

2012

MUI Abuser Registry Annual Report

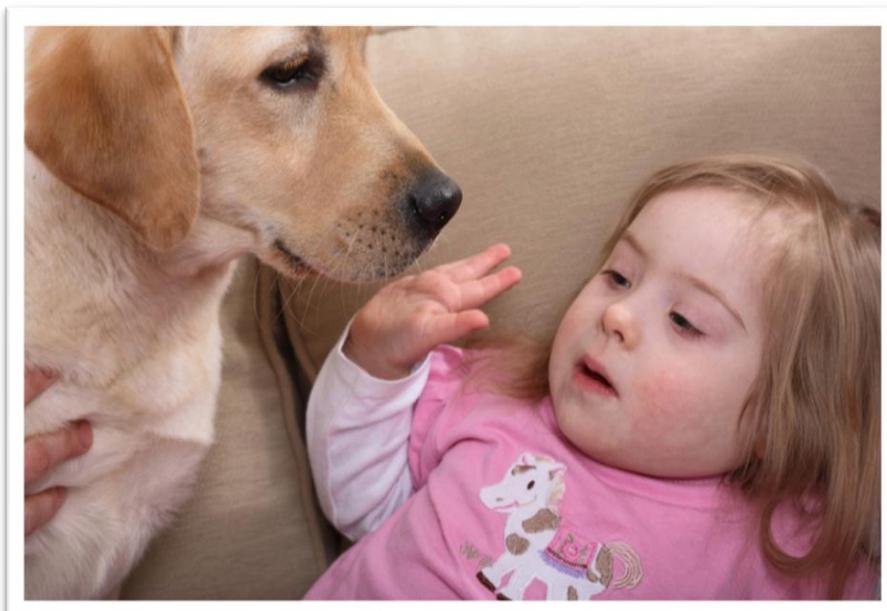


**A Review of Health and
Safety Systems for
Ohioans with
Developmental
Disabilities**



Department of
Developmental Disabilities

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The Ohio Department of Developmental Disabilities MUI / Registry Unit is proud to present the 2012 Annual Report. This report was created using data compiled from the Incident Tracking System (ITS) for calendar year 2012. The ITS is the department's online reporting system for monitoring incidents in each of Ohio's 88 counties. Analyzing data, identifying causes and contributing factors and implementing effective prevention planning have allowed Ohio to move forward as a leader in health and welfare systems.

Within this annual report you will find specific data and analysis on a number of the Major Unusual Incident (MUI) categories. The analysis has been completed to assist the department, county boards and providers with identification of systemic issues impacting health and welfare for individuals throughout the state. Information is provided regarding several MUI categories including Physical Abuse, Sexual Abuse, Verbal Abuse, Neglect, Misappropriations, Deaths, Injuries, Hospitalizations, Unapproved Behavior Supports, Attempted Suicide, Medical Emergencies and Missing Persons. The review and analysis of the data has been instrumental in assisting the field with targeting important issues in order to develop strategies for improvement.

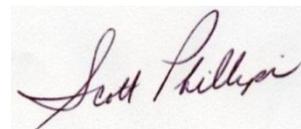
In addition to reporting on specific MUI incident categories we've also provided data regarding systemic outcomes. The data includes: 24 hour reporting, 30 day Investigations, Site Visit Reports, Department Directed Investigations, Abuser Registry Statistics, Department Hotline Calls, 5/10 Pattern Trend Reports, Mortality Review Information and other reports pertaining to the health and welfare system.

Ten health and safety alerts were published through the MUI/Registry Unit in 2012. These alerts are developed based on a review of ITS data and shared with providers of service in an effort to get information out to the field quickly regarding potential health and safety concerns. The alerts are created through committee work, pattern / trend analysis and individual case review of incidents. Some sample alert topics include: Health and Welfare is Priority One, Falls Prevention, Choking Prevention and Transition Planning.

The MUI Registry Unit reviewed over 18,500 reported incidents in 2012. This is a decrease of nearly 3% from calendar year 2011. The Department MUI Unit reviews each case to assure that appropriate immediate action has been taken to protect individual's health and welfare. Ohio provided technical assistance and supports to many states around the country in 2012. Topics of discussion include Ohio's web base reporting system (ITS) , Abuser Registry System, Mortality Review, and Statewide Patterns / Trends. Each of these elements plays a critical role in improving statewide processes that help protect individuals in Ohio.

OAC 5123:2-17-02 (MUI Rule) went through the rule review process in 2012. Feedback was requested and received from the field resulting in several positive changes. Focus has been placed on triaging incidents to assure that the right resources are allocated to the most serious incidents for investigation. The net outcome will be streamlined health and welfare systems operating more efficiently and effectively to protect those we are entrusted to support. Timely and accurate reporting, thorough investigations and comprehensive prevention planning will continue to be the pillars for a successful incident management system.

The MUI / Registry Unit would like to thank individuals, families, providers, county boards, constituents and department personnel for their hard work, dedication and commitment to making health and welfare a priority in 2012. Ohio's system is comprehensive and requires cooperation and teamwork to gain positive results. When all facets of the system work well together the benefits to the individuals we support are immeasurable.



Each of the 88 County Boards contract for services or employ an Investigative Agent (IA). The IA is required to investigate all reported MUIs. These investigations include the identification of causes and contributing factors as well as prevention plans to help reduce the likelihood of re-occurrence. IAs are certified through the Ohio Department of Developmental Disabilities (DODD) and are required to attend Civil and Criminal Investigatory Practices training and obtain credit hours to maintain their certification.

Providers and County Boards work diligently to ensure that incidents are reported accurately and timely. Working in partnership, providers and County Boards develop immediate actions to ensure the health and safety of any at-risk individual(s). The County Board conducts a thorough investigation for all MUIs entered into the Incident Tracking System (ITS) which includes prevention planning.

DODD is responsible for overseeing statewide systems of supports and services for people with developmental disabilities and their families. The Major Unusual Incident (MUI) Unit plays a critical role by providing oversight to County Boards and Providers to help assure the health and safety of individuals receiving services in Ohio.

The MUI Unit employs fifteen staff and is comprised of three primary entities: Intake, Regional Managers and Registry Investigators.

Intake Managers

- Assure that all MUIs are entered correctly into the ITS system and include effective immediate actions, meet MUI criteria and are classified accurately according to rule.
- Review each and every incident entered into the online Incident Tracking System.

The Incident Tracking System (ITS) is a DODD Application tasked with tracking the Major Unusual Incidents (MUIs) across all of Ohio's Counties. This application aids local and state Developmental Disability (DD) employees in ensuring the health and safety of the individuals we serve. The Abuser Registry is also maintained through ITS and provides a public facing program for employers to check out potential hires to confirm they have not been banned from employment in the field.

Regional Managers

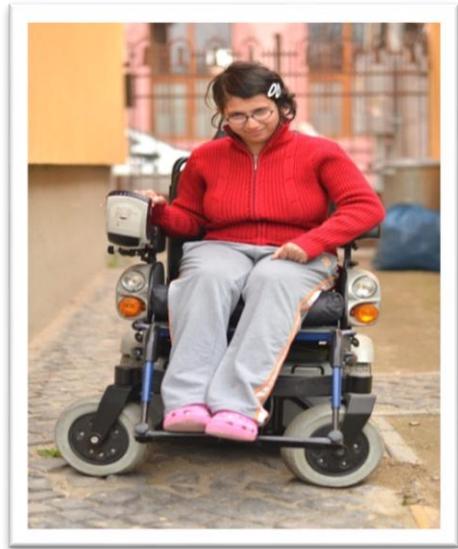
- Oversee Incident management through the online Incident Tracking System (ITS).
- Conduct site visits to Ohio's counties and providers of service as required.
- Provide training and technical assistance throughout the year.

