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Egyptian Regional Human Rights Authority
Report of Findings
Trafford Estates Case #13-110-9027
November 20, 2013

The Egyptian Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning Trafford Estates, a 16 bed intermediate care facility for the developmentally disabled (ICFDD).

1. An individual with a developmental disability was arrested after aggressive behavior which lead to him being in the county jail for an extended period of time with no follow up from Trafford Estates to ensure another placement was found.

If found substantiated, the allegations represent violations of the Mental Health and Developmental Disabilities Code and regulations that govern ICFDDs.

Trafford Estates, a part of TDL Group, Inc., is located in Fairfield and provides residential services to persons with developmental disabilities. The census at the time of investigation was 15 residents, all with developmental disabilities.

To investigate allegations, the HRA team consisting of two board members and the HRA coordinator interviewed the Sheriff at the county jail, the Administrator at Trafford Estates, the Pre-Admission Screening (PAS) agent from the community case coordination service and the Assistant Deputy Director of DHS. The HRA also examined, with guardian consent, the records from a state-operated developmental center (SODC) and Trafford Estates and reviewed the case coordination notes with the PAS agent.

COMPLAINT STATEMENT

According to the complaint, an individual with a developmental disability had been in the county jail for 3 months awaiting an available bed at the SODC forensic unit after being arrested and jailed for aggressive behavior at Trafford Estates where he resided. The HRA was told that another resident at the facility was related to a local police officer. After his arrest and court date, the individual was remanded to the Illinois Department of Human Services (DHS); however, his admission was delayed due to the lack of DHS bed availability. The HRA then spoke with the Sheriff who said the individual's condition was deteriorating daily. He needed assistance with personal care and did not understand his reason for being at the jail. They had to

put him into a medical isolation cell for safety precautions and had also put him in handcuffs to protect him from biting himself. The Sheriff reported they were doing the best that they could, but could not adequately meet his needs.

When the HRA received the call of concern for this individual, after making some initial inquiries, the Director of the Division of Developmental Disabilities and the Deputy Director of Community Services of DHS were contacted and informed of the situation. The HRA inquired if anything could be done to assist or expedite this individual's admission a state operated facility - as per the Court's order 3 months prior. The DHS representatives agreed to check into the situation and this individual was admitted about a week later.

INVESTIGATIVE INFORMATION

I. Interviews:

Assistant Deputy Director of Department of Human Services (DHS): The HRA team spoke with him regarding admissions to the forensic unit at the SODC. At the time of the interview, the forensic unit was at their maximum capacity of 30 individuals and they had a waiting list of 9. The civil units are still secure, but they are not locked like the forensics unit is. The average wait to become fit is 1 year then the judge can order another year. If the SODC is the nearest facility but their beds are full, placement at another state operated forensic unit is pursued but if there are no openings statewide, then the individual is placed on a waiting list. Currently, there are approximately 98 individuals on the state wide waiting list for forensic units. Individuals that are placed on the waiting list for the forensics stay in the county jail until a bed becomes available as there are no other options.

Trafford Estates Administrator: The HRA team spoke with the Administrator and several direct care staff were available for questioning as well. One of the direct service providers (DSP) said that the incident on November 14, 2012 began because the individual was upset over Christmas still being 6 weeks away. Staff tried to redirect him to other activities but he escalated and "swung at staff" he was also spitting at staff and trying to bite them. They implemented a 2 person crisis prevention institute (CPI) hold. He calmed down for about 5 minutes and then "started back up again" at which time the CPI hold was unsuccessful. The individual was kicking and growling at staff. At that time, staff called the police. When the police officer arrived, he tried to handcuff the individual. He pushed the officer against the wall. It took 4 people to get him handcuffed and he was then taken to the emergency room. The Administrator went to the hospital with him. The individual was at the hospital for about 2 hours and calmed down. The Administrator said that this individual would sometimes ask to be taken to the hospital when he was agitated and usually calmed down once he got there. A community counseling service completed an assessment of him at the emergency room but could not find anyone willing to admit him due to his behavioral needs and being dually diagnosed (with both a mental illness and a developmental disability). The Administrator and police officers spoke with the Chief of Police. He agreed to arrest the individual to protect the other residents in the home. The police officer, whom he pushed against the wall, pressed charges and they took him to the county jail. After his court date, the judge remanded him to DHS. The home and the jail were both told that there were no beds available at the SODC and they would be notified as soon as a

