the perpetrator. Witness statements on average were not taken until 27 days after the incident was discovered; 447 statements were not taken until more than a month after the incident was discovered. Over 200 days elapsed from the date the incident was discovered to the time of the statement for 62 witness statements.

Time to Initiate the Investigation

Improvement is also needed in the timeliness of the OIG's initiation of the investigation. In one-third (95 of 278) of investigations, the first OIG interview was not conducted for more than one month after the incident was reported to the OIG.

One way to determine how quickly an investigation is initiated is to examine the time it takes for the investigator to complete the first interview. These are conducted after the initial information is collected by the facilities. Interviews should be completed promptly for several reasons. For example, witnesses may forget their actual observation, become confused with information or opinions expressed by others, or be influenced by intimidation or peer pressure. If interviews are not taken promptly, witnesses may meet to prepare their testimony or they may move away, get sick, or otherwise become unavailable.

An average of 35 days elapsed from the time the OIG was notified of an incident to when the first interview was conducted by an OIG investigator. In four cases sampled, it was more than 200 days before the OIG interviewed a witness.

The OIG does not have specific time requirements for OIG investigators to initiate their work on the cases. Other states have established criteria for initiating an investigation. For instance, Texas requires that the investigator must begin the investigation within 24 hours of receiving the allegation.

We also measured the time it took from the OIG first interview until the last OIG interview. In seven cases, the OIG took more than 100 days between the first and last interview and one case took 194 days. The average for all cases was approximately 17 days.

Completion of Case Report

The next phase we examined was the time it took to prepare the final case report upon the conclusion of the investigation. After the investigation interviews were complete, it took almost a month on average before the OIG notified the facility of the findings in the case. During this time, the case report is written and the case file is reviewed by a supervisor.

However, in 15 of the 278 cases we sampled, it took more than 100 days to complete the case after the last interview. In one case, the status report indicated that the case was in dictation and typing for 3 months. In another case, the victim had been released from the facility and the OIG was trying to initiate contact with that victim. In order to determine the reason for the case delay, we had to review the case status reports. In some cases, status reports were missing or were not specific. The case review process is discussed further in Chapter Three.

Facility Notification and Response

On average, 64 days passed from the time the OIG sent a recommendation memo to the facility to when the OIG closed a case based on a facility response to that memo. The recommendation memo identifies any findings reached by the OIG in the investigation. Seven cases sampled took more than one year from the recommendation memo until the time that the case was closed. In one case, there was no finding and no action recommended, yet it took the facility over a year to send a memo requesting closure. In another case, the facility took seven months to retrain the staff before its closure memo was sent to the OIG.

Office of Inspector General Comment:

OIG had not developed criteria requiring facility directors to respond within a designated amount of time because of the varying time it takes the facility to complete the disciplinary process. However, this issue has been addressed in the draft rule.

Recommendation Number Two:

The Inspector General should continue to improve the timeliness of employee abuse or neglect investigations. The Inspector General should ensure that preliminary evidence, including written statements, is collected within three days as required by OIG policy. The Inspector General should consider establishing a timeliness requirement for investigators to initiate an investigation. The Inspector General should ensure that case reports are written and prepared in a timely manner.

Office of Inspector General Response:

OIG recognizes that timeliness of investigations is important to the quality of the investigation; however, it is only one factor. The newly instituted 1-hour reporting requirement to OIG will more actively involve OIG investigators at the onset, facilitating the initial written statement process or the handling of the initial written statements by OIG.

TIMELINESS OF REPORTING TO STATE POLICE

The Abused and Neglected Long Term Care Facility Residents Reporting Act requires the Inspector General to determine, within 24 hours of receiving a report of suspected abuse or neglect, whether any possible criminal act has been committed. If a possible criminal act has been committed, the Inspector General is to immediately notify the Department of State Police.

OIG policy requires that incidents involving physical or sexual abuse with a documented injury classified as moderate or above, employee theft, all deaths or homicides, and other incidents deemed appropriate by the lead investigator must be reported to the State Police. If the incident is deemed by the State Police as a potential criminal act, State Police investigates the case. If not, the case is returned to the OIG to investigate.

In our testing of investigations we found that 3.6 percent (10 of 278) of cases were reported to the State Police. Of these ten, seven were reported within the required 24 hours. One took three days to be reported, one took five days and one case was not reported to the State Police for 32 days. This time was calculated by measuring the time the OIG was notified of an incident until the time the State Police was notified.

We also identified an additional 10 investigations which involved allegations of physical abuse with an injury classified as moderate or above. According to OIG policy, these cases are required to be reported to the State Police. None of these case files contained documentation that the State Police was notified. If required allegations go unreported or are not immediately reported to State Police, then the effectiveness of the State's investigations system may be diminished.

Recommendation Number Three:

The Inspector General should ensure that all cases required by law and policy are referred to the Department of State Police within 24 hours of being reported to the OIG.

Office of Inspector General Response:

OIG practice will include documentation of notification of State Police at the time OIG becomes aware of instances of possible criminal activity, and response by State Police in all cases required by law and policy.

THOROUGHNESS OF ABUSE OR NEGLECT INVESTIGATIONS

Chapter Three

CHAPTER CONCLUSIONS

Case files lack required documentation and certain basic evidence is still not being collected. We found that 44 percent (122 of 278) of investigations were missing one or more required documents. In our prior audit, 26 percent of case files were missing required case file documentation. Some of the documentation problems noted in this audit include: photos were not taken in 46 percent of cases in which there was a visible injury; diagrams of the location where the incident occurred were not prepared in 12 percent of the cases; and medical exam records were missing in 9 percent of the cases for which there was an alleged injury.

The OIG improperly closed some cases without conducting a thorough investigation. These were cases classified as "recantations" (where a person recants the allegation made) and "improbables" (where the circumstances surrounding the allegation make it improbable that the alleged action occurred.) Forty percent (14 of 35) of cases sampled which were coded as recantations did not follow OIG procedures for closing such cases. In other cases, the victim did not actually recant the allegation. In 12 of the 35 cases (34 percent) the victim had an actual physical injury consistent with the initial allegation. In addition, 3 of the 7 cases coded as improbable should not have been closed as improbable. One did not contain information that clearly documented why the investigation was improbable. In another case coded as improbable, OIG investigators did not follow OIG procedures. In the third case, enough information existed to warrant further review. According to OIG officials, the practice of closing cases as recantations ended in Fiscal Year 1997.

OIG final case reports generally were thorough, comprehensive, and addressed the allegation. Only two case files that required a final case report did not contain one. Seven of the final case reports reviewed did not contain all of the required elements.

As in prior audits, we continued to find problems with documentation of supervisory review. We found that 54 percent (74 of 138) of the cases sampled over 60 days old were missing one or more of the required case status or 60 day reports. Of the cases that required a supervisory case review form, 8 percent (19 of 236) did not have the review form.

MEASURING THOROUGHNESS

Essential components of an abuse or neglect investigation include thoroughness in the collection of evidence, a clear and comprehensive final case report, and adequate supervisory review. The investigator's primary responsibility is to collect facts and information in order to accurately determine the manner in which the incident occurred. The type of evidence collected depends, to some extent, on the nature of the allegation. However, some types of evidence must be collected regardless of the allegation.

According to information from other states and professional journals, a thorough investigation, regardless of the nature of the complaint, should include the following elements:

- Interviews with all potential witnesses (or reason for not interviewing)
- Interview with alleged perpetrator
- Interview with alleged victim
- Signed written statements or documentation of the interviews
- Clinical history of the alleged victim
- Job history/performance of the alleged perpetrator
- Incident report
- List of all people interviewed
- Unit work schedule and/or work assignments
- Summary of any physical evidence that was collected
- Maps/diagrams of area

Investigations of allegations in which a physical injury was reported should also include the following items:

- Physical examination record/Injury Report
- Photograph of alleged injury

Some other types of investigations may also require that additional evidence be collected. For example if emotional abuse is alleged, a psychological report is required, and in cases of sexual abuse, a physical exam is also required. We found that the policies and procedures adopted by the OIG generally reflect the above criteria.

A well-written final report is essential to an effective investigation because it often provides a basis for management decision on the action warranted in the case. At the OIG the investigator's final report is reviewed by several levels of management who must "sign off" on the case before a recommendation is sent to the facility. Therefore, it is important that the final case report be clear and convincing to anyone who reads it.

Supervisory review is essential in determining if the OIG investigations meet their criteria. It is the responsibility of the OIG's supervisory staff to ensure that criteria for effective investigations are being met. Without adequate supervisory review and feedback, the quality of the investigations may suffer, and as a result, the effectiveness may be diminished.

INVESTIGATION THOROUGHNESS

Many case files lacked required documentary evidence. Of the case files reviewed, 122 (44 percent) were missing one or more pieces of required documentary evidence. Photographs were missing in 46 cases, diagrams were missing in 30 cases, and medical exams were missing in 21 cases. **Exhibit 3-1** summarizes the missing documentation. We noted a similar finding in our prior OIG audit in December 1994 where 26 percent of case files reviewed were missing required documentation.

Exhibit 3-1
EXAMPLES OF MISSING DOCUMENTATION

Document	Percent Missing	*Number Missing
Medical Exam	9%	21 of 225
Photos	46%	46 of 99
Diagrams	12%	30 of 255
Time Sheets	13%	33 of 257
Visitor's Log	15%	32 of 217
Progress Notes	7%	19 of 264
Restraint/Seclusion Monitoring Record	7%	4 of 60

Source: OAG analysis of 278 OIG abuse or neglect investigations closed in FY 1996.

Note: * Total does not equal 278 because required documentation was not applicable in all cases.

Certain initial investigatory steps taken shortly after an allegation becomes known are very important for an effective investigation. These steps include among others: taking an accurate initial written report of the allegation; completing a comprehensive physical examination report; and securing and/or sketching or photographing the scene of the incident. It is the facility's responsibility to collect this information. The investigator's primary responsibility is to ensure that the necessary information was collected in order to identify and clarify the manner in which the incident occurred. The collection of supporting documentation such as the incident report, photos, time sheets, progress notes, diagrams, injury reports, restraint/seclusion monitoring, and visitors logs are essential to completing a thorough investigation.

The OIG developed a checklist for collecting information required for abuse or neglect investigations. The checklist has been revised six times, most recently in April 1996. The OIG investigator is to obtain and review all the necessary documentation and complete the checklist for each investigation. In our previous audit we recommended that cases contain explanations for any missing documentation. Of the 278 cases tested during this audit, 44 investigation case files did not contain a checklist. Of these cases 23 were recantations or improbables. Of the cases that did contain a checklist, most contained an explanation of why the document was not applicable or not collected. The reasons for information not being applicable were taken into account in our following analysis of what required documentation was collected.

Office of Inspector General Comment:

OIG has concluded in FY-97 that the checklist should serve as a guide for each case rather than a list of what is required for every case.