Registry Investigators

- Manage the DODD Abuser Registry
- Conduct department directed investigations
- Conduct site visits to Ohio's counties as required to monitor the quality of the investigation
- Provide training and technical assistance to the Investigative Agents (IA)

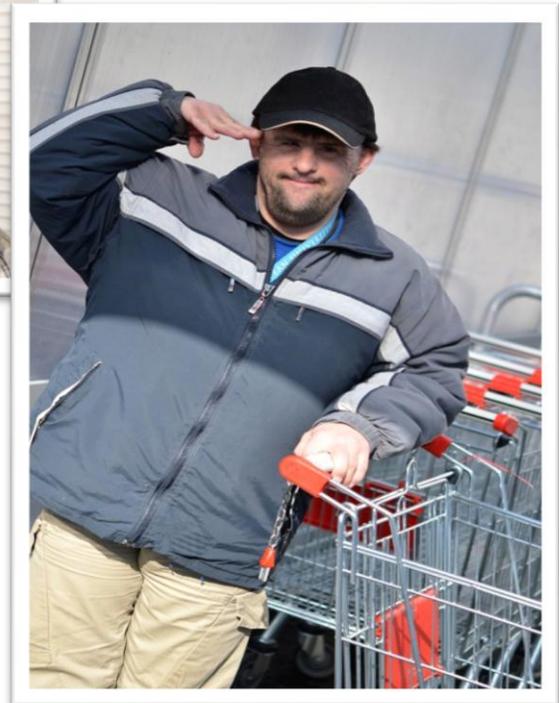
Other statewide functions include: Providing Informational Notices to Stakeholders, Issuing Health and Safety Alerts, Managing a Centralized Complaint Hotline, Conducting Statewide Mortality Review Meetings, Steering Statewide Pattern and Trends Meetings, and providing ongoing training to the field.

91,652 individuals served in 2012



Services encompassed a wide variety of supports based on need and choice.

The mission of the Ohio Department of Developmental Disabilities is continuous improvement of the quality of life for Ohio's citizens with developmental disabilities and their families.



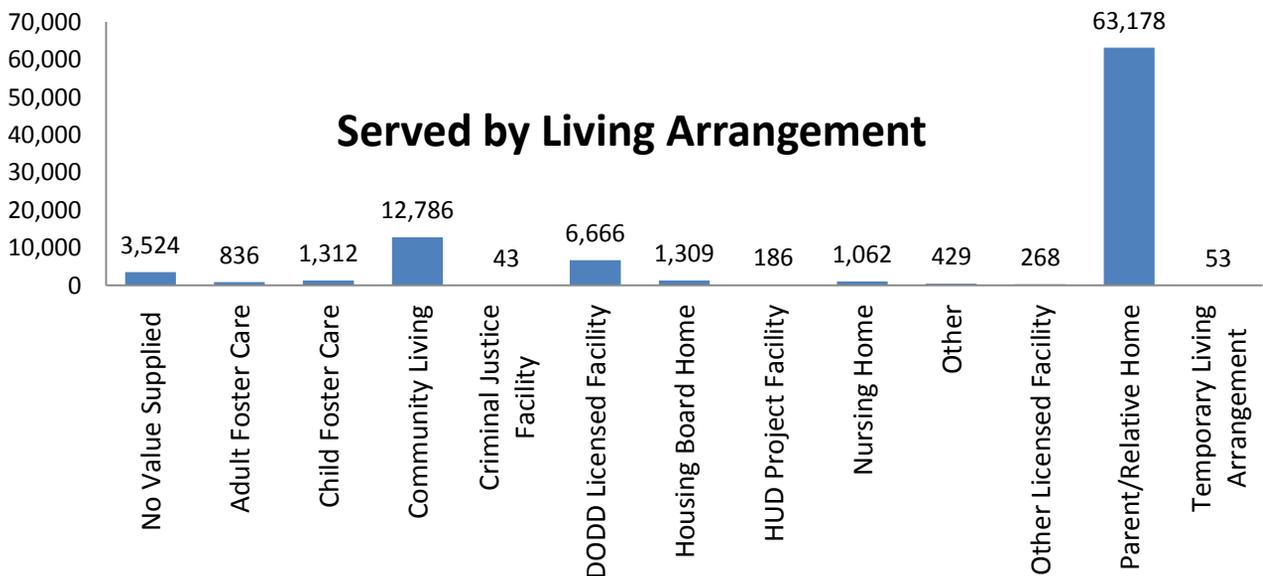


As illustrated below, individuals living at home with their parents or a relative continue to make up the largest portion of those receiving services at 69%. Individuals living in their own home with supports comprise 14% followed by individuals living in a DODD licensed facility at 7% of total individuals served. Individuals between the ages of 6-21 years of age made up the largest group at 30% while those 65 years and older represent the smallest group with 4%.

As in year's past, individuals with mild developmental disabilities encompass the largest number of those served with 17,033 according to Individual Data System completed by County Boards . This group was followed by those with moderate developmental disabilities which accounted for 13,298 of those served.. Those with profound disabilities made up the smallest group with 3,179 individuals served while individuals with severe developmental disabilities totaled 5,109.

In 2012, the number of males served reached 56,052 while the number of females served was 35,072.

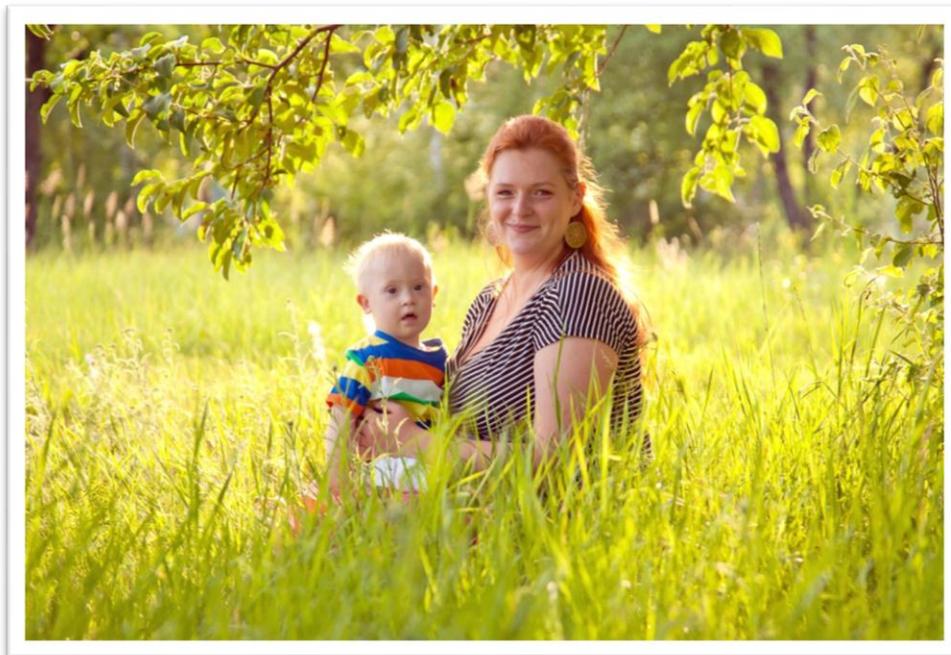
Served by Living Arrangement



The Department believes that a caring and well trained work force is critical to providing quality services and ensuring the health and safety of Ohioans with disabilities. Each year the MUI Unit utilizes data that was collected over the previous year to target training. In 2012, the MUI/Abuser Registry Unit provided training to 3,257 participants in 53 different trainings across the state. The trainings were comprised of the following topics and occurred through different sessions and webinars.

MUI Rule Training-1,353 Participants
Transition Providers Training on MUIs-930 Participants
SELF Waiver and Health and Safety-482 Participants
Advanced MUI Rule -105 Participants
Patterns and Trends-102 Participants
Rights Training-75 Participants
Civil and Criminal-64 Participants
Advocates Training-55 Participants
Coordination with Provider Standards-51 Participants
Investigations-26 Participants

3,257 Trained in 2012



Consultations and Technical Assistance

The MUI Department also offers the following supports to County Boards, COGS and Providers:

- Consultation
- Health and Safety Toolkit. The Toolkit is located on the Department's website at <http://dodd.ohio.gov/healthandsafety/Pages/Health%20+%20Safety%20Toolkit.aspx> and contains valuable resources for County Boards, Providers, Individuals and their families. The Toolkit contains informational links, training presentations, forms, reference materials and investigative tools.
- Case Reviews
- Email Notifications of Abuser Registry Updates
- Investigative Agent List Serve

In 2012, the Department issued ten Health and Safety Alerts. These notices focus on the areas in which DODD has identified a risk to people and provides guidance on what can be done to avoid or minimize the risk. By rule, all employees are required to review the Health and Safety Alerts issued since last years training.

