Final Report and Recommendations
House Bill 08-1246 and 09-1178

Abusive Caregiver Database

Presented by the
Abusive Caregiver Taskforce
June 30, 2010

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Karen Beye, Director
Colorado Department of Human Services
1575 Sherman Street
Denver, CO 80203

Dear Director Beye:

The Abusive Caregiver Taskforce was legislatively created to study and make recommendations on the development and implementation of a Database that contains the names of caregivers who have had a substantiated allegation of exploitation, mistreatment, neglect, physical abuse, or sexual abuse of a person with a developmental disability.

The Taskforce has had two legislative liaisons. Originally Representative Gwyn Green, retired, author of HB 08-1246 and HB 09-1178, offered counsel and support. Upon Representative Green's resignation, Representative Clair Levy assumed the role of legislative liaison. However, Representative Green has remained actively involved with the Taskforce as a citizen.

The Taskforce overwhelming supports the need to create an Abusive Caregiver Database. We met mostly monthly since June of 2009 without state staff support or funding and with representation from a variety of communities. The following report represents the Taskforce's final recommendations to you as Director of the Department of Human Services and as requested by HB 09-1178.

This final report with recommendations is provided as a guide. It is not intended to be all-inclusive or binding with regard to the thinking of Taskforce members. Notwithstanding, Taskforce members have agreed to continue to serve as requested and needed. Please let us know if we may be of further assistance or how else we may support the creation of this most important Database.

Sincerely,
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Xc:
Joint Legislative Health and Human Services Committee
Jenise May, Department of Human Services
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I Background

Colorado HB 08-1246 and HB 09-1178

In 2007, Sandy Toscano, guardian for her sister Stephanie who has a developmental disability, and Barb Jones, Stephanie's, then current caregiver, contacted State Representative Gwyn Green regarding concerns about abuse Stephanie had experienced by a prior caregiver.

Stephanie had experienced significant and substantiated abuse at the hands of her previous caregiver. The case was investigated by law enforcement and recommended for prosecution by the Adams County District Attorney's office. However, the Adams County District Attorney needed Stephanie to testify about the abuse to support the prosecution. Upon advice of a therapist whom Stephanie was seeing, specific to the PTSD associated with the trauma, it was determined that it was not in her best interest to testify. Consequently, the abusive caregiver was not prosecuted. It concerned Sandy that Stephanie's abusive caregiver's future employers would not have access to information about the abuse[i].

Representative Green followed up on this predicament with the Division for Developmental Disabilities (DDD), and was advised by then Director Fred DeCrescentis that the best approach to address preventing such abuse of people with developmental disabilities in the future was to legislatively create an Adult Abuse Database. Representative Green worked with Human Services, particularly the Division for Developmental Disabilities and Director DeCrescentis, on creating both HB 08-1246 and HB 09-1178.

The passage of HB 08-1246 and HB 09-1178 allowed for the creation of a Taskforce to study and make recommendations on the development and implementation of a Database that contains the names of caregivers who have had a substantiated allegation of exploitation, mistreatment, neglect, physical abuse, or sexual abuse of a person with a developmental disability.

Any future legislation that establishes an Abusive Caregiver Database is recommended to be named "Steph's Law" to honor Stephanie Yenkin. Stephanie Yenkin and her family should be credited for calling attention to the issue of abuse and the inability to stop abusive paid caregivers who are not criminally prosecuted from seeking new employment in the caregiver industry.

Child Abuse Registry and Division of Child Care Criminal Background Check Unit

The Criminal Background Check Unit is a part of the Department of Human Services (DHS), Division of Child Care. It provides fingerprint-based criminal

background check information to childcare facilities that are licensed through the DHS, Division of Child Care.

The Office of Performance Improvement, Background Investigations Unit, manages Records and Reports (formerly known as Central Registry). The central Registry was transitioned into the TRAILS system around 2004.