In the following sections we summarize the case file documentation requirements and the number of investigations missing documentation. In some instances, we identify certain facilities which accounted for a large percentage of the missing documentation. In other instances, there were no individual facilities which accounted for a large percentage of the missing documentation. In some cases required documentation was not applicable.

Incident Reports

When an incident occurs, it is reported using a DMHDD-107 incident report form. All of the 278 cases sampled included a DMHDD-107 incident report form in the case file. However, some of the incident report forms were not fully completed. Of the 278 cases reviewed, 22 percent (61) were not fully completed. Examples of missing information included dates, times, and other demographic data such as age, sex, or race. We had a similar finding of incident reports not being properly or fully completed in our April 1996 program audit of DMHDD facilities' reporting of abuse or neglect.

Office of Inspector General Comment:
OIG will work with DMHDD facilities to resolve this issue.

Medical Exams

Nine percent (21 of 225) of the investigations we reviewed which involved an alleged injury were missing a medical examination form. As with the incident reports, several of the medical exam forms were missing vital information such as the type and severity of the injury. When a resident is injured, staff are to complete a DMHDD-108 medical examination form. This form is completed by a doctor and/or nurse and includes a description of the injury and its severity.

Photographs

Many cases with a visible injury were missing photographs of the injury. Photographs provide an accurate, objective representation of the existence or nonexistence of injuries sustained. Photographs are also important pieces of documentation in evaluating the evidence and, if necessary, helpful in responding to employee grievances resulting from disciplinary action taken when that allegation is confirmed.

Of the cases reviewed which contained a medical exam, 99 injuries were classified as having a visible injury, either trivial, mild, minor, moderate, moderately severe, or severe. In the cases where there was a visible injury, 46 percent (46 of 99) of the case files did not contain a photo of the injury. Two facilities, Chester MHC (11) and Elgin MHC (10), accounted for almost half of the cases that did not include photos of a visible injury.

The OIG requires photographs to be taken only if there is a visible injury. However, investigator manuals from some states, such as Wisconsin, Pennsylvania, and Texas suggest a photo be taken even if there is no visible injury. Wisconsin's policy states that photos are to be taken of all injuries which may have been the result of abuse even when no physical evidence appears to be present. Pennsylvania's policy is to take photos whenever possible. The investigation manual for Texas states that photos can be used to show the existence or nonexistence of an injury.

Office of Inspector General Comment:

To use a photograph to prove that an allegation has no injury would be time and cost prohibitive and meaningless to the investigation.

Diagrams of the Scene

A diagram of the scene of the alleged incident helps the investigator form a picture of the incident. It also provides information for the investigator to formulate questions and shows whether a witness could clearly see or hear what occurred. In 12 percent of cases (30 of 255) we sampled the file did not contain a diagram of the scene of the incident. Almost a third (9 of 30) of cases missing a diagram were from Kiley MHC. As of April 1996, diagrams were no longer required and are listed as optional information on the OIG checklist.

Time Sheets/Shift Logs

The OIG requires that investigations include time sheets or other certifications of employees working the shift and in the area at the time of the incident. These provide documentation of which employees were at work that day and in the area. The importance of collecting this information is that it can provide a resource of undisclosed or unidentified potential witnesses. Of the cases we sampled, 13 percent (33 of 257) did not have a record of who was at work that day and more importantly, who was in the area at the time of the incident. Two facilities, Chester MHC (14) and Kiley MHC (7), accounted for almost two-thirds of the cases that were missing time sheets.

Visitor's Logs

The OIG requires that a visitor's log be collected for each case. The visitor's log can alert the investigator to possible additional witnesses to the alleged incident. Of the cases we sampled, 15 percent (32 of 217) did not contain a visitor's log in the case file.

Progress Notes

Seven percent (19 of 264) were missing required progress notes for the victim. Progress notes are an ongoing record of the resident's stay at the facility. OIG policy requires

that they should be gathered at a minimum for three days prior to, the day of, and a day after the incident. Progress notes can sometimes provide clarification if the victim is unsure of the date and/or time of the incident and may also provide relevant data leading up to the incident.

Restraint/Seclusion Monitoring Records

If an alleged incident occurs and the use of restraints or seclusion of the resident is involved, a Restraint/Seclusion Monitoring Record should be collected. This record can indicate whether the seclusion/restraint was justified and whether applicable procedures were followed. The Record can also provide a source for undisclosed or unidentified witnesses in the case. Of the 60 cases we tested in which the incident involved the use of restraints or seclusion, 93 percent (56 of 60) contained the Restraint Seclusion Monitoring Record. Of the four cases that did not include a Restraint/Seclusion Monitoring Record, three were from the Chester MHC.

Initial Written Statements

Initial written statements were not taken from all potential witnesses. We tested whether the alleged victim, alleged perpetrator, and all persons listed on the DMHDD-107 incident report form completed initial written statements. In 18 percent (50 of 278) of cases sampled, not all persons listed on the incident report completed an initial written statement for the case. In 5 percent (14 of 278) of cases sampled, a victim did not complete an initial written statement. This does not include non-verbal victims. In 8 percent (21 of 278) of cases, the alleged perpetrator did not complete an initial written statement for the case.

OIG Interviews

In 11 percent (31 of 278) of cases, OIG staff did not interview either the victim, the alleged perpetrator, or other eye witnesses. Four of the 31 cases were investigations of recantations or improbable occurrences (see following section). The remaining were cases where full investigations and case reports were required. Four facilities accounted for two-thirds of these 31 cases. These facilities were Alton (6), Chester (5), Howe (5), and Kiley (5).

Office of Inspector General Comment:

OIG policy does not require interviews by OIG if the initial written statements taken by the facility contain sufficient information.

Auditor's Comment: OIG policy did require interviews for certain cases, such as recantations and improbable investigations.

Recommendation Number Four:

The Inspector General should take the steps necessary to ensure that all required documentation is collected during the investigation process and that a documentation checklist is completed for all investigations. In addition, the Inspector General should follow-up with investigators or the individual facilities where required documentation is not being collected and take the necessary corrective action.

Office of Inspector General Response:

The OIG will take steps to ensure there is a case-by-case determination regarding relevant documentation that is deemed necessary to collect. With the 1-hour reporting requirement the OIG investigator will determine the necessary documents for the facility investigator's collection of those documents. Within OIG, the new supervisory review process focusing on completeness of the investigation will address this issue; however, it must be noted that OIG does not supervise facility investigations.

RECANTATIONS AND IMPROBABLE OCCURENCES

The OIG improperly closed some cases without conducting a thorough investigation. These were cases classified as "recantations" (where a person recanted the allegation made) and "improbables" (where the circumstances surrounding the allegation make it improbable that the alleged action occurred). Forty percent (14 of 35) of cases sampled which were coded as recantations did not follow OIG procedures for closing such cases. In other cases, the victim did not actually recant the allegation. In 12 of the 35 cases (34 percent), the victim had an actual physical injury consistent with the initial allegation. In addition, 3 of the 7 cases coded as improbable (43 percent) should not have been closed as improbable. One case did not contain information that clearly documented why the investigation was improbable. In another case coded as improbable, OIG investigators did not follow OIG procedures. In a third case closed as improbable, a patient satisfaction survey identified complaints that staff were yelling at residents and swearing. Enough evidence existed in this case to warrant further review.

Closure of Recanted Cases

The OIG established policies and procedures in August 1995 to close cases that were recanted. Since being established, this procedure was updated and changed on three occasions. According to its procedure, the OIG investigated all allegations of abuse or neglect. However, case reports were not required in cases where the allegation has been recanted and there were no reasonable leads to conduct an investigation. For a case to be closed as a recantation:

- The OIG investigator must have determined that the allegation has been recanted;
- The OIG investigator must have interviewed or at least attempted to interview the alleged victim;
- If the alleged victim was not the reporter of the allegation, the reporter also had to be interviewed by the OIG investigator;
- The victim could not have an injury consistent with the allegation; and
- There were no affirming witnesses.

In our review of 278 abuse or neglect investigations we found that 35 (13 percent) cases were classified as a recant. On the average these cases took 38 days to complete, which is well below the 60 days recommended by DMHDD policy.

We identified at least three other cases that conveyed in the recommendation memo that the case had been recanted by the victim. These cases were reported prior to the OIG's establishment of the policy for recanted cases and were fully investigated.

Of the 35 recant investigations sampled, 14 (40 percent) did not follow the OIG procedures for a recant: in 12 cases the victim had an injury consistent with the allegation, one of which also had no interview with the reporter; in one case the victim was not interviewed by the OIG; and in one case the reporter was not interviewed by the OIG. In other cases, the victim did not actually recant the allegation. Also, of the 35 files, five of the required case closure forms did not contain the required supervisory and management signatures for approval.

We noted that the use of the recant was more prevalent at some facilities than others in the cases we sampled. Kiley DC accounted for 10 (29 percent) of the 35, Choate MHDC had 6 (17 percent), and Howe DC and Jacksonville DC each had 5 (14 percent).

We also examined the entire population of cases closed in Fiscal Year 1996 for trends in closing cases as recantations or improbables. We note that at certain facilities there is a higher incident of these cases at the end of the fiscal year. Within the entire population of abuse or neglect investigations closed, Choate MHDC closed five cases during the last two months of the Fiscal Year as a recantation or improbable. Kiley DC closed 13 recantations from March 20, 1996 through the end of the Fiscal Year, nine within a two day period in March 1996. At Jacksonville DC, 38 percent of all cases closed during Fiscal Year 1996 were recantations. Jacksonville also closed four straight recantations during the last month of Fiscal Year 1996.

In some cases, we found that cases coded as recants were those in which the victim did not actually recant. These cases contained interviews in which the victim said "I want to take it back - it was my fault" or staff did grab me around the neck "just to keep me from hitting him and someone else" or the allegation actually happened, but it was an accident. Some of the Recantation Report Forms explain the reasons for the recant as the recipient has made 14 allegations of abuse over the past 18 months and none were substantiated or this resident has a long history of reporting staff abuse.

The OIG policy does not define "recant". According to The American Heritage Dictionary, the definition of recant is: "To make a formal retraction or disavowal of (a statement or belief to which one has previously committed oneself)." Those cases in which the residents state that the incident actually happened, but was their own fault or was an accident, do not meet the definition of recant. They are still saying the incident actually happened, but are placing the blame on themselves or accidental means. If a resident is injured by a staff person and the resident stated it was accidental, the case should still be investigated by the OIG according to its own criteria. Also in these cases, residents may be changing their account of what happened based on peer or employee pressure. Consequently, it is important that due care is taken in the investigation of these cases.

Closure of Improbable or Uninvestigatible Occurrences

The OIG also established policies and procedures in July 1994 to close cases that were either improbable or uninvestigatible. The procedure stated that the OIG investigate all allegations of abuse or neglect which have any reasonable likelihood of being possible and have a potential for investigation. If an allegation was made which appeared clearly unlikely or uninvestigatible, it could be closed. An example of an improbable case would be a resident alleging that a staff person beat her during a time period when that staff person was not working.