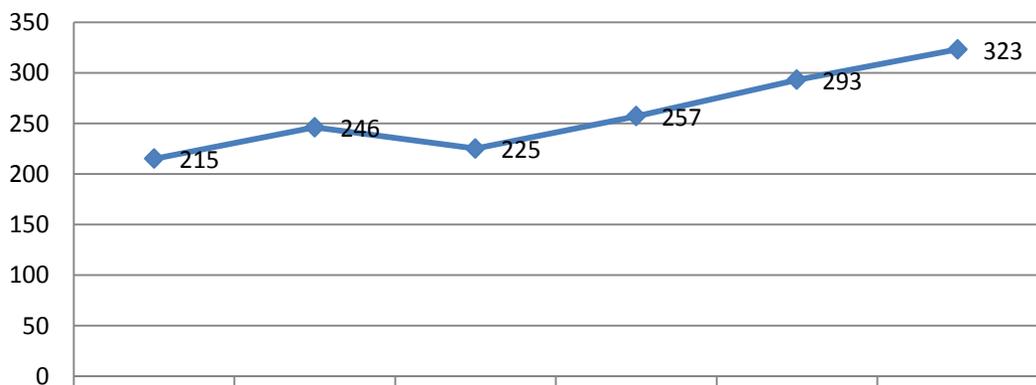
Health and Safety Alerts Issued:

- Bathtub Drowning*
- Reward Cards*
- Falls*
- Keeping Safe in the Summer-Part 1*
- Keeping Safe in the Summer-Part 2*
- Preventing the Flu*
- Choking*
- Hot Water Burns*
- Health and Safety is Priority One*
- Winter Weather*



The MUI Unit oversees the DODD Abuse/Neglect Hotline (866)313-6733. The DODD hotline is one way to report abuse, neglect and theft involving an individual with a developmental disability. Concerned parties may also contact local Law Enforcement when appropriate or the local County Board of Developmental Disabilities to make a complaint. In most cases, contacting the local Board is the quickest and easiest way to lodge a complaint. All complaints or concerns received through the Hotline will be logged and sent to the appropriate Major Unusual Incident (MUI) staff for follow up. When appropriate, that staff will make contact with the person voicing the concern to gather additional information and inform them of the action being taken. In addition, the MUI staff will determine what further action may be needed which may include referral to another entity. In most cases, the incident will be referred to the local County Board investigator. Hotlines calls continue to rise in 2012 and totaled 323.

Number of Hotlines calls received per year



Number of Calls	215	246	225	257	293	323
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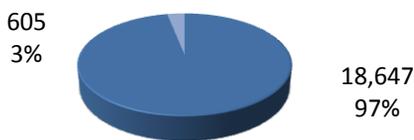
In 2012, the MUI unit conducted onsite reviews of 39 County Boards. The purpose of these visits was two-fold. The first was to monitor the Board’s compliance with Ohio Administrative Code 5123:2-17-02 and the second was to provide technical assistance and support in an effort to improve health and safety for the individuals residing within that county.

Based on the results of these reviews, County Boards received an award from 1-3 years. Of the 39 reviews completed, 29 counties were awarded a 3-year award while the remaining 9 earned a 2-year award. The majority of these reviews (20) were Quality Tier Reviews while eighteen were Accreditation reviews and there was one special review. The MUI unit continues to participate in Accreditation reviews and can conduct reviews at any time. County Boards are held to a high standard of reporting and completing MUI investigations. In 2013, the County Boards continued to achieve high results in these areas. In the areas of timely reporting and completing of investigations, the County Board achieved 97%.



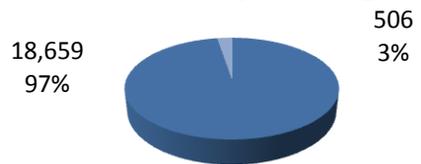
The Department’s vision is that Ohio’s citizens with developmental disabilities and their families will experience lifestyles that provide opportunities for personal security, physical and emotional well-being, full community participation, productivity and equal rights.

Timely Investigations



■ Met 30 Day Requirement ■ Requirement Not Met

24-Hour Reporting



■ Timely ■ Untimely

The timely completion of investigation includes those completed with required timelines and may include an approved extension(s).

Providers are key to our service delivery system and it is important that we continue to work together. In 2012, the MUI team provided support to providers through frequent contacts, offering resources on the Health and Safety Toolkit and participating in provider reviews.

In coordination with the Office of Provider Standards and Review (OPSR), the MUI unit participated in reviews of certified providers, licensed homes and developmental centers over the last year. Using a standardized review tool, providers are measured on compliance with the MUI rule.

Some commonly cited areas of non-compliance among agency providers included:

O.A.C. 5123:2-3-17 (L) (1) Quarterly Analysis.

All agency providers including county boards as providers shall send the county board a quarterly report regarding MUI trends and patterns.

O.A.C. 5123:2-17-02 (M) (7) Unusual Incident Log

Each agency provider and county board as a provider shall maintain a log of all UIs. The log shall include, but not be limited to, the name of the individual, a brief description of the incident, any injuries, time, date, location, and preventive measures.

O.A.C. 5123:2-2-01 (C) (3) (c) Initial Training on Incidents Adversely Affecting Health and Safety

Except for providers of services specified in paragraph (C)(4) of this rule and members of a family consortium, each independent provider and each employee, contractor, and employee of a contractor of an agency provider who is engaged in a direct services position, shall meet the training requirements relating to incidents adversely affecting health and safety.

Three Commonly Cited Areas of Non-Compliance at County Board Reviews

O.A.C. 5123:2-17-02 Appendix A Investigation Protocol (14)

The I.A. shall evaluate the relative credibility of the witnesses

O.A.C. 5123:2-17-02 (H) General Investigation Requirements

All MUIs require an investigation meeting the requirements established in either appendix A or appendix B to this rule. Investigations must

O.A.C. 5123:2-17-02 (M)(7) UI Logs

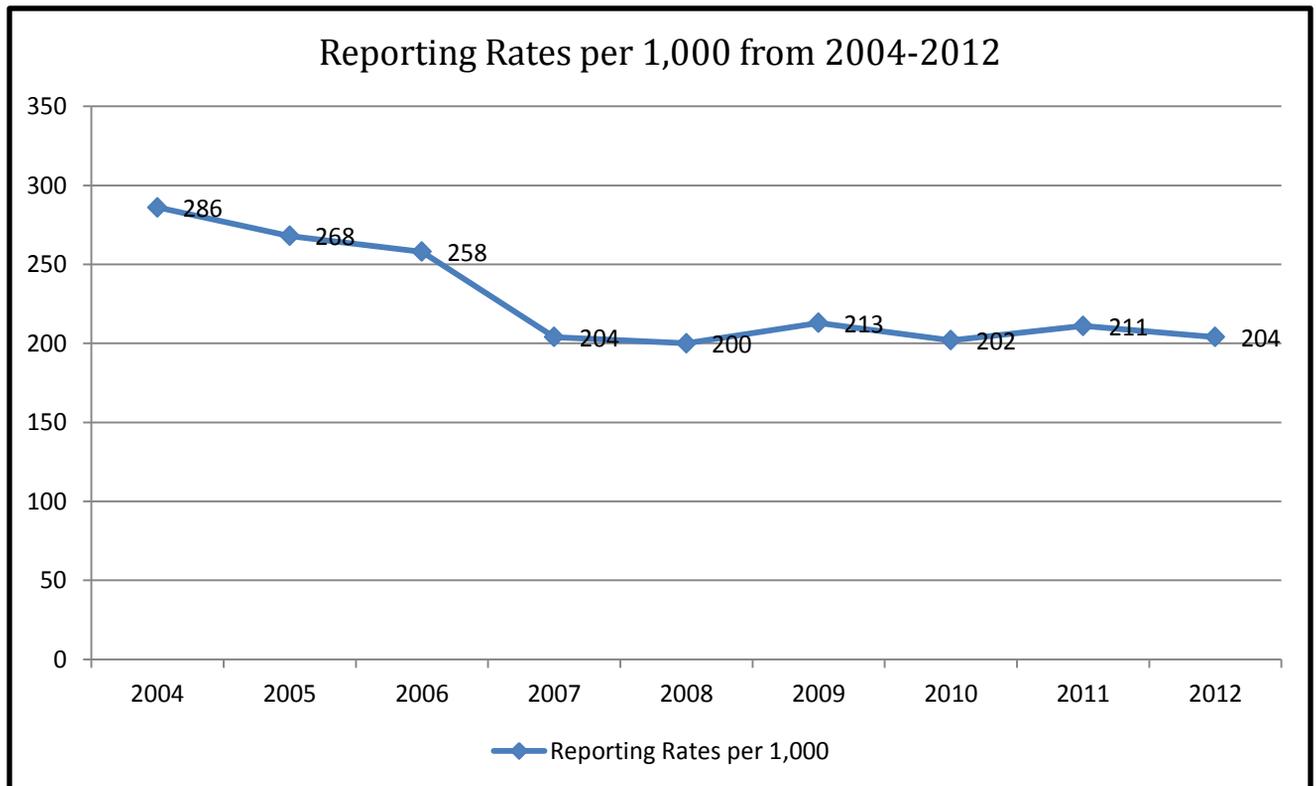
Each agency provider and county board as a provider shall maintain a log of all UIs.

