DSHS Abuse and Neglect Response Reports

On October 18, 2012, an article was published by KING 5 News regarding abuse and neglect in State Operated Living Alternative (SOLA) homes. These are homes in the community that typically have four individuals with developmental disabilities who live together as roommates and share living expenses as well as staff support.

SOLA homes are staffed by DSHS with state employees providing the support. Often, the state employees who worked at our state's Residential Habilitation Centers (state institutions for people with developmental disabilities) move from the institution with a client they were caring for in that setting when that client moved to a SOLA out in the community.

In addition to this TV news report, Disability Rights Washington (DRW) and Columbia Legal Services (CLS) published a report on November 1, 2012 that found that the Department of Social and Health Services (DSHS) does not adequately investigate and effectively respond to abuse and neglect allegations. The report focused mainly on Supported Living Services because DRW had received access to those records while working on a separate law suit (which had nothing to do with these findings). Supported Living clients live in their own homes and pay their own rent, food and other personal expenses, with supported living staff who come in to provide supports anywhere from a few hours to 24 hours a day.

The DRW report shows that DSHS rarely responds with timely investigations and often fails to investigate when people with I/DD are reportedly assaulted, sexually assaulted, or otherwise denied the dignity and care they need and deserve. Also, they seldom hold abusive or neglectful staff accountable or prevent them from having future contact with vulnerable adults. DSHS does not critically review or investigate most unexpected client deaths to determine whether abuse or neglect may have been a contributing factor.

The sad fact is that vulnerable people are prime targets for abusers. What does not need to continue is the inaction when these abuse and neglect accusations are made; they should be investigated immediately and the alleged perpetrators removed from their caregiving until the issue is resolved. The Legislature must demand that when allegations of abuse or neglect are reported that DSHS take immediate action, that the alleged perpetrator is removed from a position of caring for the victim until the case is settled and that appropriate consequences happen.

We recommend the implementation of the following short and long-term actions to end and prevent abuse, neglect, sexual assault and exploitation in our state Developmental Disabilities system:

1. When a person with an intellectual and developmental disability is sexually assaulted or raped, law enforcement must arrest, and local prosecutors must prosecute to the full extent of the law, the alleged perpetrators of these crimes.
2. The state must ensure that all workers understand they are mandated to report abuse, neglect, sexual assault and exploitation as they see it; now, not hours or days later. The Legislature should consider adding a monetary fine on individual mandatory reports who fail to report.
3. All complaints must be investigated thoroughly, completely and in a timely manner. The Legislature needs to appropriate funding to hire additional state investigators who specialize in investigations involving people with intellectual and developmental disabilities.
4. The Legislature must pass legislation to provide DSHS with the tools they need to investigate, certify and enforce quality of services.
5. The Legislature must establish a third party complaint and resolution process – a DD ombudsman function.
6. DSHS must ensure that people receiving community residential services also receive an employment or day program, which meets their needs, as a way to reduce isolation and increase community involvement.

While state government has special responsibilities to ensure the health and safety of people who are vulnerable to abuse and exploitation, we urge all the citizens of our state to share in this commitment. All of us must realize that a disability is a natural part of human life and the presence of a disability does not diminish a person's fundamental right to live a life free from abuse, neglect, sexual assault and exploitation. If we all commit to this, Washington State will be a better place for everyone.

Too Little Too Late:
A Call to End Tolerance of Abuse and Neglect

Disability Rights Washington & Columbia Legal Services—November 2012

Individuals with developmental disabilities face unacceptable risks of repeated physical harm, psychological trauma, sexual assault and even death because the Department of Social and Health Services (DSHS) does not adequately investigate and effectively respond to abuse and neglect allegations in Washington's Medicaid-funded Supported Living program.

This report documents the observations of Disability Rights Washington, Columbia Legal Services, and two nationally-recognized abuse and neglect response experts. As detailed in this report:

- DSHS rarely responds with timely investigations and often entirely fails to investigate when Supported Living clients are reportedly assaulted, sexually assaulted, or otherwise denied the dignity and care they need and deserve.
- DSHS seldom holds abusive or neglectful Supported Living employees accountable or prevents them from having future contact with vulnerable adults.
- DSHS does not critically review or investigate most unexpected client deaths to determine whether abuse or neglect may have been a contributing factor.

