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REPORT OF FINDINGS
INDIVIDUAL ADVOCACY GROUP INCORPORATED- 10-040-9023
HUMAN RIGHTS AUTHORITY- South Suburban Region

[Case Summary—— The Authority did not substantiate the complaint as presented; the public record on this case is recorded below. The provider did not provide a response to the report]

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation regarding possible rights violations in a program managed by Individual Advocacy Group Inc. The complaint alleged that a resident was physically abused by a staff person. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/2-102 [a] and 5/2-112) and the Abused and Neglected Child Reporting Act (325 ILCS 5/4).

Located in Romeoville, Individual Advocacy Group provides residential, day training, counseling, and other supportive services to children and adults with developmental disabilities, behavioral health needs and brain injuries in 21 counties throughout Illinois. This agency's Transitional Living Program has a total population of about 17 clients between the ages of 18 and 21, and all of them are wards of the Illinois Department of Children and Family Services.

METHODOLOGY

To pursue the investigation, the agency's Co-Chief Executive Officer, the Chicago-South Central Regional Director, a therapist and two direct care staff members were interviewed. The complaint was discussed with the assigned Illinois Department of Children and Family Services' Case Worker. The resident was spoken with privately regarding the complaint. Sections of the resident's record were reviewed with guardian consent. Relevant agency policies were reviewed. Additionally, the Authority reviewed the agency's investigation of the alleged abuse incident.

COMPLAINT STATEMENT

According to the complaint, the resident alleged during a hospital stay that he was physically abused by a residential staff person. The Illinois Department of Children and Family Services was notified under the mandatory abuse and neglect reporting Act, but the allegation was accepted as information only because the resident is over 17 years old. It was reported that the resident eventually agreed to return to the home upon his hospital discharge.

FINDINGS

Information from record, interviews and program policies

According to the record, the 19-year old verbal resident has been a client of the agency since 2008. He lives in a four bedroom home and has two housemates. He was diagnosed with Bipolar Disorder and Borderline Intellectual Functioning. The resident's behavioral plan implemented on August 2009 stated that he has a history of extreme anger and aggression. His plan targeted verbal and physical aggression, and non-compliancy with medication and staff's requests and rules. It stated that the House Manager or the Crisis Manager should be notified if the resident was not able to calm down and redirections failed. A "hands on" approach is only appropriate to prevent harm to self or others. For example, two staff members would be allowed to gently carry a client who was sitting in the middle of the street out of harm's way if he or she refuses to move. The resident's care plan, dated November 2009, recorded those behaviors mentioned above and retail theft. His plan included goals concerning his emotional mental health needs, educational, financial and community integration skills. There was no programming concerning his shoplifting behavior.

An Illinois Department of Children and Family Services Unusual Incident Reporting form (IDCFS) (UIR), completed on January 18th, 2010 at 7:00 p.m., leading up to the abuse allegation stated that the resident and a housemate were escorted to the shopping mall to buy video games on that same day. As they were leaving the store, the security alarm went off, and their bags were checked by store personnel. A “dog tag chain” was found in the resident's bag that he had not purchased. According to the report, the store manager determined that the resident was behaving oddly and chose not to file criminal charges against him. On January 19th, 2010, a school form documented that the resident said that he was punched several times in his chest and abdomen by a residential staff person. There was no mention of when the alleged incident had occurred or the staff person involved in the allegation. According to the form, the allegation was reported to the IDCFS under the mandatory reporting rule, and the local police were notified. An unusual incident reporting form, completed on that same day at 10:00 a.m., stated that the agency's House Manager was informed about the alleged abuse upon his arrival to the school. According to the report, the resident also claimed that he was pulled in the snow face down, but there was no visible bruising observed during a full body examination conducted by a school employee. The agency's Crisis Supervisor and administration were notified, and a formal internal investigation was initiated. A copy of both incident forms was electronically sent to the IDCFS.

On January 19th, 2010, Individual Advocacy Group's (IAG) detailed documentation indicated that staff person A was removed from his shift pending the outcome of the agency's investigation. On that same day at 4:00 p.m., the resident told the agency’s Crisis Supervisor that the incident had occurred on January 18th following his shoplifting attempt. Staff person A reportedly chased the resident in the shopping mall parking lot and eventually tackled him to the ground. He allegedly threatened to beat the resident’s [expletive] for refusing to put on his seatbelt in the car. The staff person grabbed, punched and choked the resident. Documentation states that he was pulled in the snow when they arrived at the home, and he was repeatedly hit for refusing to take off all of his clothing upon entering the home. The agency’s Crisis Supervisor documented that there were no visible bruises observed during the interview on the resident's face, arms or upper body. A full body exam was not done by the agency because the

resident reportedly was still agitated about the previous one. On that next day a Clinical Summary Report repeated that the appropriate authorities had been notified about the alleged abuse by the resident's school. It recorded that the resident was interviewed by the police at his home on January 19th, and there were no bruises found when examined.