The log shall include, but not be limited to, the name of the individual, a brief description of the incident, any injuries, time, date, location, and preventive measures.



Reporting rates are good indicators of increases and decreases in MUIs based on the total population served. In calendar year 2012, the MUI rates per thousand decreased to 204. A slight decrease in MUI reports occurred in 2007 due to MUI rule changes but overall reporting rates have remained fairly consistent.

YEAR	NUMBER OF MUIs REPORTED	NUMBER OF INDIVIDUALS SERVED	REPORTING RATE PER 1000
2004	20,244	70,702	286
2005	19,973	74,452	268
2006	19,935	77,369	258
2007*	16,247	79,583	204
2008	16,266	81,284	200
2009	17,244	81,022	213
2010	17,703	87,458	202
2011	19,078	90,237	211
2012	18,654	91,652	204



Rates reflect the number of MUIs per 1,000 individuals. For example, the unscheduled hospitalization rate for 2012 means that there are 47 MUI reports in this category for every 1,000 individuals served.

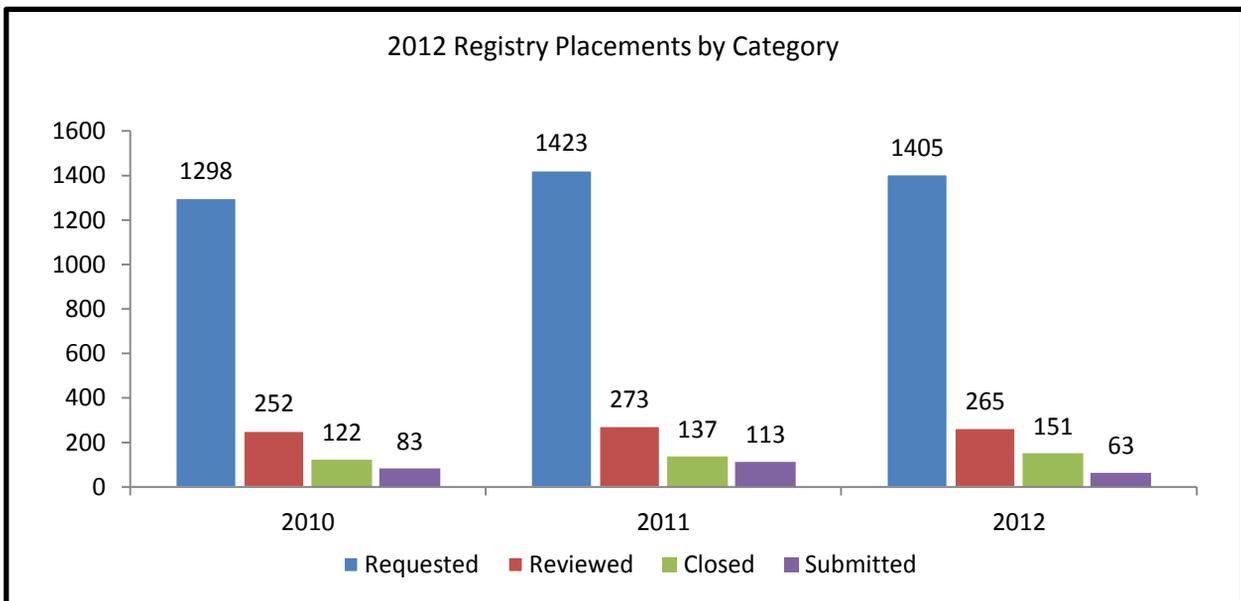
Category	2007	2008	2009	2010	2011	2012
Unscheduled Hospitalizations	48.0	48.5	54.8	49.5	49.0	47.0
I/O Waiver	141.5	132.7	149.7	137.8	141.	134.2
Level One Waiver	16.7	10.6	8.3	9.2	10.	10.9
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	2.5
Alleged Physical Abuse	17.0	16.8	16.7	15.5	16.5	16.
I/O Waiver	32.6	32.7	33.5	34.3	34.	33.7
Level One Waiver	20.3	16.7	15.5	18.2	18.5	18.
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	3
Alleged Sexual Abuse	5.4	4.7	4.4	3.8	3.78	4.0
I/O Waiver	7.5	6.7	6.5	6.6	5.8	7.0
Level One Waiver	5.3	6.5	5.1	4.4	4.6	6
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	1
Alleged Verbal Abuse	7.7	7.2	8.7	9.2	9.3	8.9
I/O Waiver	21.5	22.2	24.7	25.9	28.9	28.5
Level One Waiver	7.1	5.2	9.7	10.7	13.0	12.0
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	2
Alleged Neglect	17.0	16.5	21.2	21.1	19.5	20.
I/O Waiver	47.5	52.7	58.0	62.2	67.2	69.7
Level One Waiver	10.0	6.9	8.6	9.4	7.2	9
SELF Waiver	NA	NA	NA	NA	NA	29
Transition Waiver	NA	NA	NA	NA	NA	13
Alleged Misappropriations	15.0	14.4	18.9	21.1	16.37	14.6
I/O Waiver	53.6	61.5	61.4	70.2	71.9	64.2
Level One Waiver	10.5	15.6	16.7	17.7	22.3	18.
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	4
Injury	19.0	19.2	19.5	19.1	18.1	17.8
I/O Waiver	54.2	50.4	47.5	54.2	50.1	51.6
Level One Waiver	8.8	6.5	5.9	7.6	7.9	7.
SELF Waiver	NA	NA	NA	NA	NA	3.
Transition Waiver	NA	NA	NA	NA	NA	1
Death	8.7	9.3	9.3	8.4	8.88	7.88
I/O Waiver	5.3	5.6	6.2	5.2	7.01	7.76
Level One Waiver	2.1	2.6	1.9	1.9	2.6	2
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	3
Peer to Peer Acts	24.5	19.1	21.2	22.5	25.4	23.5
I/O Waiver	66.	51.9	50.6	61.1	72.2	63.96
Level One Waiver	25.6	23.6	21.5	24.7	26.2	28.
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	2
Unapproved Beh. Support	20.6	22.6	24.6	20.6	21.1	20.5
I/O Waiver	64.6	74.4	70.2	60.9	59.30	57.
Level One Waiver	23.3	11.5	16.3	16.3	16.7	13
SELF Waiver	NA	NA	NA	NA	NA	0
Transition Waiver	NA	NA	NA	NA	NA	7

Placement on the Abuser Registry bars that person from employment in the developmental disability field in Ohio. New background check laws enacted in 2012 and effective on January 1, 2013, will expand the reach of the Registry. Employers, outside the DD field, will now have to conduct database reviews (one of these databases is the Registry) as part of their hiring and retention of employees. Registry offenses include physical abuse, sexual abuse, verbal abuse, misappropriation, neglect, prohibited sexual relations, and failure to report. The Registry is a safety net protecting all individuals from the actions of that person in the future. Placement on the Abuser Registry requires clear and convincing evidence.

The Registry is available to everyone on the internet. Anyone can subscribe to have Registry updates e-mailed to them with new placement names. Each year employees receive an annual notice describing all of the potential Registry offenses.

Forty-nine names were added to the Registry in 2012 for a total of 447 names listed at the end of calendar year 2012. In 2012, there were 1,405 potential Registry Incident Tracking System (ITS) reports reviewed. This initial review is done within 10 days of the closure of the MUI. Approximately 82% of these cases are closed during this initial review.

In 265 of these cases, the MUI/Registry Unit requested and reviewed the complete investigation file. The number of cases closed versus those submitted shifted to more cases closed and less submitted. The chart below shows the number of cases for each of the last three years.



The Registry does not require a criminal prosecution. However, if there is pending criminal prosecution, the Registry process must either wait for the criminal process to be completed or get approval from the prosecutor to proceed. Another option is to have the person themselves waive their Registry rights and agree to placement on the Registry. This is called a voluntary consent.

When a case is submitted and does not involve a conviction, it is reviewed by the External Review Committee. This group is comprised of individuals, their immediate family, county board and provider staff, and victim’s witness groups. The External Review Committee discusses the merits of a case, as well as systems problems and solutions. The Committee makes a recommendation whether there is a reasonable basis for believing that there should be a Registry placement. Each member makes a significant investment of their time and talents. Their advice and counsel is invaluable.

