# Office of the Inspector General

# REDACTED
# INVESTIGATIVE REPORT

## CASE #: 2915-0057

## SOUTH
## INVESTIGATIVE BUREAU

| OFFICE OF THE INSPECTOR GENERAL | INVESTIGATIVE REPORT |
|---|---|
| **Case No.** | **Report Date** |
| **2915-0057** | **September 6, 2022** |
| **Facility/Agency Name** | |
| **Choate Developmental Center** | |
| **Facility/Agency Address** | **Incident Location** |
| **1000 N. Main Street**<br>**Anna, Illinois 62906** | **XXXXX XXXXX** |

## I. Introduction

An OIG investigation has established that on December 20, 2014,[1] Mental Health Technician (MHT) Mark Allen of Choate Developmental Center physically abused Individual XXXXX XXXXX by punching him multiple times in the face and placing XX XXXXX in a choke hold, which caused abrasions to XX XXXXX face, neck, and chest and a laceration to his upper lip, among other injuries. OIG's investigation further established that MHT Curt Ellis, MHT Eric Bittle, MHT Justin Butler, MHT Chris Lingle, and MHT John Dickerson were present during MHT Allen's altercation with XX XXXXX but failed to intervene and failed to subsequently report the full extent of the injuries XX XXXXX suffered and the cause of those injuries, even though, as MHT Lingle stated, it looked like XX XXXXX had "gone three rounds with Mike Tyson." As a result, XX XXXXX did not receive a complete examination, including x-rays, of all his injuries until two days after the abuse occurred, when Choate Security received an anonymous call regarding XX XXXXX which prompted Security to check-in with XX XXXXX.

MHTs Allen, Ellis, Bittle and Butler were subsequently criminally investigated; MHT Allen was charged with aggravated battery and ultimately pleaded guility to obstruction of justice, a felony. MHTs Ellis, Bittle and Butler pleaded guilty to failure to comply with reporting requirements., a misdemeanor.

OIG concludes, based on the evidence obtained in this matter, that (1) MHT Allen engaged in conduct that constituted physical abuse; (2) MHTs Ellis, Bittle, Butler, Lingle and Dickerson engaged in conduct that constituted neglect; and (3) Choate DC engaged in conduct that constituted neglect.

More specifically with respect to Choate DC, OIG's investigation revealed Choate staff systemically failed to comply with Choate policies and DHS Directives. Most notably, Choate staff collectively failed to intervene to prevent or stop the abuse, failed to report the full extent of XX XXXXX injuries, and failed to report the abuse

[1] On December 22, 2014, OIG referred this case to the Illinois State Police (ISP) for criminal investigation. In accordance with OIG policy and investigatory best practices, OIG suspended its administrative investigation while the matter was being criminally investigated and prosecuted. Although OIG received verbal permission to proceed with its administrative investigation in May 2020, OIG determined that the best course of action was to resume its investigation after the criminal process had been completed. MHT Allen ultimately pleaded guility to a felony count of Obstructing Justice and Destroying Evidence on December 15, 2021, and the other charges against him were dismissed, thus completing the criminal process for this matter. OIG received the official referral of the case from ISP on June 7, 2022 and received the official ISP file on June 29, 2022.

that occurred, which multiple Choate staff described as one of the worst incidents of abuse they had seen. In addition, the evidence reflects that the staff involved in this incident almost uniformly lied to the facility and the Illinois State Police during their subsequent investigative interviews in an attempt to cover-up MHT Allen's abuse and also colluded and conspired to obstruct investigative efforts, suggesting that, for some Choate staff, deceit is an accepted response to allegations of abuse and neglect. Such a widespread attempted cover-up, which involved at least eight Choate staff, demonstrates that the facility has not taken sufficient steps to combat the "code of silence"—wherein employees witness misconduct by another employee but conceal what they saw—that evidently exists at Choate.

Accordingly, OIG finds that the allegation of physical abuse against MHT Allen is substantiated, the allegations of neglect against MHT Ellis, MHT Bittle, MHT Butler, MHT Lingle, and MHT Dickerson are substantiated, and the allegation of neglect against Choate DC is substantiated.

Finally, Choate Developmental Center should address the recommendations set forth in Section V of this report, which are intended to prevent and deter such cover-up attempts going forward.

## II. Background

### A. Individual XXXXX XXXXX

XX XXXXX, born XXX XX XXXX, is diagnosed with and receives services for XXXXX XXXXX XXXXX, XXXXX XXXXX, and XXXXXX. According to XX XXXXX Individual Support Plan (ISP), XX XXXXX was identified in his maladaptive behavior assessment as exhibiting XXXXX XXXXX and XXXXX since his admission. XX XXXXX had been XXXXX XXXXX XXXXX, which consisted of arrests for XXXXX XXXXX, XXXXX XXXXX, XXXXXX XXXXX of a XXXXX, and XXXXX XXXXX. XX XXXXX had also had several XXXXX XXXXX, and he was described as XXXXX XXXXX. XX XXXXX was previously admitted to the XXXXX XXXXX XXXXX XXXXX in XXXXX XXXX after being diagnosed with XXXXX XXXXX XXXXX and a XXXXX XXXXX XXXXX. While at XXXXX, XX XXXXX was restrained at least one time due to XXXXX XXXXX, and had incidents of significant XXXXX towards family, police, paramedics, and others in authority. On XXXX XX, XXXX XX XXXXX was admitted to XXXXX, due to his XXXXX XX XXXXX XXXXX. At the time, XX XXXXX was facing several charges from 2012 to 2014, which included XXXXX XXXXX to a XXXXX XXXXX XX XXXXX XXXXX and XXXXX XXXXX, as well as XXXXX XXXXX to a Peace Officer. XX XXXXX was noted to frequently contradict himself, and to report things that were impossible. XX XXXXX had a XXXXX diagnosis of an XXXXX XXXXX, which was described as XXXXX to XXXXX. XX XXXXX was also diagnosed with XXXXX XXXXX XXXXX.

## B. Subjects of Investigation[2]

### 1. MHT Mark Allen

MHT Allen was hired by Choate Developmental Center on February 1, 2011. His last Rule 50 training was on October 13, 2013, and he was placed on leave pending the outcome of OIG's investigation on December 22, 2014.

### 2. MHT Curtis Ellis

MHT Ellis was hired by Choate Developmental Center on October 19, 1998. His last Rule 50 training was on August 27, 2014, and he was placed on leave pending the outcome of OIG's investigation on January 10, 2020.

### 3. MHT Justin Butler

MHT Butler was hired by Choate Developmental Center on January 3, 2011. His last Rule 50 training was on June 10, 2014, and he was placed on leave on March 22, 2019, pending the outcome of OIG's investigation.

### 4. MHT Eric Bittle

MHT Bittle was hired by Choate Developmental Center on February 16, 2010. His last Rule 50 training was on August 27, 2014, and he was placed on leave on June 18, 2019, pending the outcome of OIG's investigation.

### 5. MHT Chris Lingle

MHT Lingle was hired by Choate Developmental Center on November 7, 2003. His last Rule 50 training was on March 24, 2022. He is currently a Security Therapy Aide on Choate's Forensic Unit.

### 6. MHT Mike Dickerson

MHT Dickerson was hired by Choate Developmental Center on November 20, 1991 and retired from state service on December 29, 2017.

### 7. XXXXX XXXXX XXXXX XXXXX XXXXX XXXXX

XXXXX XXXXX XX XXXXX XXXXX was hired by Choate Developmental Center on November 1, 2010. Her last Rule 50 training was on January 5, 2022. She is currently employed at the facility.[3]

---

[2] XXX XXXXX XXXXX was identified initially as an accused. However, it was determined he was not working on grounds at the facility at the time of the incident.

[3] At the time of the initial allegation, XX XXXXX XXXXX XXXXX XXXXX was her correct name. However, since then she has married and taken on the name of XXXXX XXXXX XXXXX. Therefore, throughout the report and statements she is referred to as XX XXXXX/XX XXXXX/XX XXXXX XXXXXX.

## III. Applicable Rules, Regulations, and Law

### A. Illinois Administrative Code

Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code defines physical abuse as "[a]n employee's non-accidental and inappropriate contact with an individual that causes bodily harm." Section 50.10 further defines "bodily harm" as "[a]ny injury, damage or impairment to an individual's physical condition, or making physical contact of an insulting or provoking nature with an individual."

Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code defines neglect as "[a]n employee's, agency's or facility's failure to provide adequate medical care, personal care or maintenance," which "causes an individual pain, injury or emotional distress, results in either an individual's maladaptive behavior or the deterioration of an individual's physical condition or mental condition, or places an individual's health or safety at substantial risk of possible injury, harm or death."

Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code defines egregious neglect as "[a] finding of neglect as determined by the Inspector General that represents a gross failure to adequately provide for, or a callous indifference to, the health, safety or medical needs of an individual and results in an individual's death or other serious deterioration of an individual's physical condition or mental condition."

Pursuant to Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code an investigation is substantiated where "[t]here is a preponderance of the evidence to verify the substance of the allegation."

Pursuant to Title 59, Chapter I, Part 50, Section 50.20(a)(2) of the Illinois Administrative Code, "[i]f an employee witnesses, is told of, or suspects an incident of physical abuse, sexual abuse, mental abuse, financial exploitation, neglect or a death has occurred, the employee, community agency or facility shall report the allegation to the OIG hotline . . . immediately, but no later than . . . [w]ithin four hours after the initial discovery of an incident of alleged physical abuse, sexual abuse, mental abuse, financial exploitation or neglect."

Pursuant to Title 59, Chapter I, Part 50, Section 50.30(f)(1) of the Illinois Administrative Code, with respect to allegations of abuse, neglect or financial exploitation that fall within OIG's jurisdiction, "the authorized representative or his or designee of a community agency or facility shall . . . ensure the immediate health and safety of the involved individuals and staff, including ordering medical examinations and healthcare, when applicable . . ."

### B. Department of Human Services Act

Pursuant to 20 ILCS 1305/1-17(i), "[a]ny employee who fails to cooperate with an Office of the Inspector General investigation is in violation of [the Department of Human Services] Act." Failure to cooperate with an investigation "includes, but is not limited to, any one or more of the following: (i) creating and transmitting a false report to the Office of the Inspector General hotline, (ii) providing false information to an Office of the Inspector General Investigator during an investigation, (iii) colluding with other employees to cover up evidence, (iv) colluding with other employees to provide false information to an Office of the Inspector General investigator,

(v) destroying evidence, (vi) withholding evidence, or (vii) otherwise obstructing an Office of the Inspector General investigation.

### C. Relevant Facility Policies

Pursuant to Choate Developmental Center Standard Operating Policy/Procedure (SOPP) # 0967 Injury Reporting, any injury the nurse considers "suspicious" in nature (no matter how the injury is classified) must be examined by a physician and reported on the Significant Event Report SODC-620. Suspicious injuries may include large bruises, bruising of differing ages, injuries not previously reported, some types of burns, or those injuries where the stated cause is not plausible or reasonable. Further, any injury, regardless of classification/severity, involving abuse, neglect, or mistreatment, or those injuries determined to be suspicious in nature require reporting to the OIG, the Illinois Department of Public Health (IDPH), and the individual's parent/guardian.

### D. Relevant IDHS Administrative Directives

01.02.03.040 Rule of Employee Conduct states "[a]n Employee shall provide full cooperation with any investigation conducted by the Department, the Office of Inspector General of the Department, the Office of the Executive Inspector General (OEIG), or any official investigative entity. Such cooperation shall be truthful and complete, and if any judicial proceedings require an Employee's testimony, shall be truthful and complete. Employee cooperation is a condition of employment."

## IV. Summary of Investigation

### A. Complaint

On December 22, 2014, OIG received a report of abuse at Choate Developmental Center, alleging that on December 20, 2014, MHT Allen punched XX XXXXX in the face during breakfast and then dragged XX XXXXX from the dining room area into his bedroom to be restrained. MHT Allen also threatened to kill XX XXXXX if he reported the incident to anyone. XX XXXXX had black eyes, abrasions to his face, a busted lip, bruises to his chest and back, and pain to his thumb upon examination. MHT Curt Ellis and MHT Justin Butler were involved in the incident.

### B. Illinois State Police – Division of Internal Investigation

On December 22, 2014, OIG referred this allegation to the Illinois State Police Division of Internal Investigation (ISP/DII) and ISP/DII accepted the case to investigate that same day. The case was subsequently referred to the Union County State's Attorney Office for review and accepted for prosecution.

On March 9, 2016, MHT Allen was indicted on four felony counts with three counts of Aggravated Battery in a Public Place and one Intimidation with Physical Harm. On December 15, 2021, a superseding indictment added a felony count of Obstructing Justice and Destroying Evidence. On December 15, 2021, MHT Allen pleaded guilty to a felony count of Obstructing Justice and Destroying Evidence and the other charges were dismissed. MHT Allen was sentenced to three days in jail, 24 months' probation, fines and anger management.

II. On October 5, 2016, MHTs Ellis, Butler and Bittle were indicted on four felony counts of Obstructing Justice. On November 1, 2016, a superseding indictment added one misdemeanor count of Fail to Comply with

Reporting Requirements. On January 5, 2017, MHT Ellis pleaded guilty to the Fail to Comply with Reporting Requirements, and the four felony counts were dismissed. On February 7, 2017, MHTs Butler and Bittle pleaded guilty to the Fail to Comply with Reporting Requirements, and the four felony counts were dismissed. All three were sentenced to Conditional Discharge[4]and fines.

## A. Documents

### 1. Evaluation of Observed Injuries SODC 604A

#### a) December 20, 2014

OIG reviewed the December 20, 2014 Evaluation of Observed Injuries Incident Report. In summary, the Report states as follows.[5]

On December 20, 2014, at 7:30 a.m., XX XXXXX was eating in the kitchen and attacked staff, who blocked and attempted to redirect XX XXXXX. XX XXXXX continued to attack and received injuries from struggling in the physical hold. Staff present at the time of XX XXXXX injuries: MHTs Ellis, Dickerson and Lingle.

