



HAWAII DISABILITY RIGHTS CENTER

POLICIES AND PROCEDURES - CHAPTER I. CLIENT SERVICES

SECTION G. INVESTIGATIONS AND MONITORING

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1132 Bishop Street, Suite 2102, Honolulu, Hawaii 96813

Phone (V/TTY): (808) 949-2922 Toll Free (V/TTY): 1-800-882-1057 Fax: (808) 949-2928
E-mail: Info@HawaiiDisabilityRights.org Website: www.HawaiiDisabilityRights.org



HAWAII'S PROTECTION AND ADVOCACY SYSTEM FOR PEOPLE WITH DISABILITIES
HAWAII'S CLIENT ASSISTANCE PROGRAM

CAP

G. INTRODUCTION – INVESTIGATIONS & MONITORING

HDRC investigates allegations / reports of neglect, abuse and death of individuals with disabilities. Information about abuse, neglect or death of an individual with a disability generally comes to the attention of HDRC through:

- Written or oral reports from state or federal investigative agencies
- Communication or complaints made by individuals
- Monitoring activities
- The Press (e.g. television, newspapers, internet list serves)
- Referrals from other outside agencies or staff

HDRC also monitors conditions and practices at facilities that provide care and treatment for individuals with disabilities. Information about conditions and practices generally comes to the attention of HDRC through copies of compliance, deficiency, incident, investigative, monitoring or other reports provided by federal or state review agencies, or by the facility itself.

1. DEFINITIONS

a. Facility or Program

A ‘facility’ or ‘program’ is defined in the DD Act as a public or private facility providing services, support, care, or treatment to people with disabilities. These may include:

- Hospitals
- Long-term health care facilities
- Community living arrangements for people with disabilities (including group homes, board and care homes, individual residences or apartments of people with a disability where services are provided)
- Day programs
- Juvenile detention facilities
- Homeless shelters
- Jails or prisons
- Any facilities that are unlicensed but not exempt from licensure
- Public or private schools or other institution or program providing education, training, habilitation, therapeutic, or residential services to people with disabilities.

b. Investigation

An ‘Investigation’ is the systematic and thorough searching, gathering, examination and study of factual information from people, records, evidence and circumstances that answers questions or solves problems surrounding an allegation, usually of neglect or abuse. The end result of an investigation is a factual explanation of what happened, or what is happening now. Simply defined, an investigation is a systematic gathering of the facts.

c. Monitoring

'Monitoring' means review of reports and on-site visits of facilities to assess risk of neglect and/or abuse; identify unsafe or questionable conditions and practices; to eliminate or prevent neglect, abuse and death of individuals with disabilities receiving services in public or privately operated facilities; and to enhance the effectiveness of the systems charged with licensing and accrediting facilities that provide care and treatment for individuals with disabilities.

d. Neglect, Abuse and Death

'Neglect' means a negligent act or omission by an individual responsible for providing treatment or habilitation services which causes or may cause injury or death to an individual with disabilities, or which places an individual with disabilities at risk of injury or death, and includes acts or omissions such as failure to:

- Establish or carry out an appropriate individual program plan or treatment plan (including a discharge plan);
- Provide adequate nutrition, clothing, or health care to an individual with developmental disabilities; and
- Provide a safe environment (which also includes the failure to maintain adequate numbers of trained staff).

'Abuse' means any act or failure to act which is performed, or fails to be performed, knowingly, recklessly, or intentionally, and which causes, or may cause, injury or death to an individual with developmental disabilities, and includes such acts as:

- Verbal, nonverbal, mental and emotional harassment;
- Rape or sexual assault;
- Striking;
- The use of excessive force when placing such an individual in bodily restraints;
- The use of bodily or chemical restraints which is not in compliance with Federal and State laws; and
- Regulations or any other practice which is likely to cause immediate physical or psychological harm, or result in long-term harm if such practices continue.

'Death' means the death of individual(s) with disabilities that appears to be due to unnatural causes, restraint or seclusion, deficiencies in caliber of care or other unusual circumstances.

e. Probable Cause

'Probable Cause' is defined in DD Act regulations as:

[A] reasonable ground for belief that that an individual with developmental disabilities has been, or may be, subject to abuse or neglect. The individual making such determination may base the decision on reasonable inferences drawn from his or her experience or training regarding similar

incidents, conditions or problems that are usually associated with abuse or neglect.