For a case to be closed as improbable or uninvestigatible:

- The OIG investigator must have interviewed the alleged victim; and
- If the alleged victim was not the reporter of the allegation, the reporter also had to be interviewed by the OIG investigator.

In our review of 278 abuse or neglect investigations, we found seven cases coded as improbable. Three of the seven cases (43 percent) coded as improbable should not have been closed as improbable. One did not contain information that clearly documented why the investigation was improbable. In this case a resident witness corroborated the allegation of the victim. However, the alleged victim refused to grant an interview to the OIG. In another case coded as improbable, investigators did not follow OIG procedures. In this case the victim was not interviewed by the OIG. In a third case closed as improbable, a patient satisfaction survey identified complaints that staff were yelling at residents and swearing. Enough evidence existed in this case to warrant further review. Therefore, these cases should not have been closed as improbable. Also, one of the seven cases did not contain all of the required signatures for approval. These cases on the average took 31 days to complete.

Issues Regarding Recantation and Improbable Cases

Two issues emerge from these cases. The first is whether separate policies regarding the amount of evidence and other investigative procedures are needed for different case

categories. OIG policies for standard investigations require the collection of evidence based on the needs of each case. For example, photos are not required for allegations of verbal abuse because they would not add in determining whether or not the allegation is substantiated. Different policies and procedures for sub-categories of cases are not necessary or warranted because information not appropriate for any case is already excluded from the case requirements. The effect of creating separate policies may result in the closure of cases without thorough investigations.

Secondly, even though the OIG's required documentation for recants and improbables was less stringent than those for a standard investigation, the OIG did not even follow those procedures. As stated earlier, some cases were closed as recantations even though the person did not actually recant the allegation or where injuries were consistent with the allegation. Supervisory case review is not adequate if cases inconsistent with policies are allowed to be closed.

The determination of whether a case is a recant or an improbable is a conclusion that should come after an investigation is completed. By making a decision that a case is a valid recant or improbable without taking all necessary investigatory steps may well result in the inappropriate closing of cases. According to OIG officials, the policies concerning recants and improbables were discontinued in Fiscal Year 1997, which occurred after our testing period. We plan to follow up on this in our subsequent audit.

Recommendation Number Five:

The Inspector General should implement controls necessary to ensure that all appropriate and necessary evidence is collected in investigations of resident abuse or neglect.

Office of the Inspector General Response:

Since this recommendation follows the section on Recantation and Improbable Cases, the OIG is making the assumption this recommendation only applies to those types of cases. In early FY-97, OIG abolished the procedure for closing cases which are deemed improbable or where a recant has occurred.

FINAL CASE REPORTS

A well-written final report is essential to an effective investigation because it provides a basis for management decision on the action warranted in the case. At the OIG the investigator's final report is reviewed by several levels of management who must "sign off" on the case before a recommendation is sent to the facility. Therefore, it is important that the final case report be clear and convincing to anyone who reads it.

Several elements must be contained in a report to make it an effective tool to communicate the results of the investigation. The report must:

- Include a description of the alleged incident
- Summarize the investigative procedure (the methodology)
- Summarize the evidence gathered
- Attend to differences in witness testimony
- Include the investigator's conclusions
- Include a conclusion which addresses the allegation

Final case reports reviewed were generally thorough. We reviewed the final case reports to determine if each report contained a description of the alleged incident, a summary of the investigative procedure, a summary of the evidence gathered, attention to differences in testimony, a conclusion, and whether the conclusion addressed the allegation.

Of the 278 case files tested, 44 did not contain a final case report for the investigation. Of these 44 cases, 42 were closed as either improbable or a recantation. A final case report was not required for a case closed as improbable or recantation. Therefore, only two case files which required a final case report did not have the required report.

We also tested final case reports for required elements such as whether they contained a description of the incident, methodology, summary of evidence, investigator's conclusion, and whether the conclusion addressed the allegation. Of the cases that did contain a final case report, seven did not contain all of these elements. All seven of these were cases that were opened in 1994.

CASE REVIEW AND MONITORING

We continue to find problems with supervisory review of case files and monitoring of open investigations similar to those noted in our prior audits. Each OIG investigation is to be thoroughly reviewed prior to submission to the facility, and the reviewer is to complete a standardized case review form for each case indicating irregularities or issues that were noted during the review. For cases that take over 60 days to complete, the investigator is to complete a 60-Day Status Report to document the efforts being made to complete the case.

Supervisory Review

The OIG supervisors have an important role in that they are the ones who review cases to determine if OIG investigations are completed in a timely and thorough manner. According to the OIG procedure manual, each OIG investigation will be reviewed by a designated reviewer before the case is submitted to the facility. The reviewer is to make certain that each case meets the standards for completeness, format and investigatory content.

OIG supervisors are required to review each investigation within three working days of receipt. The reviewer completes a case review form for each investigation checking for the following elements:

- Is supporting documentation and checklist attached?
- If the case is substantiated, is contingent documentation attached?
- Is specified optional documentation attached?
- Were all key people interviewed and were all pertinent questions covered? (This includes residents.)
- Is the format of the investigator summary in accordance with (OIG) procedures?
- If additional issues were uncovered during the investigation, were they adequately investigated, documented and addressed?
- Is the body of the report clear, concise and complete?
- Are there any grammatical/spelling errors?
- Is the cover memo in conformance with (OIG) procedures and consistent with the content of the investigator summary?

In addition, if reviewers have substantive questions or concerns about the summary or the cover memo, they return the case summary to the investigator with comments and directions, or contact the investigator by telephone to discuss the issues.

Of the 236 cases that required a case review form, 19 (8 percent) did not have the review form. Without completing a supervisory case review, there is no assurance that investigations are being performed in a thorough and effective manner. We therefore could not determine to what extent the cases had been reviewed. In some cases, missing documentation was not noted in supervisory case reviews.

60 Day Reports

Fifty-four percent of the cases (74 of 138) that required either 60 Day Reports to Supervisor or 60 Day Status Reports did not contain all the required reports. These reports were required in all cases over 60 days old in order to document the reason for the investigation delay. During the audit period this process changed. Initially the process required the investigator to submit a 60 Day Report to Supervisor on the 15th of every month. Of the 61 cases that contained a 60 Day Report, 27 (44 percent) were not submitted by the 15th of that month. The OIG changed this policy during Fiscal Year 1996 to require 60 Day Status Reports in which the investigator records a daily entry. This report is not sent to the supervisor until the investigation is completed.

The 60 Day Report to Supervisor was the only review completed while the investigation was on-going and did not document the name or date of any supervisory review. Some of the problems we noted with the 60 Day Reports to Supervisor were:

- Most reports did not contain detailed descriptions of problems or concerns; and
- There was no indication of a date or signature for supervisory review. We could not determine if the reports were reviewed.

In a sample of cases that took more than 200 days to complete we found reasons cited in the status reports were general and vague such as "Investigation in progress" and "Needs complete investigation". Some comments were more specific such as "Need to interview 5 persons". One report stated that the initial statements were wrong and additional follow-up was needed. Another report stated that the investigation had not been started. We note that sometimes the investigation is delayed at the initiation, and sometimes the case takes months for the case report to be written up and then typed.

If investigations are not adequately reviewed and monitored for progress, cases may not be completed in a timely manner or thoroughly investigated, and final reports may be incomplete.

Recommendation Number Six: ***The Inspector General should ensure that adequate supervisory review occurs on OIG investigations. All investigations should be reviewed for thoroughness and a case review form completed when required. Further, case status reports should be completed within required time frames, document the reasons for investigation delays, and be reviewed and signed by a supervisor.***
Office of Inspector General Response: In early FY97, the supervisory case review process was revised to include a review for thoroughness and overall quality of the investigation. OIG has increased supervisory involvement throughout the investigation of the case.

ACTIONS, SANCTIONS, AND RECOMMENDATIONS

Chapter Four

CHAPTER CONCLUSIONS

The Office of the Inspector General does not recommend corrective actions in substantiated cases. The individual facilities decide what corrective action to take in response to a substantiated case. The Inspector General does not have the authority to require facilities to take corrective action against employees, according to OIG officials. In the 278 employee abuse or neglect investigations we reviewed, at least 34 employees were either reprimanded, suspended, discharged, or resigned.

Of the 278 investigations we reviewed, the OIG substantiated abuse or neglect in 17 cases. Facilities took administrative action, such as suspensions or terminations, against employees in 13 of the 17 cases. However, in the remaining four cases, the facilities disagreed with the findings and provided additional information after the conclusion of the investigation. This caused the OIG either to downgrade its original finding of abuse or neglect to a lesser finding or to accept the facility action taken and close the case even though the facility did not take administrative action against the employees. In two of the four cases, the facilities took no action against the employees.

The OIG conducts annual unannounced site visits to each facility. The site visits may help the OIG focus on issues which are the underlying cause of abuse or neglect. The OIG may also recommend sanctions against a facility to DMHDD or the Department of Public Health.

IMPORTANCE OF CORRECTIVE ACTION

An investigation is far less likely to have an impact on patient safety if corrective action is warranted, but none is recommended or taken. Professional literature states that direct care staff usually know when one of their colleagues is willfully neglecting or abusing residents. It further states that staff looks to management to resolve the situation and will lose confidence if the situation is not handled properly. Therefore, it is important that corrective actions be carried out.

Office of Inspector General Comment:

Since OIG does not have access to individual personnel files of employees, determining corrective action without specific knowledge of employees' work history, training history or previous disciplinary action could create an arbitrary and legally unsound system of implementing corrective action. However, OIG maintains an informal involvement of providing input for disciplinary action.

Recommendations for Corrective Action

The OIG does not make specific recommendations to facilities concerning corrective actions. After an investigation is completed, the OIG sends a recommendation memo to the facility concerning the findings of the case. The recommendation memos generally describe the incident and state the finding, but leave it to the facility to determine what, if any, corrective actions are taken. Most recommendation memos to facilities contain the following paragraphs:

> "Please review the findings and notify this office of your actions on this case as soon as possible. If disciplinary action is being considered, you may notify us after the process has been completed. If there is any subsequent change in action taken, please notify us of the change as well.
>
> Upon receipt of your response, this office will consider closure of this case file. After closure is accepted, please notify any accused employee(s) of the closure of the investigation."

The OIG requires documentation of actions taken by facilities. They maintain records of the actions taken by the facilities for each case. The corrective actions fall under one of the OIG's recommended categories:

Administrative Action Toward Staff - This includes the full range of disciplinary, counseling and training actions. It may relate to more than one staff person.

Administrative and Other Action - This includes situations in which more than one action is taken, one is related to at least one staff person and the other is not related to any specific staff person.

Other Action - This includes all action which is not directed at one or more staff. Examples of such actions include changing the unit of a person receiving services, requesting additional supervision for a person receiving services, obtaining locks for cabinets, rewriting a policy for clarification, and creating a review process.

No Action - This recommendation is appropriate when the findings of the case indicate nothing happened or what happened was not preventable (an accident).

