COMMONWEALTH OF VIRGINIA
Office of the State Inspector General

Michael C. Westfall, CPA
State Inspector General

P.O. Box 1151
Richmond, Virginia 23218

Telephone 804-625-3255
Fax 804-786-2341
www.osig.virginia.gov

May 27, 2021

The Honorable Ralph Northam
Governor of Virginia
P.O. Box 1475
Richmond, VA 23219

RE: BHDS-Project 2021-002

Dear Governor Northam:

The Office of the State Inspector General (OSIG) received a complaint through the Behavioral Health and Developmental Services Complaint Line on July 22, 2020, regarding Northern Virginia Mental Health Institute (NVMHI). The complainant alleged that NVMHI was not classifying incidents involving sexual assault and/or battery appropriately and only notifying the Virginia State Police at the Director's discretion.

As part of the review of this complaint, OSIG requested Department of Behavioral Health and Developmental Services (DBHDS) departmental instructions (DI) regarding sexual abuse as defined under *Code of Virginia* § 18.2-67.10. DBHDS informed OSIG that a DI specific to sexual abuse did not exist. However, DBHDS provided OSIG with DI 205 (RTS) 89, *Filing Criminal Charges Against Individuals Served in State Facilities.* Upon review of this DI, OSIG has the following findings and recommendations:

Finding #1
DBHDS last revised DI 205 (RTS) 89, *Filing Criminal Charges Against Individuals Served in State Facilities* in 2012 and last reviewed it in 2017. Central Office DIs are the foundation on which facilities base their policies and procedures. Current regulations and standards may not be reflected in Central Office DIs if they are not reviewed and updated at regular intervals.

Recommendation #1
Review and/or revise departmental instructions at least annually or more often as needed, to reflect current regulations and standards.

Finding #2
According to DI 205 (RTS) 89, section 205-5 *Specific Guidance*, "Any acts by individuals receiving services at a department facility that could potentially result in criminal charges shall be evaluated on a case-by-case basis to determine the level of seriousness and if the behavior would be best addressed through clinical interventions as articulated in the individual's treatment, recovery, or service plan; or through referral by the facility director to law enforcement, who will then coordinate with the Commonwealth's Attorney for disposition." Facility directors do not receive training in criminal codes in order to perform such an evaluation or make a determination of the level of seriousness of the infraction.

Because facility directors lack training in criminal codes, a criminal incident may go unreported and place a victim and other vulnerable patients in the facility at further risk.

Recommendation #2
Provide facility directors the legal resources and/or training to recognize the elements that constitute a criminal incident to ensure appropriate reporting to law enforcement.

Finding #3
According to DI 205 (RTS) 89, section 205-5 *Specific Guidance,* "Acts that would constitute a misdemeanor if convicted may be reported to law enforcement at the Facility Director's discretion." This guidance requires a facility director to know the elements of a misdemeanor crime and the probability of a conviction. According to § 63.2-1606, Protection of aged or incapacitated adults; mandated and voluntary reporting, "Matters giving reason to suspect the abuse, neglect or exploitation of adults shall be reported immediately upon the reporting person's determination that there is such reason to suspect. Reports shall be made to the local department or the adult protective services hotline in accordance with requirements of this section by the following persons acting in their professional capacity: (2.) Any mental health services provider as defined in § 54.1-2400.1." Providing facility directors with the discretion to report misdemeanor crimes such as sexual battery could potentially lead to unreported serious criminal incidents and a violation of mandatory reporting guidelines as defined in § 63.2-1606.

Recommendation #3
Remove "Acts that would constitute a misdemeanor if convicted may be reported to law enforcement at the Facility Director's discretion" from Department Instruction 205 (RTS) 89.

Finding #4
According to DI 205 (RTS) 89, section 205-5 *Specific Guidance*, "Consideration shall include whether the alleged criminal act was a result of the individual's mental health or functioning level or related to his reason for hospitalization, or whether the alleged criminal act appears unrelated to these things." This statement does not consider the rights of the victim as defined under § 37.2-400, *Rights of individuals receiving services* that assures "each consumer has the right to retain his legal rights as provided by state and federal law and be treated with dignity as a human being and be free from abuse and neglect."

Recommendation #4
Update DI 205 (RTS) 89, section 205-5, to include guidance on the victim's rights. To comport with the rights of victims receiving services under § 37.2-400, facilities should report criminal incidents to law enforcement for prosecutorial, tracking and record keeping purposes.

Finding #5
OSIG requested a DI from DBHDS for addressing sexual abuse incidents. However, a DI that specifically addresses this type of offense does not exist. The DI205 (RTS) 89 addresses criminal offenses, but does not specifically reference sexual abuse incidents.

Recommendation #5
Develop specific guidance on the handling of sexual abuse incidents involving peers to include preservation of evidence, notification of law enforcement, recording of the victim's notification of rights, and decision to pursue or decline prosecution.

Finding #6
According to DI 205 (RTS) 89, section 205-5 *Specific Guidance*, section Criminal Activity Towards Peers, "Individuals who are the victims of a crime resulting from a peer-to-peer act at the facility must be given the opportunity to report the crime to law enforcement if they choose." OSIG requested documentation for six alleged sexual offenses at NVMHI. NVMHI was unable to provide any documentation indicating the victim(s) had been given the opportunity to report the crime to law enforcement.

