



No Safe Place to Call Home – DRI’s October 29, 2018 Report on the Cycle of Abuse, Neglect, and Injury at the Southwest Idaho Treatment Center

DRI is the designated protection and advocacy system for the State of Idaho and is a member of the National Disability Rights Network.

On October 29, 2018, DRI published a report on its investigation into abuse and neglect at the Southwest Idaho Treatment Center (SWITC).

For more information or to access a copy of the report, please visit DRI’s website at: disabilityrightsidaho.org/switc-report/ or call (866)262-3462 toll free or (208) 336-5353 to request a copy of the report.

SWITC/IDHW Failed to Adequately & Appropriately Investigate Instances of Abuse & Neglect

DRI reviewed seventy (70) investigations of abuse and/or neglect allegations committed by SWITC staff from January 1, 2017 through January 31, 2018. Investigations were conducted by either SWITC or Idaho Department of Health and Welfare (IDHW) investigators. Although required by law to conduct “thorough” investigations, DRI uncovered multiple instances where SWITC/IDHW investigators:

- Failed to interview all witnesses to an event;
- Failed to identify & then resolve apparent discrepancies between witness testimony, documentary, & video evidence; and
- Failed to identify, report, & investigate all potential violations of the abuse & neglect or other facility policies, despite such violations clearly documented in the evidence collected.

Failures to identify, report, & investigate all abuse & neglect & policy violations suggest that the incidents of abuse or neglect perpetrated on residents are much higher than what was reported and investigated.

WHAT DID SWITC/IDHW INVESTIGATORS MISS & THEREBY FAIL TO INVESTIGATE:

- **15** times where allegations of abuse or neglect **were not timely reported** to Adult Protection or Child Protection;
- **5** times where **staff failed to report suspected abuse or neglect** to the SWITC Administrator;
- **5** times where **staff inappropriately restrained a resident**;
- **4** times where **additional allegations of abuse or neglect** were reported by victims or others during an investigation;
- **4** times where documents or staff statements showed **inadequate staffing ratios**, ex: we were "short staffed" or "short of time" because there not enough staff and therefore, could not comply with resident supervision requirements;
- **3** times where **staff failed to receive training on facility policies, practices, or procedures**, including abuse & neglect, client programming/plans, & behavior intervention policies;
- **2** times where **staff violated facility policy** on the use of technology, HIPAA, etc. when staff disclosed information regarding residents via their social media account(s) or used personal cell phones to photograph resident rooms;
- **1** time where **staff violated facility policy and placed residents in danger** when staff used their cellphone while driving multiple residents in a state vehicle;
- **1** time where **staff failed to follow the Suicide Prevention Policy** thus placing a resident at risk of harm;
- **1** time where **staff failed to perform required bed checks** thus placing a resident at risk of harm.

AND,

- SWITC/IDHW investigators **Allowed Staff To Re-Create Missing Or Incomplete Documentation After The Fact** during the investigation;
- SWITC/IDHW investigators **Required Residents To Sign Non-Disclosure Agreements** that **Instructed Residents To NOT Discuss WHAT HAPPENED TO THEM** With anyone outside of the facility, including **Family, Guardians, Other Investigatory Agencies, Or Advocacy Agencies/Representatives**. In some cases, if a resident refused to sign the agreement, the investigator would sign for the resident.