Records and Reports uses an automated case database known as TRAILS to provide records of confirmed incidents of child abuse and neglect from a variety of sources in Colorado. Records and Reports is a civil, rather than a criminal, tracking tool, and individuals do not have to be charged or convicted of a crime in order to be listed in TRAILS. Child protective workers input data regarding alleged cases of abuse. If an alleged case is confirmed as abuse, the information is reported as confirmed in the TRAILS database. Due process rights are provided to those who have had a substantiated case of abuse entered into TRAILS.

Due Process includes a record review and/or an administrative hearing. More than 10,000 cases are entered annually. An estimated average of 900 annual appeals are filed with a majority of cases being upheld. More than 60 counties use TRAILS.

The TRAILS database background screening service is self-funded through a fee for service arrangement. Each background check costs approximately $30. The current estimated annual budget for appeals and background screening services is $556,000. The budget and cost of background checks are revisited annually and adjusted to maintain the program's self-sufficiency.

Challenges within the TRAILS database include ensuring data accuracy, standardization of investigations and reporting, and finality of placement on the list.

Benefits of the TRAILS database include providing a one-stop place to obtain background information that could impact a child's health and well being, self-sufficiency of the funding stream, system collaboration and cooperation.

II Scope of Work

HB 09-1178 defined Scope of Work for the Taskforce as applied only to the DDD system and to include consideration of

1. Current models and processes already used in the Department.

2. Clear and consistent standards concerning what constitutes a substantiated allegation of exploitation, mistreatment, neglect, physical abuse, or sexual abuse of a person with a developmental disability.

3. A definition of "family" and a determination of whether a family member who acts as caregiver to a person with a developmental disability should be included on the Database.

4. Due process considerations for those who names would be placed on the Database, including the right to be advised of any allegations and an opportunity to be heard, request a hearing, and be represented by legal counsel.

5. Determining who would perform investigations and establishing uniform standards and training for those investigators.

6. Any statutes that would need modification as a result of the creation of such a Database.

7. Information technology needs and personnel services associated with the creation, implementation, and ongoing administration of a caregiver abuse Database.

8. Costs associated with creating and maintaining such a Database, and whether federal funds or other outside funding sources might be available to cover any part of such costs.

9. Establishing a process and timeline to phase in the Database.

This report outlines each of these areas with recommendations.

III Current Models and Processes

Investigation Duties and Responsibilities

The health and safety of persons with developmental disabilities receiving services is of utmost importance to the people served, their families, and those working within the Developmental Disabilities service system. The DHS Division for Developmental Disabilities (DDD) requires that investigations be conducted for all allegations of mistreatment, abuse, neglect, and exploitation (MANE)[ii] that occur within the service delivery system in accordance with C.R.S. 27-10.5-102(17)[iii]. DDD further requires the investigation process be thorough and complete.

DDD has delegated the duty of investigating MANE allegations to the Community Centered Boards (CCB) in accordance with Rule 16.580 B and D[iv]. Further those rules defining investigation do not prohibit the delegation of the investigation function to the Program Approved Service Agencies (PASA). The policies and procedures of each CCB regarding who conducts investigations vary greatly and

should be referenced to determine which agency is responsible for implementing these practices.

DDD program quality standards states, an "investigation must be conducted by a person with expertise in the investigative techniques and who has no conflict of interest"[v].

DDD has authorized, but not limited or mandated, basic investigation training by Labor Relations Alternatives, Inc[vi] (LRA). LRA, a nationwide organization, provides generic training on the proper techniques for conducting an investigation. LRA training does not address issues that are unique to the DDD system in Colorado. LRA focuses on providing training on how to conduct an investigation, not on the broader systemic issues that should be addressed through the investigation process, e.g., staff training needs, safety/supervision issues, Interdisciplinary Team (IDT) processes, etc.

Investigation Process

Upon an allegation or suspicion of MANE, a designated individual from the CCB notifies the PASA of the MANE allegation. These allegations come from many sources, which may include the PASA. Once an allegation has been made, it triggers a need for a MANE investigation. Allegations that include a possible criminal offense must be reported to the appropriate law enforcement agency.

If the MANE allegation is made against a staff, contractor, or volunteer, the CCB and PASA generally discuss what actions need to be taken to assure the health and safety of the individual with developmental disabilities.