bed becomes available. Trafford Estates coordinated care with the jail and kept him enrolled until January 22, 2013 when he was formally discharged. However, Trafford Estates remained his representative payee until another placement could be secured. Once he was admitted to the SODC, his checking and savings were sent there and the SODC became his representative payee. The Administrator advised the HRA team that "the judge said he couldn't come back to Trafford he had to go to a DHS facility." When the jail called, staff from Trafford Estates would take his medications to the jail or provide care as needed such as nail trimming etc…The Administrator said they talked to the jail daily early on to help them understand how to care for the individual, but didn't visit because they didn't want to create a worse situation for the jail by seeing him face to face. The jail would call Trafford Estates after checking on the status of placement and would say they were told he was going to one state operated facility and then they would be told he was going to another but nothing would ever happen. The Administrator contacted the Southern Region Network Representative for DHS division of Developmental Disabilities (network representative) and was just told that the SODC would call when they had an opening and he would be placed.

The Administrator said they had been trying to find an alternative placement for this individual for at least 2 years; due to his behavioral needs, they did not feel they could care for him any longer at Trafford Estates. The Administrator had contacted Support Services Team (SST), DHS, and a community case coordination agency to see if they could assist in finding placement for the individual. All placements they pursued rejected him due to his behavioral needs. The SST representative told the Administrator that it was their job to keep people out of state operated facilities, not to get them admitted. The Administrator said that the individual did well for the first few months then behavioral problems began. He would escalate himself by obsessing over holidays or the weather and he was difficult to redirect or calm down. He is diagnosed with autism, atypical psychosis and mild mental retardation. His maladaptive behaviors were more often directed towards staff than peers however, he would also make fists in a threatening manner towards peers.

Guardian: The HRA team spoke with the individual's father who is his legal guardian. He told the HRA that his son has high emotions, screams, bites his hand, lashes out, punches people and has thrown furniture. He was informed of the November 14, 2012 incident and was told that the home had to call the police and his son threw the police officer against the wall and almost had to be "tazered" and the police officer pressed charges. He said the Administrator from Trafford Estates told him that they were waiting for a bed at the SODC and that the home could not take him back because he was a danger to himself and others. The father told the HRA that he feels his son needs to be at the SODC for treatment. He has had a developmental disability since birth and needs therapy. He likes Trafford Estates and said they were very tolerant and provided good care for his son.

Sheriff: The HRA questioned the Sheriff on this incident and the individual's stay at the county jail. The county jail has 12 cells: 2 holding, 2 isolation, 4 male and 1 female and 3 general use/multipurpose cells. He said this individual was placed in one of the medical isolation cells to keep him safe from the other inmates. A medical isolation cell is generally used to keep an inmate separated from the other population when he/she is on crutches, has stitches, MRSA, etc. It has its own camera and has a shower and toilet. The cell is approximately 10 X 12 feet in size.

It was the Sheriff's understanding that the individual struck a peer and was arrested on battery charges. On 11/17/12 he was sent to another county jail that had facilities to better meet his needs and they were just going to pay them to house him. The psychiatrist said they could not take him and they returned him back to the original county jail on 11/20/12. He was adjudicated at the 11/27/12 court date and the judge ordered inpatient treatment in a DHS state operated facility. He was supposed to be assessed and placed within 30 days, according to the judge. DHS did come to evaluate him and he was taken to Belleville to a psychiatrist for evaluation. That report was sent through the public defender, and the Sheriff sent it to DHS who was supposed to place him after that. This individual was not placed with DHS until March 1, 2013 after the HRA became involved in the case. He spent approximately 3 ½ - 4 months in jail in an isolation cell until a bed could be secured for him at a DHS state operated facility. The Sheriff said that after the HRA director contacted him, it was 1-2 days later when the SODC called and came and got him.