Recommendation #6
A. Provide patients and court-appointed guardians written, detailed information of their rights (upon admission and when an incident occurs) to report any criminal act, including sexual abuse, to law enforcement. This information should include the following:
    1. Detailed information about victim's rights to report and file charges.
    2. The timeframe to report and file charges (statute of limitations).
    3. A statement that the crime may be reported even after discharge of the perpetrator or the victim, as long as it falls within the statute of limitations.
    4. A statement informing the patient of the right to waive reporting of the crime.

B. Include the following in facility documentation:
    1. Verification through signature that the patient was informed of their rights on admission and in the event of a criminal incident.
    2. Verification through signature if the patient waived their right to seek prosecution.
    3. Verification that the facility immediately notified the authorized representative (AR) or guardian about the incident and that the AR or guardian served as proxy in the decision-making process in filing of charges when the victim lacked capacity.
    4. Clear and adequate documentation in the victim's record should include the following:
        a. Appropriate incident forms completed.
        b. Action taken by all appropriate entities (Virginia State Police, Adult Protective Services, patient advocate, AR, treatment team, etc.) notified and action taken.
        c. Detailed description of the offense and when it occurred.
        d. Detailed description of the patient's status, both physical and mental as a result of the offense.
        e. Detailed description of the steps taken to address any physical or mental concerns because of the offense.
        f. Detailed description of the steps taken to mitigate the risk of future offenses.
        g. Detailed notes in the days following the incident to monitor any further concerns or changes in the patient's status.
        h. Documentation from the patient advocate visit and treatment team meetings.
        i. Video tape, witness statements and any other evidence related to the incident, if available.
    5. Clear and adequate documentation in the perpetrator's record should include the following:
        a. Appropriate incident forms completed.
        b. Action taken by all appropriate entities (Virginia State Police, Adult Protective Services, patient advocate, AR, treatment team, etc.) notified and action taken.
        c. Detailed description of the offense and when it occurred.
        d. Detailed description of the perpetrator's status, both physical and mental, at the time of the incident.
        e. Detailed description of the steps taken to address any physical or mental concerns because of the offense.

f. Detailed description of the steps taken to mitigate the risk of future offenses.
g. Detailed notes in the days following the incident, to monitor any further concerns or changes in patient's status or signs of potential re-offense in the future.
h. Documentation from the patient advocate visit and treatment team meetings.
i. Video tape, witness statements and any other evidence related to the incident, if available.

Finding #7

OSIG's review of patient records and CHRIS reports determined that NVMHI misclassified incidents sexual in nature as "other" as opposed to "sexual" which is an option provided on the CHRIS V5.1 reporting form. The misclassification of adverse events will prevent accurate reporting and analysis.

Recommendation #7

Instruct facilities that CHRIS reporting criteria should be included when handling sexual abuse incidents. Facilities should consistently label criminal sexual incidents as sexual abuse.

OSIG appreciates DBHDS Commissioner Alison Land, her staff at Central Office and NVMHI for their cooperation during this review.

Respectfully,

Michael C. Westfall, CPA
State Inspector General

cc: The Honorable Clark Mercer, Chief of Staff to Governor Northam
The Honorable Daniel Carey, M.D., Secretary of Health and Human Resources
The Honorable Delegate Patrick A. Hope, Chair, Joint Commission on Health Care
The Honorable Senator George L. Barker, Vice Chair, Joint Commission on Health Care
Alison G. Land, Commissioner, DBHDS
Heidi Dix, Deputy Commissioner, Quality Management and Government Relations, DBHDS
Angela Harvell, Deputy Commissioner, Facilities, DBHDS
Alvie Edwards, Assistant Commissioner for Compliance, Risk Management and Audit

COMMONWEALTH of VIRGINIA

ALISON G. LAND, FACHE
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
Post Office Box 1797
Richmond, Virginia 23218-1797

Telephone (804) 786-3921
Fax (804) 371-6638
www.dbhds.virginia.gov

May 20, 2021

Michael Westfall, State Inspector General
Office of the State Inspector General
P.O. Box 1151
Richmond, VA 23218

Dear Mr. Westfall:

We appreciate the opportunity to review the allegation and several incidents noted during the course of this investigation. As requested by the Office of the State Inspector General (OSIG), the Department of Behavioral Health and Developmental Services (DBHDS) Central Office reviewed nine events with the Virginia State Police (VSP) and Northern Virginia Mental Health Institute (NVMHI). We are pleased to report that VSP was in agreement with the handling of the nine incidents and no further action is deemed necessary to pursue criminal charges against the patients involved in those incidents. Our review with NVMHI and VSP also identified areas for improvement and we will continue working with VSP and the Office of the Attorney General (OAG) to review opportunities to enhance our current Departmental Instruction and documentation standards for filing criminal charges against patients or residents.

The opportunities identified for improvement generally align with several findings and recommendations noted in this report. More specifically, we agree that the current Departmental Instruction should be reviewed and enhanced with further definition and details on handling these events; additional resources and training related to criminal charges and the updated Departmental Instruction should be provided to facility directors and staff; and documentation standards, required content, and consistency for managing these potentially criminal incidents can be improved to support facility decisions. Further review of the specific details within each of the OSIG recommendations will be considered by a broader stakeholder group as the Departmental Instruction is reviewed.

Sincerely,

Alison G. Land

Alison G. Land, FACHE
Commissioner