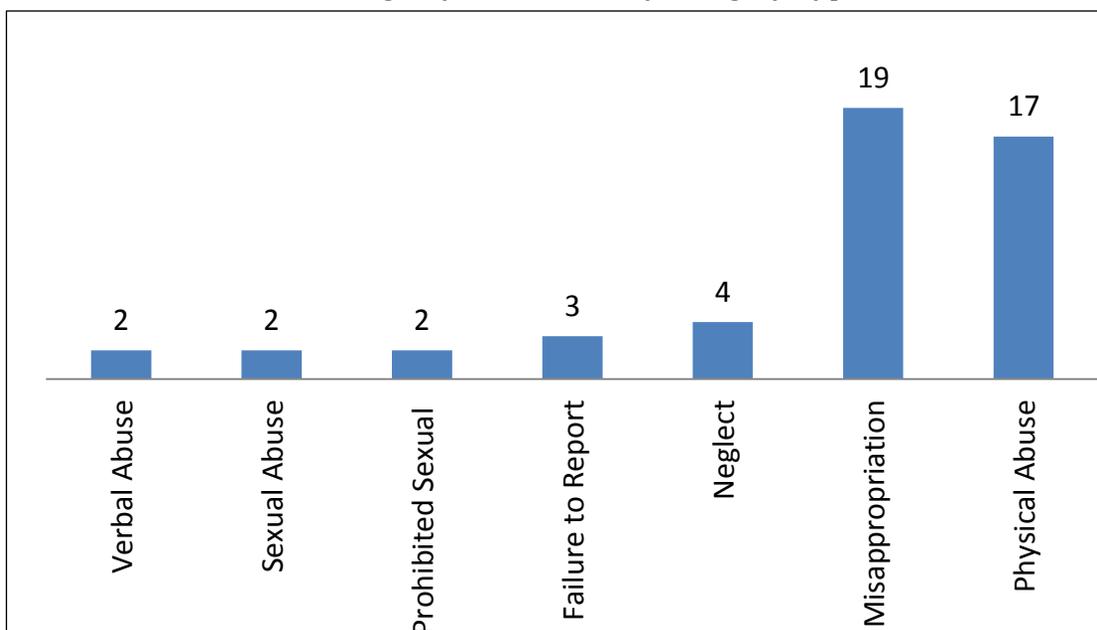
There are two ways to continue to improve the quality of the Registry process. Since Registry cases are not reviewed until the corresponding MUI is closed, closing the MUI sooner is one way to speed up the process. The new MUI Rule considers this, especially in cases that involve criminal charges, and allows for closure after the important elements of the MUI are completed.

Sixty-five percent of the 2012 Registry placements involved a criminal case. This is a slight increase from sixty-two percent criminal cases from 2011. Earlier closure of MUIs should result in more opportunities for voluntary consent agreements and cases that are easier to identify and speak with witnesses, the individual, and get critical documentation.

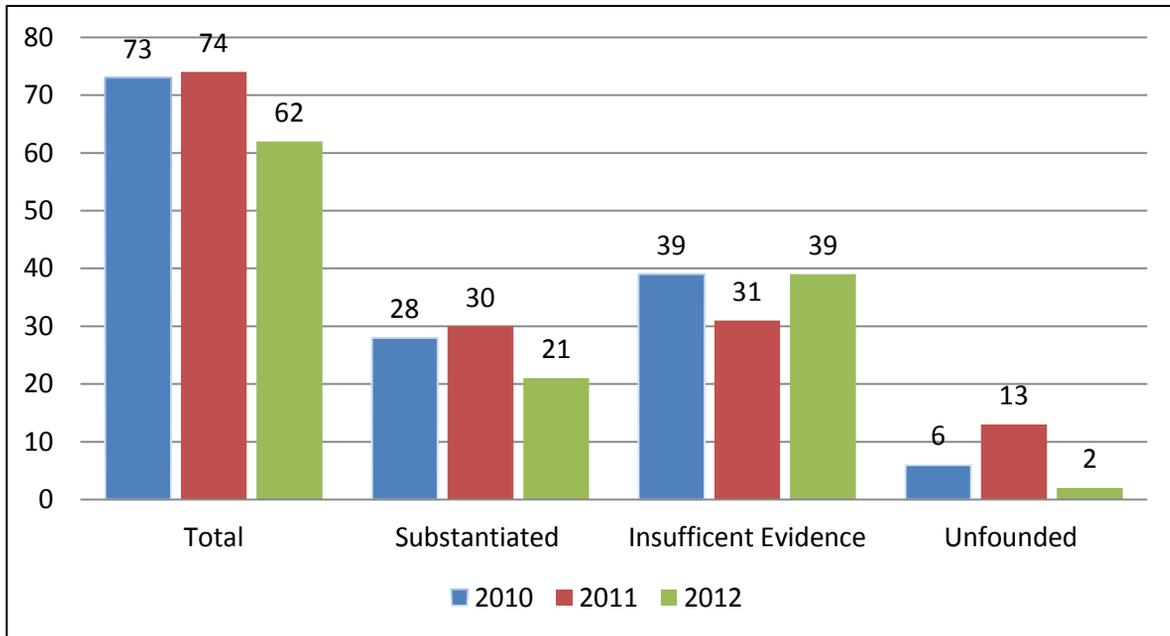
The second way is to continue to have quality MUI investigations. Investigations that are thorough and easily readable, contain all of the needed documentation, and show clearly the reasoning behind the substantiation finding.

As depicted below, misappropriation (19) was the leading case of placement on the registry followed by physical abuse (17), neglect (4) and failure to report (3). Prohibited sexual, verbal s abuse and sexual abuse each accounted for 2 placements for a total of forty nine people placed in 2012.

2012 Registry Placements by Category Type:



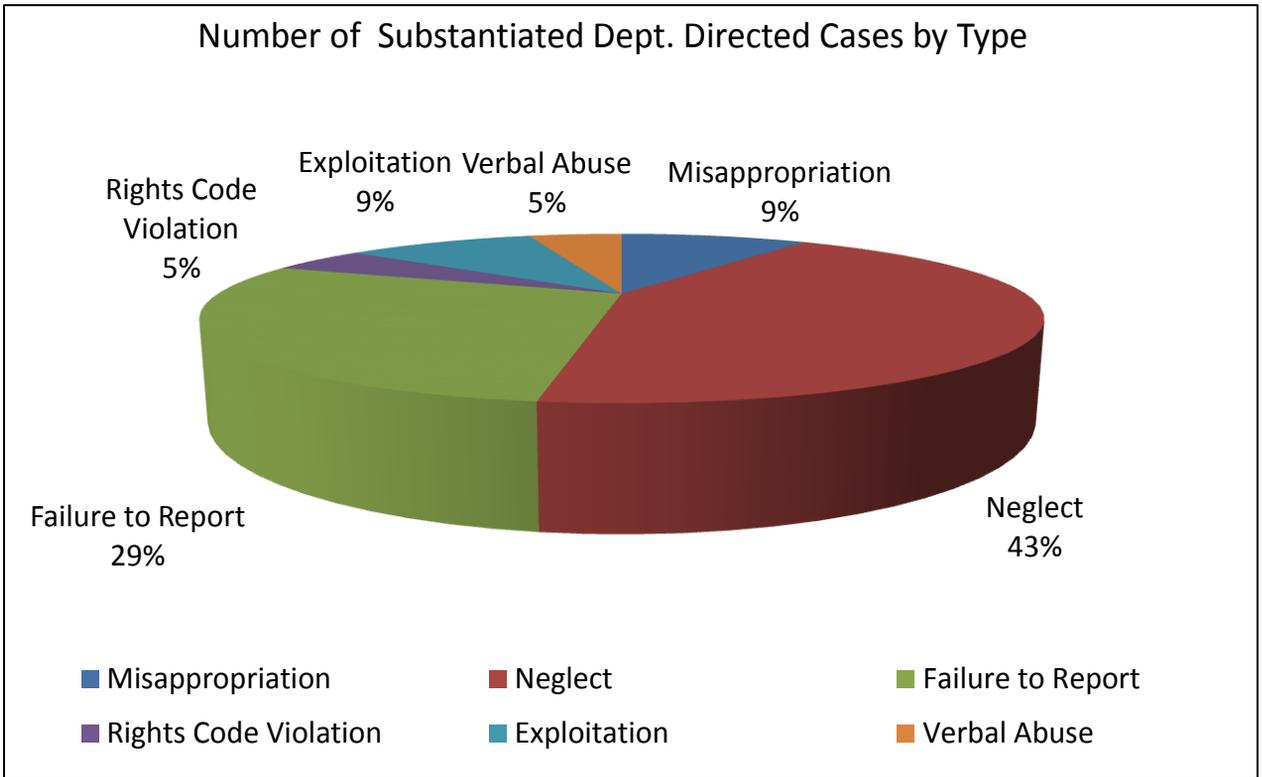
Ohio Revised Code Section 5123:2-17-02(l) describes the allegations in which the MUI/Registry Unit is required to conduct a Department Directed Investigation. It would be a conflict for the county board or developmental center to conduct the MUI investigation. There are also cases in which the individual, a family member, a provider, or the county board requests that the Department conduct the MUI investigation. In 2012, there were 62 investigations conducted. Below is a chart with the findings for each allegation:



The chart below shows the substantiation percentage for the last three years.