The regulations establish a low threshold on the amount of factual information required to make a determination of probable cause.

Some of the confusion surrounding "probable cause" stems from criminal law requirements that pertain to search or arrest warrants. In the criminal law context, there is a stringent requirement for probable cause because such a finding will result in the serious infringement of someone's liberty. The legal system will not permit actions such as search, seizure and arrest without a reasonable threshold of hard evidence.

In the context of an investigation by the P&A System, however, the courts have uniformly held that the liberty interest to be protected is significantly lower. P&A systems are not regulatory agencies or oversight agencies and they do not have the power to fine or arrest individuals or entities. If the P&A System declares probable cause, all it can do is to enter a facility to observe conditions, meet with individuals or residents with disabilities, take photographs, or examine records.

2. PURPOSES OF INVESTIGATION AND MONITORING

Investigations are undertaken to determine if there is basis for administrative or legal action on behalf of a client.

Monitoring is conducted to: Assess risk of neglect and/or abuse; identify unsafe or questionable conditions and practices; eliminate or prevent neglect, abuse and death of individuals with disabilities receiving services in public or privately operated facilities; and to enhance the effectiveness of the systems charged with licensing and accrediting facilities that provide care and treatment for individuals with disabilities.

3. AUTHORITY

HDRC, Hawaii's designated Protection and Advocacy (P&A) System, has broad statutory authority under the following federal laws to investigate incidents of neglect and abuse of people with disabilities, and to monitor conditions and practices at facilities and programs providing care and treatment for individuals with disabilities:

- Developmental Disabilities Assistance and Bill of Rights Act (DD Act), 42 U.S.C. § 15001 et seq.
- Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. § 10801 et seq.
- Protection and Advocacy of Individual Rights (PAIR), authorized in the Rehabilitation Act, 29 U.S.C. § 794e.

Congress intended that the authorities provided in the DD, PAIMI and PAIR laws be applied in a consistent manner. The PAIR Program expressly incorporates by reference (at 29 U.S.C. § 794(e)(f)) the authority to access facilities and records for the purpose of investigating neglect and abuse set forth in the DD Act.

To protect and advocate for the rights of people with disabilities, HDRC may:

- Provide information and referral, outreach and education concerning programs and services that address the needs of eligible individuals, and training about individual rights and services available from HDRC
- Investigate incidents of neglect, abuse and death if the incident is reported to HDRC or if HDRC determines that there is probable cause to believe the incident occurred.
- Monitor conditions and practices at facilities and programs providing care and treatment for individuals with disabilities.
- Pursue administrative, legal, and other appropriate remedies or approaches to ensure the protection of rights of people with disabilities. This may be through individual as well as systemic casework (class actions, group interventions and regulatory and legislative changes).

4. STAFF TRAINING REQUIREMENTS

Federal regulations require that the P&A System provide adequate training for its staff to ensure that they have the minimum skills needed to conduct investigations of abuse and/or neglect as well as monitoring activities (see generally 42 C.F.R. § 51.7).

Upon hire, HDRC staff must possess the minimum requirements established in the job description. In addition, all staff receive continuing education throughout their employment, including training on neglect and abuse investigations. At a minimum, HDRC provides, and staff attend, quarterly formal staff trainings. Guest trainers are selected from various areas of expertise and present trainings specific to neglect and abuse investigations, such as 'Detection and Prevention of Neglect and Abuse'; and 'Confidentiality Issues in Public Reporting of Investigations'.

Trainers may also present more generic trainings that apply to federal law and current practice in a variety of areas, such as, 'Juvenile Justice and Youth Correctional Facilities'; and 'Olmstead and Self Determination for People with Disabilities'.

in addition, staff are provided opportunities to attend other community seminars and mainland conferences, as appropriate.

While formal training provides the basic foundation for staff investigative and monitoring skills, the mentoring of new staff by more experienced staff is a critical component in the acquisition of effective skills. During a staff member's first year of employment at HDRC, s/he will "shadow" experienced staff in their assigned case work and work closely with them in a variety of settings.