Some CCB's allow PASA's to self-investigate MANE allegations. DDD requires those CCBs provide guidance and document approval[vii] of such self-investigations. The decision regarding who will conduct the investigation may be impacted by

- Whether the CCB has staff to complete the investigation in a timely manner;
- The expertise of the agency in conducting investigations;
- The severity of the allegation; and
- Any other extenuating circumstances (such as two service agencies having involvement in the allegation).

The more serious the allegation, the more likely the CCB will conduct the investigation rather than the Service Agency.

If the service agency conducts the investigation, the PASA employed investigator should not be directly involved in the care of the alleged victim with developmental disabilities. Further, any CCB or PASA investigator should not be a subordinate of any individual they are investigating for alleged MANE.

The investigation process typically begins with a review of the initial incident report and allegation. Priority would be given to examining and substantiating physical evidence that is not permanent, such as bruising or swelling.

A list of witnesses is created, and each witness is questioned in sequential order based on what his/her level of involvement or what information it is suspected that person can provide. For example, the person who reports the allegation may be the first to be interviewed so that all other investigatory questions and witnesses can be determined based on the information obtained.

An investigation is concluded when a substantiated or unsubstantiated recommendation is made.

In conjunction with the incident investigation, the PASA is required to conduct an inquiry into the event that led to the allegation of MANE. This inquiry is to serve as an administrative review for the service agency to determine whether there are processes, procedures, or policies that were violated, not followed, or are needed and not currently in place.

A report is then generated which outlines all of the information gathered, and provides a weighing of the evidence and the conclusion of the investigation. In general, the report makes recommendations regardless of the conclusion. These recommendations could include but are not limited to

- Removing the staff, contractor, or volunteer from any interaction with the person with developmental disabilities;
- Retraining the staff, contractor, or volunteer involved;
- Increased monitoring of the PASA;
- Developing protocols for health or behavioral issues; and/or
- Making environmental changes, etc.

The report is presented to the local CCB-coordinated Human Rights Committee (HRC)[viii] for its review of the investigation, findings and recommendations. The HRC may accept the finding and recommendations, choose to propose an additional investigation or make additional recommendations. The report and the HRC recommendations are sent to the person at the service agency that is responsible for responding to all recommendations. If the PASA conducts the investigation, the report is sent to the CCB.

In situations where allegations of MANE are substantiated, the PASA and the CCB should work with the victim (and family, as appropriate) to minimize additional trauma to his/her life while assuring that he/she is safe.

The PASA keeps a record of the incident report outlining the MANE; the investigation report that documents the findings, conclusions, and recommendations; and the follow up to the recommendations from the administrator in charge of the agency from which the consumer is served.

Critical Incident Reporting Systems

DDD administers a web-based application known as the Critical Incident Reporting System (CIRS)[ix]. This system is one of the systematic methods used to meet the requirements of the federal Centers for Medicare and Medicaid Services (CMS) and statutory requirements for ensuring the health and welfare of individuals receiving services.

Specifically, the purpose of CIRS is to inform DDD of the most critical incidents[x] that occur to individuals receiving services, assist in the identification of statewide and agency specific trends, prompt DDD follow up to critical incidents that warrant additional review, and allow DDD to serve as a resource in the remediation efforts to respond to such incidents.

This CIRS database also includes required reporting on many other types of incidents other than mistreatment, abuse, neglect, and exploitation.

The CIRS enables a CCB to receive incident reports from PASAs and case managers, and to screen those incident reports to ensure they meet DDD's critical incident report criteria. The CIRS does not replace requirements for reporting incidents to other authorities as specified in DDD Rule 16.580.C or the Colorado Department of Public Health and Environment (CDPHE) reporting requirements for incidents in licensed group homes. All reporting agencies must immediately report critical incidents to CCB or Regional Center (RC) administration as soon as the reporting agency has been made aware of the incident, and must submit documentation of a critical incident to the CCB/RC within 24 hours of the occurrence of the incident. A template is available for use and allows the reporting agency to provide all information needed from submission of an incident in the CIRS system as an attachment to an e-mail sent to the CCB/RC.