Year	Substantiated	Insufficient Evidence	Unfounded
2010	38%	54%	8%
2011	41%	42%	17%
2012	34%	63%	3%

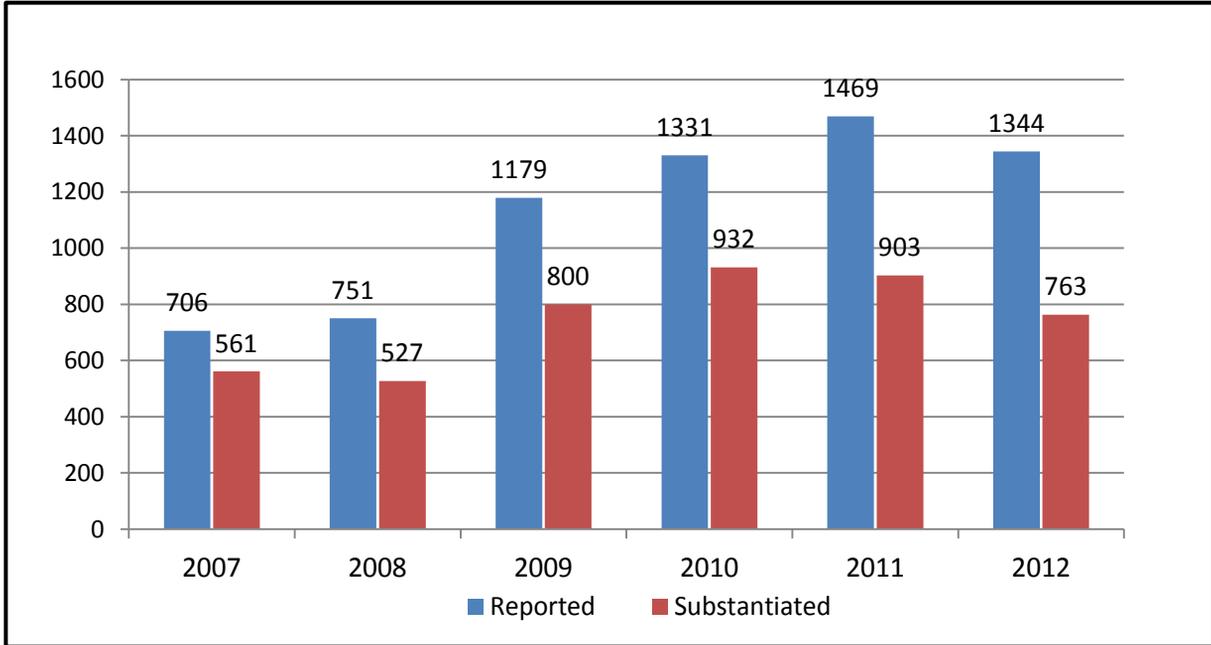
The numbers of allegations and substantiations rose in the categories of verbal abuse, neglect and failure to report for Department directed investigations completed in 2012 .



Types of Allegation	Allegations per category	Number Substantiated	Percentage Substantiated
Misappropriation	6	2	33%
Neglect	19	9	47%
Sexual Abuse	9	0	0%
Prohibited Sexual	3	0	0%
Failure to Report	10	6	60%
Rights Code Violation	1	1	100%
Exploitation	2	2	100%
Verbal Abuse	5	1	20%
Physical Abuse	6	0	0%
Known Injury	1	NA	NA
Totals	62	21	34%

Misappropriation means depriving, defrauding or otherwise obtaining the real or personal property of an individual by any means prohibited by the Ohio Revised Code, including Chapters 2911 and 2913 of the Revised Code.

In 2012, there were 1344 reported allegations of misappropriation and 763 incidents were substantiated.

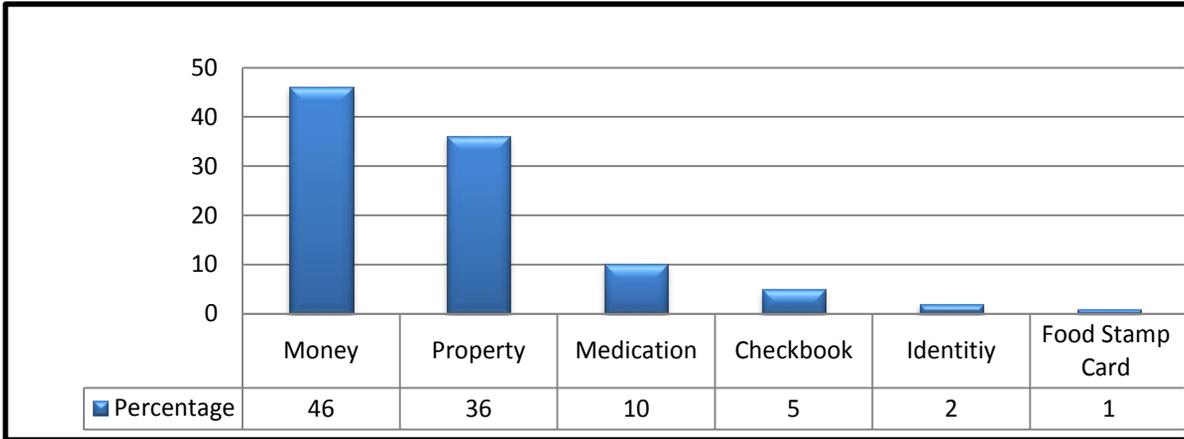


The percentage of cases substantiated in 2012 was 57% percent which was a decrease of 13 % in substantiated rate from 2010 (70%). The largest increase is found in the substantiated cases where the PPI is unknown. This category rose from 50% in 2010 and remained at 56% in 2011-2012. The rate of cases with unknown PPI is concerning but did not increase in 2012.

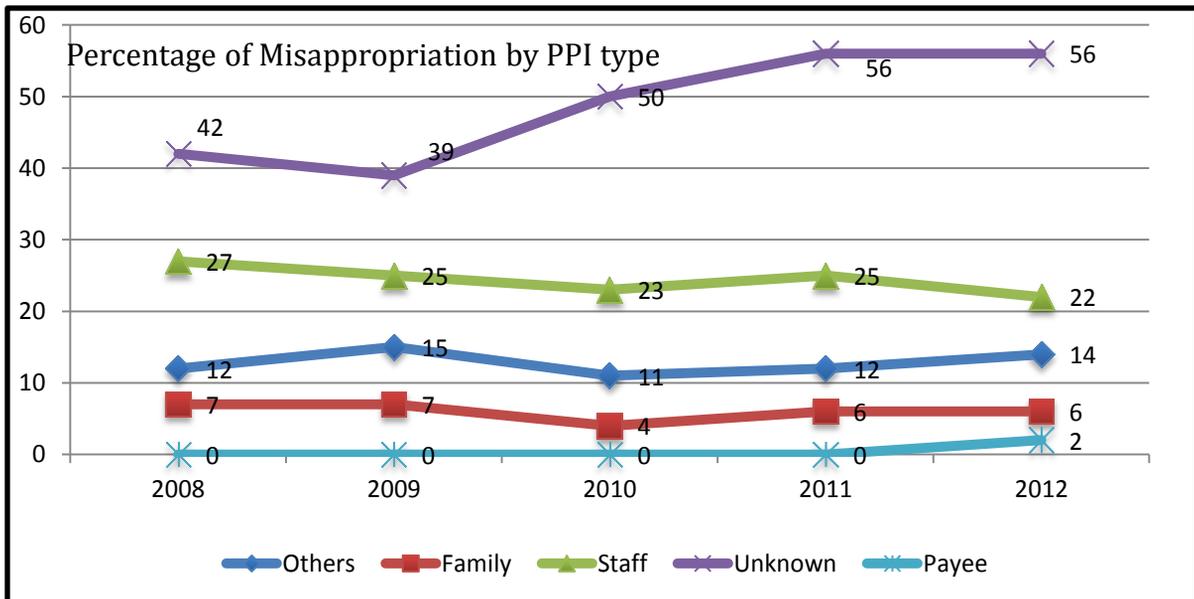
A committee of Department staff and various stakeholders, was formed in 2011 and continues today, with the purpose of providing guidance and support to the field regarding funds management and misappropriation prevention. Forms such as funds transaction records, inventory and gift card tracking were developed and made available on line. Other were posted on the MUI Health and Safety Tool Kit at <http://dodd.ohio.gov/healthandsafety/Pages/Money-Management-Folder.aspx>

Year	Reported	Substantiated	Percentage
2007	706	561	79%
2008	751	521	70%
2009	1179	800	69%
2010	1331	932	70%
2011	1469	903	61%
2012	1433	763	57%

The following charts illustrates the percentage of items that were commonly taken and by whom.