5. INTAKE, REVIEW, ACCEPTANCE AND ASSIGNMENT OF: NEGLECT / ABUSE / DEATH REPORTS FOR INVESTIGATION; AND COMPLIANCE / DEFICIENCY / INCIDENT REPORTS FOR MONITORING

HDRC maintains a process by which all requests for assistance or reports of neglect and abuse are first reviewed by the Intake Committee to determine if the request meets Center eligibility and priority requirements. The Intake Committee meets weekly to review all requests for HDRC services. The decision to initiate or open an investigation or to conduct monitoring is made by the Intake Committee. See 'Section F, Applications, Eligibility and Intake' of 'Chapter I, Client Services Policies and Procedures' for complete information on this process.

Information that does not result in the initiation of an investigation or monitoring may be maintained (along with other information related to that facility, program, or issue) for future reference or result in an Outreach visit where inquiries may be made and additional information may be obtained.

6. LEVELS OF INVESTIGATION

The conduct of investigations generally includes three levels of activity in the following sequence:

a. Review

This is generally the first stage of any investigation, the main objective being to see if the client meets the criteria for assistance by HDRC and if the incident fits into HDRC priorities. A Review may include, but is not necessarily limited to, the following:

- Very limited review of selected documents, such as incident reports, coroner's reports, police reports, licensing reports, or individual medical and case management records.
- Very limited interviews, such as the victim and family members, or the person reporting the alleged abuse/neglect to HDRC.

At the end of a Review, a determination is made to do one of the following:

- Conduct a Preliminary Investigation
- Conduct a Full Investigation
- Close the Review

b. Preliminary Investigation

This may follow a Review or it may, if the incident is serious and compelling enough, be the starting point for a larger investigation. It may consist of, but is not necessarily limited to, the following:

- A limited review of the following records and documents: Medical or clinical records, investigator reports, coroner's or medical examiner's reports, police reports, licensing and certification records, and individual case management and financial records.
- Interview of the initial reporter.
- Limited interviews with victim, family, witnesses to incident.

Does the information suggest that injury or death resulted from inadequate care or untimely provision of care, inadequate supervision, dangerous restraint usage, medication errors, choking or suicide? Sudden death of a reportedly healthy individual or of a child? Other unusual circumstances?

At the end of a Preliminary Investigation, a determination is made whether to continue on with a Full Investigation or to close the case.

c. Full Investigation

This is initiated after either a Review or a Preliminary Investigation has been completed. Such an investigation, due to the amount of hours involved and resources available to the Investigations Unit, is only done in those cases that are extremely compelling or are indicative of a larger systemic problem affecting many of our clients, and where the conduct of a Full Investigation presents the opportunity for systems reform. It may include, but is not limited to, the following:

- An extensive review of the following records or documents: Medical or clinical records, special investigator reports, coroner's or medical examiner's reports, police reports, and licensing and certification records, and individual case management and financial records.
- Inspecting the facility or location where the neglect/abuse took place
- Taking and/or inspecting photographs
- Consulting with experts
- Conducting extensive interviews with witnesses, staff people and other relevant people.

At the end of a Full Investigation, either a confidential Closing Memo or a Confidential Investigator's Report is prepared and a determination is made to do one or more of the following, including, but not limited to:

- Release a public report, advisory, or alert
- Conduct a media campaign
- File an Administrative Complaint, or litigation
- Refer to other agencies, such as United States Department of Justice
- Initiate policy changes, including legislation
- File a formal complaint with other agencies
- Close the case

7. INVESTIGATIVE CONSIDERATIONS

a. Assignment of Investigators

At any point during an investigation, HDRC may assign additional staff to the investigation and allocate multiple assignments to the team members, as necessary.

b. Conflicts of Interest

HDRC investigators shall apprise HDRC management of any potential conflict of interest related to the assigned case and investigation, including possible conflict with the client, guardian or targeted party(s) of the allegation. If a conflict is determined to exist, the case will be reassigned.

c. Shielding an Investigation

If a determination is made to screen/exclude/shield a staff member from an investigation, that member will not participate in any discussion of the investigation, both internally within HDRC and externally with outside agencies and will not have access to any written documentation regarding the investigation.

a. Investigations and Litigation

If a decision is made to open an investigation for a case currently in litigation, or to file litigation in a case currently under investigation, HDRC legal staff will assume responsibility for the conduct of the investigation. Legal staff will approve the plan of action, will supervise the investigating staff, and will determine the use and disposition of the records and findings of the investigation.

