EXECUTIVE MEMO

TO: Executive Directors, DSN Boards
Executive Directors, QPLs

FROM: State Director Mary Poole

SUBJECT: Significant Increase in Direct Support Professional (DSP) ANE Arrests in FY 2018

DATE: January 16, 2019

Twenty-one DSPs in residential programs were arrested for ANE in FY 2018 (July 1, 2017 – June 30, 2018), which is a 140% increase from the average 8.75 arrests per FY. The below chart compares the 21 arrests from staff working in residential programs in FY 18 with the average for the prior eight years:

Categorization of Criminal Arrests Community Residential and Regional Centers	FY11-FY18	8 year average	FY18 (only)	Difference 8 yr. avg./ FY18
Category of Conduct Leading to Criminal Arrest	Frequency		Frequency	
Threatening Victim Without Physical Contact	2	0.25	1	0.75
Theft of Consumer Medications	2	0.25	1	0.75
Fraud with Consumer Funds	7	0.88	2	1.13
Neglect of Consumer – No Physical Contact	6	0.75	0	-0.75
Strike Causing Bruising- No Substantial Injury	35	4.38	10	5.63
Strike- Substantial Injury	4	0.50	1	0.50
Push- No Substantial Injury	1	0.13	0	-0.13
Push with Fall- Substantial Injury	3	0.38	0	-0.38
Sexual Abuse	3	0.38	0	-0.38
Failure to Report	7	0.88	6	5.13
Total	70	8.75	21	12.25

Observations of interest include:

- 130% increase in striking consumer with no substantial injury;
- 480% increase in failure to report; and
- Of the 40 striking incidents in the past 8 years, nearly 2/3rd occurred after a consumer exhibited increased behaviors.

In FY 18, 14 separate ANE incidents generated these 21 arrests of provider staff. Of the 14 incidents, 11 were reported for investigation by providers and three by citizens. However, three incidents generated seven arrests for failure to report and another three incidents led to five employees being administratively discipline for delayed reporting. It is positive most of the incidents were self-reported by providers, yet the increased volume of failure to report or delayed reporting is concerning.

DDSN's analysis of this increase in arrests determined the arrests were not a function of inadequate ANE policies or management deficiencies to keep "predator" employees out of the system. Almost all of the FY 18 arrests for striking a consumer occurred in a reactive manner associated with a consumer behavior or non-compliance. In short, arrests correlate with stress in the delivery system generated from a number of areas:

- Eroding DSP capacity & capabilities due to high turnover;
- Consumer population's increasing behavioral needs require direct care with higher skill levels (70% of critical needs placements have high behavior support needs);
- Lack of standardized training for direct care workers and 1st line supervisors; and
- The need for executive level training to ensure each provider has a robust risk management process to stimulate proactive ANE risk mitigation and lessons learned.

The good news is DDSN Residential Observations conducted by DDSN's independent auditor (Alliant) and annual National Core Indicator interviews both depicted residential providers operate safe environments for approximately 5000 residential consumers. This just reinforces the significant increase in arrests for striking & failure to report correlate with training deficiencies compounded by less experienced staff and consumers with higher behavioral needs. In short, DSPs are operating in a higher stress environment and their reactions to consumer behaviors are not being adequately controlled by training to respond in a more disciplined, controlled, and measured manner.

DDSN, as well as everyone who works in this industry, recognizes the stressful environments DSPs must work in. However, there is no excuse to strike a consumer leading to an arrest. I firmly believe the vast majority of DSPs arrested for striking a consumer did not wake up the morning of the arrest thinking about striking a consumer. I believe the vast majority of these arrests result from unaddressed prior bad habits coupled with the lack of training, which then creates the conditions for a DSP to impulsively over-react to a consumer's escalating behavior. I believe many of these arrests are preventable.

DDSN will be working with providers on a standardized training program to address escalating consumer behaviors; improving providers' risk management systems to prevent incidents and leverage lessons learned; and quarterly awareness material to assist in your training efforts. In addition, DDSN will begin monthly risk reviews of ANE incidents across the state to better inform providers of issues and trends.