MHT Dickerson, as lead worker, reviewed and signed the form on December 20, 2014. XX XXXXX-XXXXX completed the nursing section on December 20, 2014. XX XXXXX-XXXXX documented that, based on her assessment, the injury did not appear suspicious or the result of abuse neglect or mistreatment. The Unit Director Section was completed on December 23, 2014. It could not be determined who completed this section as the signature is illegible. This section documents that the injuries were under investigation due to an allegation of staff abuse.

#### b) December 22, 2014

OIG reviewed the December 22, 2014 Evaluation of Observed Injuries completed by XX XXXXX-XXXXX. In summary, the Report states as follows.

XX XXXXX stated a staff member hit him causing the bruises on his face but did not indicate what caused the bruising on his shoulders. The form was signed by XX XXXXX-XXXXX and MHT Dickerson. Again, the Unit Director's signature is illegible.

### 2. Restraint Documentation

OIG reviewed the Restraint Documentation for XX XXXXX on December 20, 2014. In summary, the documentation states as follows.

[4] Pursuant to 730 ILCS 5/5-6-1, the court may impose a sentence of conditional discharge for an offense if the court is of the opinion that neither a sentence of imprisonment nor of periodic imprisonment nor of probation supervision is appropriate.

[5] The report does not indicate the staff who observed the injury and completed the form, other than their title "MHT II."

**a) Order for Restraint**

On December 20, 2014, XX XXXXX-XXXXX ordered the Initial Temporary Order at 7:30 a.m. for attacking staff, the Order was given at 7:25 a.m., Verbal/Phone Physician Order was received at 7:40 a.m. for 5-point restraints, and the Physician's Validation (the physician's signature is illegible) was given at 7:50 a.m. Administration was notified at 7:40 a.m.

**b) Restraint Monitoring Record**

MHT Allen was assigned to monitor XX XXXXX while he was in restraints. MHT Allen and XX XXXXX-XXXXX documented XX XXXXX behaviors while he was in restraints from 7:30 a.m. until he was released at 9:20 a.m.

**c) Notice Regarding Restriction of Rights of an Individual**

XX XXXXX was placed in physical hold, restraints and then five-point restraints for attacking staff and not being able to be redirected. The form was signed by XX XXXXX-XXXXX.

**d) Restraint Debriefing Tool**

This form is used to document questions and responses by the individual within the shift following their release from restraints. MHT Allen completed the form. XX XXXXX said he was placed in restraints for attacking staff and he understood his exit criteria. He should have talked to staff when he had a problem to avoid being placed in restraints. Staff can help XX XXXXX by asking him what is wrong.

**e) Supplemental Report on Use of Restraint**

OIG could not determine the staff who completed the Supplemental Report on Use of Restraint. The Report stated that an unplanned emergency transport of XX XXXXX occurred at 7:35 a.m. when a 2-man walking forward hold was used from the dining room to the dorm. XX XXXXX was in restraints from 7:40 a.m. until 9:20 a.m. Staff that implemented the procedure were MHT Allen, MHT Dickerson, MHT Lingle, MHT Ellis and XX XXXXX-XXXXX. XX XXXXX was placed in restraints due to being non-compliant, verbally aggressive, and physically aggressive in the kitchen at 7:30 a.m. The restraint was documented to be effective. MHT Allen completed the debriefing with XX XXXXX.

**3. Injury Report**

**a) December 20, 2014**

OIG reviewed the December 20, 2014 Injury Report concerning XX XXXXX injury, authored and signed by MHT Mark Allen and reported to XX XXXXX XXXXX. In summary, the Injury Report states as follows.

XX XXXXX injuries were documented by MHT Allen as observed and as self-injurious behavior. XX XXXXX reportedly attacked staff who attempted to block XX XXXXX, but XX XXXXX continued swinging punches at staff. XX XXXXX was placed in a physical hold, but XX XXXXX continued to exhibit physical aggression by punching staff in the face. XX XXXXX also began to display self-injurious behavior by hitting himself in the face and head against the wall and floor. XX XXXXX had noted abrasions to his face, neck, and chest. XX XXXXX also had a raised area to his right forehead, bruising to his nose, and a 1 cm laceration to upper lip.

**b) December 22, 2014**

OIG reviewed the December 22, 2014 Injury Report concerning XX XXXXX injury, authored by XX XXXXX XXXXX.
In summary, the Injury Report states as follows. XX XXXXX injuries were documented as unobserved and discovered at 8:40 a.m. Bruising to bilateral front and back shoulders. These injuries were not visible on the date of the facial and chest injuries. XX XXXXX said staff hit him.

**4. Nursing Shift Report**

OIG reviewed the December 20, 2014 through December 25, 2014 Nursing Shift Reports. In summary, the reports state as follows.

On December 20, 2014, XX XXXXX was placed in 5-point restraints from 7:30 a.m. until 9:20 a.m. XX XXXXX engaged in self-injurious behavior when he scratched himself and banged his head on the floor and walls. Neurological checks were ordered.[6] On December 21, 2014, the neurological checks were completed.

On December 22, 2014, the neurological checks were completed. Staff abuse was alleged, and XX XXXXX was seen by doctor and security and sent to XXXXX XXXXX Hospital for x-rays of his face. Neurological checks were to be completed. In a note of different handwriting, it is stated that the neurological checks were good, but XX XXXXX "really looks bad." On December 23, 2014 and December 25, 2014, XX XXXXX was given XXXXX for complaint of headache.

**5. Acute Care Log**

OIG reviewed the XXXXX XXXXX Acute Care Log for December 2014. In relevant part, the log states as follows.

RN K. Harris documented that on December 20, 2014, XX XXXXX engaged in self-injurious behavior when he headbutted the wall and floor and scratched his face. Neurological checks were ordered.

**6. XXXXX XXXXX Hospital Radiology Report**

OIG reviewed the December 22, 2014 Radiology Report. In summary, the Report states as follows.

No evidence of fracture or dislocation to right thumb. Facial bones were normal.

**7. Significant Event Report**

OIG reviewed the December 22, 2014 Significant Event Report completed by Security Officer (SO) Jason Wece at 9:10 a.m. In summary, the report states as follows.

---

[6] Choate Developmental Center SOPP #1042 defines a head injury as "any injury to the head involving trauma to the scalp, skull and/or brain." In the event of a head injury, a neurological assessment, which will be documented on a Neurological Assessment Check Sheet (CDC-1042a) is to be completed by the RN/LPN initially and then by every shift for the next 72 hours. This information will be shared in the nursing shift change meetings. Even if checks are discontinued, the nurse is still responsible for monitoring the individual's condition and documenting on the acute care log and in the individual's clinical daily record for no less than 14 days.

SO Wece discovered the allegation of abuse involving XX XXXXX and MHT Allen at 8:05 a.m. on December 22, 2014. Choate Security Chief XXXXX XXXXX directed SO Wece to see XX XXXXX. XX XXXXX alleged he was assaulted by MHT Allen on December 20, 2014, during morning breakfast in the dining room. MHT Allen punched XX XXXXX multiple times in the face and dragged him to his bedroom where he was placed in restraints. XX XXXXX said MHT Allen bent his thumb back and said XX XXXXX "sucked dick" and had killed his brother.[7]

XX XXXXX-XXXXX was notified of the allegation that XX XXXXX facial and other bruising was caused by staff abuse on December 22, 2014. XX XXXXX-XXXXX notified the doctor. Examination revealed more bruising to XX XXXXX front and posterior shoulder. XX XXXXX was sent to XXXXX XXXXX Hospital for facial x-rays. XX XXXXX-XXXXX documented that on December 20, 2014, she was called to the east end dining room where XX XXXXX was being held on the floor by MHT Allen due to attacking staff, banging his head on the floor/wall, and refusing redirection. XX XXXXX-XXXXX observed XX XXXXX fighting with staff, kicking, swinging his body/arms/legs, and threatening to kill staff. MHT Allen, as the accused, was removed from contact.

### 8. Critical/Incident Report

OIG reviewed the December 22, 2014 Critical/Incident Report completed by SO Connie Friend at 8:00 p.m. In summary, the report states as follows.

At 5:30 p.m., SO Friend went to the unit to interview individuals who were in the kitchen area at the time of the incident. Several individuals stated MHT Ellis and MHT Butler were present during the incident and hit XX XXXXX during the incident.

### 9. Photographs

OIG reviewed the photographs of XX XXXXX injuries taken on December 26, 2014. In summary, the photographs show the following.

Photographs obtained show areas of injuries identified in the Injury Report to XX XXXXX face, forehead, right side of head, torso, and shoulder. In addition, photographs show evidentiary images of blood spatter on the walls and floors.

### 10. Text Messages

ISP reviewed text messages from MHT Allen's cellular phone. In summary, the text messages related to the December 20, 2014 altercation between MHT Allen and XX XXXXX stated as follows.

On December 20, 2014, in response to a text from MHT Jackie Howard, MHT Allen stated that he was busy, and that they had just got done "strapping XXXXX in," and further stated, "I fucked his world up this morning." MHT Howard replied back to MHT Allen "U guys always do lol…".

---

[7] According to XX XXXXX ISP, on June 30, 2013, when XX XXXXX was questioned regarding the death of his brother, XXXX, XX XXXXX said he and XXXX had an argument earlier on the day of XXXXX disappearance.

On December 22, 2014, MHT Allen received MHT Chris Lingle's cell phone number from MHT Butler. MHT Allen sent a text message to MHT Lingle asking for MHT Ellis' phone number to get their "story straight." MHT Lingle provided MHT Allen with MHT Ellis' phone number and wished him good luck.

On December 23, 2014, MHT Allen instructed MHT Ellis to tell investigators he was not in the kitchen, but that he was in the bathroom during the incident and MHT Allen would say he was in the kitchen by himself.

On January 13, 2015, MHT Allen told Case Manager (CM) Melinda Miller that he was doing his best to think he was going to be okay, even though he did not believe he was going to be okay, and CM Miller said she had not heard anything, but would let him know if she did. CM Miller also sent text messages to MHT Allen several times to let him know what ISP-DII Agents were asking people during their interviews. CM Miller stated she was paranoid about using cell phones to communicate with MHT Allen about the incident. CM Miller told MHT Allen that she would only talk to him about the information face to face, and not via the telephone. Eventually, MHT Allen agreed to go to CM Miller's residence to discuss the investigation.

### B. Interviews[8]

#### 1. XX XXXXX XXXXX

##### a) Facility Statement

The facility interviewed individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

MHT Allen punched XX XXXXX causing his injuries. MHT Allen told XX XXXXX that if XX XXXXX turned MHT Allen in, MHT Allen would beat him up. MHT Allen punched XX XXXXX a bunch of times in his face. XX XXXXX did not know why MHT Allen hit him and said, “just for the heck of it.” This happened Saturday at breakfast in the dining room. Individuals from Groups X, X and X were present at the time of the incident. There were some other staff present but XX XXXXX did not know if they saw it. XX XXXXX recalled MHTs Regina Hubble, Erich Bittle and Mike Dickerson being there. XX XXXXX was examined by the doctor and MHT Allen told XX XXXXX to say he fell.

Prior to the incident, MHT Allen said XX XXXXX was at Choate because XX XXXXX killed his brother. XX XXXXX said fuck you to MHT Allen. MHT Allen then punched XX XXXXX in the mouth and then put him in restraints in his bedroom. MHT Allen said XX XXXXX did not have a girlfriend because he “sucks dick.” XX XXXXX responded, “fuck you” and said he was not gay. MHT Allen punched XX XXXXX in the mouth, jaw, nose and eyes. XX XXXXX did not know how many times MHT Allen hit him. MHT Allen just kept hitting XX XXXXX while in the dining room and then dragged him on the floor, across the hallway to his bedroom, and

[8] During their facility interviews individuals XXXXX XXXXX, XXXXX XXXXX, XXXXX XXXXXX, XXXXX XXXXX, XXXXX XXXXX, and XXXXX XXXXX stated they did not know anything regarding the incident, while XXXXX XXXXX and XXXXX XXXXX refused to provide a statement.

placed him in restraints. MHT Allen twisted XX XXXXX thumb backwards and said if XX XXXXX turned him in, MHT Allen would kill him after the investigation. While putting XX XXXXX in restraints, MHT Allen broke the electrical outlet and XX XXXXX blood was all over the wall and on the floor in the dining room.

**b) Facility Follow-up Statement**

The facility re-interviewed XX XXXXX on December 24, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX told his mother about MHT Allen hitting him and blackening his eyes and putting him in restraints. XX XXXXX had not seen MHT Allen since the incident. No one else abused XX XXXXX.

**c) OIG Interview**

OIG interviewed XX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was in the dining room and MHT Allen was mad about something at home. Then, for no reason, MHT Allen walked up to XX XXXXX and punched him in the face. MHT Allen then dragged XX XXXXX to his room and placed him in restraints. The restraints were really tight. MHT Allen said “fuck you” to XX XXXXX and XX XXXXX said the same back to MHT Allen. XX XXXXX was fighting back and MHT Allen bent XX XXXXX fingers back to break them. MHT Allen then said XX XXXXX killed his brother and XX XXXXX said he did not. MHT Allen said he would kill XX XXXXX if he came back. XX XXXXX was x-rayed and there was blood all over.

Not many people were present when this occurred. XX XXXXX said he was not doing anything when MHT Allen started pounding on him. MHT Allen was the only one to drag XX XXXXX to his bedroom and put him in restraints.

**d) ISP Interview**

ISP interviewed XX XXXXX on January 29, 2015. In summary, XX XXXXX stated as follows.