8. COLLECTING INFORMATION AND EVIDENCE DURING INVESTIGATIONS

a. Personal Information

Collect all the information requested on the Client Master Record Personal Information form.

b. Incident Finding of Facts

Obtain and record the following basic information about the alleged incident:

- Date, time and location of the occurrence of the alleged incident
- Name(s) of the victim(s) and the perpetrator(s)
- Name(s), title(s) and other identifying features of person(s) reporting the incident
- Time incident was reported to facility personnel
- Name(s), title(s) and other identifying features of facility personnel

c. Progress of the Investigation

The following information is collected to track the progress of the investigation. The details are maintained in the database case notes, but the Form exists as a tool for the investigator. Although most investigations can be completed in a reasonably short amount of time, some may extend over a longer period of time because of complicating factors or reluctance by parties to cooperate in the investigation:

- Nature of the allegation and/or information provided when the report was made to HDRC.
- List date(s) and times investigator visited site of alleged incident.
- Identify person(s) spoken to at site to access initial issues/ needs of investigation.
- Identify if and how scene of incident was secured.

d. Testimonial Evidence

- Identify method used to determine whom to interview.
- Identify all people interviewed in chronological order, and indicate Witness Interview Statement #.
- Identify the person(s), if any, as target(s) of investigation.
- Identify method used by investigator to afford any right of representation to those interviewed.

e. Physical Evidence

- Identify each piece of physical evidence collected.
- Identify manner in which physical evidence was collected and logged:
- Identify manner in which physical evidence was kept after collection to maintain chain of custody.

f. Documentary Evidence

- Identify/list any photographs taken (in chronological review).
- Identify/list diagrams, maps, floor plans, x-rays, medical records, etc.
- Identify/list any other documents collected for investigation.

g. Summary of Evidence

- Identify and list separately the questions that must be answered by this investigation.
- List all evidence available to answer each question.
- Identify applicable Statutes, Regulations, Policies and/or Procedures.

h. Conclusions and Recommendations

Conclusions and recommendations that will be included in any publicly released report should be fully documented in the case notes of the investigation file.

9. MONITORING FACILITY REPORTS

Pursuant to federal and state statutes and regulations, HDRC has access to information and reports from a number of federal and state agencies, including the Hawaii state Departments of Health, Human Services, Education, Labor, Public Safety; as well as federal agencies such as the Center on Medicare and Medicaid Service (CMS) and the Department of Justice (DOJ).

HDRC will maintain a process by which all these compliance, deficiency, incident, investigative, monitoring and other reports and surveys are thoroughly reviewed and analyzed to determine if additional activity or investigation by HDRC is warranted to assure the protection of individuals with disabilities.

Reports on seminal events; death; use of seclusion or restraint; physical injury; health care and medications mismanagement; involuntary servitude; questionable patterns or trends in treatment or care; will be evaluated for follow-up monitoring of the facility; for a neglect/abuse/death investigation; or for referral to an appropriate enforcement agency.

10. VISITING FACILITIES AND PROGRAMS FOR INVESTIGATIONS OR MONITORING

a. Prior to the facility visit, HDRC will:

- Research the facility and the issues of concern – using available information such as surveys from regulatory agencies, reports or other materials, and internet websites.
- Identify the records that may be sought during the visit and clarify the access authority regarding documents and records.
- Obtain any necessary consents to review records.

Note: When there is a public guardian, Office of Public Guardian (OPG), HDRC's federal access authority grants access to individuals' records without guardian consent. (see 45 CFR 1386.22 (a)(2)). OPG must, however, be given notice following access to a ward's records. It has been HDRC's practice, in cooperation with OPG, to obtain signed Consents for their wards in advance.