The Sheriff said they tried to do the best they could with him, but they were not set up to meet all his needs. He said they would bring him in the TV room where he could interact with the other inmates who were in their cells and they would order pizza at times for him. He also said giving him a diet Pepsi solved a lot of issues and made him happy. They did have to restrain him one time in handcuffs for his and others' protection. This incident lasted maybe 5 minutes. They had no other behavioral incidents during his stay. The Sheriff said if they would call Trafford Estates, staff would come over and clip his nails or provide shower assistance. Staff also brought his medications until he was discharged. However, staff from Trafford did not visit or check on him on their own. He said this individual was ok after their visits, but he did not understand what was going on or why he was there. His father called and checked on him, but never visited. After discharge, Trafford Estates brought over his personal belongings and medical card from that point on, the county jail had to buy his medications. He said most medications were covered by his medical card, but they would pay the difference to make sure he had his medications. The correctional officers administered medication to this individual during his stay in jail and the pharmacist educated them on medication issues. The Sheriff said that Trafford Estates did not tell them that he had to have routine blood work for his medications; they found that out later from the pharmacist and made sure that was done once they knew it was needed. The jail has a registered nurse that comes in to do evaluations and examinations but inmates go directly to the hospital or clinic if issues come up.

PAS Agent: The HRA interviewed the PAS agent who had been involved with this individual since 2/19/08. She was first involved as a Clinical Administrative Review Team (CART) member who conducted an independent assessment of him. She said he was difficult to manage and they met to address his behavioral issues. She said "the old SST" had also been involved when they dealt with more crisis situations and they had recommended admission to a state operated facility back then (around 7/18/11) but that could never be accomplished. She was then involved again in late 2012 when Trafford Estates had contacted their agency to help find alternative placement for him. She said this was out of the ordinary because their agency usually helps place individuals from larger facilities into the community once they are stable and this individual was not. She said their administrative rules state that they cannot refer someone for CILA placement if they are a danger to themselves or others. She said that Trafford Estates, being an ICFDD, would be responsible for finding alternative placement in either another

ICFDD or state operated facility for someone who was unstable and needed inpatient treatment to stabilize. However, she agreed to help after being directed to do so. She sent out a minimum of 5 packets to both community integrated living arrangements (CILA) homes and ICFDDs. She informed the HRA that CILA homes can get more funding for additional staff when someone requires 1:1 staff. All placements she attempted either said no due to his physical aggression or simply did not respond at all, which means they are not interested. She tried working with Trafford Estates to see where they had tried referring this individual but she could not get specifics regarding referrals from the Administrator on where he had tried previously. The "new SST" also became involved in trying to assist with stabilizing this individual and finding alternative placement with no success. She was informed on 11/29/12 that this individual was in jail for assaulting a police officer after she inquired about him informally at another meeting with Trafford Estates. She said the Administrator at Trafford Estates informed her that he had been in contact with the Southern Region Network Representative for DHS division of Developmental Disabilities (network representative) and this individual had went before the judge and the case was now with DHS and he assumed the individual would go to the SODC and the jail would make the arrangements to take him there.

On 1/2/13 she called the Administrator who informed her that this individual was still in jail waiting on court action. The Administrator told her that he had contacted the DHS network representative on 12/21/12 to follow up. At this time, the PAS agent contacted the executive director of their organization and told him that this individual had been in jail for over a month and asked "who was supposed to do what" because no one was following up on this individual. On 1/17/13 she again contacted the Administrator regarding the status and was told that Trafford Estates planned on visiting him soon but he was still in jail. On 2/14/13 the PAS agent still had not heard anything and again contacted the Administrator who told her "as of last week he was still in jail and the jailers were calling [the SODC], but he is still waiting for a bed." She told the Administrator that this is not how it normally works and stated it was wrong that this individual was still in jail. The Administrator agreed but, in her opinion, it was evident that "he was done."