XX XXXXX was seated when MHT Allen began to yell at residents in the dining room. MHT Allen accused XX XXXXX of killing his brother and made derogatory comments about XX XXXXX and his mother. MHT Allen pushed XX XXXXX out of his chair onto the floor where he hit his head on the floor and MHT Allen began to punch XX XXXXX "100 times" to his face, body, and groin.

XX XXXXX described the incident starting when he was asked by MHT Allen to pull his pants up. XX XXXXX said MHT Allen and another staff member (who he could not recall) dragged him from the dining room to his bedroom. MHTs Allen, Ellis, and Butler were all in his bedroom while he was in restraints, and they all punched him in the face, body, and groin. At some point XX XXXXX recalled XX XXXXX XXXXXX telling the other staff to “give him a few minutes” and then after a while they all took the restraints off.

After being released from restraints XX XXXXX was in the bathroom washing blood from his face when MHT Allen threatened to “kill” XX XXXXX if he turned him in. XX XXXXX described there being a “ton of blood everywhere” in his bedroom and dining room. XX XXXXX admitted to striking MHT Allen in self-defense, stating he was fighting MHT Allen the entire time MHT Allen was attempting to control XX XXXXX in the dining room and restraining. XX XXXXX indicated MHT Allen had broken his DVD player.

XX XXXXX said he did not recall seeing MHT Dickerson during the incident and said MHT Dickerson was a nice person. XX XXXXX witnessed MHT Allen strike other residents in the past. XX XXXXX was extremely scared of MHT Allen and was worried he would be harmed if MHT Allen came back to work.

**2. XX XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX witnessed the incident between MHT Allen and XX XXXXX. XX XXXXX spit in the faces of MHTs Allen, Ellis, and Butler. Then things got really bad and MHTs Allen, Ellis and Butler hit XX XXXXX. XX XXXXX then went to his bedroom and did not see anything else.

**b) ISP Interview**

ISP interviewed XX XXXXX on January 29, 2015. In summary, XX XXXXX stated as follows.

MHT Allen had told XX XXXXX to pull his pants up, causing XX XXXXX to become angry. MHT Allen yelled back at XX XXXXX and they began to argue. XX XXXXX believed the injuries to XX XXXXX were caused by MHT Allen, MHT Ellis, and MHT Butler, while XX XXXXX was restrained in his bedroom; however, XX XXXXX did not observe any of them strike XX XXXXX.

**3. XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed Individual XXXXX XXXXX. In summary, XX XXXXX stated he did not know anything about the incident.

**b) ISP Interview**

ISP interviewed XX XXXXX on January 29, 2015. In summary, XX XXXXX stated as follows.

XX XXXXX was in the XXXXX XXXXX Dining Room when the incident began. MHT Allen called XX XXXXX a "bitch," and pushed XX XXXXX to the ground. XX XXXXX did not witness MHT Allen strike XX XXXXX.

**4. XX XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was present for the incident between MHT Allen and XX XXXXX. MHT Allen asked XX XXXXX to pull his pants up and XX XXXXX said no. MHT Allen told XX XXXXX that he was going to write him up. XX XXXXX was sitting on the side of the table and MHT Allen came up from behind XX XXXXX, pushed XX XXXXX to the floor and hit him twice with a fist. There were no other staff around. MHT Allen then called for

staff to put XX XXXXX into restraints. XX XXXXX did not see anyone drag XX XXXXX. XX XXXXX did not hit himself or the wall. XX XXXXX feared MHT Allen and did not like him.

**b) ISP Interview**

ISP interviewed XX XXXXX on January 21, 2015. In summary, XX XXXXX stated as follows.

MHT Allen told XX XXXXX to pull his pants up, but XX XXXXX refused. After threatening to write XX XXXXX up, MHT Allen took XX XXXXX to the ground. XX XXXXX said he did not observe MHT Allen strike XX XXXXX.

**5. XX XXXXX XXXXX**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was in the kitchen when MHT Allen and XX XXXXX had an altercation. MHTs Allen and Ellis stomped on XX XXXXX head because XX XXXXX spit on them. XX XXXXX saw a bloody towel that was really red that MHT Allen threw in the trash can. XX XXXXX did not think MHT Ellis hurt XX XXXXX but was holding XX XXXXX head down with his foot. XX XXXXX was telling them to get off him and that they were hurting him. MHT Allen and Ellis then dragged XX XXXXX out of the room to his bedroom and XX XXXXX was placed into restraints. XX XXXXX feared MHTs Allen and Ellis.

**6. XX XXXXX XXXXX**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was present when MHT Allen placed XX XXXXX in a physical hold and MHTs Eric Bittle and Chris Lingle came down to see what was going on. XX XXXXX then left the kitchen and did not see what else happened. XX XXXXX did spit on some staff.

**7. XX XXXXX XXXXX**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was present for the incident in the dining room involving MHT Allen and XX XXXXX. XX XXXXX was sitting in the middle and MHT Allen grabbed him. It happened fast and XX XXXXX saw XX XXXXX hit the floor. Prior to this, MHT Allen told XX XXXXX to pull up his pants. XX XXXXX did not hear XX XXXXX response because XX XXXXX got out of the way and walked out of the kitchen. MHTs Bittle and Ellis were present. XX XXXXX did not see anyone drag XX XXXXX.

**8. XX XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX was present for the incident between XX XXXXX and MHT Allen. MHT Allen told XX XXXXX to pull up his pants, but they were already up. MHT Allen shoved XX XXXXX down and hit XX XXXXX with his fist and choked XX XXXXX. MHT Ellis took off XX XXXXX shoes and tried to hold him down. MHT Ellis bent XX XXXXX fingers back while MHT Allen hit XX XXXXX until his face was bloody. XX XXXXX was bleeding from his mouth and upper eye. MHT Allen cleaned up the blood and threw the rag away. There was another staff present, but XX XXXXX did not know his name. XX XXXXX was dragged out of the kitchen by MHTs Allen and Ellis. XX XXXXX did not see what occurred in XX XXXXX bedroom because the door was closed.

**b) ISP Interview**

ISP interviewed XX XXXXX on January 21, 2015. In summary, XX XXXXX stated as follows.

XX XXXXX observed MHT Allen get in XX XXXXX face, which started the incident. MHT Allen struck XX XXXXX in the face several times, and XX XXXXX defended himself by striking MHT Allen. XX XXXXX looked into XX XXXXX room while XX XXXXX was restrained to his bed, and XX XXXXX nose was bleeding and XX XXXXX was hitting his head off the mattress while yelling, "let me out."

**9. XX XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed Individual XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX stated as follows.

XX XXXXX spit in MHT Allen's face and MHT Allen hit XX XXXXX two to three times in the face. Regina[9] told the individuals to leave the kitchen and XX XXXXX was taken to his room. Regina was not in the room when MHT Allen hit XX XXXXX. Regina came in when MHTs Allen and Ellis were taking XX XXXXX to his bedroom for restraints. MHT Ellis held XX XXXXX down by his legs. There was blood in the kitchen which MHT Allen cleaned up with a towel or sheet and threw it in the trash can. XX XXXXX was going to retrieve it but did not because he was scared. XX XXXXX looked in XX XXXXX bedroom and saw MHT Allen punching XX XXXXX in the face. XX XXXXX was not sure if other staff were in the room.

**b) ISP Interview**

ISP interviewed XX XXXXX on January 21, 2015. In summary, XX XXXXX stated as follows.

MHT Allen and XX XXXXX began arguing because XX XXXXX refused to eat his meat, claiming he was allergic to it. After XX XXXXX refused to eat his meat, MHT Allen grabbed XX XXXXX by the shirt and threw him to the ground. XX XXXXX then spit in MHT Allen's face, and MHT Allen responded by striking XX XXXXX in the face with closed fists an unknown number of times. XX XXXXX pointed to the eye area when asked where XX XXXXX was struck. MHT Allen also kicked XX XXXXX with his brown steel-toed boots. XX

[9] XX XXXXX did not provide the last name or title for Regina. However, XX XXXXX stated MHT Regina Hubble was present in the dining room when the incident began.

XXXXX observed MHT Ellis throw a bloody sheet away, and XX XXXXX was going to retrieve it, but he was afraid MHT Ellis would hurt him.

### 10. MHT Jackie Howard

ISP interviewed MHT Jackie Howard on May 28, 2015. In summary, MHT Howard stated as follows.

MHT Allen bragged to MHT Howard about the injuries MHT Allen inflicted on XX XXXXX. MHT Allen first bragged via text message approximately one hour after the incident. MHT Allen again bragged to MHT Howard on December 20, 2014, when MHT Howard went into work and MHT Allen told her to go look at XX XXXXX. MHT Allen bragged to several other employees at XXXXX about striking XX XXXXX. MHT Howard believed the injuries occurred while XX XXXXX was in restraints in XX XXXXX bedroom.

According to MHT Howard, MHT Allen was known to lose his temper with residents in the past and would grab residents and "slam" them against walls, sometimes without provocation. MHT Howard believed MHT Allen to go overboard in restraining residents. MHT Howard and other staff members had to intervene at least five times in the past to prevent MHT Allen from hurting residents. MHT Howard also observed MHT Butler grab residents in a similar manner in the past, although, she did not believe MHT Butler's actions were as severe as MHT Allen's actions. MHT Butler would drag residents from common areas to their rooms by himself in the past.

### 11. Case Manager Melinda Miller

#### a) ISP Interview

ISP interviewed Case Manager (CM) Melinda Miller on January 29, 2015. In summary, CM Miller stated as follows.

XX XXXXX had harmed himself in the past by punching walls and himself, but XX XXXXX injuries from December 20, 2014, were worse than any other injuries he had in the past from SIB. XX XXXXX past injuries from SIB displayed as redness, with some bruising and scratches to his face. CM Miller was shocked at the severity and physical appearance of XX XXXXX injuries from December 20, 2014.

MHT Allen was a good worker. MHT Allen had previously told CM Miller that he had [redacted]. CM Miller had witnessed MHT Allen get so angry at work that he could not speak.

#### b) ISP Follow-up Interview

ISP re-interviewed CM Miller on May 28, 2015. In summary, CM Miller stated as follows.

CM Miller admitted to having a romantic relationship with MHT Allen prior to, during, and after the incident but said she was no longer in the relationship. CM Miller admitted to speaking with MHT Allen after being interviewed by ISP but stated she did not tell him any pertinent information. CM Miller knew the incident was being investigated criminally, but she did not believe she had any pertinent information to give DII, and therefore, had no information to give MHT Allen. CM Miller could not provide a reason why she sent MHT Allen several text messages telling him not to talk with her using his cellular phone.

MHT Allen said that XX XXXXX injuries were a result of SIB. MHT Allen also told CM Miller that MHT Bittle was angry with him over the incident and told her that MHT Butler and MHT Ellis were present during the incident.

**12. MHT Nicole Rosenthal**

**a) Facility Statement**

The facility interviewed MHT Nicole Rosenthal on December 22, 2014. In summary, MHT Rosenthal stated as follows.

MHT Rosenthal did not have any contact with XX XXXXX on December 20, 2014, and had never seen MHT Allen punch, curse, threaten or drag XX XXXXX.

**b) ISP Interview**

ISP interviewed MHT Nicole Rosenthal on January 29, 2015. In summary, MHT Rosenthal stated as follows.

MHT Rosenthal was on the opposite end of the XXXXX XXXXX Building when the incident occurred. MHT Rosenthal was told by MHT Allen about his difficulties with the death of a friend while MHT Allen was in Iraq, along with MHT Allen suffering from [redacted] MHT Rosenthal was leery of MHT Allen because other employees told her he had mood swings from friendly to distant.

**13. Qualified Intellectual Disability Professional Edwina Bellamy**

**a) Facility Statement**

The facility interviewed Qualified Intellectual Disability Professional (QIDP) Edwina Bellamy on December 29, 2014. In summary, QIDP Bellamy stated as follows.

On December 24, 2014, QIDP Bellamy walked into the group room and XX XXXXX handed her the telephone and said his mother was on the line. His mother said XX XXXXX could not talk about what happened to him. QIDP Bellamy responded that she had tried to call her several times to inform her about had happened. At no time during this call did QIDP Bellamy tell XX XXXXX to get off the phone and she denied monitoring his call with mother.

**b) ISP Interview**

ISP interviewed QIDP Bellamy on January 29, 2015. In summary, QIDP Bellamy stated as follows.

QIDP Bellamy oversaw XX XXXXX file and interacted with him daily. XX XXXXX injuries were the worst she had ever seen. XX XXXXX hit himself in the past, but nothing which required a doctor's visit. QIDP Bellamy did not know MHT Allen very well, but he would become agitated, which would cause him to become quiet and "stalk" around the XXXXX XXXXX Building.

**14. Dr. Joel Vercide**

**a) Facility Statement**

The facility interviewed Dr. Joel Vercide on December 22, 2014. In summary, Dr. Vercide stated as follows.

XX XXXXX told Dr. Vercide that he was hit multiple times on Friday. The physical examination revealed bilateral periorbital ecchymosis (black eye).

**b) ISP Statement**

ISP interviewed Dr. Vercide on January 25, 2015. In summary, Dr. Vercide stated as follows.

Dr. Vercide examined XX XXXXX after he was removed from restraints. XX XXXXX lip had a small laceration but did not require stitches. Both of XX XXXXX eyes were puffy and black in color. It was possible XX XXXXX injuries were caused by XX XXXXX injuring himself, but Dr. Vercide did not believe XX XXXXX caused his own injuries as he does not have the type of personality to inflict such harm upon himself. Dr. Vercide said in the 12 years he has been employed at XXXXX, XX XXXXX injuries were the worst he had ever seen, but he could not determine if the injuries were from self-injurious behavior or abuse.

**c) OIG Statement**

OIG interviewed Dr. Vercide on July 26, 2022. In summary, Dr. Vercide stated as follows.