In order to review the records of someone with a private Guardian or who does not have a Guardian, written consent must be obtained prior to reviewing records (but note exceptions in federal and state regulations in the case of death, imminent jeopardy or when groups of individuals are affected see: 42 USC 15043; 405 ILCS 40/1; 42 USC 10805; and 405 ILCS 45/1).

- Develop a plan which includes an explanation regarding the basic focus of the visit, whether a particular incident, issue or individual is the focus of the site visit, the documents/records to be reviewed, specific concerns to be addressed and whether the visit will be announced or unannounced.

b. Upon Arrival at the Facility

- HDRC staff will identify themselves to the appropriate facility staff, present their HDRC identification, and wear their identification throughout the visit.
- HDRC staff will provide information regarding the activities and services of HDRC and the purpose of the protection and advocacy system.
- As appropriate, information related to the purpose of the visit will be provided along with information related to the activities that may be undertaken during the visit.
- The facility Director or Representative will be advised that if there are serious concerns (and if HDRC has authority to disclose these concerns), related to a significant health or safety risk, they will be communicated promptly.
- The Director or Representative should also be advised that following the visit a follow-up letter may be sent requesting additional information as necessary.

c. At the Conclusion of the Visit

- HDRC staff will thank the facility staff for their cooperation, inform them that they are leaving, and leave promptly.
- HDRC will prepare site visit case notes that include:
 - Date, time and location of the visit;
 - Description of individuals interviewed and the information disclosed during the interviews;
 - Observations made during the visit; and any other information of significance.
 - Notes on records reviewed relevant to purposes of the site visit;
 - Concerns or recommended follow-up
- HDRC staff should modify the monitoring plan of action as a result of information obtained during the site visit;
- Or submit to Intake any recommended new case activity.

11. CLOSING AN INVESTIGATION

Investigations are completed in as timely a manner as the cooperation of the facility, the review of all information and findings, and the implementation and conclusion of appropriate interventions, allow. The records of the investigation will accurately reflect the activities undertaken and the outcomes achieved.

When the HDRC staff assigned to the matter conclude that the findings are complete, interventions have been implemented, outcomes achieved, and the investigation is ready to be closed, they will meet with the investigation supervisor to review all actions

and ensure that the investigation has been conducted in a thorough manner and that there is no further action that should be taken. The investigation supervisor is responsible for ensuring that sufficient information has been obtained and satisfactory outcomes have been achieved to justify closing the investigation. The file and recommendations are then reviewed with the President for final action.

The investigation supervisor is responsible for informing the complainant, where appropriate, of the closing of the investigation and the basis for that decision. Case closing procedures from the Client Services policies and procedures will be completed for all closed investigations.

12. CONFIDENTIALITY OF RECORDS

It is the policy of HDRC to keep confidential all information obtained during the course of a neglect/abuse/death investigation until released in a public report or advisory. This policy applies as soon as an allegation or report is received, or HDRC determines there is probable cause that a person with a disability has been subject to, or is at significant risk of being subject to, neglect or abuse.

All investigatory case records are under the direct supervision of the HDRC legal staff. As a matter of general policy, HDRC does not disclose its attorney work product, investigatory work, or any other confidential work product to any individuals or organizations, including lawyers representing people with disabilities.

Facts, information, or reports available to the public or within the public domain (i.e. coroner's reports, media accounts, licensing citations) are exempted from this policy and may be disclosed.

Records obtained pursuant to HDRC statutory authority to investigate neglect or abuse allegations that are not a part of an individual client's record and not accessible to the client will be maintained separately from the individual client's records. These records may include facility incident reports or the entire investigation file of a licensing agency.

13. PUBLIC RELEASE OF INFORMATION

Pursuant to Protection and Advocacy statutory authority, HDRC may issue a public report of the results of an investigation (see 42 C.F.R. § 51.45 (b)(1)).

HDRC will ensure compliance with all applicable confidentiality laws and regulations and will protect from disclosure the internal investigatory work product underlying the public report to any individuals, organizations, including lawyers representing individuals with disabilities in civil actions not brought by HDRC.

Note: An exception to the disclosure policy occurs only when necessary to effectuate an appropriate referral or complaint to another investigatory or prosecutorial agency (e.g. law enforcement).