She also contacted the State's Attorney's office and said they were very helpful and concerned about this individual and stated no one there felt he should be in jail, but they were still waiting for a bed to open up at the SODC. The State's Attorney had been in contact with the SODC's "legal contact over forensics" and discussed with the PAS agent how this individual was remanded to DHS back on 11/27/12 and it was 2 1/2 months later and he was still in jail but there was nothing else they could do. The PAS agent gave them contact information for 3 people in DHS: the Southern Network Representative, the Bureau Chief of the Developmental Disabilities Division & the Deputy Director of Community Services and asked them to "go up the ladder" to try and get this individual admitted.

II. Trafford Estates Record Review:

Behavioral Documentation: The HRA reviewed several behavioral reports completed by staff at Trafford Estates dating from January through November of 2012. Most of the staff behavioral reports involve the same general reasons for maladaptive behavior: obsessing about things from moving, to music CDs and most often revolved around the weather or when the next holiday was. The individual would obsess about these things and was not easily redirected. He would

often escalate to the point of balling up his fists and shaking it at staff or peers in a threatening manner and would also act on this and strike out at staff or peers. There was also documentation where the individual would bite his own hand when he became agitated. The HRA reviewed 3 behavior reports for January, 4 for March, 4 for May, 4 for June, 1 for July, 3 for September, 1 for October and 1 for November which resulted in his arrest.

The 11/14/12 note states "[name] started obbsing about wanting a CD case for Christmas. Staff tried to explien to [name] that Christmas was a little way away. He then became upset and start standing over female peer with his fist raised. Male staff stepped in between [name] and female peer. [name] then spit in staff face and was trying to punch male staff. Female staff tried talking to [name] then grabbed female staff arm and other female staff and male peer proformed 2 person CPI on [name] he then said he would quit so when staff let him go he then went towards other female peer. Staff then got all other peers to there room while [name] was going after staff trying to punch and kick at male and female staff. Staff then proformed 2 person CPI till the police got here then they took him to hospital." [sic]

Also reviewed were 2 hospital reports dated 6/17/12 and 7/6/12 where this individual was admitted to the hospital for behavioral needs. The 6/17/12 admission reason was "This 36 year old man was referred for psychiatric hospitalization from the Emergency Department [hospital name] on a certificate and petition for involuntary admission because 'patient has displayed assaultive behavior towards staff and other residents at the group home where he lives. Over the past two weeks he punched the staff and tried to choke another resident. He had to be subdued by local enforcement officials.' [doctor's name]" Also listed were the following quotes but it is unclear who was being quoted:

> "He has not been sleeping well and has repetitive asking of same two or three questions."
> "The patient in ER per law enforcement due to behavioral issues at home for the developmentally disabled."
> "Tried to hit his preacher and was upset because he can't go to church. Police went to pick him up and thought they might have to taser him but did not have to do so."

This admission note lists a past psychiatric admission to this hospital from 10/14/10-10/20/10 for "aggressive, hurting self and others, making threats, drooling." His diagnosis is listed as Axis I Psychotic disorder nos (not otherwise specified), Axis II Mental retardation IQ 55, Axis III Dyslipidemia, diabetes mellitus, Axis IV Agitation, threatening behavior, and Axis V GAF (global assessment of functioning) 30 Past Year 35.

The 7/6/12 discharge note reviewed was from another hospital than the 6/17/12 admission note. It lists his diagnosis as Axis I Psychosis NOS & Autistic Disorder, Axis II Mental Retardation, Axis II Arthritis, seizures, HTN (hypertension), DM (diabetes mellitus) and hypothyroidism, Axis IV (illegible), and Axis V 42/100. He was discharged with medication to address seizures, anxiety, mood, Obsessive Compulsive Disorder/mood, psychosis, diabetes and hypercholesterol. The nursing discharge note states "Patient anxious, calm and cooperative. Appears to be excited about discharge. Denies suicidal/homicidal ideations. Medications reviewed with patient and prescriptions provided." The reason for hospitalization is listed as "mood instability, aggression, impulsive judgment".