Closed With Referral To - If action taken was to refer the case to another bureau for investigation/action, this item is selected and the bureau to which the case is referred is identified.

According to OIG policies for coding data entry, the corrective actions taken should mirror the category of the action recommend by OIG. However, since the OIG does not recommend specific action, we were unable to determine with certainty whether the OIG recommendation and corrective actions taken were consistent. The OIG is not always consistent in coding its cases according to the type of recommendation and action taken. For instance, facilities often fail to take initial written statements in the proper manner. For an investigation at Shapiro Developmental Center, OIG recorded the finding as "no employee misconduct." When the Chicago Read Mental Health Center committed this very same error, the OIG coded it as "administrative issue other than employee misconduct" in their records. Inconsistent coding results in inconsistent data that is used for case tracking and reporting.

Action taken by facilities against staff guilty of a similar violation is inconsistent. For instance, in one case, a DMHDD employee failed to report an incident in a timely manner. She received a 5-day suspension. In another case when an allegation was not promptly reported, the staff person received counseling from the facility. The lack of specific recommendations may contribute to inconsistent actions taken by facilities for the same infractions.

Exhibit 4-1
CORRECTIVE ACTION TAKEN BY FACILITIES

Action Taken	Number of Employees
Counseled	11
Written Reprimand	6
Trained	2
Suspension	
1 Day	3
3 Day	3
5 Day	4
7 Day	1
10 Day	1
15 Day	1
20 Day	3
30 Day	2
Pending Discharge	2
Discharged/Terminated	5
Administrative leave pending pre-disciplinary meeting	1
Multiple Actions against one employee	3
Employee resigned	3
Total	**51**

Source: OAG analysis of 278 OIG investigations.

CORRECTIVE ACTIONS

Although the Office of the Inspector General does not recommend to the facilities the type of corrective actions that should be taken against an abusive or neglectful staff member, the OIG requires the facility to inform it of the disciplinary actions taken. The OIG then keeps a record of any applicable action that was taken against the perpetrators in the case file. According to OIG and DMHDD officials, the OIG does not have the authority to require facilities to take corrective actions against employees. The OIG

is required to provide a complete report of substantiated abuse or neglect cases to the Director of DMHDD.

For the 278 abuse allegations we sampled, **Exhibit 4-1** shows corrective action taken against employees which the OIG coded as administrative action or administrative and other action. Some corrective action resulted from facilities disciplining employees found by the OIG to have abused or neglected residents. In other cases the abuse allegation may not have been substantiated, but the facility took action against an employee based on a concern raised by the OIG after an investigation was conducted. Thirty-four employees were either reprimanded, suspended, discharged, or resigned.

Not all corrective actions resulted from substantiated abuse investigations. However, they accounted for all five of the staff discharged or terminated, the two suspensions pending discharge and two of the three employee resignations. One of the 30-day suspensions, one of the 20-day suspensions, and the 10-day suspension also resulted from substantiated abuse or neglect cases.

Substantiated Abuse Cases

Of the 278 cases sampled, the OIG investigations substantiated abuse or neglect in 17 cases. As shown in **Exhibit 4-2**, facilities took administrative action against employees in 13 of the 17 cases. Such administrative action included suspensions and terminations.

In the remaining four cases where the OIG investigation substantiated employee abuse or neglect of a facility resident, the facility either took less severe action against an employee (such as counseling) or took no action at all. The facilities disagreed with the OIG findings and provided additional information after the investigation was completed which caused the OIG either to downgrade its original finding of abuse or neglect to a lesser finding and to accept the facility action taken (two cases) or to close the case even though the facility did not take administrative action against the employee (two cases). The following are examples of these cases.

Exhibit 4-2
LEVEL OF ACTION TAKEN FOR 17 SUBSTANTIATED ABUSE OR NEGLECT CASES

Level of Action Taken	Number of Cases
Administrative Action Taken	13
Less Severe Action Taken	2
No Action Taken	2

Source: OAG Analysis of 278 investigations

In one case in which the finding was downgraded, the OIG found that a staff member had picked a resident up and slammed him to the floor. Although the incident was witnessed by four people on the unit, the facility did not concur with the finding. The facility provided the perpetrator with counseling and instruction regarding the need to clearly assess a situation prior to responding. The OIG downgraded the severity of the case from substantiated abuse to other employee misconduct. When questioned about the outcome of the case, OIG officials responded that the case was originally substantiated by a slight preponderance of evidence. The facility sent a response providing additional information that weighted the evidence in a different direction, so the OIG decided to change the case finding. We reviewed the facility

response and found that it stated the facility did not agree with the conclusion that the Mental Health Technician physically abused two residents. The facility argued that being inappropriately slammed to the floor surely would result in some injury but no injuries were found other than bruising to the resident's biceps. The facility argued that the other resident was not physically abused because he was examined by a physician who found no injury. The facility did acknowledge that both residents were taken to the floor by the employee.

In an example in which the OIG closed the case with no action taken, a female resident was sexually assaulted by a male resident known to have a history of sexual aggressiveness. The facility placed the male resident beside the front desk so he could be closely observed. The OIG found two facility staff guilty of neglect in their failure to closely observe the male resident. The facility took no action in this case. Facility officials argued that the imposition of discipline would be unfair and not timely since the incident occurred 11 months before the OIG issued the finding. The OIG responded by downgrading the finding in its records from substantiated neglect to no employee misconduct. When questioned about the outcome of this case, OIG officials responded that the case was originally founded as neglect based on the facility's failure to assign one staff person to supervise the male resident at all times. However, this type of close supervision requires a physician's order. Since there was no physician's order for this resident, he was not officially on close observation.

Office of Inspector General Comment:

The facilities did not take action; rather, they presented valid reasons why they disagreed with OIG's position and identified investigative errors.

Substantiated Other Employee Misconduct

In 22 cases "other employee misconduct" was substantiated. **Exhibit 4-3** shows that in 5 cases the corrective action taken was less severe than in the other 16 cases. And in one case no action was taken against the employee.

Exhibit 4-3
LEVEL OF ACTION TAKEN FOR 22 SUBSTANTIATED CASES OF OTHER EMPLOYEE MISCONDUCT

Level of Action Taken	Number of Cases
Administrative Action Taken	16
Less Severe Action Taken	5
No Action Taken	1

Source: OAG analysis of 278 investigations.

The OIG finding of employee misconduct includes any finding in which one or more staff people are identified as responsible for what occurred or failed to occur. Examples of employee misconduct include actions such as staff failing to examine a resident after an allegation of physical abuse, an employee threatening another employee if she reported an allegation of abuse, and an employee failing to document a resident behavioral episode in the resident's records.

Recommendation Number Seven:

The Inspector General should monitor action taken by the facilities for consistency. The Inspector General should refer to the Director of DMHDD cases where the corrective action taken by facilities is not consistent with the finding of the OIG investigation. For cases in which the facility provides additional information to overturn the finding, the Inspector General should document why the finding was changed.

Office of Inspector General Response:

Actions taken by the facilities regarding disciplinary measures are monitored by the Labor Relations staff of the Department of Mental Health and Developmental Disabilities to ensure the corrective action is consistent with the finding of an OIG investigation and prior history of the employee. The case file contains the additional information provided which results in overturning the finding. The draft administrative rule requires the Inspector General document in the final report, response to requests for reconsideration based on additional information submitted.

SANCTIONS

The OIG has not issued sanctions against any facility during the last two years. In addition, the OIG has not developed formal written criteria to determine when sanctions should be recommended. The Act (210 ILCS 30/6.2) gives the Inspector General broad authority to recommend sanctions. Sanctions are intended to protect residents of DMHDD-run facilities and include actions such as closing a facility, transferring or relocating residents or appointing on-site monitors.

While no facilities were sanctioned during the last two years, the OIG has recommended sanctions prior to that. During Fiscal Year 1993, sanctions were implemented against three facilities regarding labor management training and environmental conditions. In Fiscal Year 1992, the OIG appointed on-site monitors at two facilities.

The Act does not clearly define when and under what circumstances a sanction should be issued by the OIG. By clearly defining criteria or occurrences where a sanction should be considered, and formalizing the process for issuing a sanction, the OIG could clarify and strengthen its role in ensuring the safety of residents in State-operated facilities.

Recommendation Number Eight:

The Inspector General should develop specific criteria for sanctions and implement them as necessary.

Office of Inspector General Response:

As noted in the OAG's FY-94 audit, these instances of "sanctions" were not as a result of abuse investigations. OIG has never needed to use sanctions to ensure some actions were taken as a result of allegations of abuse or neglect. Since the term "sanction" has never been defined, it is difficult to identify when and how sanction activity occurred. The OIG maintains that it is not within OIG's purview to define "sanction" in the statute as the legislative intent is unknown. OIG is willing, however, to participate in discussions with appropriate parties to define this term and develop criteria for such.

SITE VISITS

The OIG is conducting annual unannounced site visits of all facilities as required by 210 ILCS 30/6.2. The site visits usually last between two days and a week and include meeting with patients, reviewing progress notes, behavior plans, restraint records, following patients on their daily routines, observing interactions between staff and patients, and meeting with various facility personnel.

The OIG is currently developing a protocol for conducting the visits. According to the OIG, the goal of the site visit is to address issues related to the prevention of abuse or neglect which are consumer-focused and outcome-based.

Exhibit 4-4
EXAMPLES OF OBSERVATIONS NOTED IN OIG SITE VISITS

Comments:
"I would recommend additional staff for this facility to enable more focus on individual needs." "Treatment plans are focused on problems. Strengths of individual(s) are seldom identified."
"I observed some problems of communication between staff and patients because of language (differences)..." "I recommended that pictures of patients be taken and put into charts for identification and to prevent errors at medication time."
"I found a lot of 'institutional behavior' on the part of staff i.e. ordering of residents around, pulling them, herding them from one place to another, talking about them as if they were not in the room."
"The lack of transportation continues to be a barrier that prevents individuals from going into the community for shopping and activities."

Source: OIG site visits conducted in Fiscal Year 1996.

Currently, the site visit information is shared with facility administrators and OIG officials. The OIG also meets with representatives of advocacy groups in order to ask for input

regarding the site visits. **Exhibit 4-4** illustrates the types of observations made in unannounced site visits conducted by the OIG.

OTHER ISSUES

Chapter Five

CHAPTER CONCLUSIONS

OIG investigators have not received the training required by OIG policy. Of the 19 OIG investigators, 11 were lacking 5 or more of the required courses.

Untrained facility staff collected preliminary investigation evidence, contrary to OIG policy. Of the 2,299 written statements reviewed, 321 (14 percent) were taken by facility staff untrained in the required Basic Investigations Course. Furthermore, the OIG frequently found problems with the facilities' collection of the initial evidence. In 110 of the 278 investigations we reviewed (40 percent), the OIG noted a problem with the facilities' collection of preliminary evidence.