Upon receipt of the critical incident report from the reporting agency, the CCB/RC must submit the critical incident report via the CIRS by the end of the next business day. If DDD determines additional follow-up or reporting related to a specific incident is warranted, the CCB/RC is required to respond to the requested follow-up within the "Follow-up" data fields in the CIRS and within the specified time period. DDD ensures that an incident manager is available each business day in the State office to review reports submitted in the CIRS and to respond to any questions from the reporting agencies, CCBs or RCs.

CIRS is not an Abusive Caregiver Database and does not maintain information on the outcome of the investigation of any incident reported.

IV Clear and Consistent Standards and Definitions

Mistreatment, Abuse, Neglect and Exploitation (MANE)

RECOMMENDATION: The current definitions of MANE within Colorado rules and regulations are sufficient and require no further attention. (These rules are only specific to the DDD system of care.)

Colorado DD Rules 2 CCR 503-1, Section 16.120 -- Definitions of Abuse, Neglect, Mistreatment, Exploitation

"Mistreatment" means an act or omission which threatens the health, safety, or welfare of a person.

"Abuse" includes, but is not limited to:

> *A. "Physical abuse", which means the infliction of physical pain, injury, or the imposition of unreasonable confinement or restraint on a person. This includes directing a person to physically abuse another person receiving services.*
> *B. "Sexual abuse", which means subjecting a person to nonconsensual sexual conduct or contact classified as a crime under the "Colorado Criminal Code", Title 18, C.R.S. This may include, but is not limited to, such actions as sexual assault, rape, fondling, or sexual exploitation. Additionally, any sexual interaction between employees or contractors and persons receiving services shall constitute sexual abuse.*
> *C. "Mental or psychological abuse", which means any verbal or nonverbal act which creates, is intended to create, or reasonably could be expected to create mental anguish for a person. This includes, but is not limited to, such actions as discriminatory remarks, belittlement, derogatory name calling, teasing, and unreasonable exclusion from conversations or activities.*

"Neglect" means an act or failure to act by a person who is responsible for another's well being so that inadequate food, clothing, shelter, psychological care, physical care, medical care, or supervision is provided. This may include, but is not limited to, denial of meals, medication, habilitation, or other treatment necessities and which is not otherwise within the scope of Section 27-10.5, C.R.S., or these rules and regulations.

"Exploitation" means an illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.

Definition of "substantiated"

RECOMMENDATION: Substantiated[xi] is sufficient and requires no further attention.

"(1) Substantiated means the allegation is verified by proof or a preponderance of the evidence (preponderance means superiority of weight, importance, or strength of evidence).

(2) That determination is made by the investigator and by applying the definitions of mistreatment, abuse, neglect, and exploitation to the incident being investigated."

V Family Members and Caregiver Abuse

A. **RECOMMENDATION:** The current definition of "family" within Colorado Statute (CRS 27-10.5-102) is sufficient and requires no further attention.

B. **RECOMMENDATION**: If a "family" member as defined in statute is also a staff, contractor, or volunteer pursuant to CRS 27-10.5, then a finding of substantiated MANE in his/her staff, contractor, or volunteer capacity would merit placement on the Caregiver Abuse Database.

27-10.5-102. Definitions

(15) (a) "Family" means the interdependent group of persons that consists of:

(I) A parent, child, sibling, grandparent, aunt, uncle, spouse, or any combination thereof and a family member with a developmental disability;

(II) An adoptive parent of and a family member with a developmental disability;

(III) One or more persons to whom legal custody of a person with a developmental disability has been given by a court and in whose home such person resides; or

(IV) Any other family unit as may be defined in rules developed pursuant to section 27-10.5-407.

(b) Department rules shall define the families that are eligible to receive services and supports pursuant to this article.

VI Due Process Considerations

The Taskforce reviewed several other states' processes for considering Due Process protections[xii] in relationship to Abusive Caregivers. Any proposed legislation and rules and regulations to support an Abusive Caregiver Database are recommended to include the following.

A. **RECOMMENDATION:** A defined "Threshold"[xiii] for MANE substantiated acts that would trigger placement of staff, contractor, or volunteer on an Abusive Caregiver Database.