I will end with some better news. In comparison with FY 18, the first half of FY 19 is much improved with only three arrests. I am hopeful FY 18 results have already been absorbed by the community to encourage re-doubling our FY 19 ANE training and awareness efforts.

<u>DDSN REQUEST TO RESIDENTIAL PROVIDERS</u>: DDSN requests all providers to conduct refresher training with your DSP staff regarding engaging consumers with escalating behaviors. Additionally, please emphasize to staff their criminal liability for failure to report ANE incidents, which law enforcement appears to be much more willing to charge than compared to previous years. To assist you in your training efforts, DDSN summarized the 21 ANE residential arrests and two day program arrests in FY 18 (non-attribution), as well as raise immediate awareness of this issue to the approximately 7500 DSPs in the DDSN delivery system (Attached to Memo). Additionally, a

PowerPoint on this topic with more detail suitable for editing to meet your needs is located at Internet link: https://ddsn.sc.gov/sites/default/files/Documents/Quality%20Management/ANE%20Lessons%20Learned%20Presentation.pdf.

If you have any questions regarding the ANE information provided, please contact Quality Management Director Ann Dalton at 803/898-9813 or adalton@ddsn.sc.gov.

Thank you--Mary.

Vignettes of Fiscal Year 2018 Staff Arrests

Incident #	# Staff Arrested	Location Type	Antecedent	Initial Complainant	Brief Summary (All described conduct is considered "alleged" prior to final criminal court disposition)
1	1	CTH II	Consumer non-compliance with requested action.	DSP reported incident to detectives when being interviewed about another case.	Direct care professional (DSP) reportedly struck a consumer twice across the face and then dragged the consumer to another room of the home. He also locked another consumer in the van because the consumer undressed. The DSP was charged with 2 counts of Abuse of a Vulnerable Adult. The DSP making the report did not report timely. She received disciplinary action from the provider agency.
2	5	CTH II	Consumer non-compliance; consumer refused to go to bed upon request.	DSP staff witnessed the incident, but did not report it for several weeks.	A DSP slapped, punched, and pulled a consumer's hair. On the same day, the same DSP slapped, punched, and threw a second consumer to the floor. This second consumer attempted to use a chair to get up from the floor, and the staff knocked the chair over. This DSP was arrested for 2 counts of Abuse of a Vulnerable Adult. The DSP complainant did not report incidents until nearly two months later. In addition, three other DSPs were found to have direct knowledge of the incidents, but failed to report. These 4 DSPs were arrested for Failure to Report ANE of a Vulnerable Adult. Three additional staff received disciplinary action because they had third-hand knowledge of the abuse and did not report. All of the staff worked in the same home.
3	2	Community ICF/IID vehicle	Consumer non-compliance with requested action.	DSP witnessed the incident.	While transporting a consumer in an agency vehicle from the Day Program to the ICF/IID, the victim was being physically aggressive to other consumers and staff. Two staff (1 DSP and 1 Supervisor) struck the victim 2-3 times in the face while redirecting the consumer. The supervisor on the van remarked that the victim needed to be handled like she was in the streets. The victim had scratches on her face as a result of the incident. The DSP and Supervisor were both arrested for Abuse of a Vulnerable Adult.
4	1	CTH II	DSP woken from sleeping by a neighbor reporting a consumer left the residence, which resulted in DSP hitting consumer with a kitchen pan upon reentering the home.	Neighbor contacted the Provider Executive Director to report.	A DSP provided consumers with medications not prescribed to them and physically assaulted a consumer. The DSP gave consumers Zantac and Benadryl so that they would sleep during his/her shift to eliminate direct care. DSP struck a consumer five to six times with a kitchen pan, to include in the face, because the consumer wandered away while the DSP was asleep.
5	1	CTH II	There was an argument between the consumer and DSP the day before the incident.	DSP witnessed incident.	The DSP arrived at the home when he was not scheduled to work. He went into the consumer's bedroom and struck him in the chest. The DSP was later arrested for Abuse of a Vulnerable Adult.