OIG investigators do not investigate all cases of alleged abuse as defined by the Act. "Abuse" is defined by the Act to be any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. DMHDD's reporting policies define abuse as mistreatment of a service recipient by an employee. OIG staff investigate alleged abuse or neglect of a resident by an employee. Facility staff investigate non-employee abuse cases. OIG personnel review these facility investigations. However, there is no policy or control to ensure that facility investigations of abuse are conducted in a consistent manner.

The OIG's investigations of alleged incidents of abuse or neglect that occur at community agencies are different in style and content than the investigations conducted at State-operated facilities. There was no established protocol or procedure for the conduct of investigations at community agencies.

The OIG had inadequate controls over its Investigations Log database and in the past has reported inaccurate information to the General Assembly. There were weaknesses within the database and its environment which affected the reliability of the data used to record and track reported incidents of abuse or neglect. We identified weaknesses in data integrity, systems and programming, and a general lack of documentation and change controls.

OIG INVESTIGATOR TRAINING

OIG investigators are not receiving the training required by The Abused and Neglected Long Term Care Facility Residents Reporting Act (Act) and OIG policy. The Act requires the OIG to establish a comprehensive program to ensure that every person employed or newly hired to conduct investigations shall receive training on an on-going basis concerning investigative techniques, communication skills, and the appropriate means of contact with persons admitted or committed to the facilities under the jurisdiction of the Department.

To conduct an effective investigation, OIG investigators must be adequately trained. The criteria for OIG investigator training are clearly defined in OIG's policies and procedures. As of July 15, 1994 all OIG investigators were required to receive the training courses in **Exhibit 5-1**.

As of June 30, 1996, two of the nineteen investigators had received all the training required by OIG policy. The other 17 investigators were missing between 1 and 12 of the required courses, as shown on **Exhibit 5-2**. Eleven investigators were lacking 5 or more of the required courses.

The majority of the required courses are not conducted by OIG staff. Instead, each OIG investigator receives these courses at a facility.

Exhibit 5-1
INVESTIGATORY TRAINING REQUIRED FOR OIG INVESTIGATORS

Basic Investigatory Training
Advanced Investigatory Training
Active Treatment
Communications
CPR
Habilitation/Treatment Planning Process
Hearing Impairment
Introduction to Developmental Disabilities
Introduction to Mental Illness
Legal Issues
Leisure Time Activities
Mental Health Needs of People with Mental Retardation
Positive Interactions
Restraints
Aggression Management I-IV

Source: OIG Procedure Manual (Procedure #104)

Exhibit 5-2
NUMBER OF INVESTIGATORY COURSE DEFICIENCIES BY OIG INVESTIGATORS

Number of Courses Needed	Number of Investigators
None	2
1-4 courses needed	6
5-9 courses needed	7
10-12 courses needed	4

Source: OAG analysis of OIG data.

In November 1995, the OIG added two more courses, Abuse/Neglect of Residents and Drug-Free Work Place, to the list of requirements. The OIG has also provided additional training for its investigators. The OIG recently trained all investigators in The Reid Technique of Interviewing and Interrogation on June 18-20, 1996. The Reid training is nationally

recognized as a method which is highly successful in eliciting confessions and identifying deception. The Inspector General said that this will not replace current interviewing techniques, but will be another tool that investigators can use in some cases. While an additional course is useful, investigators lacking core training courses may be lacking the skills necessary to conduct investigations in a fully effective manner.

Recommendation Number Nine:

The Inspector General should ensure that every person employed or newly hired to conduct investigations receives the required investigatory training courses as established by OIG policy.

Office of Inspector General Response:

During the audit period, OIG policy specifying required courses was modified. Such modifications are likely to be continuous because of the inclusion of additional mandates within the Department and within the OIG. Five of the courses noted as deficiencies have been deleted from the mandate list as irrelevant to maintaining professional investigative techniques (for example, the course entitled "Leisure Time Activities").

Auditor's Comment: It is unclear when the policy specifying the required courses was modified. Policies provided by the OIG in September 1996, still contain these courses.

TRAINING OF FACILITY STAFF

Untrained facility staff are collecting preliminary investigation evidence, contrary to OIG policy. OIG policy requires that at the scene of an alleged incident of abuse or neglect, a trained facility designee is to follow initial investigative procedures. The trained facility staff should secure the scene and collect relevant physical evidence, including items such as progress notes, restraint records, assignment sheets, and photographs of visible injuries. Also, according to OIG policy, facility staff can take initial written statements if they have been trained in basic investigations. If staff have not been trained in basic investigations, OIG field investigators are responsible for ensuring that initial written statements are obtained.

In our review of 2,299 written statements, we found that 321, or 14 percent, were taken by facility staff not trained in the Basic Investigations Course. Eighty-four percent of the statements were taken by either OIG investigators or trained facility staff. It could not be determined who took the remaining written statements.

At some facilities, all staff taking initial witness statements were trained. These facilities included Chicago-Read, Fox, Lincoln, and Singer. At other facilities, however, untrained staff took written statements on a regular basis. At Elgin and Howe, over 35 percent of the facility staff taking statements were untrained.

Furthermore, in OIG's review of investigations of abuse or neglect, the OIG frequently noted problems with the facilities' collection of the initial evidence. In 110 of the 278 cases sampled (40 percent), the OIG noted a problem with the facilities' collection of preliminary evidence.

In one case reviewed, the facility requested training in the area of taking written statements. OIG officials responded to the request by saying that "retraining of all facility staff responsible for obtaining initial written statements is an option for the future" and recommended that "all appropriate staff be asked to review their manuals."

In our April 1996 audit of DMHDD facilities' reporting of resident abuse or neglect, we concluded that additional training of facility staff on the reporting of abuse or neglect was needed. The April 1996 audit recommended that the Department review and revise its current training requirements related to the reporting of abuse or neglect to address identified reporting problems.

The Abused and Neglected Long Term Care Facility Residents Reporting Act requires the OIG to establish and conduct periodic training programs for Department employees concerning the prevention and reporting of neglect and abuse. The OIG does not conduct training at Department facilities in the prevention and reporting of abuse or neglect. The Department provides a basic course, "Preventing and Identifying Recipient Abuse and Neglect," which is provided by DMHDD's central office. Most employees at facilities had received this basic course, according to data provided by DMHDD.

Office of Inspector General Comment:

Training in the Reporting of Incidents is completed via facility-provided programs at each facility. Continuous feedback systems for prevention efforts comes from specific cases, in compliance studies, and in under-reporting audits. All these actions feed a remedial, corrective system of learning that, while not conducted in a classroom, certainly qualify as training, and may be far more effective in reducing incidents of abuse and neglect.

During the course of this audit, the OIG began to provide training to facility staff related to the collection of initial written statements. The OIG had developed an outline and tentative schedule for a two-day course that includes training at each facility by the end of Fiscal Year 1997. As of the end of Fiscal Year 1996 staff at two of the twenty facilities, Alton and Chester, had received the training.

The proper collection of evidence is a critical component of an abuse investigation. Having facility staff who are untrained in the proper methods of evidence collection could impair the overall effectiveness of the OIG investigation.

Recommendation Number Ten:

The Inspector General should ensure that all DMHDD employees involved in the reporting and collecting of initial evidence of resident abuse or neglect receive required training.

Office of Inspector General Response:

A major training campaign was initiated in FY96 to conduct an in-service training for the conduct of initial written statements at every facility and is ongoing. The basic investigatory course is being provided as a major component to this two-day training program conducted by OIG. By April, 1997, all staff identified by the facility as those who obtain initial written statements will be trained.

FACILITY ABUSE INVESTIGATIONS

The Office of the Inspector General is not ensuring that all investigations of abuse or neglect are being conducted in a thorough and consistent manner. The Abused and Neglected Long Term Care Facility Residents Reporting Act states that the "Inspector General shall investigate reports of suspected abuse or neglect **(as those terms are defined in Section 3 of this Act)** of patients or residents in any facility operated by the Department . . . ." (emphasis added). The 1995 revisions to the Act added the language that the OIG is required to investigate reports of suspected abuse or neglect as those terms are defined in the Act. "Abuse" is defined by the Act to include any physical injury, sexual abuse, or mental injury inflicted on a resident other than by accidental means. "Neglect" occurs when the failure to provide adequate medical or personal care results in a physical or mental injury or causes the resident's physical or mental condition to deteriorate.

OIG investigators do not investigate all cases of alleged abuse as defined by the Act. DMHDD's reporting policy defines abuse as "mistreatment of a service recipient by employees." Consequently, OIG staff only investigate alleged abuse or neglect of a resident by an employee. If the alleged abuse was caused by another party, DMHDD policy does not classify it as abuse. For example, DMHDD policy classifies a non-accidental injury inflicted on a resident by another resident not as abuse but as a reportable injury. Under the Act, such an incident would be considered abuse. In Fiscal Year 1996, the OIG reported receiving 3,984 incidents involving non-accidental injuries inflicted by another person.

Office of Inspector General Comment:

The audit comments reveal the auditor's opinion about responsibility ownership of recipient to recipient injuries. Reserving the authority to accept and close a facility-conducted investigation has been the key element of OIG control. The selection, training, timeliness expectations, and supervision of the facility employees used to conduct investigations was placed under facility leadership several years ago; however, the Auditor General has failed to identify this in previous audits.

Auditor's Comment: As noted in the report text, the 1995 revisions to the Abused and Neglected Long Term Care Facility Residents Reporting Act clearly give the OIG the responsibility for investigations of all abuse allegations.

According to an OIG official the facilities are responsible for investigating all incidents other than employee abuse or neglect of residents. When the incident is discovered, the facility is required to notify the OIG. The OIG reviews the incident report, and if there is no indication of employee abuse or neglect, the facility investigates the case. Upon completion of the facility investigation, a copy of the investigation file is sent to the OIG for review and approval to close the case.

Presently, there is no policy or control to ensure that facility investigations of abuse or neglect are conducted in a consistent manner. DMHDD policy requires that each facility have detailed procedures for reporting and investigating abuse allegations. DMHDD policy does not specify how facility investigations should be conducted. An OIG official noted that each facility conducts investigations a little differently. Furthermore, there are no uniform training requirements for facility investigators, nor does the OIG monitor the training these investigators receive. In fact, the OIG was unable to provide us with a complete listing of investigators at DMHDD facilities.

According to DMHDD policy, depending on the nature of the incident and the special information provided on the DMHDD-107, the OIG may approve the facilities' closure of the case without an investigation. Requests for such closures are to be made on a separate memorandum which summarizes the initial information and subsequent action taken, if any, and submitted to the OIG with the initial incident reporting form. If the facility actually investigates the case, DMHDD policy requires that the facility submit a final case report which summarizes the investigation undertaken.

Our review of 25 facility investigations found a wide variance in the content of the case files facilities submitted to the OIG for review at the conclusion of an investigation. For instance, some facilities submitted nothing more to the OIG than an incident reporting form and an injury report, if an injury was sustained. In other cases, the facilities submitted items such as clinical team progress notes and reporting fact sheets completed by staff on duty at the

time of the incident. In a few cases, there was a case report or other summary of the investigation undertaken. Although the OIG investigated three of the cases, in most instances the only evidence of OIG review of the facility investigation was the signature or initials of the OIG lead investigator on a library (case tracking) sheet.