Dr. Vercide had no recollection of the incident under investigation. Dr. Vercide reviewed documentation related to XX XXXXX restraint and Dr. Vercide recognized his handwriting and signature on the documentation. According to the documentation, Dr. Vercide saw XX XXXXX during the first hour of the restraint and the purpose of the examination was to determine if the restraint caused any medical complications and if the restraint needed to be extended.

Follow-up exams may or may not be needed depending on the severity of the initial injury and could also be determined by the nurse caring for the individual. Neuro checks are performed when there is a head injury, and they are done for 24 hours depending on the physician's discretion. Nursing staff initiates the checks if there is a head injury.

Dr. Vercide was provided a copy of his January 25, 2015 ISP statement to review. In reference to this statement, Dr. Vercide noted that there appeared to be a few statements he made in the January 25, 2015 ISP interview that conflicted with the notes Dr. Vercide wrote on December 20, 2014, like "the worst injury I have seen in years," since the documentation he completed did not indicate the severity of the injury. Also, in the January 25, 2015 interview, Dr Vercide stated that both of XX XXXXX eyes were puffy and black in color, even though the injury report did not document this. Dr. Vercide did not recall arguing with the nurse at that time about the cause of XX XXXXX injuries.

**15. Dr. Dale Vorbrich**

ISP interviewed Dr. Dale Vorbrich on January 29, 2015. In summary, Dr. Vorbrich stated as follows.

Dr. Vorbrich was concerned XX XXXXX had a broken nose, based on the bruising and swelling around XX XXXXX nose. The injuries were consistent with being caused by blunt force trauma. X-rays did not reveal any breaks or fractures in XX XXXXX nose. Dr. Vorbrich also observed bruising on XX XXXXX torso, which he did not believe to have occurred during the same incident which injured XX XXXXX face.

### 16. Choate Internal Security Investigator I Jason Wece[10]

OIG interviewed Internal Security Investigator I (ISI) Jason Wece on July 7, 2022. In summary, ISI Wece stated as follows.

ISI Wece called in the allegation regarding the incident with MHT Mark Allen. On the Monday morning after the incident, XXXXX XXXXX came into work and said he got a tip or a call over the weekend that XX XXXXX needed to be checked. ISI Wece was not sure exactly when XXXXX received this call and XXXXX never said who it was from, but XXXXX had staff who he used as sources.

ISI Wece found out where XX XXXXX resided and then went up to see him. When ISI Wece arrived on the unit, everyone scattered. When he asked to see XX XXXXX, that staff's eyes got big. As soon as XX XXXXX saw ISI Wece, XX XXXXX said, "Look at what Mark Allen did." ISI Wece then interviewed XX XXXXX in private.

This was one of the worst beatings ISI Wece had seen in his 25 years at Choate. XX XXXXX looked like Rocky at the end of Rocky 1 with his eyes all swollen. ISI Wece had XX XXXXX examined and MHT Allen removed. XX XXXXX said there was blood everywhere but when ISI Wece went to look, he could not find any because the area had been cleaned.

Later, ISI Wece took then-ISI 1 XXXXX XXXXX over to the unit to look for blood. Because of XXXXX background in forensic science, they found blood traces.

### 17. ISI XXXXX XXXXX[11]

The facility obtained an initial statement from ISI XXXXX on December 26, 2014. In summary, ISI XXXXX stated as follows.

ISI XXXXX examined XX XXXXX room and had the following observations. The majority of the observed blood was on the north wall of the room. ISI XXXXX used oblique light to look for blood on the floor south of the bed, but none was observed. No obvious blood was observed on the dorm room side of the wooden door. Upon examination of photographs, blood was present on the floor that were not circled. There was a void in area B consistent with the wall being blocked by an object onto which apparent blood was deposited.

### 18. Housekeeper Kimberly Jones

#### a) Facility Statement

The facility interviewed Housekeeper Kimberly Jones on December 23, 2014. In summary, Housekeeper Jones stated as follows.

[10] At the time of the incident, ISI Wece was a Security Officer at Choate.

[11] At the time of this incident, ISI XXXXX worked for Choate Developmental Center. XXXXX later became an Internal Security Investigator II for IDHS OIG. XXXXX retired from state service in 2019.

When Housekeeper Jones worked on December 19, 2014, she did not notice a broken outlet when cleaning east end rooms. If there was one in XX XXXXX room, Housekeeper Jones would not have noticed because his bed was pushed against that wall covering the outlet. XX XXXXX would usually tell her when an outlet was broken and had done so four months prior. On December 22, 2014, Housekeeper Jones noticed the outlet in XX XXXXX room was broken. Housekeeper Jones did not see any blood on the walls or floor.

**b) ISP Interview**

ISP interviewed Housekeeper Jones on January 29, 2015. In summary, Housekeeper Jones stated as follows.

Housekeeper Jones cleaned XX XXXXX room before and after the incident and did not observe any blood in the bedroom prior to the incident and all outlets were secured to the wall. After being told about the discovery of blood in XX XXXXX bedroom, Housekeeper Jones cleaned the bedroom and discovered a "medium" amount of blood which appeared to be diluted, possibly with spit. XX XXXXX injuries were the worst Housekeeper Jones had ever seen. Housekeeper Jones previously worked with MHT Allen when an unknown allegation of abuse had been made against him, but she described him as friendly and funny.

**19. MHT Curtis Ellis**

**a) Facility Statement**

The facility interviewed MHT Curtis Ellis on December 25, 2021. In summary, MHT Ellis stated as follows.

On December 20, 2021, MHT Ellis was working on XXXXX XXXXX in XXXXX XXXXX X. At approximately 7:20 a.m., the group was called to the kitchen to eat breakfast. Upon entry to the dining room, MHT Allen was in the dining room and MHT Regina Hubble was in the kitchen. MHT Ellis asked MHT Allen to watch his living room while MHT Ellis went to the bathroom. MHT Ellis left the dining room, used the restroom, and checked his blood sugar.

While walking back to the dining room, MHT Allen called for assistance on the radio. MHT Ellis ran to the dining room and saw MHT Allen and XX XXXXX on the floor next to the windows. XX XXXXX was hitting and kicking MHT Allen. MHT Ellis moved in to assist with the behavior and grabbed XX XXXXX left leg to keep him from kicking individuals and staff. MHT Ellis got XX XXXXX legs under control; MHT Ellis was facing XX XXXXX feet as MHT Ellis was laying on the floor on his left side. Once XX XXXXX was under control, they got up from the floor and MHTs Ellis, Allen and Dickerson escorted XX XXXXX to his bedroom. XX XXXXX was placed in mechanical restraints on his bed. MHT Ellis secured XX XXXXX right arm.

Once in restraints, XX XXXXX started spitting at staff. MHT Ellis noticed a very small amount of blood in the spit and thought that XX XXXXX must have bit the inside of his cheek so he could spit blood on staff. MHT Ellis exited XX XXXXX room and returned to his group.

MHT Ellis did not notice if XX XXXXX was bleeding while they were in the kitchen and did not see his face at this time because MHT Ellis was facing XX XXXXX feet while holding his legs. MHT Ellis said that he did not see MHT Allen punch XX XXXXX and MHT Ellis denied putting his foot on XX XXXXX head. MHT Ellis had never seen any staff abuse XX XXXXX while he was assigned to XXXXX XXXXX. MHT Ellis was not in the dining room when MHT Allen told XX XXXXX to pull up his pants. MHT Ellis did not see MHT Butler on the east end during the behavior or the restraint process.

**b) ISP Interview**

ISP interviewed MHT Ellis on February 6, 2015. In summary, MHT Ellis stated as follows.

MHT Ellis walked into the dining room and observed MHT Allen drinking coffee. MHT Ellis left MHT Allen in charge of XXXXX XXXXX X so he could go to the bathroom. On the way back from the bathroom, MHT Ellis heard a call for help in the dining room.

Upon entering the dining room, MHT Ellis observed MHT Allen straddling XX XXXXX on the floor by the north windows. MHT Ellis wrapped XX XXXXX legs to prevent him from kicking. MHT Ellis escorted XX XXXXX with MHT Allen to XX XXXXX bedroom, where MHT Dickerson had prepared the restraints. MHT Ellis initially stated that he had restrained XX XXXXX right side, but later stated that MHT Dickerson may have restrained the right side.

MHT Ellis believed XX XXXXX spit on him during the incident, due to the fact he had a small amount of pink colored spit on his arm after applying restraints. XX XXXXX was cursing at MHT Allen but did not direct any anger towards MHT Ellis or MHT Dickerson. MHT Ellis did not observe any swelling or bleeding on XX XXXXX during the incident. MHT Ellis never observed MHT Allen strike XX XXXXX, and XX XXXXX appearance was "fine" when he left XX XXXXX alone with MHT Allen in restraints.

MHT Ellis said that MHTs Lingle, Butler, and Bittle were not present during the incident. MHT Ellis was "floored" when he observed XX XXXXX injuries, and said it appeared XX XXXXX had been involved in a brawl. MHT Ellis only talked to his wife and MHT Bittle about the incident.

**c) ISP Follow-up Interview**

ISP re-interviewed MHT Ellis on July 10, 2015. In summary, MHT Ellis stated as follows.

MHT Ellis initially refused to admit to any knowledge of abuse and said he never touched XX XXXXX and remained on XX XXXXX legs during the incident. MHT Ellis said he was hard of hearing and could not hear if any abuse occurred while restraining XX XXXXX legs. MHT Ellis admitted that MHT Butler was present during the incident. MHT Ellis did not previously admit that MHT Butler was there because MHT Ellis did not know if MHT Butler could be around Resident XXXXX.

When MHT Ellis exited the bathroom, he observed MHT Allen on top of XX XXXXX on the floor. When MHT Ellis walked into the dining room, all he could see was MHT Allen’s hands swinging. MHT Ellis stated MHT Allen "beat the fuck out of him (XX XXXXX) in the kitchen in front of God and everybody." MHT Allen struck XX XXXXX four to five times in the face and head before MHT Ellis got to XX XXXXX feet. MHT Ellis did not observe anyone else strike XX XXXXX.

The reason MHT Ellis did not initially tell the truth was because he did not want to be known as a snitch. MHT Butler entered the dining room approximately 45 seconds to one minute after MHT Ellis. MHT Dickerson then entered the dining room, but then left to retrieve the restraints. While MHT Ellis had XX XXXXX' s feet, MHT Bittle also responded and grabbed XX XXXXX feet. MHT Ellis believed MHT Butler had grabbed XX XXXXX left arm, and MHT Allen was trying to pin XX XXXXX right arm.

After XX XXXXX was placed in restraints, MHTs Ellis and Bittle went into the hallway and spoke about the incident. MHT Bittle told MHT Ellis there was no doubt that MHT Allen had struck XX XXXXX and both MHT

Ellis and MHT Bittle were "pissed" about the incident. MHT Butler told them to say MHT Butler was not present, because he knew he was not supposed to be on that end of the building.

### 20. MHT Regina Hubble

#### a) Facility Statement

The facility interviewed MHT Regina Hubble on December 22, 2014. In summary, MHT Hubble stated as follows.

MHT Hubble was assigned as float on December 20, 2014. During breakfast, MHT Hubble was in the kitchen preparing breakfast and heard XX XXXXX say “fuck you” and MHT Allen then called for assistance. MHT Hubble entered the dining room and observed MHT Allen and XX XXXXX on the floor and it appeared MHT Allen was blocking XX XXXXX from hitting him. MHT Hubble escorted the individuals out of the room and as MHT Hubble exited the room, she saw MHT Dickerson coming down the hall. MHT Hubble did not see MHT Allen hit, drag, curse, or threaten to kill XX XXXXX. MHT Hubble never saw or heard MHT Allen abuse XX XXXXX in any way.

#### b) ISP Interview

ISP interviewed MHT Hubble January 29, 2015. In summary, MHT Hubble stated as follows.

MHT Hubble was in the kitchen when she heard XX XXXXX yell and MHT Allen tell XX XXXXX to calm down. When MHT Hubble entered the dining room, she observed XX XXXXX laying with his back on the floor and kicking. MHT Allen was on XX XXXXX left side attempting to gain control of him. While removing the residents from the dining room, MHT Hubble saw MHT Dickerson running down to the dining room from the other end of the hallway.

#### c) ISP Follow-up Interview

ISP re-interviewed MHT Hubble on July 1, 2015. In summary, MHT Hubble stated as follows.

MHT Hubble reiterated the information provided during her first interview. However, she believed there was a resident with her in the kitchen at the time of the incident. MHT Hubble did not believe MHT Bittle was in the kitchen with her, but she was working and was not worried about who was behind her. MHT Hubble called herself an "old lady" who others would not confide in.

### 21. XXX XXXXX XXXXX

#### a) Facility Statement

The facility interviewed XXX XXXXX XXXXX on December 29, 2014. In summary, XXX XXXXX stated as follows.

XXX XXXXX was off on December 20, 2014 and was not on Choate grounds at any time. XXX XXXXX had no direct knowledge of the incident and denied abusing XX XXXXX.

#### b) ISP Interview

ISP interviewed XXX XXXXX on February 2, 2015. In summary, XXX XXXXX stated as follows.

XXX XXXXX had been supervising MHT Allen for eight months. XXX XXXXX could not determine if MHT Allen's Incident Report was truthful or not. XXX XXXXX had knowledge that MHT Allen had [redacted] but he had not had any problems with MHT Allen. XX XXXXX was not known to injure himself. XXX XXXXX described XX XXXXX injuries as the worst he had seen in 16 years at XXXXX.

**22. XX XXXXX XXXXXX XXXXX XXXXX**

**a) Facility Statement**

The facility interviewed XX XXXXX XXXXX on December 22, 2014. In summary, XX XXXXX XXXXX stated as follows.