B. **RECOMMENDATION**: Defined and published Due Process opportunities including written notice and right to appeal prior to placement on the Abusive Caregiver Database.

C. **RECOMMENDATION:** Any written notice should include a summary of the substantiated findings.

D. **RECOMMENDATION**: Protections if an appeal is requested to include not being named on the Database pending the outcome of the appeal.

E. **RECOMMENDATION**: Any staff, contractor, or volunteer who is successful through the Right to Appeal in reversing a recommendation to be placed on the Abusive Caregiver Database shall be treated for all purposes as if no recommendation had occurred.

VII Investigations and Investigator Training

It was determined that more than six State Authorities are responsible for investigation and responding to MANE[xiv]. The Taskforce recognized, though, that it was only charged with addressing the DDD system of investigations[xv]. The Taskforce supported the generally accepted standard that ideally no CCB or PASA should be charged with self-investigation of staff, contractors, or volunteers.

A. **RECOMMENDATION**: Define and create an integrated communication protocol among and between all authorities.

B. **RECOMMENDATION:** Define and mandate a uniform method for training all investigators to include certification or successful completion measures [xvi].

VIII Statutes

The determination of statute modification is a function of the Colorado Legislative Council bill drafters an occurs at the time of drafting legislation. Thus, the Taskforce was limited in responding to the request for recommendations.

A. **RECOMMENDATION**: Any legislation that establishes an Abusive Caregiver Database should be named “Steph's Law”, in honor of Stephanie Yenkin whose situation called attention to the issue.

IX Implementation and Administrative Issues

ESTIMATED START-UP COSTS: The Taskforce cannot make exact dollar recommendations, as final costs will be specific to the model proposed. However, whenever final consideration is made for costs, that consideration should include examination of existing Colorado systems and possible cost savings through expansion of those systems as opposed to creating a separate entity.

A. **RECOMMENDATION:** Examine combining the Caregiver Abuse Database with other Colorado databases such as CBI Background Checks or TRAILS.

B. **RECOMMENDATION:** Determine what federal funds or other outside funding sources including state monies is available to cover any part of start up or maintenance costs.

C. **RECOMMENDATION:** Consider whether on-going administration and program costs could be sustained through fees associated with a background check as with TRAILS.

X Timeline and Process

RECOMMENDATION: PHASE ONE

A. Propose legislation and supporting rules and regulations to create an Abusive Caregiver Database.
B. Define and mandate a uniform method for training all DDD sanctioned investigators to include certification or successful completion measures.
C. Examine current employment law to allow former employers to share information about substantiated allegations of MANE. Encourage the use of an employment application format that contains a place for prospective employees to check permission to contact previous employers.

RECOMMENDATION: PHASE TWO

A. Consider expansion of Abusive Caregiver Database to other systems of care for vulnerable adults and/or Medicaid Waiver-ed programs.

XI Secondary Discussions

The Taskforce considered and/or initiated the following activities in relationship to its Scope of Work:

A. Myers and Stauffer, LC, Report to Study Funding Associated with SEP and TCM Activities Performed by the CCBs, 2009

The Taskforce considered that DDD systems change regarding investigations may occur separate from its recommendations due to this 2009 Report that indicated that, although there are insufficient funds currently provided for investigations and training, DDD should[xvii]:

1. Evaluate and determine which entity is best suited to conduct MANE Investigation.
2. Provide regular and scheduled training and updates of the Investigations Manual.
3. Consider the benefits of an agency whose sole occupation is to conduct investigations.

B. Conflict of Interest Taskforce

In 2010, in order to obtain recommendations to address conflicts of interests in DDD system, Colorado Health Care Policy and Financing (HCPF) and DHS established a CCB Conflict of Interest Taskforce. The Taskforce began meeting in early March and is expected to produce a report with final recommendations in 2010. The subject of MANE investigations, although not a primary focus, was officially discussed and may be addressed in the final recommendations.

C. Colorado Attorney General's Office Medicaid Fraud Unit

The Taskforce met with a representative of the Medicaid Fraud Unit housed in the Colorado Attorney General's Office. Discussion included the Medicaid Fraud investigation process.