Progress Notes: The HRA reviewed progress notes from Trafford Estates dating from 7/22/09 (admission date) through 1/22/13 (discharge date). 9/22/09 was the first note indicating there was a behavioral incident. On that date he threatened peers and staff members and it was recommended that staff call local police after reaching out to the RSD (residential services director). When the police arrived, the individual's behavior subsided and they contacted his guardian and informed him that they would be contacting a psychiatrist to evaluate his needs. On 10/5/09 he saw the psychiatrist and some medication changes were made with guardian's consent. The home was going to hold a special meeting with behavior management/human rights committee the next day to discuss recommendations before implementing the medication changes. The guardian also requested counseling as part of treatment and the RSD agreed to contact a community counseling service.

The next note regarding behavior was **on 8/4/10** when the RSD spoke with the guardian regarding the individual's behavior and notified the guardian that he had been admitted to the hospital for behavioral issues. There was also a note that stated "due to the aggressive nature of his incidents we have notified [guardian] that **we will be pursuing placement at another facility** who can better meet his behavioral needs." There was a note 5 days later where they had scheduled a visit with another facility but they did not accept him for placement at their facility. On 9/8/10 the RSD again spoke with the guardian regarding "extreme aggressive incidents" and discussed other possible placements. The individual was returned to the psychiatrist on 9/20/10 to address physical aggression and OCD and some medication changes were recommended. On 9/21/10 the support services team (SST) met to try and help address the individual's behaviors. The recommended medication changes were implemented on 10/1/10. He was sent to the ER on 10/9/10 due to interactions with the new medication which was decreased. SST met again on 10/19/10 regarding the interaction and was returned to the hospital for another evaluation and was then discharged 10/20/10 with more medication changes. The notes from 10/29/10 through 6/16/11 noted that he seemed to be doing better and was improving.

On 6/16/11 there is a case note that he was taken to the psychiatrist again for physical aggression and saw the PA (physician's assistant). During that visit the individual became agitated and "balled up his fist and reared back to hit staff". The PA told the staff to take him to the emergency room at the local hospital to be evaluated for admission to the SODC. The intake counselor was called in and a petition for involuntary admission was filled out. The PA, ER doctor and counselor all agreed that he needed inpatient care at the SODC, however the SODC would not accept him there was no reason noted in progress notes. The note just said "[name] was discharged from ER while still obsessing over vacation, staying at hospital etc..[name] continued to obsess for the 2 ½ hour drive home." Upon arrival the PA was contacted and a prescription for Ativan was given. On 6/23/11 he was again taken by ambulance to the ER due to "extremely aggressive behavior." **On 6/24/11** the notes state **"a call was made to [name's] father [name] was notified of our decision to provide him notice of involuntary discharge effective this date."**

On 8/19/11 a call was made to the guardian regarding the SST recommendation to seek SODC placement. The guardian gave consent to release information to get the application sent to them for review. **The guardian stated that he was in agreement that his son needed more care than Trafford could provide and he felt SODC placement was appropriate.**

From 6/16/12 through 6/22/12 he was at the hospital for behavioral issues and admitted to a psychiatric unit. There was another admission from 7/6/12 to 7/18/12 when he was taken to ambulance to the hospital for "further psychiatric evaluation." The next entry is the 11/14/12 note when he was taken to the hospital for aggression which led to his arrest.

On 11/15/12 the RSD spoke with SST regarding the incident seeking assistance, he was told that "she would notify her committees in Springfield but knew of nothing else to do at this time." The HRA also reviewed a letter dated this same date notifying the Department of Public Health of the ER visit and arrest.