On December 22, 2014, XX XXXXX XXXXX was notified that XX XXXXX alleged that staff abuse caused his facial and other bruising that occurred on December 20, 2014. The physician was notified, and an exam was completed revealing additional bruising to XX XXXXX front and posterior shoulder. A physician order was received to send XX XXXXX to radiology for facial X-rays. A significant event per security was initiated and an additional injury report was completed by XX XXXXX XXXXX. A physical examination revealed additional bruising to XX XXXXX front and posterior shoulders. XX XXXXX was sent for facial x-rays.

XX XXXXX XXXXX added to her statement the following information. On December 20, 2014, XX XXXXX XXXXX was called to the east end dining room where XX XXXXX was being held on the floor for attacking staff, banging his head on the floor/wall, and refusing redirection. XX XXXXX XXXXX observed XX XXXXX fighting, kicking, swinging his arms and legs, and threatening to kill staff. MHT Allen implemented the "holding restraint." XX XXXXX XXXXX observed XX XXXXX being taken to his room in a forward escort to be placed in mechanical restraints.

When XX XXXXX was released from restraints, he was sorry for attacking staff and was upset about a phone call from his mother that said either his mother or grandma was dying and was going to commit suicide. This made him so upset he could not stop thinking about it and when MHT Allen asked him to pull up his pants in the dining room, XX XXXXX should have listened and not attacked staff. XX XXXXX XXXXX indicated XX XXXXX did not make any allegation on December 20, 2014 or December 21, 2014. XX XXXXX XXXXX added she saw XX XXXXX in a forward transport to his room for mechanical restraints, but denied seeing staff hit, drag or abuse XX XXXXX.

**b) ISP Interview**

ISP interviewed XX XXXXX XXXXX on January 23, 2015. In summary, XX XXXXX XXXXX stated as follows.

XX XXXXX XXXXX went to the dining room after being told about an unknown problem. Upon entering the dining room, XX XXXXX XXXXX observed MHT Allen holding XX XXXXX on the floor with MHT Allen positioned on XX XXXXX right side. XX XXXXX stomach was on the floor with his head facing away from MHT Allen. XX XXXXX was yelling, cursing, and threatening staff while thrashing around on the floor. XX XXXXX XXXXX believed MHT Allen followed protocols and restrained XX XXXXX properly. XX XXXXX XXXXX believed MHT Ellis was also present in the dining room at the time.

After the order was given to place restraints on XX XXXXX, XX XXXXX XXXXX left the dining room to get the restraints. When XX XXXXX XXXXX returned to the dining room, XX XXXXX injuries appeared to be the

same as when she left, consisting of primarily a cut on his lip which was bleeding. MHT Allen and MHT Ellis used a "two-man forward carry" to get XX XXXXX to his bedroom to be restrained.

XX XXXXX XXXXX did not see MHT Dickerson during the incident. XX XXXXX XXXXX never heard residents complain about MHT Allen. XX XXXXX XXXXX knew of a prior incident with XX XXXXX where he attacked and tore hair from an MHT's head. XX XXXXX XXXXX had been working with XX XXXXX for a year and could not recall treating him for SIB. While XX XXXXX was in restraints, he mentioned being upset because of a phone call he received regarding a family member threatening suicide.

**c) OIG Interview**

OIG interviewed XX XXXXX XXXXX XXXXX XXXXX on July 1, 2022. In summary, XX XXXXX-XXXXX stated as follows.

On December 20, 2014, XX XXXXX-XXXXX was called to the east end dining room at approximately 7:25 a.m. for restraints. XX XXXXX-XXXXX saw MHTs Allen, Butler and Ellis and others she did not know utilizing a holding restraint on XX XXXXX on the floor. XX XXXXX was thrashing around, swinging, kicking, spitting, banging his head on the floor, and screaming he was going to kill everyone. XX XXXXX-XXXXX approved the use of mechanical restraints and immediately left to get the restraint packet.

When XX XXXXX-XXXXX returned a few minutes later to XX XXXXX room, she observed MHTs Allen, Ellis and others she did not know applying the restraints. XX XXXXX was thrashing, swinging, and spitting blood. When XX XXXXX-XXXXX asked what happened to XX XXXXX lip, MHT Allen said he bit his lip.

XX XXXXX-XXXXX stepped outside the door to write the restraint order and packet while restraints were being applied. A privacy curtain was put in place for XX XXXXX privacy and to avoid blood spitting. It took XX XXXXX-XXXXX 3 to 6 minutes to complete the paperwork, which she gave to the staff who was assigned to sit with XX XXXXX. XX XXXXX-XXXXX then informed the staff that she was going to call the MD to finish the packet and she would be back in 55 minutes for the nurse's circulation check.

XX XXXXX-XXXXX went to the clinic and called the MD, who came and examined XX XXXXX. XX XXXXX-XXXXX completed the AM medication pass. XX XXXXX-XXXXX returned to check on XX XXXXX 55 minutes later and observed redness to his face and a cut on his lip. XX XXXXX-XXXXX completed the circulation check and assessed to see if XX XXXXX was calming down, but he continued to scream and yell threats, ball his fists, jerking and trying to buck the bed. There were no incongruencies with the redness to the face scratch on his forehead and the reported self-inflicted bite on his lip at that time.

During the entire process of the physical restraint and mechanical restraint, XX XXXXX-XXXXX did not see any staff hit, kick or punch XX XXXXX. She also observed the appropriate application of the physical hold. XX XXXXX-XXXXX did not observe the transfer of XX XXXXX from the dining room to his bedroom.

XX XXXXX-XXXXX did not observe XX XXXXX bite his lip and the injury did not seem suspicious. The bruising on XX XXXXX did not appear until approximately two days later. At no time in between did XX XXXXX or any staff inform her that there had been any abuse. XX XXXXX XXXXX XXXXX passed medication at 8:00 a.m. and 9:00 p.m. on December 20, 2014 and December 21, 2014, to XX XXXXX and did not observe bruising until December 22, 2014. That was when she notified the doctor and completed a significant event form.

Dr. Vorbrich examined XX XXXXX and ordered facial x-rays, which were completed at XXXXX XXXXX Hospital. XX XXXXX-XXXXX and Dr. Vorbrich completed a head-to-toe examination of XX XXXXX and discovered bruising to his face and front and back of torso. They agreed that the injuries were suspicious for abuse. XX XXXXX-XXXXX denied having an argument with Dr. Vercide or Dr. Vorbrich about the origins of the injuries.

When she saw XX XXXXX spitting blood in his bedroom, she did not see him bleeding from anywhere other than his lip. XX XXXXX-XXXXX did not recall any conversations with Dr. Vercide or Dr. Vorbrich about restraint usage or the injuries. Any accusations that XX XXXXX-XXXXX was present when the abuse occurred were false.

The Incident Reports she completed were a combination of what she saw and was told by staff. The photographs of XX XXXXX injuries were not consistent with Self-Injurious Behavior or head banging and were not present until two days later.

### 23. RN Supervisor Christina Harris

ISP interviewed RN Supervisor Christina Harris on February 2, 2015. In summary, RN Supervisor Harris stated as follows.

When RN Harris asked XX XXXXX how his injuries occurred, he responded that "Mark" had struck him. Based on the injuries to XX XXXXX, RN Harris did not believe XX XXXXX had harmed himself.

### 24. MHT Chris Lingle

#### a) Facility Statement

The facility interviewed MHT Chris Lingle on December 22, 2014. In summary, MHT Lingle stated as follows.

MHT Lingle was assigned to group X on the west end. Around breakfast, MHT Lingle was called to assist with restraints. When MHT Lingle arrived on the east end, XX XXXXX was in his room, on his bed and fighting and thrashing around, attempting to hit himself and staff. MHT Lingle applied restraints on XX XXXXX right arm and leg. MHT Lingle's best recollection was that MHT Dickerson was applying restraints on the left side and MHT Allen and MHT Ellis were also in the room. After applying restraints, MHT Lingle returned to the west end and had no further contact with XX XXXXX. MHT Lingle did not see MHT Allen punch, drag or threaten to kill XX XXXXX or call him names.

#### b) ISP Interview

ISP interviewed MHT Lingle on January 30, 2015. In summary, MHT Lingle stated as follows.

MHT Lingle was on the opposite end of the XXXXX XXXXX Building when the incident occurred. MHT Lingle did not enter the dining room because MHT Dickerson told him to apply restraints to XX XXXXX bed. MHT Lingle restrained XX XXXXX right arm and leg, while MHT Dickerson and MHT Allen restrained XX XXXXX left side. XX XXXXX had spit on the staff members attempting to restrain him. When MHT Lingle asked MHT Allen what had occurred, MHT Allen only stated that XX XXXXX had fought him. XX XXXXX injuries were on par to be the worst injuries MHT Lingle had observed in his career.

**c) ISP Follow-up Interview**

ISP re-interviewed MHT Lingle on July 1, 2015. In summary, MHT Lingle stated as follows.

MHT Lingle assumed XX XXXXX had been battered because it appeared, he had "gone three rounds with Mike Tyson." MHT Lingle had difficulty stating the same story twice and was inconsistent on the actions of himself and others. When it was mentioned to MHT Lingle that other employees said he was in the dining room when the incident occurred, MHT Lingle said, "if they say I was there, I must have been there."

Initially, MHT Lingle stated that MHT Butler was not there, but later admitted MHT Butler was there and that MHT Lingle told MHT Butler to say he was not there so no one would get in trouble. MHT Lingle helped MHT Allen get MHT Ellis' phone number via text message to "get their story straight." When MHT Lingle was asked what he thought MHT Allen meant in the text message, he said it could have meant any number of things.

MHT Lingle was "almost positive" he did not assist during the escort of XX XXXXX to his bedroom. MHT Lingle did not believe XX XXXXX injuries happened in the dining room, because when MHT Lingle observed XX XXXXX, he was only bleeding from his mouth. MHT Lingle believed MHT Allen was angry because XX XXXXX spit blood on him.

MHT Butler entered XX XXXXX room after MHT Lingle, but he did not know how long MHT Butler remained in the room. MHT Allen had never bragged to MHT Lingle about the incident, but he had heard MHT Allen was bragging to others. MHT Lingle believed all MHTs working either had first or secondhand knowledge about the abuse.

**25. MHT Donna Whittington**

ISP interviewed MHT Donna Whittington on January 23, 2015. In summary, MHT Whittington stated as follows.

MHT Whittington was not working during the incident but witnessed the injuries to XX XXXXX on December 20, 2014. MHT Whittington read all the reports written by staff regarding the incident, and they did not match the behaviors MHT Whittington knew XX XXXXX to have. The injuries to XX XXXXX were so severe that MHT Whittington had to go to the bathroom and vomit. MHT Whittington was concerned MHT Allen would injure XX XXXXX again, so she restricted MHT Allen to where he could not have contact with XX XXXXX. MHT Whittington never knew XX XXXXX to injure himself in the past.

MHT Allen confided in MHT Whittington in the past about having difficulty managing [redacted], however, MHT Whittington did not believe MHT Allen was a bad person. MHT Dickerson told MHT Whittington that the injuries on XX XXXXX were not present when XX XXXXX was restrained, but MHT Whittington believed MHT Dickerson would lie to protect employees from getting in trouble.

**26. Public Service Administrator Karen Boyd**

ISP interviewed Public Service Administrator (PSA) Karen Boyd on January 29, 2015. In summary, PSA Boyd stated as follows.

PSA Boyd observed XX XXXXX while he was restrained to the bed in his bedroom. XX XXXXX had two black eyes and a cut lip. XX XXXXX told PSA Boyd that he was "being bad," and hit his head on the floor. PSA Boyd knew residents to "repent" while in restraints and say anything they had to in order to get out of restraints. PSA

Boyd believed XX XXXXX was telling the staff whatever they wanted to hear to get out of restraints. Although, PSA Boyd knew XX XXXXX to become hostile and threatening after talking with his mother.

**27. MHT John "Mike" Dickerson**

**a) Facility Statement**

The facility interviewed MHT John Dickerson on December 22, 2014. In summary, MHT Dickerson stated as follows.

On December 20, 2014, MHT Dickerson, as the lead worker, assigned MHT Allen as east side relief. About 7:20 a.m., the east side called for assistance and MHT Dickerson saw MHT Hubble escorting individuals from the dining room. MHT Dickerson grabbed the restraint box and ran to the dining room where MHT Dickerson saw MHT Allen trying to block XX XXXXX from hitting himself and from thrashing around on the floor and against the wall. MHT Dickerson took XX XXXXX right arm and MHT Allen took him by the left arm and escorted XX XXXXX across the hall to his room. XX XXXXX continued to attempt physical aggression and SIB. XX XXXXX was bleeding from the mouth and attempted to spit on staff while they were escorting him to and placing him in restraints. MHTs Dickerson, Allen, Lingle and Ellis were involved in the restraint. MHT Dickerson did not see MHT Allen punch or drag XX XXXXX. MHTs Dickerson and Allen walked XX XXXXX to his room. MHT Dickerson did not hear MHT Allen tell XX XXXXX that he would kill him.

**b) ISP Interview**

ISP interviewed MHT Dickerson on January 29, 2015. In summary, MHT Dickerson stated as follows.

MHT Dickerson was in charge of assigning all MHTs to their positions on December 20, 2014. MHT Dickerson heard a commotion and saw MHT Hubble escorting residents from the dining room to another room. MHT Dickerson brought the restraints to the dining room. MHTs Allen and Ellis were struggling with XX XXXXX on the dining room floor. MHT Dickerson gained control of XX XXXXX right arm and MHT Allen gained control of XX XXXXX left arm. MHTs Dickerson and Allen escorted XX XXXXX to his bedroom, where MHT Lingle had prepared restraints on XX XXXXX bed. MHT Dickerson believed the injuries to XX XXXXX occurred when XX XXXXX was struggling on the ground in the dining room, stating, "that's the only time those injuries could have occurred." XX XXXXX spit and screamed death threats toward MHT Allen during the incident. MHT Allen told MHT Dickerson the incident began after MHT Allen asked XX XXXXX to pull his pants up.