D. HB 10-1283 -- Patient Safety and Professional Accountability

HB 10-1283 included, but was not limited to, language that would have given health care facilities immunity from defamation if they share adverse employment history information about a current/former employee or independent contractor. Some care environments used to support people with developmental disabilities were designated within the definition of health care facilities. HB 10-1283 did not pass and is expected to be reintroduced in the future.

E. Other Vulnerable Populations

Other vulnerable populations including people who are elderly and/or medically fragile shared information about their work in relationship to addressing the employability of Abusive Caregivers.

F. Other Systems

The Taskforce supports outreach to other systems, such as Judicial, Law Enforcement, and Adult and Child Protective to share information about DDD Abusive Caregiver issues.

G. Sufficient Funding

Funding for existing and new systems is always a challenge. Examination of existing expenditures by no means indicates that the system is not efficiently using public dollars. Future consideration of the cost effectiveness of an Abusive Caregiver Database should include:

1. When someone suffers MANE, do they have an increase in symptoms or difficult behaviors that cost more to manage in both the short and long run?
2. Could litigation against PASA's and CCB's be reduced or avoided if substantiated allegations of MANE are recorded and available for consideration prior to hiring?
3. Actual cost effectiveness of multiple investigators and on-going training.

XII Appendices

1. Endnotes
2. House Bill 08-1246 (attachment)
3. House Bill 09-1178 (attachment)
4. DDD Investigation Manual, 2006 (attachment)
5. DDD CIRS Memo, 2006 (attachment)
6. Maine Due Process Consent Decree (attachment)
7. Oregon Process for Determining Abuse Threshold (attachment)
8. Oregon Due Process Consideration (attachment)
9. Matrix on Investigation Duties (attachment)
10. Fact Sheet on Crime Victimization of People with Disabilities (attachment)
11. Protocol on Abuse and Neglect Investigations (attachment)

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[i] See Appendix 10 Fact Sheet on Crime Victimization and People with Disabilities

[ii] See page 11 for definitions of MANE.

[iii] CRS 27-10.5-102 (17) "Human rights committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by … at the committee's option, either providing or ensuring the investigation of allegations of abuse or neglect of persons with developmental disabilities who are receiving services or supports under this article.

[iv] COLORADO DEPARTMENT OF HUMAN SERVICES DEVELOPMENTAL DISABILITIES SERVICES RULES16.580 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION
B. Community centered boards, program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;
2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:
   a. Incident reports;

b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,
c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;
4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;
5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;
6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;
7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and community centered board or regional center;
8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or community centered board pending the outcome of the investigation. Actions may include, but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;
9. Provide necessary victim supports;
10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements pursuant to Section 16.580, C, of these rules;
11. Ensure Human Rights Committee review of all allegations; and,
12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation by agency employees or contractors shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Section C, herein.

1. Within twenty-four hours of becoming aware of the incident, a written incident report shall be made available o the agency administrator or designee and the community centered board or regional center.
2. The agency shall maintain a written administrative record of all such investigations including:
   a. The incident report and preliminary results of the investigation;
   b. A summary of the investigative procedures utilized;
   c. The full investigative finding(s);
   d. The actions taken; and,
   e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

[v] DDD Program Quality Standards For On Site Surveys CCB ADMINISTRATION AND CASE MANAGEMENT SERVICES With Interpretive Guidelines CCB Administration E. SERIOUS INCIDENTS RECEIVE ADDITIONAL SCRUTINY AND FOLLOW-UP "… When such incidents

involve allegations of mistreatment, abuse, neglect and exploitation the CCB and RC ensures timely and competent investigations are conducted and appropriate follow-up action taken."

[vi] Since 1984 Austin, Texas based, Labor Relations Alternatives, Inc. has provided training and consultation in the development of incident management systems and conducting investigations in 40 states including the District of Columbia. LRA's training and consultation includes:

- Incident Management;
- Conducting Investigations;
- Advanced Course in Investigations and Weighing Evidence and Drawing Conclusions.
- Certification Program for Investigators; and
- Evaluating the Quality of Investigations.