Recommendations

Washington must stop ignoring the safety of the vulnerable citizens participating in the state's Supporting Living program. This report explains why Washington should commit to the following reforms:

1. Mandate prompt investigations of abuse and neglect.
2. Allocate sufficient investigators to ensure timely and thorough investigations.
3. Make Supported Living provider requirements more specific.
4. Enhance state regulatory authority to enforce provider certification requirements.
5. Establish an interdisciplinary committee of clinicians, state officials, and stakeholders to review unexpected, suspicious, or potentially preventable client deaths.

This report makes a series of policy recommendations for strengthening the response to abuse and neglect allegations involving Supported Living DDD clients. Although the focus of this report is on Supported Living, the same concerns discussed in this report may be present for DSHS oversight of other kinds of community and institutional providers and applicable to law enforcement or other agencies charged with responding to abuse and neglect. This report is not intended to be a substitute for any examinations or recommendations by any clients, advocates, task forces, or committees reviewing the incident response and oversight systems for any setting where people with disabilities are at risk of abuse or neglect.

Finally, the purpose of this report is not to suggest or in any way support the idea that people with developmental disabilities ought to be institutionalized for their safety. DRW and CLS have not recently conducted a systemic investigation into the adequacy of the response to abuse and neglect in institutions, and this report provides no basis for comparison between community and institutional services.

The full report can be found online at:

www.disabilityrightswa.org/sites/default/files/uploads/Too%20Little%20Too%20Late_Redacted.pdf

"Repeat violations threaten shutdown of 13 state-run group homes"

by Susannah Frame at KING 5 News was posted on October 18, 2012.

The article opens with:

"A pattern of broken laws meant to keep disabled citizens in the state of Washington safe has led to the potential shut down of 13 state run adult group homes in King County. The KING 5 Investigators have obtained state records showing the regulatory arm of the Department of Social and Health Services (**DSHS**) has put King County SOLA (State Operated Living Alternatives) on a short leash. The SOLA homes are now operating under what is called a "**provisional certification**". That means administrators have 90 days to prove they can keep the 50 vulnerable adults who live in the homes healthy and safe, or face a shutdown of the program. There are 38 SOLA homes in the state which care for 130 clients. The homes are located in Tacoma, Bremerton, Yakima, Spokane and Seattle. They are unique in that they aren't simply licensed by the state to operate as a group home; they are managed and run by state employees. The provisional certification only applies to the KING County program. The action was taken on July 19, 2012 after homes were repeatedly cited for "serious deficiencies determined to jeopardize client's health, safety and/or welfare". The problems range from repeatedly leaving hazardous chemicals unlocked to failing to keep a vulnerable client safe from sexual assault."

The article goes on to detail some specific abuse and neglect incidents, then reports that in following up, DSHS provided information as to what they have done to correct the problems:

"DSHS spokespeople tell KING 5 the agency has made **changes to the program** "to ensure the high quality of care provided to the majority of our clients is consistent across the state". Improvements include:

- Completed risk assessments on each resident.
- Directed that SOLA staff be retrained on behavior support policies.
- Conducted site reviews in all King County SOLA homes.

DSHS also says the agency has held people accountable.

- The accused caregiver and supervisor in the sexual assault case were fired.
- The program Administrator, Robbie Rigby, was reassigned last month. All of the incidents detailed in this report occurred on her watch. Rigby has been reassigned by DSHS and now works as a fair hearings coordinator for the agency in Everett."