In 2012, the Department reviewed several misappropriation cases that involved sophisticated schemes depriving individuals of their funds. The common factors in many of these cases was that a trusted mid-level manager had access to many accounts with little to no oversight. With no additional monitoring in place, this person was able to steal thousands of dollars without being detected for months. Some of the agencies involved had solid financial protocols for monitoring but these procedures were not followed at the time. In addition to the negative impact on the individual(s), the agency lost funds due to having to reimburse the funds and time spent following up on the investigation.



Causes and Contributing Factors of Misappropriation Cases:

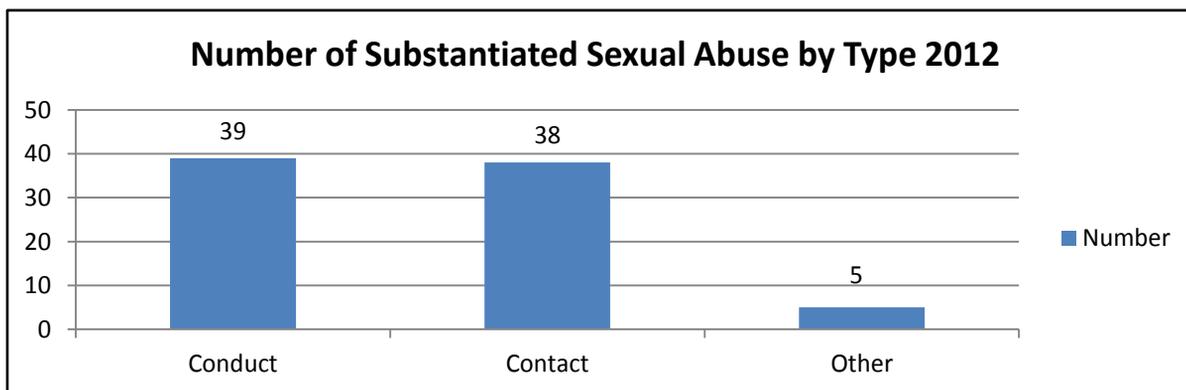
- Individual opens the door to a stranger or acquaintance who steals money or items
- Family members files taxes on their family member in order to get a person's tax refund
- Individual's homes are left unlocked for staff convenience. In several cases, individuals and staff have left their homes and within an hour, all items of value have been taken from their home.
- Individuals are vulnerable to theft by people in the community
- Personal Information is given out over the phone and used by un authorized people
- Medications are not being counted per agency's policy
- No auditing system for checking purchases that are made and to assure receipts are accounted for especially after large purchases
- Employees are allowed to keep shopping money for long periods of time
- Little oversight for lump sum payments such as spend downs
- No accounting for ongoing payments such as burial plans and/or life insurance policies
- Staff are not trained on money management procedures
- Social networking has increased and so have opportunities to be taken advantage of on-line
- Gift cards are purchased but are not tracked and often come up missing
- Trusted Employees, Family members, Payees have access to credit cards, bank cards, and personal information with little oversight
- Individuals rely on family and/or caregivers to do the banking (Deposits / Withdrawals)
- Money storage (Safes, lock boxes, and folders) aren't secured or too many people have access
- Personal property (I-Pods, Gaming Systems and Laptops) are not secure

Prevention Planning:

- Secure methods for storing cash, checks, medication and property appropriate for the person served
- Safety Skills reviewed with individuals
- Carefully review all incoming bills to ensure that only purchases made by individual are being charged to them
- Complete Routine Credit Checks (many are free)
- Minimizing the number of staff with access to medication and cash on hand
- Ensure oversight of those responsible to manage and monitor money in the homes
- Regular reconciliation of accounts including obtaining receipts and matching them up to actual purchases
- Ensure windows, doors and garages lock properly
- Check that medications are accounted for on each shift
- Discuss trips and other large expenditures in advance with the team
- Ensure that individual's personal information such as social security number, date of birth and Medicaid/Medicare numbers are not left out where someone else could take and use
- Be cautious when applying for lines of credit or opening new accounts
- Ask that credit restrictions be placed so that written or additional approvals are required before new lines of credit be approved

There are three types of Sexual Abuse MUI allegations: Conduct, Contact, and Other. Conduct is the most egregious and would include any type of rape, oral sex, or penetration. Contact is touching breasts or genitalia either over or under clothing. Other would include voyeurism, taking pictures of the individual, promoting prostitution, and anything else that would not fit the category of conduct or contact.

Sexual Abuse MUIs are also broken down into categories of who is alleged to have committed the act. MUIs result in a finding of either substantiated or unsubstantiated. The standard for substantiation is preponderance of the evidence. This means that it is more likely than not that there was sexual abuse. In 2012, there was a 6% increase in staff related sexual abuse. In response, the Department has provided additional training in this area and issued information to the field about sexual abuse prevention and reporting.



Break Down by PPI	Number	Percentage
Family	18	24%
Other (friend, neighbor, acquaintance)	30	39%
Unknown	8	11%
Staff	13	17%

Year	Allegations	Substantiated	% Substantiated
2009	345	83	24%
2010	328	81	25%
2011	333	67	20%
2012	371	76	20%

Please note that this report includes a section for Peer to Peer Acts and therefore above data does not include peer to peer sexual acts.

Service providers have duties and responsibilities to protect individuals from harm, including reporting suspected sexual abuse. According to the National Sexual Violence Resource Center, sexual abuse is under-reported. This means that incidents of suspected sexual abuse are not reported to the proper authorities as they should be.

There are different reasons why suspected sexual abuse may not be reported. They include:

- The individual may not be able to clearly express what occurred (or is occurring) in ways that others understand.
- The individual may not realize that he or she has been victimized.
- The individual may be afraid to reveal what has occurred.
- The individual's allegations may be dismissed as fabrications or untruthful reports.
- Persons aware of the suspected sexual abuse may be reluctant to get involved and remain silent.
- Possible signs of sexual abuse are not recognized or are not fully considered by staff and others close to the individual.
- Staff may fear reprisal if a co-worker is the suspected perpetrator.
- Staff may be uncertain if the actions described or observed constitute sexual abuse.
- Staff may also be uncertain about what to do – how the suspected sexual abuse should be reported and to whom.
- When suspected sexual abuse is not reported, the individual may continue to be victimized and suffer the consequences repeatedly. Needed services and supports to assist the individual in response to such an event cannot then be provided.

Be aware of the possible signs of sexual abuse. This includes but is not limited to:

- Bruising, bleeding, soreness, redness, irritation, itching, and unusual discharges.
- Torn or stained underwear or linens.
- Difficulty in walking or sitting.
- Ongoing and unexplained health problems such as stomach pain.
- Display of new fears.
- Withdrawal from previously enjoyable activities, places, or persons. The person may suddenly avoid these places or people, or display fear or discomfort.
- Changes in sleep patterns such as nightmares, trouble sleeping, sudden bedwetting, and other sleep problems.

Take Action:

- Get the individual appropriate medical attention.
- Take immediate action to protect the person from further assault
- Report immediately to law enforcement or CSB
- Report to the County Board immediately but within 4 hours
- Sexual assault assessment, when appropriate, should be sought immediately.
- Remember to NOT infer blame on the victim.
- Ask questions like "Were you able to" instead of "Why didn't you" when talking to the individual.
- Emotionally support the alleged victim
- Remember to refer the individual for counseling and victim's assistance as appropriate.
- Screen the individual for pregnancy and/or sexually transmitted disease.
- Notify DODD MUI Unit if the alleged PPI is a County Board Employee.

Children with disabilities are three times more likely than children without them to be victims of sexual abuse, and the likelihood is even higher for children with certain types of disabilities, such as intellectual or mental health disabilities according to the Sexual Abuse of Children with Disabilities: A National Snapshot, issued in March of 2013.