[vii] DDD Program Quality Standards For On Site Surveys CCB ADMINISTRATION AND CASE MANAGEMENT SERVICES With Interpretive Guidelines CCB Administration Section E -- Interpretive Guideline E- 3, 4 and 5. "If the CCB allows PASAs to conduct investigations, it should have a policy regarding delegation of investigations. Such a policy should specify under what conditions a service agency will be allowed to conduct its own investigation and that the investigation, and all documentation, must meet DDS requirements (per this standard). If the investigating entity decides that an investigation of the incident is
not warranted, the CCB maintains adequate documentation to support such a decision

a) The CCB must maintain documentation of the service agency's actions to protect the safety of persons, including relocating persons, placing staff on leave, etc.
b) The CCB ensures that other entities are notified of the allegation pursuant to statutory and regulatory requirements.
c) When a service agency conducts investigations the CCB should stay sufficiently involved to know that a thorough investigation is being conducted (appropriate parties are interviewed using appropriate investigation techniques, social services/police are involved as needed, investigators are trained and unbiased, etc.).
d) The CCB must review investigative findings that are documented ininvestigative reports to ensure conclusions are based upon findings of fact and are reasonable. Conclusions drawn should be in accordance with the definition of mistreatment, abuse, neglect or exploitation as specified in DDD Rules.
e) Recommendations and actions must be supported by the findings of the investigation and, if followed, should assist the victim with coping with the incident and help to safeguard persons from similar instances of mistreatment, abuse, neglect and exploitation. The CCB must ensure that the PASA takes appropriate disciplinary or legal action against the employee/contractor when allegations are substantiated.

4. Administrative records of investigations conducted by the PASA contain at minimum a copy of incident reports and an investigative report and any recommendations. The file also includes documentation of review/disposition by the CCB, HRC reviews and follow-up by the agency (ies) involved to agency and HRC recommendations.
5. In addition to the items in standard E 4, the administrative record should also include any evidence collected (e.g., witness statements, photographs, etc). "

[viii] COLORADO DEPARTMENT OF HUMAN SERVICES DEVELOPMENTAL DISABILITIES SERVICES RULES 16.550 HUMAN RIGHTS COMMITTEES (HRC)
A. Each community centered board and regional center shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of persons receiving services. The Human Rights Committee is an advisory and review body to the administration of the community centered board or regional center.

[ix] DDD DIRECTIVE MEMORANDUM on Revised Critical Incident Reporting System November 29, 2006: "Effective December 4, 2006, all CCBs, RCs and PASAs will be required to report all

critical incidents through the CIRS. All critical incident reports submitted to DDD must be submitted to the CCB/RC responsible for providing case management to the involved person(s) receiving services."

[x] Division for Developmental Disabilities, Critical Incident Reporting System, Criteria / Elements / Examples May 2007 CRITERION ELEMENTS: Allegations of MANE: "Fits at least one of the definitions specified in 16.120; and,
- Is committed by a staff person, contractor, or volunteer; and,
- Involves at least one of the following factors:
    • Injury (must be fundamental element and requires immediate emergency medical treatment to preserve life and/or limb; or, results in emergency admission to the hospital); or,
    • Death, or,
    • Adverse medical/health outcome; or,
    • Crime has been committed; or,
    • Exploitation involves potential loss in excess of $300; or,
    • Police are involved (not when contacted only); or,
    • Does not otherwise meet criteria but identified through trend analysis requiring investigation."

[xi] See Appendix 4 DDD Investigation Manual, 2009 - page 56.

[xii] See Appendices 6 and 8 for examples from other states on formal Due Process Appeal Protections.

[xiii] See Appendix for Oregon Process for Determining Abuse Threshold

[xiv] See Appendix 8 for Matrix of Investigation Duties.

[xv] See Appendix 11 on Protocol on Abuse and Neglect Investigations.

[xvi] See Appendix 4 for DDD Investigation Manual.

[xvii] "Study Funding Associated with SEP and TCM Activities Performed by the CCBs" Myers and Stauffer, LC, 2009, page 59.