On 11/17/12 the RSD spoke with the Deputy Sheriff to coordinate care and was advised the Sheriff would be seeking an alternative facility to better care for his needs. That afternoon the RSD was notified that this individual was taken to another county jail and that he would be taken to Belleville for court ordered psychological evaluation. 11/20/12 the Belleville psychiatrist called requesting information on his history of physical attacks on others. That same day the RSD spoke with SST to update them on the situation.

On 11/26/12 the RSD received a call from the Sheriff stating that the individual had been transported back to their county jail and they needed medication. Trafford was still coordinating the supplying of medications at this time. On 11/28/12 SST was again updated on the situation.

On 11/28/12 The RSD contacted the DHS network representative requesting a return call to "ascertain any development in placement assistance" for this individual.

On 11/29/12 The RSD spoke with the PAS agent at the community case coordination agency as well as SST regarding the current situation.

On 12/4/12 The RSD spoke with the DHS network representative regarding the situation and was told that DHS had not been contacted by the Sheriff yet. The RSD informed him that the judge ordered the individual to be held until alternative placement could be located and that the judge had ordered that DHS be contacted to coordinate this placement. The DHS network representative again stated that they had not been notified yet but that "he would inform the appropriate committee." On 12/14/12 the RSD again contacted the DHS network representative and left a message requesting any information so that care could be coordinated.

On 1/12/13 Trafford Estates staff provided personal care for this individual (trimming nails etc..) The next note in the chart was on 1/22/13 and stated "[name] has been **discharged from Trafford Estates effective 1/18/13**. This writer spoke with Sheriff [name], [guardian name], the DHS network representative [name] informing them of this discharge.

Discharge Correspondence: The HRA reviewed a letter to the Department of Public Health dated 1/18/13 notifying them that the individual had been discharged from Trafford Estates effective 1/18/13.

There was also a Notice of Involuntary Transfer or Discharge and Opportunity for hearing which listed 7/23/11 as the date of notice to the resident and his guardian. The reason indicated was "the safety of individuals in this facility is endangered" and noted that it was discussed with the guardian on 6/23/11. On the Request for Hearing form a sticky note was attached saying "[guardian name] this form won't be necessary to fill out since we do not intend to put him without a home. We will continue to care for [name] until the appropriate placement can be located" and was signed by the RSD.

Person Centered Individual Habilitation Plan dated 1/19/12: On the summary page of this document it states "[name] was admitted July of 2009. [Name] experienced some emotional issues within the first few months of his admission. These emotional issues and resulting behaviors have continued on a sporadic basis throughout this entire time. In response to these issues we have made adjustments to [name's] psychotropic medications, hospitalized [name] for psychiatric assessment and tried several different behavioral techniques. In June of 2011 we provided [name's] guardian with a notice of involuntary discharge papers. This was done in order to protect our residents, facility staff members and visitors from physical harm. On two separate occasions the support services team has been involved with assisting in lessening the effects of [name's] behaviors. We have attempted all provided behavioral techniques from the SST to no avail. [Name's] behavior continues to be very erratic and time consuming with incidents often lasting hours at a time requiring efforts of all staff members who are on duty at that time. Along with SST assistance we have contacted all homes in our region regarding possible interest in moving [name] to another home. To date, we have had no interest due to his extreme behavioral issues. We have completed and submitted an application for [name] to be admitted to a state operated facility in the State of Illinois. [Name] has been declined such admission stating his behaviors do not merit such need. [Name's] guardian continues to assist us in the endeavor of securing appropriate placement to properly care for [name's] needs. [Guardian name] has visited a residential facility and [name's] packet was sent to them. This home decided that they could not adequately meet his needs. We are awaiting [guardian name] to visit other homes so that packets can be sent to them respectively. [Name] received a visit from a director of a home in Rosiclaire, Illinois. Upon meeting [name] this director determined that his staff members could not provide [name] with the amount of attention that he requires. He was denied consideration for this reason."

Monthly Progress Report: The monthly progress reports from the individual's day training program were reviewed. The Training objective for behavior at this time was "display inappropriate work behavior 20 or fewer times per month for 2 consecutive months." The 1/11/12 report stated that in December, 2011 he had 10+ incidents in one day. The incidents included refusing, biting his hand, kicking staff, hitting staff and pushing on staff.