In some cases, however, the facility did not provide enough information to determine if the case had been thoroughly investigated or not. For instance, based on facility documentation one investigation into possible physical abuse consisted entirely of interviewing the alleged perpetrator and looking at the alleged victim's rehabilitation plan. Other witnesses and the person reporting the incident were not interviewed. In another case, the facility investigator interviewed both the alleged perpetrator and the victim without attempting to identify other witnesses.

Finally, in some cases of resident on resident abuse, facilities did not provide documentation on the steps taken to correct the problem. While some facilities informed the OIG that an aggressor's treatment plan had been evaluated, other facilities simply reported the incident without any indication of how officials planned to keep the incident from recurring.

The Act gives the Inspector General the responsibility to conduct investigations of all abuse allegations. Without ensuring that all investigations of abuse or neglect are conducted by appropriately trained staff and meet basic investigation requirements, the OIG cannot assure that it is meeting this statutory mandate.

Recommendation Number Eleven:

The Inspector General should ensure that all facility investigations of abuse or neglect allegations are conducted by trained investigators, follow established investigation protocols, adequately document the investigation procedures and conclusions reached, and are adequately reviewed by supervisory personnel.

Office of Inspector General Response:

Facility conducted investigations involve resident-to-resident alleged abuse or neglect, not abuse or neglect by an employee of the facility. OIG agrees with this recommendation and notes that the proposed draft rule completed in October 1996 requires OIG approval for facility and community agency protocols which must include documentation of investigative procedures, conclusions reached, and reviews.

DEATH INVESTIGATIONS

The OIG did not investigate all death cases as defined by its policies and procedures. OIG policy requires that it investigate those death cases when there is an allegation of abuse or neglect by facility staff or when a specific complaint comes from family members, friends, or advocates. The OIG is also required to investigate deaths that are allegedly due to suicide or homicide, or the cause of death implicates the treatment, involves unusual circumstances, or occurs within six hours after the use of restraints, seclusion, time-out, emergency PRN medication, or a physical altercation involving staff.

Facility designees are responsible for investigating other death cases such as: those by accidental causes; suicides and deaths from unusual or non-accidental causes within 30 days of discharge from a facility; deaths within 6 to 24 hours after the use of restraints, seclusion, time out, or emergency PRN medication; or a physical altercation involving staff. The OIG may choose to investigate these cases as well. In addition, the State Police may accept any death case.

In Fiscal Years 1995 and 1996, 162 death cases were reported. The OIG conducted investigations of nine (5.6 percent) deaths. Four of these cases were still open at the time of our review. We reviewed the five closed OIG investigated death cases. In these five cases, the OIG did not substantiate abuse or neglect.

In a random sample of 64 death cases investigated by facilities, we identified one case which met the criteria for an OIG investigation and, therefore, should have been investigated by OIG investigators. In this case, a resident committed suicide while on a home visit from a facility.

Recommendation Number Twelve: ***The Inspector General should implement controls to ensure it investigates death cases which meet the criteria specified in OIG policy.***
Office of Inspector General Response: It is questionable to change a procedure due to one case of all cases investigated. This recommendation is based on one case of 64 death cases (1 ½ %) properly investigated by the facility. Albeit, OIG is reviewing its policy regarding facility investigations of death cases in conjunction with the overall policy and procedure review. The OIG maintains that this recommendation has nothing to do with the effectiveness or quality of this investigation, but is an ownership issue.

COMMUNITY INVESTIGATIONS

The OIG's investigations of alleged incidents of abuse or neglect that occur at community agencies are different in style and content than the investigations conducted at State-operated facilities. Currently, there is no established protocol or procedure for the conduct of investigations at community agencies.

Public Act 89-0427, effective December 7, 1995, gave the OIG the authority to investigate allegations of abuse or neglect in any facility or program (community agency) which is licensed, certified, or funded by DMHDD and not licensed by any other agency. The Act is permissive and does not require the OIG to investigate all cases of abuse or neglect reported at community agencies.

An OIG official said that the OIG investigates any complaints that come from an outside source, such as a parent, employee, or a resident. The OIG also investigates resident on resident sexual assault and looks for neglect in these cases.

Between December 7, 1995 and June 30, 1996, the OIG received approximately 197 complaints from community agencies. During this period, the OIG closed approximately 145 of those cases. Due to limited information from the OIG, we could not determine how many of these investigations were conducted by OIG and how many were conducted by the community agency.

We reviewed a sample of 23 community investigations. Of the 23 investigations, 8 were investigated by the OIG. One case was investigated by DMHDD's Office of Accreditation and Licensure; the other 14 cases were investigated by the community agency. Eight of the 14 cases investigated by the community agency were substantiated, while 2 of the 8 OIG investigations substantiated an allegation of neglect.

The cases investigated by the community agencies did not contain much supporting documentation related to the case. Many of these cases involved a reported allegation that was investigated and substantiated by the community agency and the OIG was notified of the outcome.

In investigations conducted by community agencies, facilities sent materials to the OIG describing the incident and what corrective action was taken. Materials were typically gathered by program directors, house managers, and administrators. The OIG reviewed the case and if the investigator agreed with the way in which the community agency handled the case, it was closed. The community agency investigations we reviewed usually contained an intake report, a short case summary by the agency, and correspondence between the agency and OIG.

The OIG investigations at community agencies contained more information than those conducted by community agencies, but not as much as OIG investigations at State-operated facilities. The OIG investigations contained interviews with witnesses, notes and records collected from the agency, a case summary, and correspondence with the agency.

As more individuals are being moved from State-operated facilities to community agencies, investigations of abuse or neglect at these agencies has become more important. DMHDD statistics estimated that in Fiscal Year 1996, 195,941 people received service at community agencies and facilities. There were 14,331 people served in the 20 State-operated facilities and 838 allegations of abuse or neglect.

Public Act 89-0427 states that "The Inspector General shall promulgate rules establishing minimum requirements for initiating, conducting, and completing investigations." The OIG is currently in the drafting process of promulgating rules that will clarify the role of the OIG and set forth protocol for conducting investigations of alleged abuse or neglect at State-operated and community agency facilities.

Recommendation Number Thirteen: ***The Inspector General should continue in the effort to establish a protocol for conducting investigations of abuse or neglect at community agencies which specifies which cases the OIG will investigate and what information should be collected. In addition, the Inspector General should establish a database to monitor and report on these community investigations.***
Office of Inspector General Response: The database to monitor and report community investigations was developed during FY96 and has been implemented reflecting investigations since July 1, 1996 for FY97.

OIG INVESTIGATIONS LOG COMPUTER SYSTEM

The OIG Investigations Log computer system contains inaccurate information. This condition was primarily due to a lack of an adequate control structure. We identified weaknesses in data integrity and accuracy, systems and programming, and general administration. These control weaknesses affect the reliability and accuracy of the information used to record and track reported incidents of abuse or neglect.

OIG uses the Investigations Log computer system to record and track all reported incidents involving residents and/or DMHDD employees. The computer system is also used by OIG staff to prepare their statutorily-required annual report to the General Assembly and for internal management purposes.

At the time of our fieldwork, the computer system had ten users; nine OIG employees (six from the Chicago OIG headquarters and three from the Springfield area headquarters) and one DMHDD technical Information Systems staff person. The computer system has

approximately 40,000 archive records (cases from 1987 to June 30, 1993) and approximately 30,000 records from July 1, 1993, to present.

The computer system is an integral element of OIG's monitoring and tracking of reported incidents of abuse or neglect. We identified significant security weaknesses, such as inadequate password controls that placed the integrity and accuracy of the information at risk.

Problems with Data Accuracy and Integrity

Data accuracy and integrity issues have the potential to affect the reliability of the data which is used by the OIG to manage its daily activities and in mandated information reported to the General Assembly. The OIG has reported inaccurate information in the past to the General Assembly. The OIG should take steps to ensure that data is reliable as was recommended in our prior audit in 1994.

Office of Inspector General Comment:

As a result of the continuing data accuracy problems we had identified, OIG began in FY96 a complete overhaul of the investigations database. OIG implemented the new database as of July 1, 1996 for FY97.(see OIG Response to Recommendation 15)

Information concerning number and types of allegations, case findings, and closed cases requested and received from the OIG is often inconsistent with prior information received from the OIG or that is printed in the OIG's Annual Reports. The following are examples of inaccuracies and changes made to data by the OIG.

- The number of Fiscal Year 1992 abuse or neglect allegations changed from 1,079 in the Fiscal Year 1992 Annual Report to 896 in the Fiscal Year 1993 Annual Report to 1,090 in the Fiscal Year 1994 Annual Report.

- The number of cases closed in Fiscal Year 1994 changed from 971 to 990 between June and October of 1996, in information we requested for this audit.

- The number of allegations of a resident with an injury that required emergency medical treatment in Fiscal Year 1996 changed from 240 to 123 for the Kiley MHC. OIG officials stated that the reduction was due to cases being reported in error.

- The OIG changed the closure dates for recanted cases. Originally, the closure dates were the same as the dates that OIG was notified of the incident. Some of these dates were changed to the dates the cases were completed. However, the closure dates of some cases were not changed.

Office of Inspector General Comment:

First Dot Point: Although the audit period was FY96, this comments reflects information used from the FY92 audit. Second Dot Point: When OIG gave this draft list to the auditors, it was explained that a final Quality Assurance check had not been completed and the numbers would undoubtedly change to reflect accuracy. Third Dot Point: This was changed in FY97 after the end of the auditors' field work. The change was due to an earlier failure to eliminate non-reportable injuries. Fourth Dot Point: OIG discovered these case had been improperly closed as dates of closure had been backdated to the date the case was opened. To remedy this problem, OIG changed the incorrectly documented closure date to the actual closure date. This policy by inaccurate closure reporting dates was recognized by OIG during the past fiscal year, and a new procedure has been established.

The changes to the data are not documented and it is often unclear why and how the data changed. Documentation of changes made to the database would allow for a clear audit trail as well as discourage data manipulation.

The OIG added a qualifying statement to their last annual report which reads (from the Fiscal Year 1995 report) "Note: Due to later revisions, the numbers of incidents reported and closed during Fiscal Years 1993 and 1994 in the tables that follow may be different than the number reported in previous OIG annual reports."

Finally, incorrect data was input into OIG's database in over a third of the cases in our sample. In 104 of the 278 (37 percent) OIG investigations reviewed, at least one piece of information in the Investigations Log database did not agree with that in the case file. Examples of discrepancies include differences between times or dates, incorrect investigation finding codes, and recommendation codes. In 23 of the 278 (8 percent) cases sampled, 1 or more data fields were blank in the Investigations Log database, which means that the OIG is not capturing all the required data from their investigations.

Recommendation Number Fourteen:

The Inspector General should take the steps necessary to ensure that data is valid and consistent from year to year. If existing data is subsequently modified, documentation should detail the changes made and purpose of the changes.