The entire news article can be found online at:

www.king5.com/news/investigators/Repeat-violations-threaten-shut-down-of-group-of-state-run-group-homes-174864591.html

Reported Incidents of Abuse, Neglect and Death in RHCs

This document details some reports of abuse which has led to inhumane and deadly treatment of residents in the RHC facilities. Abuses also happen in the community, usually with greater media coverage, because community records are more available to the public, than incident records in the institutions. The articles include:

Sheriff"s Dept. investigating death at Fircrest: *In June 2010 a resident at Fircrest died while being restrained by staff members.* **www.king5.com/news/local/Sheriffs-Dept-investigating-death-at-Fircrest.html**

Abuse and Death at Rainier School: *Video footage taken in 2007 by KIRO TV of violent physical abuse of residents by Rainier staff.* **www.kirotv.com/news/14264936/detail.html**

Detectives Open Death Investigation at Rainier: *Investigation of the death in 2007 of Peter Bohnke, who a staff member told KIRO TV was routinely abused by other staff at Rainier. The medical report showed he had a broken neck, yet the Rainier in-house physician listed his death as natural, calling it respiratory failure from pneumonia.* **www.kirotv.com/investigations/14643193/detail.html**

Medicine Mistake Kills Disabled Patient at Rainier School: *A fatal dose of the wrong medication given by Rainier staff caused the death of Kent Zimbleman in 2007. Twenty-six other medication errors occurred in the six months prior to this death due to a lack of availability of nurses in the facility.* **www.kirotv.com/investigations/18001536/detail.html**

Trial in Lakeland Village drowning begins: *In 2006 Kathleen Smith drowned in a bathtub while having a seizure at Lakeland Village because she was unsupervised by staff despite a policy requiring employees to visually supervise Smith within an arm's-length while she bathed. The trial began in 2009, the staff member was found not guilty.* **www.spokesman.com/stories/2009/may/12/lakeland-village-attendant-trial-drowning-there/**

Death And Denial: *In 2005* Krissy Shannon collapsed in the common room at a *Frances Haddon Morgan Center* (FHMC) duplex. Paramedics and Krissy's family believed the 29 year-old had a heart attack or seizure, *but six weeks after Krissy's death, Pathologist Dr. Emmanuel Lacsina ruled she died of acute drug intoxication from an over the counter allergy medication,Chlortrimeton.27-year-old Jenny Jessup collapsed in a bathroom at FHMC and died of septic shock from a perforated bowel. Jenny complained of a stomachache and began vomiting the night before she died, but no one called a doctor or took Jenny to the emergency room or did more than give her Pepto Bismol -- until she collapsed. February 2000, when Brandon Newman was 16, his caretaker at FHMC Bill Wilson, confessed to raping the boy, repeatedly, for a year.* **www.komonews.com/news/archive/4168516.html**

Feds Say Problems Are Worse At State's Largest Institution: *In 2002 the Department of Justice (DOJ) released a report criticizing Rainier for abuse and neglect of residents, including using inhumane devices such as wrist-to-waist shackles.* www.inclusiondaily.com/news/institutions/wa/rainier.htm

State firing Fircrest worker accused of rape: *In 2002 a staff member at Fircrest was charged with raping a woman in his care at that facility.* **http://community.seattletimes.nwsource.com/archive/?date=20020508&slug=fircrest08m**

Feds allege civil rights violations: *In 2002 federal investigators listed their findings of civil rights violations against the Morgan Center and against the Rainier School in Buckley saying staff were misusing physical restraints, overusing medications, offering inadequate psychiatric and health care, and failing to protect the safety of the residents.* **www.inclusiondaily.com/news/institutions/wa/rainier.htm**

***Former Rainier School Employee Convicted Of Indecent Liberties**: In 2001 a Rainier School employee was convicted of sexually assaulting a male resident at the state-run institution.* **www.inclusiondaily.com/news/institutions/wa/rainier.htm**

Yakima Valley School sued over alleged sexual abuse: *In 1994 a resident at Yakima Valley turned up pregnant while at the facility, her family sued the facility and DSHS in 1998.* **www.highbeam.com/doc/1P2-18473542.html**

Case rests on disabled victims: *In 2000 a staff member at Rainier School reported seeing Wei Tang Chen on top of a non speaking resident who was partly clothed. When the staff member confronted Chen, Chen allegedly placed $40 in his hand and told him not to say anything. When staff began interviewing residents of a dormitory under Chen's supervision, another man said Chen had sex with him "lots of times".* **http://community.seattletimes.nwsource.com/archive/?date=20011011&slug=hearsay11m**