The training objective for behavior at this time was "display inappropriate work behavior during 5 or less days per month for 2 consecutive months." The 11/6/12 report stated that he displayed no inappropriate work behavior for the month of October and met his objective for the first month.

Police Report: The report provides a narrative of the dispatch call on 11/14/12 which led to this individual's arrest. The situation is described as residents sitting at the table eating supper when

this individual asked about Christmas and was informed that it would be 6 weeks away; as a result, the individual began to get angry and fight. One staff person had a cut on her right forearm that was bleeding and stated she received it while this individual was fighting staff. Two other staff members stated that he began to fight after he was told numerous times that Christmas was still 6 weeks away. He stood up and bit his own hand and began swinging at other people and struck this staff person in the left eye. That is when staff "began to subdue him to keep any other residents from being battered." One of the "bosses" was called who advised the police officer that this individual needed to go to the hospital emergency room for evaluation. This supervisor also advised the officer that this was not the first time and the officer and supervisor agreed that he needed to be transported. The officer called for an ambulance and he was transported to the ER without incident. Once at the ER the administrator arrived and advised this police officer and a sergeant that he had "previously spoken with Chief [name] in regards to [individual's name] and his behavior. [Administrator name] advised that he and chief [name] agreed to have [individual's name] arrested if it were to happen again." The sergeant called the chief to verify and the police chief instructed the officer and sergeant to arrest this individual and transport him to the jail for battery if the ER cleared him. Once the individual was cleared by the doctor, he was "taken into custody and transported to the county jail where he was booked and lodged". The officers advised jail staff that the administrator would bring up his medication. The jail staff contacted the sheriff and advised him of the situation. The police officers then departed.

Court Documents: The document entitled "Information" stated under Count I "that on or about November 14, 2012, in said county and state, and within the statute of limitations, [name] herinafter called defendant, committed the offense of BATTERY in violation of 720 Illinois Compiled Statutes, Act 5 Section 12-3(a)(2), to with: that said defendant, knowingly made physical contact of an insulting and provoking nature with [staff name] in that he struck [staff name] in the face, against the peace and dignity of the people of the State of Illinois."

The "Order Finding Unfitness of the Defendant" was filed and the individual was admitted to the SODC approximately 3 months later.

III. Policy Review

Trafford Estates Contract Between Resident and Facility: In section two: term of the contract it states "The resident may be discharged after the resident or the legal representative or responsible party provides a twenty- one (21) day written notice of the desire for discharge, unless a court order requires otherwise. All charges shall be prorated as of the day on which the contract terminates." It also states "The facility may transfer or discharge the resident for the following reasons: medical reasons, for the safety of the resident, for the safety of the other residents for non-payment of stay."

MANDATES

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-102) states "A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to an individual services plan… If the services include the

administration of electroconvulsive therapy or psychotropic medication, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment…If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only pursuant to the provisions of Section 2-107 or 2-107.1…"

Regulations that govern ICFDDs (77 Ill. Admin. Code 350.3300) state the following reasons for which a resident can be involuntarily transferred/discharged. "For medical reasons; for the resident's physical safety; for the physical safety of other residents, the facility staff or facility visitors; for either late payment or nonpayment for the resident's stay…" It goes on to say "Involuntary transfer or discharge of a resident from a facility shall be preceded by the discussion required under subsection (j) of this section and by a minimum written notice of 2l days. **The 2l-day requirement shall not apply in any of the following instances**:

1) When an emergency transfer or discharge is mandated by the resident's health care needs and is in accord with the written orders and medical justification of the attending physician; (Section 3-402(a) of the Act)

2) When the transfer or discharge is mandated by the physical safety of other residents as documented in the clinical record. (Section 3-402(b) of the Act)"

The regulations go on to say "The notice required by subsection (d) of this section shall be on a form prescribed by the Department and shall contain all of the following:

1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act)

2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act)

3) A statement in not less than l2-point type, which reads: 'You have a right to appeal the facility's decision to transfer or discharge you. If you think you should not have to leave this facility, you may file a request for a hearing with the Department of Public Health within ten days after receiving this notice. If you request a hearing, it will be held not later than ten days after your request, and you generally will not be transferred or discharged during that time. If the decision following the hearing is not in you favor, you generally will not be transferred or discharged prior to the expiration of 30 days following receipt of the original notice of the transfer or discharge. A form to appeal the facility's decision and to request a hearing is attached. If you have any questions, call the Department of Public Health at the telephone number listed below,' (Section 3-403(c) of the Act)

4) A hearing request form, together with a postage paid, preaddressed envelope to the Department; and (Section 3-403(d) of the Act)

5) The name, address, and telephone number of the person charged with the responsibility of supervising the transfer or discharge. (Section 3-403(e) of the Act) "

The Code of Criminal Procedure (730 ILCS 5/104-17) states "If the defendant's disability is mental, the court may order him placed for treatment in the custody of the Department of Human Services… If the defendant is placed in the custody of the Department of Human

Services, the defendant shall be placed in a secure setting unless the court determines that there are compelling reasons why such placement is not necessary. During the period of time required to determine the appropriate placement the defendant shall remain in jail…upon completion of the placement process, the sheriff shall be notified and shall transport the defendant to the designated facility. The placement may be ordered either on an inpatient or an outpatient basis…. **Within 30 days of entry of an order to undergo treatment, the person supervising the defendant's treatment shall file with the court, the State, and the defense a report assessing the facility's or program's capacity to provide appropriate treatment for the defendant and indicating his opinion as to the probability of the defendant's attaining fitness within a period of one year from the date of the finding of unfitness**. If the report indicates that there is a substantial probability that the defendant will attain fitness within the time period, the treatment supervisor shall also file a treatment plan which shall include: (1) A diagnosis of the defendant's disability; (2) A description of treatment goals with respect to rendering the defendant fit, a specification of the proposed treatment modalities, and an estimated timetable for attainment of the goals; (3) An identification of the person in charge of supervising the defendant's treatment."

CONCLUSIONS

It was noted in Trafford Estates' records that on at least two separate occasions and over the course of 2 years prior to the 11/14/12 incident leading to his arrest, notice was given to the guardian of their intent to discharge this individual due to his extreme behavioral needs. Trafford Estates also kept this individual in their home while trying to find an appropriate placement. It was documented where Trafford Estates involved both the SST and community organizations for help in trying to find an appropriate placement for this individual as well as treatment interventions while in their care over the period of at least 2 years with no success. Although, the HRA questions if having this individual arrested was an appropriate "next step" it did appear that it was pursued as a "last resort" in trying to get this individual the treatment that he needed after several attempts at alternative placement, including placement in a state operated facility, were unsuccessful. It was also documented where this individual threatened and at times harmed peers in the home and Trafford Estates has a responsibility to provide a safe living environment for those individuals as well. It was also noted that Trafford Estates coordinated medications with the jail and care as needed when it was requested of them. Therefore, the allegation that the individual was arrested with no follow up from Trafford Estates to ensure another placement was found is **unsubstantiated**. The HRA would like to make the following suggestions:

1. That administration at Trafford Estates consider creating a policy that requires that as long as an individual is still admitted to their facility, even if temporarily housed somewhere else such as in this case, direct care staff should still provide consistent monitoring or "well checks" of this individual to ensure that he/she has appropriate medications and no other care is needed instead of waiting to be contacted by the temporary facility.

2. When an individual is discharged from their facility, this should include immediately being discharged as representative payee and that the new facility is made representative payee. If this is not possible due to it being

a temporary placement, as in this case, then Trafford Estates should continue providing medications and other necessities to avoid the burden of cost being on the temporary facility.

The HRA acknowledges the full cooperation of the agencies and their staff during the course of the Authority's investigation.