Office of Inspector General Response:

We are committed to reporting accurate data. To document revisions and the reasons for these revisions after the end of the fiscal year, we have developed a manual log which is maintained by the database manager. Further, the form now includes: date and name fields that automatically record the date that a record was entered, the date the record was last modified, and the name of the person who made the entries.

System and Programming

Systems and programming issues have the potential to impact data integrity and system compatibility. System and programming issues include the:

- adequacy of documentation to provide the capability to modify the system and provide users with the essential information to effectively and efficiently use the computer system.

- implementation of controls to monitor changes and ensure compatibility of computer system software.

- inclusion of suitable edit checks, audit trails, and error reports to ensure that valid and complete information is entered into the system.

Systems development and programming standards were not used to ensure that these vital issues were consistently and adequately addressed. The system and user documentation was non-existent or insufficient. We found that three different versions of vendor software were utilized simultaneously which caused compatibility problems. Our testing also revealed that changes made to one component of the system were not incorporated in the other two, thereby making system components incompatible and resulting in the data input being rejected. However, the proposed establishment of the wide area network in July 1996 will require the use of the same software thus alleviating some of the compatibility issues.

We identified programming issues that could improve data accuracy and integrity. The addition of or strengthening of data edits to include checks to determine that data is valid and reasonable, such as preventing case closure dates from preceding case opening dates, would enhance data accuracy and integrity.

Office of Inspector General Comment:

Many of these were done during FY96 or during the time period of the auditor's fieldwork.(see OIG Response to Recommendation 15)

General Administration

General administration issues have the potential to impact appropriate uses of systems and data and the ability to recover systems and data. OIG has no microcomputer/LAN policy and procedures manual and staff were unaware of any Department related policies and procedures. Although backups of the computer system are prepared, they are not stored at a secure off-site location. Effective security controls to protect the integrity of the computer system were not implemented.

A comprehensive microcomputer/LAN policy sets the basic security parameters and helps ensure staff are aware of relevant issues. Although a LAN security option has been set to require passwords to be changed every 40 days, a parameter allowing the user to retain the same password indefinitely is employed, thus negating the password change requirement. In addition, passwords that permit access to reported incidents of abuse or neglect information are not required to be changed. Off-site backups of the computer system are necessary to ensure the availability of the over 70,000 historical records and to ensure that the data is available to monitor reported incidents of abuse or neglect and prepare reports to the General Assembly.

This finding is expanded and repeated from our 1994 audit report in which we also found a lack of controls related to the OIG's Investigations Log computer system.

Office of Inspector General Comment:

Most of these issues relate to the McFarland MHC network (where OIG is based) and the Department's policies over which OIG has neither control nor authority. For example, the lack of a network policy manual is not an issue relevant to the OIG database itself.

Recommendation Number Fifteen:

The Inspector General should strengthen controls over the Investigations Log computer system. Specifically, the Inspector General should:

- ***Develop or adhere to available systems development and programming standards to ensure the adequacy of system and user documentation, implementation of controls to monitor system changes and compatibility, and inclusion of suitable edit checks, audit trails, and error reports to ensure that valid and complete information is entered into the system.***
- ***Adhere to Departmental computer policies and guidelines that establish basic security parameters. In addition, the OIG should implement a program to increase staff awareness of relevant issues and appropriate Department policies, and ensure that computerized information is adequately protected. OIG should comply with Department policies and enforce a password change interval (at least every 35 days to a unique password) and ensure that the complete Investigations Log computer system is backed-up and stored in a secure off-site location at least every two weeks.***

Note: Detailed information regarding the information systems control environment and recommendations to improve the control environment were provided to the agency prior to the release of this audit.

Office of Inspector General Response:

Some of the issues raised are outside OIG's jurisdiction. The Department has policies and procedures in effect which govern all of its facilities and budgetary entities, including OIG, which the Department considers relevant to this finding and recommendation.(Copies available upon request.) We have addressed those issues within OIG jurisdiction during our FY96 complete overhaul of our database, with the help of the Department's Information Services (BIS) staff.(see Appendix E for full response)

APPENDICES

APPENDIX A

PUBLIC ACT 89-0427

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Appendix A

Public Act 89-0427

Sec. 6.8. Program audit. The Auditor General shall conduct a biennial program audit of the office of the Inspector General in relation to the Inspector General's compliance with this Act. The audit shall specifically include the Inspector General's effectiveness in investigating reports of alleged neglect or abuse of residents in any facility operated by the Department and in making recommendations for sanctions to the Departments of Mental Health and Developmental Disabilities and Public Health. The Auditor General shall conduct the program audit according to the provisions of the Illinois State Auditing Act and shall report its findings to the General Assembly no later than January 1 of each odd-numbered year.

This Section is repealed on January 1, 2000.

APPENDIX B

METHODOLOGY

APPENDIX B

SAMPLING AND ANALYTICAL METHODOLOGY

We conducted a random sample of 278 employee abuse or neglect investigations closed by the OIG during Fiscal Year 1996 to assess their effectiveness.

The universe for the sample consisted of 991 cases closed during Fiscal Year 1996 obtained from the OIG at the beginning of our fieldwork. The sample size was statistically significant with a 95% confidence level and a margin of error of 5%. Cases to be tested were selected using a computer random number generator. We compared characteristics of the population to the sample to determine that the sample was representative of the larger population. We tested cases at the Madden Mental Health Center near Chicago for Northern investigations and at the McFarland Mental Health Center for Southern investigations.

Audit testing focused on investigation and documentation completeness, investigation timeliness, recommendations, corrective actions, supervisory review, and case summary thoroughness.

To assess the timeliness of OIG investigations we reviewed files and examined the length of time from the date that OIG was notified of the alleged incident by mail, facsimile, or phone until the recommendation was sent to the facility director. We also reviewed internal steps in the investigations for their timeliness. These time frames were developed using previous audits conducted by the Auditor General's Office, internal evaluations conducted by the OIG, and information collected from other states. (see Chapter Two - Timeliness of Abuse or Neglect Investigations)

To assess the thoroughness of the investigation and case file documentation we tested each case file to determine if and when required documentation was collected. Documentation required for each investigation was developed using previous audits, information gathered from other states, and the OIG's Policies and Procedures Manual. (See Chapter Three - Thoroughness of Abuse or Neglect Investigations)

Using selected fields from a data collection instrument developed to compile information from the files, a database was created using the information collected in the sample. The data was proofed before our analysis was conducted.

OTHER FILE TESTING

In addition to the statistical sample, we also conducted a sample of investigations that took more than 200 days to complete, as well as random samples of:

- Abuse or neglect investigations conducted by facility investigators;
- Death Investigations; and
- Community agency investigations.

OIG DATABASE TESTING

The Auditor General's Information Systems Division staff conducted an expanded scope review of the OIG's Investigations Log Database and Local Area Network in June 1996. The review consisted of an application review of the computerized system database as well as testing controls in conjunction with the OIG's local area network (LAN). The review included interviews, observations, tests of compliance with procedures, and identification of specific control objectives.

We also tested the OIG's Investigations Log Database for accuracy by comparing the screen print of cases to the hard copy files. This was conducted as part of the 278 cases sampled to determine the effectiveness of investigations.

APPENDIX C

RATES OF SUBSTANTIATED EMPLOYEE ABUSE OR NEGLECT CASES BY FACILITY FOR INVESTIGATIONS CLOSED FISCAL YEARS 1995 AND 1996

Appendix C

Rate of Substantiated Employee Abuse or Neglect Cases by Facility

	FISCAL YEAR 95			FISCAL YEAR 96		
Facility	Number Closed	Number Substantiated by OIG	Substantiation Rate	Number Closed	Number Substantiated by OIG	Substantiation Rate
Alton	152	7	5%	59	2	3%
Chester	132	4	3%	124	2	2%
Chicago-Read	46	6	13%	21	4	19%
Choate	73	6	8%	119	4	3%
Elgin	133	14	11%	153	16	10%
Fox	2	1	50%	4	1	25%
Howe	64	8	13%	70	3	4%
Jacksonville	42	5	12%	60	3	5%
Kiley	44	12	27%	102	18	18%
Lincoln	46	9	20%	19	2	11%
Ludeman	30	4	13%	34	1	3%
Mabley	4	3	75%	2	0	0%
Madden	19	4	21%	10	1	10%
McFarland	25	4	16%	10	2	20%
Metro C&A	35	4	11%	35	1	3%
Meyer	64	3	5%	6	0	0%
Murray	5	2	40%	5	1	20%
Shapiro	69	9	13%	74	4	5%
Singer	40	4	10%	53	8	15%
Tinley Park	18	4	22%	25	3	12%
Zeller	34	4	12%	16	0	0%
TOTALS	**1,077** *	**117**	**11%**	**1,001** *	**76**	**8%**

* The number of cases closed for Fiscal Year 1995 and 1996 includes cases investigated by the Illinois State Police (Fiscal Year 1995 - 10 cases, Fiscal Year 1996 - 9 cases). The number of cases substantiated only includes those cases substantiated by the OIG.

Source: OAG Analysis of OIG Data

APPENDIX D

ALLEGATIONS OF ABUSE OR NEGLECT REPORTED FISCAL YEARS 1995 AND 1996

Appendix D
All Incidents and Allegations Reported by Incident Category
Fiscal Year 96

FACILITIES	Abuse/ Neglect	Other Employee Miscond	Recipient Death	Serious Recipient Injury	Recipient On Recipient Injury	UA	Recipient Sexual Miscond	Theft of Recipient Property	Other	Total Number Reported
DD FACILITIES										
Fox DC	2	1	3	3	49	0	1	0	0	59
Howe DC	84	4	6	68	292	0	7	2	37	500
Jacksonville DC	58	2	5	83	499	58	23	2	19	749
Kiley DC	81	11	2	123	272	12	24	7	29	561
Lincoln DC	14	1	9	2	322	0	1	0	1	350
Ludeman DC	28	0	3	2	338	9	8	1	4	393
Mabley DC	0	2	0	20	89	5	18	0	7	141
Murray DC	4	2	17	2	184	1	1	0	0	211
Shapiro DC	68	4	13	32	131	3	2	0	8	261
DUAL FACILITIES										
Choate MHDC	88	24	1	2	408	13	39	0	9	584
Singer MHDC	41	13	1	9	63	10	14	1	4	156
Meyer MHDC	2	0	1	0	9	0	2	0	1	15
MH FACILITIES										
Alton MHC	65	23	2	0	139	7	12	1	3	252
Chester MHC	92	57	1	13	134	0	8	0	2	307
Chicago-Read MHC	18	8	5	2	155	65	17	0	4	274
Elgin MHC	111	53	7	3	566	27	32	11	32	842
Madden MHC	6	5	2	6	117	31	9	1	4	181
McFarland MHC	14	7	1	30	16	9	7	0	15	99
Metro C&A MHC	27	22	0	33	22	5	8	0	10	127
Tinley Park MHC	19	11	4	10	123	13	7	0	3	190
Zeller MHC	16	3	2	4	56	10	4	0	3	98
TOTALS	**838**	**253**	**85**	**447**	**3,984**	**278**	**244**	**26**	**195**	**6,350**

Source: OIG Data

APPENDIX E

INSPECTOR GENERAL RESPONSES

Note: **Following the Agency Responses are eight Auditor's Comments. Numbers for comments appear in the right hand margins of the agency responses.**

Illinois Department of Mental Health and Developmental Disabilities

401 William Stratton Building Springfield, Illinois 62765

Jim Edgar, Governor Ann Patla, Director

December 6, 1996

RECEIVED
AUDITOR GENERAL
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Mr. William G. Holland
Auditor General
State of Illinois
Iles Park Plaza
740 East Ash
Springfield, Illinois 62703

Dear Mr. Holland:

See Auditor Comment Number:

Attached are our responses and comments to the Auditor General Report of the Office of Inspector General submitted in December of 1996.