MHT Dickerson previously witnessed XX XXXXX have SIB by hitting walls, which was the only other time MHT Dickerson recalled placing XX XXXXX in restraints. MHT Dickerson described XX XXXXX injuries as severe and further stated that he could not recall seeing injuries that severe before.

MHT Butler was not allowed on the east end of the XXXXX XXXXX building, due to the fact he had an allegation of abuse from another resident. As a result, MHT Dickerson told MHT Butler to go back to the west end when MHT Butler came to assist. MHT Ellis was working in the XXXXX XXXXX Building because of an unknown allegation of abuse in another location at XXXXX. MHT Dickerson stated that he hated that the incident had occurred, and believed it gave a bad impression of the other XXXXX employees.

**c) ISP Follow-up Interview**

ISP interviewed MHT Dickerson on July 15, 2015. In summary, MHT Dickerson stated as follows.

MHT Dickerson would not admit to telling MHTs to say that they were not present during the incident. However, MHT Dickerson would not say that they were lying. MHT Dickerson was adamant that he stopped MHT Butler from participating in the incident. MHT Dickerson said XX XXXXX bruising was not caused by SIB.

**28. MHT Justin Butler**

**a) Facility Statement**

The facility interview MHT Butler on December 24, 2014. In summary, MHT Butler stated as follows.

During breakfast on December 20, 2014, there was a call for help on the east end. When MHT Butler asked if he was needed, MHT Dickerson said no, and the situation was under control. MHT Butler did not go down to the east end because he was assigned to the west end due to an allegation by XX XXXXX. The only time MHT Butler went to the east end was at mealtimes, and he had another staff escort him.

MHT Butler did not have any contact with XX XXXXX, did not see him and was not involved in placing him in restraints. MHT Butler did not see MHTs Allen or Ellis punch or kick XX XXXXX in the face, nor did he see anyone drag XX XXXXX. MHT Butler denied abusing or punching XX XXXXX.

**b) ISP Interview**

ISP interviewed MHT Butler on February 6, 2015. In summary, MHT Butler stated as follows.

MHT Butler was adamant he was not present and had no part in any of the incident. MHT Butler relieved MHT Lingle, so MHT Lingle could go and assist. MHT Butler remained on the opposite end of the XXXXX XXXXX Unit with MHT Rosenthal, due to the fact he was not allowed on the east end for an unrelated allegation of abuse from another resident. MHT Butler never attempted to go down to the dining room to assist and was never told by MHT Dickerson to go back to the other end as MHT Dickerson claimed.

MHT Butler knew XX XXXXX had been "messed up pretty bad," and had a good idea of who struck XX XXXXX but was "going to keep his piece on that." MHT Butler then stated nine times out of ten, he was the first person to show up for a call for help.

**c) ISP Follow-up Interview**

ISP re-interviewed MHT Butler on August 28, 2015. In summary, MHT Butler stated as follows.

Although MHT Butler initially stated he had not participated during the incident, he eventually admitted that he had gone to XX XXXXX bedroom to assist with placing restraints on his bed while the other MHTs were still in the kitchen. At the beginning of the incident, MHT Dickerson told MHT Butler to relieve MHT Lingle so that MHT Lingle could assist with restraining XX XXXXX. However, MHT Rosenthal had already relieved MHT Lingle, and MHT Rosenthal told MHT Butler he could assist with restraining XX XXXXX.

MHT Butler was not allowed to be around Resident XXXXX but believed he could assist during a call for help as long as XX XXXXX was not involved. When XX XXXXX was brought into his bedroom, MHT Butler said XX XXXXX face was "fucked up," with a knot on his head and his mouth was bleeding "pretty bad." MHT Butler said it appeared as if they were bringing a beaten dog into the room. MHT Butler rated XX XXXXX injuries as a nine on a scale of ten, with ten being near death.

MHT Butler then restrained XX XXXXX right arm to the bed and then left the bedroom. He believed he was one of the first MHTs to leave the room. MHT Butler said MHTs Ellis, Dickerson, Lingle, and Allen had brought XX XXXXX into his bedroom. MHT Butler said he should have been truthful during the first interview, but he did not want to get himself or others in trouble for covering for him.

Following the incident, MHT Dickerson told MHT Butler that MHT Butler had been left off the paperwork, due to the fact there were enough people to "fill in the blanks." Sometime in January 2015, MHT Butler called MHT Ellis and said since he did not know anything about the incident, he was going to leave himself out of it as much as possible. MHT Ellis told MHT Butler that he was not going to bring MHT Butler into it. MHTs Dickerson, Ellis, and Lingle all told MHT Butler to say he was not a part of the incident.

MHT Butler believed MHT Allen caused XX XXXXX injuries, although, he did not witness him inflict any of the injuries. MHT Butler did not believe MHT Ellis would have struck XX XXXXX, because MHT Ellis had never acted out against any other individuals.

Approximately one month prior to the incident with XX XXXXX, MHT Butler had to intervene between MHT Allen and Resident XXXXX XXXXX. MHT Allen was going to strike XX XXXXX, but instead struck MHT Butler after he intervened. MHT Butler believed MHT Allen "had problems" and needed to be fired.

When MHT Butler told MHT Allen he believed he would lose his job because of the incident with XX XXXXX while they were building a pole barn together, MHT Allen said that he could "give a fuck less about Choate." MHT Allen then admitted he had kicked XX XXXXX in the face with steel-toed boots during the incident. MHT Allen further said that XX XXXXX had "gotten wild" on him and he placed XX XXXXX on the ground. MHT Allen also told MHT Butler that "we fucked him up," but MHT Butler did not know whom else MHT Allen was referring to.

MHT Butler did not believe that MHT Allen felt it was wrong what he did to XX XXXXX and acted as if it was the same thing as "flicking a bug off of his shoulder."

**29. MHT Eric Bittle**

**a) Facility Statement**

The facility interviewed MHT Eric Bittle on December 22, 2014. In summary, MHT Bittle stated as follows.

MHT Bittle was assigned to group X on December 20, 2014. Around 7:30 a.m., MHT Allen relieved him for morning break. When MHT Bittle returned from break, XX XXXXX was in restraints in his bedroom. MHT Bittle did not recall any behaviors or anything odd when escorting the individuals to breakfast. When XX XXXXX returned to the group after being released from restraints, MHT Bittle asked what had happened. XX XXXXX said his mother or sister told him about his grandfather possibly passing away which upset him, and he punched himself.

MHT Bittle did not see MHT Allen punch XX XXXXX or hear MHT Allen say he was going to kill XX XXXXX if XX XXXXX turned MHT Allen in. MHT Bittle did not hear MHT Allen call XX XXXXX any derogatory names. MHT Bittle did not observe XX XXXXX being placed into restraints. When MHT Bittle returned to the dining room, he did not see any blood.

**b) ISP Statement**

ISP interviewed MHT Bittle on January 20, 2015. In summary, MHT Bittle stated as follows.

MHT Bittle was assigned to XX XXXXX Group, Group X. MHT Allen relieved MHT Bittle in the dining room so MHT Bittle could go use the bathroom. MHT Bittle was gone five to ten minutes while the incident occurred. When asked what happened, XX XXXXX stated he was upset about his grandfather becoming sick and started punching himself.

**c) ISP Follow-up Statement**

ISP re-interviewed MHT Bittle on July 1, 2015. In summary, MHT Bittle stated as follows.

MHT Bittle admitted not being honest during his first interview and said he was in the kitchen with MHT Hubble at the beginning of the incident. While in the kitchen, MHT Bittle heard MHT Allen yelling and then heard crashing. MHT Bittle immediately went to the dining room, where XX XXXXX was laying on the ground with MHT Allen on XX XXXXX upper left side and MHT Ellis on XX XXXXX upper right side. At the time, XX XXXXX was yelling at MHT Allen, and was struggling against MHT Allen and MHT Ellis. MHT Bittle then placed his body on top of XX XXXXX legs and wrapped his arms around them to restrain them from hurting anyone. MHT Bittle had his back toward MHT Ellis and MHT Allen and did not see how they were restraining XX XXXXX.

MHT Bittle then heard several "thuds," which he was not certain if they were punches striking XX XXXXX or XX XXXXX head hitting the floor. MHT Bittle heard XX XXXXX yell at MHT Allen and MHT Ellis to quit spitting on him. MHT Bittle also believed there was one other MHT in the dining room, but he could not remember who it was.

MHT Bittle then helped escort XX XXXXX with MHT Ellis and MHT Allen to XX XXXXX bedroom, along with another unknown MHT. MHTs Bittle, Ellis, and Allen were restraining XX XXXXX to his bed when MHT Butler entered the room. MHTs Ellis and Bittle then went to the hallway outside of XX XXXXX bedroom, talked briefly, and then both went back to their respective groups.

Several hours after the incident, MHT Bittle saw the injuries to XX XXXXX and became extremely angry with MHT Allen. MHTs Dickerson and Lingle each separately approached MHT Bittle and told him to tell investigators he was in the bathroom during the incident, so he would not get in trouble. MHT Bittle believed there were several XXXXX staff members who knew about the cover up and believed MHT Dickerson was worried about getting in trouble because he was the lead worker for the shift and wanted to make sure no one got in trouble.

MHT Bittle did not know why MHT Lingle would get involved because he was not a part of the incident. MHT Bittle did not see MHT Dickerson at all during the incident. MHT Bittle believed XX XXXXX received his injuries from MHT Allen while XX XXXXX was in restraints.

**30. MHT Mark Allen**

**a) Facility Statement**

The facility interviewed MHT Mark Allen on December 22, 2014. In summary, MHT Allen stated as follows.

MHT Allen was relieved by MHT Bittle as Group X leader. The individuals were eating in the kitchen. MHT Allen asked XX XXXXX to pull up his pants because they were falling to the floor. XX XXXXX stood up and started cussing at MHT Allen. MHT Allen asked XX XXXXX what was wrong, and XX XXXXX responded, "fuck you" and XX XXXXX was a gangster. MHT Allen redirected XX XXXXX to eat. XX XXXXX then started punching himself in the face multiple times.

MHT Allen blocked XX XXXXX SIB by placing his open hand between XX XXXXX fist and face. XX XXXXX continued to attempt his SIB and was placed in a physical hold for his safety. XX XXXXX appeared to calm and was released.

As MHT Allen stepped away from XX XXXXX, XX XXXXX walked toward the kitchen and started hitting his head against the wall. MHT Allen placed his open hand between the wall and XX XXXXX face to block his SIB.

XX XXXXX attacked MHT Allen by punching MHT Allen multiple times in the face, chest, and shoulder. XX XXXXX was placed in a physical hold and assistance was called for. XX XXXXX continued to struggle and attempt SIB by hitting his head against the ground. MHT Allen blocked this by placing his open hand between XX XXXXX head and the floor.

Assistance arrived and a two-person escort was used to take XX XXXXX to his bedroom. MHT Allen could not recall who assisted with the escort. XX XXXXX spit and cussed at staff and tried to kick at staff. XX XXXXX was placed in four-point restraints per XX XXXXX XXXXX request. XX XXXXX continued to spit at staff and attempted to bite staff. A fifth point restraint was applied. MHTs Dickerson, Lingle and Ellis assisted with putting XX XXXXX into restraints. XX XXXXX spit at and attempted to kick these staff.

XX XXXXX said he attacked staff because his mother made him mad during a phone call the previous evening when he learned his grandfather was dying. XX XXXXX relayed the same information when the doctor came in to examine him.

MHT Allen denied punching XX XXXXX, bending his fingers, dragging him on the floor or threatening to kill him. MHT Allen denied telling XX XXXXX that he did not have a girlfriend because he "sucks dick," nor did MHT Allen accused XX XXXXX of killing his brother.

MHT Allen did not recall any other staff in the dining room at the start of the incident. MHT Allen had no knowledge about an electrical outlet box in XX XXXXX bedroom. MHT Allen sustained a minor injury to his lower lip where he was hit by XX XXXXX during the physical hold and blocking XX XXXXX SIB.

**b) OIG Interview**

OIG interviewed MHT Allen on December 22, 2014. In summary, MHT Allen stated as follows.

MHT Allen was in the dining room at breakfast on Saturday December 20, 2014, along with Groups X X and X. XX XXXXX was walking around and getting prepared to eat. XX XXXXX had his hands on his crotch and appeared to be holding up his pants. MHT Allen asked XX XXXXX to adjust his belt because grabbing his crotch was not socially appropriated. XX XXXXX stood up and started cussing at MHT Allen. XX XXXXX sat down and appeared to eat, and then started hitting himself in the face. MHT Allen was standing at the door and ran over to block XX XXXXX SIB with open palms between XX XXXXX face and fist. XX XXXXX continued his attempts of SIB and became physically aggressive toward MHT Allen. MHT Allen placed XX XXXXX in a physical hold to protect him and others.

XX XXXXX appeared calm and MHT Allen released him and redirected him to eat. XX XXXXX complied, but immediately stood up and came after MHT Allen with a closed fist. MHT Allen blocked with an open palm. XX XXXXX ran toward the wall and banged his head on the wall. MHT Allen blocked but XX XXXXX turned toward MHT Allen and started swinging at MHT Allen. MHT Allen used a physical hold again and assistance was called for.

While using the physical hold, MHT Allen and XX XXXXX fell to the floor and MHT Allen continued the physical hold from the side of XX XXXXX upper torso with open palms to protect XX XXXXX from hitting himself. XX XXXXX began hitting his head on the floor and tried to hit MHT Allen and himself with his free hand. XX XXXXX spit at staff and attempted to bite. MHT Allen called for help from MHTs Dickerson, Lingle, and Ellis.

