



PRESS RELEASE – FOR IMMEDIATE RELEASE

Contact: James R. Baugh, Executive Director, DisAbility Rights Idaho  
208-336-5353, [jbaugh@disabilityrightsidaho.org](mailto:jbaugh@disabilityrightsidaho.org) or

Amy Cunningham, Legal Director, DisAbility Rights Idaho  
208-232-4680, [amy@disabilityrightsidaho.org](mailto:amy@disabilityrightsidaho.org)

Full Text of the report is at [www.disabilityrightsidaho.org/switc-report](http://www.disabilityrightsidaho.org/switc-report)

DisAbility Rights Idaho (DRI) released a report on their investigation of abuse and neglect at Southwest Idaho Treatment Center (SWITC) titled “No Safe Place to Call Home”. The report is the result of a yearlong investigation into incidents of abuse and neglect of SWITC residents from January 1, 2017 to January 31, 2018. The report examines 70 internal Department of Health and Welfare (IDHW) investigations that substantiated 49 cases of abuse or neglect of residents. During this period, almost half of SWITC residents (14) were victims of confirmed abuse or neglect. “In a facility with only about 23 residents on average, these numbers are appalling. They point to systemic failures” according to Jim Baugh, Executive Director of DRI.

The report is the result of what is known in the abuse investigation world as a “systemic secondary investigation”. We reviewed documentation from all of the internal investigations, the reviews by the Bureau of Facility Standards, and the human resources division. DRI did not “re-investigate” the events. The report does not address anything that may have happened before or after the time period covered by the report. We did review over 20,000 pages of documents and have meticulously identified the source material for each of our claims.

IDHW notified DRI and the public in the summer of 2017 that abuse had occurred. We acknowledge the Department’s openness in providing this information. However, the narrative that was presented suggested that the abuse and neglect was confined to the misconduct of small group of direct care staff over a short period. This report documents that abuse and neglect was widespread and that systemic failures and inadequacies created the conditions for the abuse and neglect to occur. Inadequate staffing, training, and supervision were all factors. Lack of individualized active treatment, failure to provide therapies, and the failure to implement a trauma informed practices also contributed.

The report documents that residents were slapped, head-butted, thrown to the ground,

and threatened with physical violence if they did not comply with staff's orders. Staff ignored residents when they called for help after collapsing to the floor. They allowed residents to harm themselves by repeatedly hitting their head on a hard surface while staff stood by and watched. Staff left residents to sit, eat, and sleep in feces soiled clothing, and use bathrooms that were covered in feces. In one case staff failed to do scheduled status checks on a resident who died during that period, and then falsified the records to show that the checks were done.

"It is reasonable to assume that there were more instances, which are not among the confirmed cases. In fact, the documents from the internal investigations include references by witnesses to forty (40) other acts of abuse and neglect, which were never investigated. It is reasonable to assume that some acts of abuse were never reported at all because some residents are unable to communicate their complaints." Baugh said.

The report also examines SWITC's response to abuse and neglect by staff. We found that investigations conducted by SWITC/IDHW investigators were not thorough and resulted in some conclusions that were unsupported by the evidence collected. SWITC/IDHW investigators in some cases allowed staff to re-create missing or incomplete documentation after the fact.

DRI found that investigators routinely told residents that they could not tell anyone about the abuse. Investigators had residents sign non-disclosure agreements saying they could not talk to anyone including their guardians, and advocacy agencies

DRI found that, in spite of the frequency and duration of abuse and neglect, internal investigations focused almost exclusively on the direct care staff involved, and did not hold supervisors or professional staff accountable. Of seventy (70) investigations, only one (1) acknowledged the responsibility of a supervisor, one (1) acknowledged some responsibility by a facility nurse. Two others noted failures of "the treatment team". All of the remaining investigations focused solely on whether a direct care staff had committed the abuse. Investigation interviews often contained statements by staff that they seldom saw a supervisor, or that the direct care staff were "on their own", but these issues were not addressed.

The DRI report makes eighteen (19) recommendations to address these problems. They include recommendations to:

1. Discontinue the practice of telling residents that they cannot report abuse or neglect to family, guardians, and advocacy groups, and to stop requiring residents to sign non-disclosure agreements.
2. Improve training and supervision for direct care staff
3. Improve the internal investigation process

4. Seek outside expertise in working with residents who have both a developmental disability and a mental illness, incorporating "Trauma Informed Practices", and improving abuse and neglect investigation procedures.
5. Revising policies to promote Trauma Informed Care Principals, and establish a zero tolerance for abuse and neglect.

We provided a more extensive and un-redacted version of this report to IDHW on October 1, 2018. We have included their response as Appendix A.

The report does not address any changes or improvements made by IDHW after January 31, 2018.

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