While your audit identifies itself as the FY-95 and FY-96 Audit of the OIG, information included reflects OIG activities from FY-92 and FY-94. We have limited our responses to those issues identified for the audit period you originally designated. (1)

Our responses are also somewhat limited since the largest percentage of case files we were able to review were required to be reviewed in your office with Auditors present and without the complete case file available in most instances. Since we do not have the case specific numbers for all files reviewed in your sample, we cannot comment or respond to a number of issues identified in the audit. Since this practice was not implemented in your previous audits of OIG, we respectfully request some reason for this deviation in past practice. (2)

You have informed us that our comments will not be accepted for the Executive Summary. However, it is imperative that I inform you that the summary reflects an unfair bias in the information selected and that bias is reflected in the manner and tone in which it is presented.

While the audit attempts to provide a comprehensive review of the OIG, one of the most significant changes in the Office has been the designation of a new Inspector General this past fiscal year. Although you refer to OIG leadership in your previous OIG audits, you fail to recognize this change in this audit. None of the testing you completed reflects the differences in leadership and since you have not yet provided us with sufficient information to determine this ourselves from your sample, we are also unable to gauge the effectiveness of the leadership change. (3)

OFFICE OF INSPECTOR GENERAL **Patricia Curtis, Inspector Gener**

Voice: AC 217/786-6865 Fax: AC 217/786-6921 TTY: AC 217/524-2504

See Auditor Comment Number: 4

We take the audit information very seriously and see it as an opportunity to identify our strengths and strengthen our weaknesses. However, this can only be accomplished when an objective and accurate audit is completed.

Sincerely,

Patricia Curtis

Patricia Curtis
Inspector General

PC:sm
enclosure

cc: Ann Patla, Director, Department of Mental Health & Developmental Disabilities
Len Beck, DMHDD Internal Auditor

OIG COMMENTS TO AUDITOR GENERAL FY 96

1. **OIG Response to RECOMMENDATION #1:**
The working draft of the rules establishes that OIG would conduct an investigation only at DCFS' request. However, the Abused and Neglected Child Reporting Act requires a report, but confidentiality provisions of this Act may prohibit any indication in the file that DCFS was contacted if the case is not substantiated. The resolution of this issue must precede any final agreement. The DMHDD Legal Department has begun its review.

2. **OIG Comment after paragraph 1 on page 9 in "Trends in Abuse Reporting and Investigations" Section:**
This is only one variable. Other variables include new medications, effects of residential care in the private sector, preferences of younger families of not seeking institutional care for their family members, placement of people with disabilities in small group homes across the State, etc.

3. **OIG Comment after Exhibit 1-6 (page 9 in draft):**
The previous OAG audit found a "substantiation rate" of 7% in FY92 and 12% in FY93. Thus, these current rates seem to be within normal variation.

4. **OIG Comment after paragraph 1 on page 10:**
OIG intends to study this issue.

5. **OIG Comment after paragraph 2 on page 10:**
Substantiations or lack of such are based on the facts of each case, and no conclusion can be reached by reviewing a substantiation rate without reviewing the investigative quality of each case.

See Auditor Comment Number: 5

6. **OIG Comment after paragraph 4 on page 10 in the "Audit Scope & Methodology" Section:**
While the sample was selected randomly over the year, the Auditor General failed to test whether progress was made throughout the year and under new leadership.

7. **OIG Comment after the second full paragraph on page 14:**
All OIG investigations closed in FY96 took an average of 53 days to complete. During the first three months of FY96, the average was 66 days; during the last three months, the average was 46 days.

8. **OIG Comment after paragraph 4 on page 15:**
OIG acknowledges that statements should be taken within the allotted time. However, an analysis of the number of cases, the number of other witnesses interviewed in each case, and reasons for the delay would more clearly indicate whether this had an impact on the ultimate quality of the investigation.

9. **OIG Comment after paragraph 7 on page 17:**
OIG had not developed criteria requiring facility directors to respond within a designated amount of time because of the varying time it takes the facility to complete the disciplinary process. However, this issue has been addressed in the draft rule.

10. **OIG Response to Recommendation Number 2 on page 18:**
OIG recognizes that timeliness of investigations is important to the quality of the investigation; however, it is only one factor. The newly instituted 1-hour reporting requirement to OIG will more actively involve OIG investigators at the onset, facilitating the initial written statement process or the handling of the initial written statements by OIG.

11. **OIG Comment after paragraph 1 on page 18 in "Timeliness of Reporting to State Police" Section:**
As stated by the Auditor General in another section of this audit report, the OIG entered into a memo of agreement with the Illinois State Police in May of 1993. In April of 1996 this interagency agreement was updated.

12. **OIG Response to Recommendation Number 3 on page 18:**
OIG practice will include documentation of notification of State Police at the time OIG becomes aware of instances of possible criminal activity, and response by State Police in all cases required by law and policy.

13. **OIG Comment after paragraph xx on page 21:**
OIG has concluded in FY-97 that the checklist should serve as a guide for each case rather than a list of what is required for every case.

14. **OIG Comment after paragraph 1 on page 22 in "Incident Report" Section:**
OIG will work with DMHDD facilities to resolve this issue.

15. **OIG Comment after the last paragraph on page 22 in "Photographs" Section:**
To use a photograph to prove that an allegation has no injury would be time and cost prohibitive and meaningless to the investigation.

See Auditor Comment Number: 6

16. **OIG Comment after paragraph 1 on page 24:**
OIG policy does not require interviews by OIG if the initial written statements taken by the facility contain sufficient information.

17. **OIG Response after Recommendation Number 4 on page 24:**
The OIG will take steps to ensure there is a case-by-case determination regarding relevant documentation that is deemed necessary to collect. With the 1-hour reporting requirement the OIG Investigator will determine the necessary documents for the facility investigator's collection of those documents. Within OIG, the new supervisory review process focusing on

completeness of the investigation will address this issue; however, it must be noted that OIG does not supervise facility investigations.

18. **OIG Response to Recommendation Number 5 on page 27:**
Since this recommendation follows the section on Recantation and Improbable Cases, the OIG is making the assumption this recommendation only applies to those types of cases. In early FY-97, OIG abolished the procedure for closing cases which are deemed improbable or where a recant has occurred.

19. **OIG Response to Recommendation Number 6 on page 30:**
In early FY97, the supervisory case review process was revised to include a review for thoroughness and overall quality of the investigation. OIG has increased supervisory involvement throughout the investigation of the case.

20. **OIG Comment after paragraph 4 on page 31:**
Since OIG does not have access to individual personnel files of employees, determining corrective action without specific knowledge of employees' work history, training history or previous disciplinary action could create an arbitrary and legally unsound system of implementing corrective action. However, OIG maintains an informal involvement of providing input for disciplinary action.

21. **OIG Comment after paragraph 1 on page 35:**
The facilities did not take action; rather, they presented valid reasons why they disagreed with OIG's position and identified investigative errors.

22. **OIG Response to Recommendation Number 7 on page 35:**
Actions taken by the facilities regarding disciplinary measures are monitored by the Labor Relations staff of the Department of Mental Health and Developmental Disabilities to ensure the corrective action is consistent with the finding of an OIG investigation and prior history of the employee. The case file contains the additional information provided which results in overturning the finding. The draft administrative rule requires the Inspector General document in the final report, response to requests for reconsideration based on additional information submitted.

23. **OIG Response to Recommendation Number 8 on page 36:**
As noted in the OAG's FY-94 audit, these instances of "sanctions" were not as a result of abuse investigations. OIG has never needed to use sanctions to ensure some actions were taken as a result of allegations of abuse or neglect. Since the term "sanction" has never been defined, it is difficult to identify when and how sanction activity occurred. The OIG maintains that it is not within OIG's purview to define "sanction" in the statute as the legislative intent is unknown. OIG is willing, however, to participate in discussions with appropriate parties to define this term and develop criteria for such.

AUDITOR'S COMMENTS

1. Consistent with the methodology in our December 1994 audit, a statistically valid sample of cases closed in Fiscal Year 1996 was examined (e.g., a case is closed when the investigation is completed and the facility responds to the Inspector General's recommendation memo). All of the Inspector General's investigations associated with these cases were completed either in Fiscal Year 1995 (96 or 35%) or Fiscal Year 1996 (182 or 65%). Our review of the policies and management controls of the Office of the Inspector General focused on those in effect during Fiscal Year 1996.

2. As was done in prior audits, case numbers were made available to the Inspector General. The OIG was given an opportunity to review and comment on each case. Case numbers requested were either compiled in lists and given to the Inspector General or were made available to OIG staff during meetings with OAG staff to review the cases in question. In total, 17 separate case lists were either provided to or reviewed with OIG staff. On November 26, 1996, OIG was sent a memo which stated, "Enclosed are the final case lists that were requested at the exit conference. We have now either provided or reviewed with you in person all the case numbers requested at the exit conference. . . If you have any questions please call . . . ." No request for additional information was received.

   Three meetings were held between OAG and Inspector General staff to review cases in question. OAG staff were available for additional meetings. At the suggestion of Inspector General staff, some meetings occurred in the Office of the Auditor General. It was the decision of the Inspector General's staff not to access the original case files.

3. Page 2 of the report states that "The current Inspector General was appointed in October 1995."

4. We conducted a statistically valid sample of cases closed in Fiscal Year 1996. Documented findings from our statistically valid sample are presented in the report. Prior to the release of our report, OIG officials were given the opportunity to review and comment upon the support for findings and conclusions contained in the report.

5. The sampling methodology used was consistent with prior audits. Our review of the policies and management controls of the Office of the Inspector General focused on those in effect during Fiscal Year 1996.

6. OIG policy did require interviews for certain cases, such as recantations and improbable investigations.

7. It is unclear when the policy specifying the required courses was modified. Policies provided by the OIG in September 1996, still contain these courses.

8. As noted in the report text, the 1995 revisions to the Abused and Neglected Long Term Care Facility Residents Reporting Act clearly give the OIG the responsibility for investigations of all abuse allegations.

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