On January 21st at 3:18 p.m., the resident's housemate, who was reportedly present when the alleged incident occurred, denied the allegation when he was interviewed by the agency's Crisis Supervisor. His housemate recalled the events that happened in the store and said that staff person A asked the store manager not to send the resident to jail. He told the agency's investigator about the staff person running after the resident upon leaving the store. The resident sat on the ground after the chase ended; he directed profanity at the staff person and said that he wanted to go to jail. Staff person A reportedly called staff person B for help. Documentation states that once they got in the car, the resident continued to use profanity; he refused to put on his seatbelt; he tried to break the car window; he tried to jump out of the moving car, and the staff person grabbed the door to prevent this. His housemate said that they sat in the car until the resident was calmer, but he started "hitting" when the staff person started to drive. Once they arrived at the home, he went inside and told staff person B that staff person A needed help with the resident. His housemate reportedly heard both staff members ask the resident to remove his coat and shoes once they were inside of the home. According to the report, the resident's housemates could not eat in the dining room nor did they have access to the living room and kitchen because of the resident's behaviors.

On January 21st, at 4:30 p.m., staff person A was interviewed by the agency's Crisis Supervisor concerning possible abuse. According to the staff person A, the resident started shaking and biting his bottom lip when the stolen neck chain was found in his bag. His behaviors escalated, redirections failed, and he started running toward a busy intersection. The staff person gave chase and was able to catch him. He then sat on the ground and said "I don't want to go home and I don't care anymore about anything." Staff person A said that he spoke calmly to the resident during the incident and called staff person B for assistance. He seemed calmer about twenty minutes later and voluntarily got in the staff's car. But, they had to sit in the car until the resident complied with putting on his seat belt. According to the staff person, he then drove to a nearby fast-food drive-thru restaurant to buy dinner for the resident and his housemate. The resident reportedly tried to jump out of the car and run toward moving cars again. He grabbed the resident by his clothing (hood) to prevent self harm and redirected him. He stopped the car while driving back to the home because the resident started hitting and kicking the dashboard.

According to the agency's "Investigator Summary of Findings" dated on January 22nd, 2010, there was no evidence found to corroborate the abuse allegation. Staff person A was retrained on abuse and neglect. The HRA was provided with documentation to support this. On February 15th, 2010, the resident was hospitalized for threatening to kill everyone in the home and self harm. Nine days later, the agency's clinical team met, and a psychiatric evaluation to reaffirm the appropriateness of the resident's Bipolar Disorder diagnosis was recommended. On March 3rd, 2010, the hospital notified IAG that the resident had reported that he was physically abused by an employee of the agency. The HRA determined during the investigation that the January and March abuse allegations are the same. Subsequent to the site visit, the agency

provided documentation that the resident was seen by a psychiatrist on April 22nd, 2010. And, the psychiatric review form indicated that only his medications were changed.

The HRA discussed the complaint with the resident, who is able to speak and easy to understand. He acknowledged trying to steal the neck chain from the store. He reported that staff person A punched him in the mouth because he tried to get out of his car on that same day. He stated that he was hit in his face and stomach when they stopped at a local restaurant. He reportedly was thrown in the snow when they arrived at the home. He indicated that he was thrown on the floor upon entering the home, and he stayed there for a couple of hours before getting up. According to the resident, he reported the alleged incident to a school employee and was interviewed by the police.

Staff person A denied the allegation when he was interviewed by the HRA. He reported that the resident tried to steal two neck chains from the store and usually becomes upset whenever he does something wrong. He chased the resident as recorded by the agency's Crisis Supervisor. The resident subsequently started hitting the dashboard and windows in the staff's car. According to the staff person, he drove to a nearby fast-food drive-thru restaurant to buy some ice cream for the resident as a calming measure, but he tried to jump out of the car. He grabbed the resident's arm and pulled him back in the car; he put on the safety locks and drove away. The resident continued to use profanity upon entering the home and kept saying that he wanted to kill himself. Staff person B was reportedly present when the resident was asked to take off his shoes and coat, but he left the room to check on the resident's housemates. Staff person A confirmed that he was retrained on abuse and neglect and said that this training is provided during orientation. On questioning, staff person B said that the resident was upset and laid in the snow upon returning from the shopping mall. He helped staff person A to carry the resident in the home. He reportedly sat on the floor for about 40 minutes and later apologized to staff person A for his behaviors.