MHTs Allen and Lingle used a two-person escort to walk XX XXXXX to his bedroom. XX XXXXX was attempting to kick and bite staff and spit at staff. XX XXXXX could have injured his lip during the physical hold when thrashing his head around or when he attempted to bite staff's leather boots when he was held on the ground.

MHT Allen said he did not place a hand on XX XXXXX to abuse him, did not threaten to kill XX XXXXX, verbally abuse him or drag XX XXXXX to his room. When PSA Boyd asked XX XXXXX why he attacked staff, XX XXXXX said he was "pissed off" over a phone call with his mother the night before. XX XXXXX also said this to the doctor and XX XXXXX XXXXX.

**c) ISP Interview**

ISP interviewed MHT Allen on February 6, 2015. In summary, MHT Allen stated as follows.

MHT Allen instructed XX XXXXX to pull up his pants, due to the fact they were being worn in a socially and sexually inappropriate manner. XX XXXXX initially complied with MHT Allen's request. However, when XX XXXXX again left the table, his pants were sagging again. When MHT Allen again told XX XXXXX to pull his pants up, XX XXXXX said, "f'ing pants," and "I'm a gangster, this is how we do it where I'm from."

XX XXXXX pulled up his pants and began eating but became angry and punched the table. MHT Allen blocked XX XXXXX from punching the table by placing his hands between XX XXXXX fist and the table. XX XXXXX then struck MHT Allen a couple of times, but eventually calmed down.

Since XX XXXXX appeared to be calm, MHT Allen went and talked to another unknown staff member. XX XXXXX then stood up from the table and came after MHT Allen. XX XXXXX and MHT Allen went to the ground, where XX XXXXX bit the back portion of MHT Allen's left boot and attempted to bite MHT Allen. MHT Allen was on the side of XX XXXXX body, and XX XXXXX head was "flailing" and hitting the ground. MHT Allen then yelled for assistance.

MHTs Lingle, Dickerson, and Bittle then arrived, and MHT Allen and MHT Lingle escorted XX XXXXX to his bedroom to place him in restraints. XX XXXXX was spitting blood, kicking staff, and yelling throughout the incident. MHT Allen did not observe that XX XXXXX was bleeding until they arrived in his bedroom, and MHT Allen noticed blood coming out of XX XXXXX mouth. MHT Allen sat with XX XXXXX in his bedroom for two hours while he was in restraints.

MHT Allen subsequently admitted to ISP that he had been covering up on behalf of MHT Ellis and MHT Butler, who had families. MHT Allen stated that he did not want them to lose their jobs. MHT Allen further stated that

MHT Butler was not allowed on the east end of the XXXXX XXXXX Building, due to a past incident with another resident.

When MHT Allen called for assistance, MHTs Butler, Bittle, and Lingle came to assist. MHT Dickerson did not respond to the dining room, due to the fact he was obtaining the restraints. MHT Ellis was present in the dining room at the time the incident began.

MHT Allen then showed ISP text messages between MHT Ellis and him, where MHT Allen instructed MHT Ellis to tell XXXXX Security that MHT Ellis was in the bathroom during the incident. MHT Allen witnessed MHT Ellis strike XX XXXXX five to ten times in the face while on the ground in the dining room after XX XXXXX spit on MHT Ellis several times. MHT Butler had also struck XX XXXXX in the torso with his fist and with his knee twice.

MHT Allen admitted to applying more pressure than was necessary to XX XXXXX torso while taking XX XXXXX to the ground by placing his knee to XX XXXXX back and then applying downward pressure.

MHT Allen said that he did not recall deliberately striking XX XXXXX, but noted that when he becomes angry or aggressive, MHT Allen cannot recall approximately five percent of an incident.

XX XXXXX was positioned with his back on the dining room floor. MHT Ellis was on XX XXXXX upper right torso, while MHT Allen was on XX XXXXX upper left torso. MHT Butler was on XX XXXXX lower right torso area, and MHTs Lingle and Bittle were at XX XXXXX feet. MHT Allen was holding XX XXXXX shoulder down until XX XXXXX began to spit, and MHT Allen moved his hand to XX XXXXX forehead. MHT Lingle helped escort XX XXXXX to his bedroom. MHTs Lingle, Bittle, Ellis, and Butler had come to the dining room to assist. MHT Dickerson was not present in the dining room because he was retrieving the restraints.

When MHT Allen was confronted with the fact that XX XXXXX described being struck "100 times," MHT Allen believed XX XXXXX could have felt that way due to MHT Ellis and MHT Butler striking XX XXXXX and XX XXXXX body subsequently hitting the floor as a result of the strikes. After XX XXXXX spit on MHT Butler, MHT Allen heard either MHT Butler or MHT Bittle say, "awe you done pissed me off now." MHT Butler then struck XX XXXXX rib area with his knee twice. MHT Butler also struck XX XXXXX with a fist in both his chest and abdomen area. MHT Allen denied causing any of the injuries to XX XXXXX and said that all of XX XXXXX injuries were from MHT Ellis and MHT Butler. MHT Allen believed MHT Bittle and MHT Lingle were in a position to observe the abuse throughout the incident.

MHT Allen said he would not hit XX XXXXX because of his mental status. MHT Allen said he had difficulty managing his anger when he was a child, as well as after being deployed to Iraq. MHT Allen could control his anger 95% of the time and said that he was in control of his anger during the incident with XX XXXXX.

While sitting in XX XXXXX bedroom, he was an arm’s length away from XX XXXXX. XX XXXXX continued to spit blood and yell. MHT Allen denied abusing XX XXXXX while he was in restraints. MHT Allen stated he was "the start, the beginning, and the end" to the entire incident.

**d) ISP Follow-up Interview**

ISP re-interviewed MHT Allen on September 4, 2015. In summary, MHT Allen stated as follows.

MHT Allen admitted to sending a text message to MHT Howard about how MHT Allen had "fucked his (XX XXXXX) world up." MHT Allen stated he acted in self-defense against XX XXXXX after XX XXXXX struck him in the face. MHT Allen struck XX XXXXX in the face with his closed right fist when XX XXXXX came towards him. While taking XX XXXXX to the ground, MHT Allen wrapped his left arm around XX XXXXX throat in a choke hold. While going to the ground, MHT Allen struck XX XXXXX in the throat area and then placed pressure to XX XXXXX throat with his fist to inflict more pain. MHT Allen struck XX XXXXX one or two times while they were on the ground, while XX XXXXX was still swinging at him. While on the ground, MHT Allen may have struck XX XXXXX hard enough to cause blood to come out of XX XXXXX mouth. MHT Allen denied kicking XX XXXXX and could not recall what footwear he was wearing during the incident.

MHT Allen again said that MHTs Ellis, Butler, Bittle and Lingle were present during the incident. According to MHT Allen, they did not arrive until thirty to sixty seconds after MHT Allen had taken XX XXXXX to the ground. MHT Allen witnessed MHT Ellis strike XX XXXXX on the right side of his face approximately ten times, after XX XXXXX spit blood on MHT Ellis. MHT Allen believed MHT Butler had struck XX XXXXX in the stomach, although MHT Allen did not observe this and only heard and saw XX XXXXX reaction. MHT Allen did not believe any of his strikes injured XX XXXXX.

MHT Allen would have acted the same way as XX XXXXX if he had been in XX XXXXX position. MHT Allen believed he could have handled the situation better and should have walked away from XX XXXXX. MHT Allen admitted other staff members had to intervene between himself and residents on three to five occasions for MHT Allen being too aggressive.

## V. Analysis and Findings

### A. Physical Abuse – MHT Allen

OIG's investigation clearly established that MHT Allen physically abused XX XXXXX. More specifically, the evidence reflects that MHT Allen struck XX XXXXX multiple times in the face with a closed fist, took XX XXXXX to the ground, put him in a choke hold, struck XX XXXXX in the throat while on the ground, applied pressure to XX XXXXX throat with his fist in order to inflict more pain, and struck XX XXXXX one or two more times while on the ground.

Although MHT Allen claimed he acted in self-defense, the above-described actions clearly constitute the use of excessive force, as evidenced by XX XXXXX significant injuries. In addition, MHT Allen's claim that he engaged in self-defense has little credibility as he first falsely claimed that XX XXXXX engaged in SIB. Moreover, MHT Allen's communications to his fellow staff, including his text to MHT Howard, in which MHT Allen stated he had "fucked [XX XXXXX] world up," are a clear indication that he was not acting in self-defense, but rather acted with intent.

Therefore, the allegation against MHT Allen of physical abuse, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG identified aggravating factors in that MHT Allen's physical abuse of XX XXXXX lasted for an extended time and resulted in serious injuries to XX XXXXX, which multiple Choate staff identified as the worst injuries they had seen at Choate. In addition, MHT Allen showed no remorse for his physical abuse of XX XXXXX—bragging about it to MHT Howard—lied about his

conduct during the subsequent investigation, and also conspired with other Choate staff to cover up his wrongdoing. OIG did not identify any mitigating circumstances.

**B. Neglect - MHT Ellis**

OIG's investigation further established that MHT Ellis neglected XX XXXXX when he, by his own admission, failed to respond in any material way to MHT Allen's physical abuse of XX XXXXX. More specifically, MHT Ellis admitted that he observed MHT Allen "beat the fuck out of [XX XXXXX] in the kitchen in front of God and everybody." MHT Ellis added that MHT Allen struck XX XXXXX four to five times in the face and head before MHT Ellis got to XX XXXXX feet.

Upon witnessing this abuse, however, there is no indication that MHT Ellis took any meaningful action to stop MHT Allen's assault of XX XXXXX. The evidence further reflects that MHT Ellis subsequently failed to report the misconduct he witnessed and failed to report the injuries he knew XX XXXXX suffered to ensure that XX XXXXX received appropriate medical care. As a result, XX XXXXX did not receive a complete medical examination of his injuries, including x-rays, until two days later, after Choate security received an anonymous call regarding XX XXXXX. That anonymous call prompted Choate ISI I Wece to check in with XX XXXXX, whereupon ISI I Wece said he found XX XXXXX looking like Rocky at the end of Rocky 1 with his eyes all swollen. ISI Wece then had XX XXXXX examined, and the doctor ordered that XX XXXXX receive x-rays to determine whether his nose was broken.

In addition, when initially questioned about the abuse, MHT Ellis, by his own admission, lied to ISP and said that he did not see MHT Allen punch XX XXXXX. Thus, MHT Ellis not only failed to report the injuries that XX XXXXX suffered, but he also took active steps to cover-up MHT Allen's misconduct. Following a criminal investigation of his actions, MHT Ellis ultimately pleaded guilty to one count of Failure to Comply with Reporting Requirements, a misdemeanor.

Based on the above-described evidence, OIG determined that the allegation against MHT Ellis of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG further determined that MHT Ellis's failure to respond to XX XXXXX abuse constituted a gross failure to adequately provide for XX XXXXX safety and demonstrated a callous indifference to XX XXXXX wellbeing. However, under the law, OIG cannot find MHT Ellis's neglect to be egregious because it did not result in XX XXXXX death or a serious deterioration in his physical condition. Rather, it was MHT Allen who was directly responsible for XX XXXXX injures. Therefore, OIG cannot report MHT Ellis to the Health Care Worker Registry for his conduct. However, MHT Ellis's conduct is certainly profoundly troubling and raises serious questions about his fitness to continue serving as an MHT.

**C. Neglect – MHT Bittle**

OIG's investigation established that MHT Bittle neglected XX XXXXX by failing to respond in any material way to MHT Allen's physical abuse of XX XXXXX. According to MHT Bittle's testimony, while he was assisting in holding XX XXXXX on the floor, MHT Bittle heard several "thuds." MHT Bittle knew or should have known that those sounds were reflective of physical abuse. However, there is no indication that MHT Bittle took any

action to stop the abuse or even make any attempt to determine whether XX XXXXX was in fact being abused. As a result of MHT Bittle's inaction, XX XXXXX ultimately suffered extensive injuries.

In addition, several hours after MHT Allen abused XX XXXXX, MHT Bittle stated that he saw XX XXXXX injuries, which he admitted he believed were caused by MHT Allen. MHT Bittle said he was angry with MHT Allen upon seeing the injuries—presumably because he knew that MHT Allen had physically abused XX XXXXX—but he did not report MHT Allen's misconduct as he was mandated to do or ensure that XX XXXXX received appropriate treatment for his injuries. As a result, XX XXXXX did not receive a full medical examination of his injuries, including x-rays, until two days later, after Choate security received an anonymous call regarding XX XXXXX.

In addition, when initially questioned about the abuse, MHT Bittle, by his own admission, lied to ISP about MHT Allen's altercation with XX XXXXX. Thus, MHT Bittle, like MHT Ellis, not only failed to report the injuries that XX XXXXX suffered, but he also took active steps to cover-up MHT Allen's misconduct. Following a criminal investigation of his actions, MHT Bittle ultimately pleaded guilty to one count of Fail to Comply with Reporting Requirements, a misdemeanor.

Therefore, the allegation against MHT Bittle of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG further determined that MHT Bittle's failure to respond to XX XXXXX abuse constituted a gross failure to adequately provide for XX XXXXX safety and demonstrated a callous indifference to XX XXXXX wellbeing. However, under the law, OIG cannot find MHT Bittle's neglect to be egregious because it did not result in XX XXXXX death or a serious deterioration in his physical condition. Rather, it was MHT Allen who was directly responsible for XX XXXXX injures. Therefore, OIG cannot report MHT Bittle to the Health Care Worker Registry for his conduct. However, MHT Bittle's conduct is certainly profoundly troubling and raises serious questions about his fitness to serve as an MHT.

**D. Neglect – MHT Butler**

OIG's investigation also established that MHT Butler neglected XX XXXXX by failing to respond in any material way to MHT Allen's physical abuse of XX XXXXX. MHT Butler eventually admitted that he participated in XX XXXXX restraint and further admitted that when he saw XX XXXXX, his face was "fucked up," with a knot on his head and his mouth bleeding badly. MHT Butler added that it appeared as if they were bringing a beaten dog into the room. MHT Butler rated XX XXXXX injuries as a nine on a scale of ten, with ten being near death.