6	1	CTH II	Unknown.	The DSP/Perpetrator made the report as an injury of unknown origin. The ER physician indicated possible abuse.	The DSP reported bruises on the consumer's arm, back, and leg when assisting with bathing. After an evaluation at the ER, the physician indicated possible physical abuse. There was one bruise that appeared to be a belt buckle impression. The DSP was later arrested for Abuse of a Vulnerable Adult after admitting to her actions.
7	1	CTH II	Unknown.	Contractor in home witnessed incident and reported to providers.	A service contractor working in the home witnessed the staff person and consumer fighting when he arrived. At that point, he saw the DSP strike the consumer in the stomach with a closed fist. The contractor initially reported the incident to the Program Supervisor, but the supervisor failed to report to SLED. The Supervisor also received disciplinary action for failure to report. The DSP was arrested for Abuse of a Vulnerable Adult.
8	3	CTH II	Individual was arguing with peer and staff. Physical assault occurred on the next day.	Initially reported with brief detail by Residential Coordinator. Upon additional reports by another manager, SLED was contacted a second time.	Based on an argument between the victim consumer and staff the prior day, a DSP intentionally punched a consumer. The residential director and another DSP covered up the incident in the initial paperwork of the incident. One DSP was arrested for Abuse of a Vulnerable Adult, and the residential director and a second DSP were arrested for Failure to Report Abuse of a Vulnerable Adult.
9	2	Work Activity Center	Consumer was non-compliant and aggressive toward other consumers and staff.	Initially reported as a Critical Incident. After review of video, it was determined that staff used an unapproved restraint and one staff appeared to purposefully step on the consumer's hand.	The victim was aggressive towards other consumers and staff. Two DSPs inappropriately restrained the victim and held on the floor. One DSP stepped on the victim's hand and twisted her foot while victim was lying on the floor.
10	1	Regional Center	Consumer was in another person's room and would not leave.	DSP witnessed the incident.	The consumer went into another person's room. The staff started yelling for him to leave and struck him on the head with a wooden brush.
11	1	CTH II	Reaction to a consumer behavior.	DSP witnessed the incident.	DSP struck the victim on the foot with a spoon. DSP admitted striking victim and was arrested for Abuse of a Vulnerable Adult.
12	1	CTH II	Reaction to consumer behavior- DSP used a water bottle to spray consumer in the face to redirect	Executive Director received a report of the incidents and reported to SLED.	DSP used a spray cleaner bottle, filled with water, to spray a consumer in the face as a form of behavior management. The DSP was arrested for Abuse of a Vulnerable Adult.
13	1	CTH II	End of year audited detected anomalies which resulted in identifying the fraud.	Provider Finance Staff.	Staff took nearly $44,000 in consumer funds for personal use from four consumers. Purchases were made with consumer checks. Upon further review, it was determined the consumers did not receive the items purchased. The DSP was charged with 3 counts of Willful Exploitation of a Vulnerable Adult and 3 counts of Breach of Trust with Fraudulent Intent.
14	1	SLP II	Consumer's bank noticed unusual large withdrawals from consumer's checking account.	Bank notified provider agency.	The victim's bank contacted the provider due the consumer making large withdrawals from his/her bank account. When questioned about the transaction, the consumer reported being threatened by a DSP House Manager, so consumer gave the DSP House Manager the money for his/her family. Bank ATM photos identified the DSP House Manager and spouse. DSP House Manager charged with financial transaction fraud and breach of trust.
15	1	CTH II	Residential Administrator reported suspicious activity when medication counts did not match the MAR.	Residential Administrator.	DSP stole 11 doses of a consumer's Oxycodone and signed another DSP's initials on the MAR. DSP arrested for Forgery and Breach of Trust.