IAG's' Chicago-South Central Regional Director explained that the resident is a client of the agency's Specialized Transitional Living Program (TLP) that is funded by the IDCFS. She said that supervision in the community is usually 1:1 or 1:2. Staff person A was reassigned to another home during the agency's investigation. The resident and his housemate were interviewed, and the allegation was determined to be unfounded. His therapist said that he receives individual therapy weekly and sometimes refuses medication. As before, the HRA was told that the resident makes up things when he feels shamed. The assigned IDCFS' Case Worker reported that the resident also claimed that he had been stunned with a taser gun during the alleged incident, but there were no bruises. He eventually agreed to return to the home post-hospital discharge and will be transitioned to a Community Integrated Living Arrangement program when appropriate. Further, those interviewed above said that the resident has been moved to several IAG homes because of allegations made by him, and all of them have proved to be unfounded.

According to the agency's program policy entitled "Unusual Incident Reporting," the IDCFS will be notified about all incidents as soon as possible. An IDCFS' reporting form will be completed and submitted within 48 hours of the incident. According to the policy, the appropriate personnel will be informed and action will be taken to address the incident.

The agency's program policy entitled "Abuse and Neglect Prevention" states that all employees will be trained on abuse and neglect. Employees are directed to provide immediate interventions on behalf of any recipient and to report the abuse using the agency's guidelines. It states that failure to report abuse or neglect constitutes abuse. All allegations regarding abuse or neglect will be promptly and thoroughly investigated. Physical interactions by an employee that include but are not limited to hitting, kicking, pinching, choking, shoving, pushing, biting, chocking, etc that causes either psychological or physical injury to a client is prohibited and subject to investigation. According to the policy, an investigator will be assigned from outside of the program area of the alleged incident. All interviews and evidence will be fully documented. The Director or designee will call the IDCFS Abuse Hotline upon notification of possible abuse or neglect. The employee involved in the allegation will be removed from his or her shift pending the agency's internal investigation.

CONCLUSION

According to Section 5/1-101.1 of the Code, "abuse" means any physical injury, sexual abuse, or mental injury inflicted on a recipient of services other than by accidental means.

Sections 5/2-102 (a) and 5/2-112 of the Code and the agency's client right statement guarantee that services shall be provided with adequate and humane care based on an individualized treatment plan and that every recipient of services shall be free from abuse and neglect.

The Abused and Neglected Child Reporting Act Section 325 5/4, provides for the reporting of suspected child abuse or neglect and identifies certain professionals such as clinical staff member as mandated reporters. The Act states that any mandated reporter who has reasonable cause to believe that a child known to them in their profession or official capacity may be abused or neglected shall immediately report or cause a report to be made to the Department of Children And Family Services.

The Act also states that any other person may make a report if such person has reasonable cause to believe that a child may be abused or neglected (325 ILCS 5/4).

The complaint alleged that a resident was physically abused by a staff person. Documentation on Jan 19th, 2010 stated that the IDCFS was notified about the allegation under the mandatory abuse and neglect reporting Act. On that same day the agency initiated an investigation upon notification of possible abuse. The employee involved in the allegation was removed from his shift pending the outcome of the investigation. IAG reportedly determined that the allegation was unfounded, but the resident reported the same incident when he was hospitalized in March 2010. On that next month the resident's medications were changed after he was seen by a psychiatrist concerning the appropriateness of his Bipolar Disorder diagnosis. The Authority found no evidence that the incident, as stated in the complaint, occurred. The staff person, who allegedly abused the resident, denied the allegation. No violations of the above Sections, the agency's client right statement or program policies were found. The complaint is unsubstantiated.

SUGGESTIONS

1. At the time of this alleged incident, The Abused and Neglected Child Reporting Act designated the IDCFS to receive and investigate reports of alleged abuse/neglect for anyone through 17 years of age. Effective in August 2010, the Act was amended to require the Department to receive and investigate reports of alleged abuse/neglect for adult residents between 18 and 22 years of age who remain in Department-licensed facilities (325 ILCS 5/2 and 5/7.3). IAG should be sure that all staff are aware of this development and to modify any policies as appropriate.

2. The agency should consider developing interventions concerning the resident's shoplifting behavior.