MHT Butler also acknowledged that he believed MHT Allen caused XX XXXXX injuries. However, like MHTs Ellis and Bittle, MHT Butler failed to report MHT Allen's misconduct as he was mandated to do or ensure that XX XXXXX received appropriate treatment for his injuries. As a result, XX XXXXX did not receive a full medical examination of his injuries, including x-rays until two days later, after Choate security received an anonymous call regarding XX XXXXX.

In addition, when initially questioned about the abuse, MHT Butler, by his own admission, lied to ISP and said that he was not involved in the restraint of XX XXXXX. Following a criminal investigation of his actions, MHT Butler ultimately pleaded guilty to one count of Fail to Comply with Reporting Requirements, a misdemeanor.

Therefore, the allegation against MHT Butler of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG further determined that MHT Butler's failure to respond to XX XXXXX abuse in any material way constituted a gross failure to adequately provide for XX XXXXX safety and demonstrated a callous indifference to XX XXXXX wellbeing. However, under the law, OIG cannot find MHT Butler's neglect to be egregious because it did not result in XX XXXXX death or a serious deterioration in his physical condition. Rather, it was MHT Allen who was directly responsible for XX XXXXX injures. Therefore, OIG cannot report MHT Butler to the Health Care Worker Registry for his conduct. However, as with MHT Ellis and MHT Bittle, MHT Butler's conduct is profoundly troubling and raises serious questions about his fitness to serve as an MHT.

**E. Neglect – MHT Lingle**

OIG's investigation established that MHT Lingle neglected XX XXXXX by failing to respond in any material way to MHT Allen's physical abuse of XX XXXXX. MHT Lingle admitted that he participated in XX XXXXX restraint and further admitted that he assumed that XX XXXXX had been battered because it appeared as if XX XXXXX had "gone three rounds with Mike Tyson." However, the evidence reflects that MHT Lingle failed to report MHT Allen's misconduct as he was mandated to do and further failed to ensure that XX XXXXX received appropriate treatment for his injuries. As a result, XX XXXXX did not receive a full medical examination of his injuries, including x-rays until two days later, after Choate security received an anonymous call regarding XX XXXXX.

MHT Lingle, like MHTs Allen, Ellis, Bittle and Butler, was not truthful when questioned about the incident. MHT Lingle initially told ISP that MHT Butler was not present for the incident, but later admitted MHT Butler was present. MHT Lingle further admitted that he told MHT Butler to say he was not present during the incident so that no one would get in trouble. MHT Lingle also acknowledged helping MHT Allen get MHT Ellis' phone number via text message to "get their story straight." Thus, MHT Lingle clearly colluded with other Choate staff to cover up the misconduct that occurred.

Therefore, the allegation against MHT Lingle of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG further determined that MHT Lingle's failure to respond to XX XXXXX abuse in any material way constituted a gross failure to adequately provide for XX XXXXX safety and demonstrated a callous indifference to XX XXXXX wellbeing. However, under the law, OIG cannot find MHT Lingle's neglect to be egregious because it did not result in XX XXXXX death or a serious deterioration in his physical condition. Rather, it was MHT Allen who was directly responsible for XX XXXXX injures. Therefore, OIG cannot report MHT Lingle to the Health Care Worker Registry for his conduct. However, MHT Lingle's conduct both during the incident and after the incident is profoundly troubling and raises serious questions about his fitness to serve as an MHT.

**F. Neglect – MHT Dickerson**

OIG's investigation established that MHT Dickerson neglected XX XXXXX by failing to respond in any material way to MHT Allen's physical abuse of XX XXXXX. MHT Dickerson admitted that he participated in XX XXXXX restraint and further admitted that at the end of that restraint XX XXXXX had suffered severe injuries. However, there is no indication that MHT Dickerson took any steps to ensure that XX XXXXX received

appropriate treatment for his obvious injuries. Rather, the evidence reflects that MHT Dickerson repeatedly took steps to cover up the nature of MHT Allen's abuse.

Among other actions, MHT Dickerson signed off on a false Evaluation Observation of Injuries Incident Report, which stated that XX XXXXX continued to attack and received injuries from struggling in the physical hold, and which also failed to identify all the MHTs present at the scene. The evidence reflects that MHT Dickerson knowingly and intentionally failed to identify MHT Butler as being present, as MHT Dickerson told MHT Butler that MHT Butler had been left off the paperwork due to the fact there were enough people to "fill in the blanks."

MHT Dickerson then lied to the facility in an attempt to cover up the abuse of XX XXXXX, stating that XX XXXXX engaged in SIB, which MHT Dickerson later admitted was not true. MHT Dickerson also lied to ISP, stating that he told MHT Butler to go back to the west end when MHT Butler came to assist. MHT Butler's testimony demonstrates that MHT Dickerson's statement to ISP was false and likely made to ensure that MHT Butler faced no consequences for his participation in the altercation. MHT Dickerson also lied to Choate staff, as MHT Dickerson told MHT Whittington that XX XXXXX injuries were not present when XX XXXXX was restrained, which is contradicted by MHT Lingle, MHT Butler, among others.

Finally, the evidence reflects that MHT Dickerson attempted to collude with Choate staff to cover up the abuse. More specifically, according to MHT Bittle, MHT Dickerson approached him and told him to tell investigators he was in the bathroom during the incident, so he would not get in trouble.

Thus, MHT Dickerson had numerous opportunities to do the right thing and tell the truth about what he witnessed. Instead, he knowingly signed false reports, lied to facility and ISP investigators, and colluded with his fellow staff members to cover up the abuse that occurred.

Based in part on MHT Dickerson's actions (or lack thereof), XX XXXXX did not receive a full medical examination of his injuries, including x-rays until two days later, after Choate security received an anonymous call regarding XX XXXXX.

Therefore, the allegation against MHT Dickerson of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated. OIG further determined that MHT Dickerson's failure to respond to XX XXXXX abuse in any material way (other than lying to investigators and seemingly doing everything in his power to cover up the true nature of that abuse) constituted a gross failure to adequately provide for XX XXXXX safety and demonstrated a callous indifference to XX XXXXX wellbeing. However, under the law, OIG cannot find MHT Dickerson's neglect to be egregious because it did not result in XX XXXXX death or a serious deterioration in his physical condition. Rather, it was MHT Allen who was directly responsible for XX XXXXX injures. Therefore, OIG cannot report MHT Dickerson to the Health Care Worker Registry for his conduct.[12]

[12] MHT Dickerson retired from state service in December 2017.

### G. Neglect – Choate Developmental Center

Finally, OIG's investigation established a systemic failure on the part of Choate Developmental Center staff to prevent and report abuse. Most notably, at least eight Choate staff actively colluded to obstruct ISP and OIG's investigations or lied to cover up the beating of XX XXXXX. In addition, multiple staff failed to report the abuse they witnessed, although his injuries were what multiple witnesses described as the worst injuries they had seen. It was not until an anonymous call to Security that the abuse was reported, two days after the abuse occurred.

This is a textbook example of a code of silence, in which staff seek to protect each other from the consequences of their misconduct by remaining silent about what they witnessed or lying to protect their fellow employees. Understanding that the majority of events described in this report (including the facility and ISP interviews of involved staff) occurred at least six years ago, that so many employees participated in the cover-up of the abuse of XX XXXXX suggests that this type of conduct may be endemic at Choate. Accordingly, the facility must be held responsible for failing to prevent the establishment of a culture in which so many employees chose to protect their fellow employees instead of protecting an abused individual and apparently felt comfortable doing so. It is telling that when a call was finally made regarding the incident, it was done anonymously. Therefore, the allegation against Choate Developmental Center of neglect as defined by Title 59, Chapter 1, Part 50, Section 50.10 of the Illinois Administrative Code, is substantiated.

### H. Unsubstantiated Physical Abuse – [redacted]

OIG's investigation did not establish by a preponderance of the evidence that [redacted] physically abused XX XXXXX during the incident with MHT Allen. During the investigation, MHT Allen and multiple individuals alleged that [redacted] and [redacted] abused XX XXXXX during the incidents. However, these accounts were not entirely consistent. In particular, MHT Allen's generally implausible account—in which he claimed that [redacted] and [redacted] caused XX XXXXX injuries--was self-serving, as it placed the responsibility for XX XXXXX injuries on other staff members, and lacking in credibility, as it was contradicted by his text messages and subsequent statements to other Choate staff. In addition, XX XXXXX consistently stated that only MHT Allen abused him and he never made any mention of [redacted] or [redacted] abusing him. Therefore, the allegation against [redacted] and [redacted] of physical abuse, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is unsubstantiated.

### I. Unsubstantiated Neglect – XX XXXXX XXXXX XXXXX

Several aspects of XX XXXXX XXXXX XXXXX conduct during and after MHT Allen's altercation with XX XXXXX raise questions regarding the propriety of her response to the incident. Most notably, XX XXXXX XXXXX XXXXX was present for a substantial part of the restraint of XX XXXXX, yet she claimed to see no improper conduct on the part of MHT Allen. After the restraint, she claimed in the Evaluation of Observed Injuries form that XX XXXXX injuries did not raise of suspicion and neglect, even though MHT Lingle stated that it looked like XX XXXXX went three rounds with Mike Tyson, and multiple other staff members said his injuries were the worst they had seen at Choate.

However, as there is no video of the altercation, *see infra* Section V(J)(3) (recommending that Choate install security cameras at the facility), and the testimony is not clear as to what portions of the restraint XX XXXXX XXXXX XXXXX was present for, in light of XX XXXXX XXXXX denials, OIG cannot definitively prove that

she witnessed MHT Allen's abuse of XX XXXXX. With respect to XX XXXXX XXXXX XXXXX determination that XX XXXXX injuries were not suspicious, since no photographs were taken of XX XXXXX at the time of his December 20, 2014 examination, it is again difficult for OIG to establish that XX XXXXX XXXXX finding was a deliberate attempt to cover up MHT Allen's abuse, as opposed to a determination partially based on the various false and misleading accounts that had been provided to her. *See* Section IV(B)(21) (XX XXXXX XXXXX XXXXX stating that her injury reports were a combination of what she saw and was told by staff). As a result, OIG was not able to establish by a preponderance of the evidence that XX XXXXX XXXXX XXXXX engaged in conduct that constituted neglect. Therefore, the allegation against XX XXXXX XXXXX XXXXX of neglect, as defined by Title 59, Chapter I, Part 50, Section 50.10 of the Illinois Administrative Code, is unsubstantiated.[13]

### J. Recommendations

OIG recommends Choate Developmental Center address:

1. MHT Allen, MHT Ellis, MHT Butler and MHT Bittle's intentional obstruction of the investigation. The DHS Act (20 ILCS 1305/1-17) and DHS Administrative Directive 01.02.03.040 require that employees fully cooperate with any investigation. In the present case, as set forth in the analysis section above, the evidence clearly reflects that all four of these employees provided false information during the investigation and, as a result, MHT Allen was convicted of felony Obstruction of Justice and MHTs Ellis, Butler and Bittle were convicted of misdemeanor Fail to Comply with Reporting Requirements in relation to this case. Full cooperation with abuse and neglect investigations is imperative to criminal and administrative fact-finding and is necessary to prevent further abuse and neglect going forward.

2. CM Melinda Miller, MHT Charles Mike Dickerson, MHT Chris Lingle, and SSW Kimberly Jones's intentional obstruction of the investigation. The DHS Act 20 ILCS 1305/1-17 and DHS Administrative Directive 01.02.03.040 require employees to fully cooperate with any investigation, which includes providing truthful testimony. In the present case, the evidence reflects that CM Miller, MHT Dickerson, MHT Lingle and SSW Jones all obstructed the criminal and administrative investigations of this incident. MHT Dickerson and MHT Lingle's obstructions of the investigation are detailed in the above analysis sections. With respect to CM Miller, MHT Allen's text messages make clear that she provided MHT Allen with information regarding the questions that ISP personnel were asking other Choate staff about the incidents. As to SSW Jones, she initially told the facility that she did not see any blood on the walls or floor of XX XXXXX room. However, she later admitted to ISP that she discovered a "medium" amount of blood in XX XXXXX room, which is a significant change in her statement as it suggests that XX XXXXX suffered significant injuries.

3. Finally, it is OIG's understanding that there are currently efforts underway to install security cameras at Choate. The present case demonstrates the importance of such endeavors. Cover-up attempts like the one detailed in this

[13] The allegation of neglect against XXX XXXXX XXXXX, who was initially identified as an accused, is unfounded, as it was determined he was not working on grounds at the facility at the time of the incident.

report would have a much lower chance of success if there was security video of the incident in question. ISP and OIG would not have to rely on witnesses and subjects finally telling the truth on the second or third questioning; rather the evidence would, at least in certain instances, be readily apparent on video. The code of silence would be broken from the onset.

At the present time, though, the unpleasant truth is that conspiracies to obstruct investigations—to invoke and carry out the code of silence—can, on occasion, allow for those who engaged in misconduct to avoid discipline. That is why it is crucial that when staff members are determined to have lied or withheld information from investigatory bodies, they experience consequences for their actions. Otherwise, they will continue to obstruct and lie, and cover-up and abuse and neglect will continue. And one of the best ways to identify such conspiracies is through video footage of the incident under investigation. Accordingly, OIG recommends that Choate take action sufficient to ensure that security cameras be installed at the facility, in accordance with all applicable laws and regulations, in a manner that would render them able to capture incidents such as the one described in this report. OIG believes it to be self-evident that such cameras would have at least some deterrence value with respect to acts of abuse and would also assist OIG and ISP in their fact-finding endeavors. This would also be an important step in combatting the culture of deception that appears to have taken hold among at least some of Choate's staff.