To view this publication: click link below:

<http://www.vera.org/sites/default/files/resources/downloads/sexual-abuse-of-children-with-disabilities-national-snapshot-v2.pdf>



The Report Highlights the following facts:

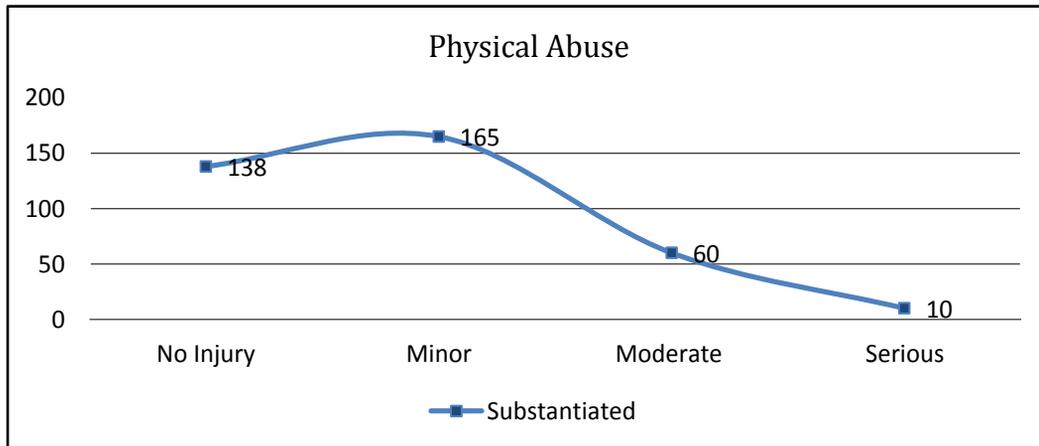
- Children with disabilities are at higher risk for child sexual abuse than children without disabilities.
- The risk of sexual abuse is exacerbated and heightened because of unique dynamics related to disability and the supports these children receive.
- There is an alarming lack of primary prevention efforts geared to preventing sexual abuse of children with disabilities.
- Children with disabilities who experience sexual abuse are less likely to receive the services and supports they need to heal and seek justice.
- Public awareness about sexual abuse of children with disabilities is lacking on every level.

The VERA Institute for Justice recommends that “People and organizations charged with supporting children with disabilities and those addressing sexual abuse must strengthen their commitment and action to stop this epidemic and to assist the children who have been affected by it”.

Physical abuse means the use of physical force that can reasonably be expected to result in physical harm. Since 2007, incidents have been split up into two different types of MUIs depending on the aggressor. If the incident involves another individual with developmental disabilities, it is listed as a Peer to Peer Act. The 2012 annual report includes a Peer to Peer Act section that will address those incidents.

In 2012, there was slight decrease in the number of physical abuse allegations reported from last year, 1,497 to 1469. The rate of reporting per 1,000 was 16 during this time. The number of cases substantiated based on a preponderance level (it is more likely than not the abuse happened) went from 412 to 373. The percentage of allegations that result in a substantiated finding has been consistently at 25%-28% over the last three years. Ohio gathers reports on reasonable risks of harm and therefore, many cases have no injury. In many cases, future issues are avoided prior to any harm by virtue of this systematic intervention. In 2012, there were a total of 1,469 allegations made of physical abuse. In 37% of these cases there was no injury; in 44% of the cases there was a minor injury.

The chart below shows the number of substantiated physical abuse cases by the level of injury occurred. For example, there were 165 of substantiated physical abuse that involved minor injuries in 2012 and made up 44 % of the total substantiated physical abuses.



Law enforcement was notified in 774 of the cases and investigated the allegation in 409 of the cases.

There were 373 substantiated cases of physical abuse (non-peer). Of these cases the abuser falls into one of five categories:

Break Down by PPI	Number	Percentage
Family	98	26%
Other (Neighbor, Acquaintance)	54	14%
Staff	107	29%
Unknown	56	15%
Guardian	4	1%
Friend	53	14%
Payee	1	1%

Red Flags of an Abuser

- *Laughing about abuse*
- *Encouraging others to abuse individual*
- *Prior history of abuse/neglect*
- *Prior criminal history of assault/domestic violence*
- *Prior criminal history of drug trafficking/theft*
- *Under influence of alcohol and/or drugs*
- *Enforcer mentality – control struggles*
- *Isolating individual*
- *Stealing from the individual*
- *Impatience*
- *Verbally abusive – demeaning*
- *Blaming the Victim*
- *Texting coworkers about event*

An additional red flag for violence in 2012 is when the person would laugh about either their hitting the individual or the individual's reaction to their assault. They would also laugh about peer to peer actions that result in injury. These abusers have also made comments that others must share their viewpoint – even going to the point of encouraging abuse by other people. If the other person does assault the individual, they are now complicit and cannot report the abuse without their actions coming to light. Sometimes these violent assaults on individuals are cloaked in telling new employees that this is what you have to do to keep control of him/her; even going to the point of calling the abuse a restraint.

Causal factors listed in physical abuse cases are similar to last year's factors. The abuser was stealing from the individual. Individuals were told to keep quiet and not disclose that the abuser had stolen their money, property, or medications. Intimidation and physical violence were a part of controlling the individual and allowing the abuser to continue to steal from them. In some cases, conditional verbal threats either accompanied or preceded the assault. The abuser was frequently seeking to dominate and control the individual in every aspect of their lives. The idea that the individual would be late or need extra help, may enrage abusers. Individuals were threatened that they would be hit again if they told. There are a small number of cases, although more than last year, in which the individual's choice to engage in high risk activities carries with it increased risk of being around violent abusive people.

Another red flag is when the abuser isolates the individual and doesn't want them to see a doctor, other staff, or family and friends. Many of these abusers target certain individuals and claim afterwards that the individuals' behaviors drove them to a breaking point. Some cases have the aggressor taunting the individual to "hit me again"; "say that again"; "go ahead and pull my hair" and see what happens. Even when the aggressor could easily avoid being hit (the individual uses a wheelchair) or move to another room, they confront the individual and hit them. Several cases have the individual fleeing to another room in the house seeking safety and the abuser following them or dragging them to another location.

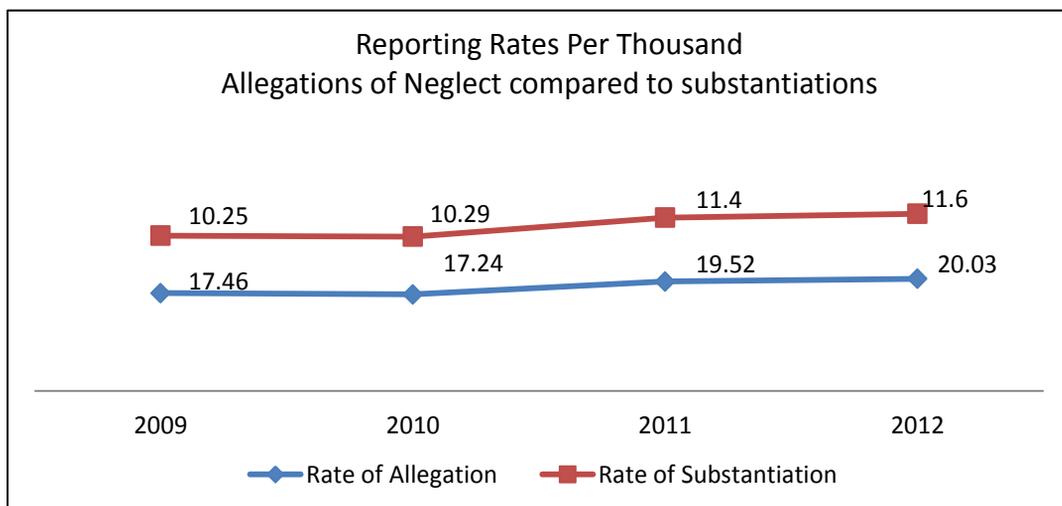
“Neglect” means when there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision, or services necessary to maintain the health and safety of the individual. Neglect MUIs do not require that there be a resulting injury, they do require that there is a reasonable risk of harm.

All Neglect MUIs require immediate action, an administrative investigation to determine causal factors, and prevention plan implementation. These three elements are addressed in each and every case.

The MUI investigation results in a finding of unsubstantiated or substantiated. The standard for a finding of substantiation is by a preponderance level – it is more likely than not that the neglect happened. There were a total of 1,072 substantiated cases of neglect in 2012. The chart below shows the reporting and substantiation numbers and the substantiation percentage over a four year period:

Year	Allegations	Substantiations	% of Substantiations
2009	1415	831	58%
2010	1510	901	60%
2011	1762	1030	58%
2012	1836	1072	58%

While the total number of reported and substantiated cases has grown over the last year, the number of individuals served has grown as well. To better understand the context of the number of MUIs, the rate per 1,000 individuals of both reported and substantiated cases of neglect are shown below:

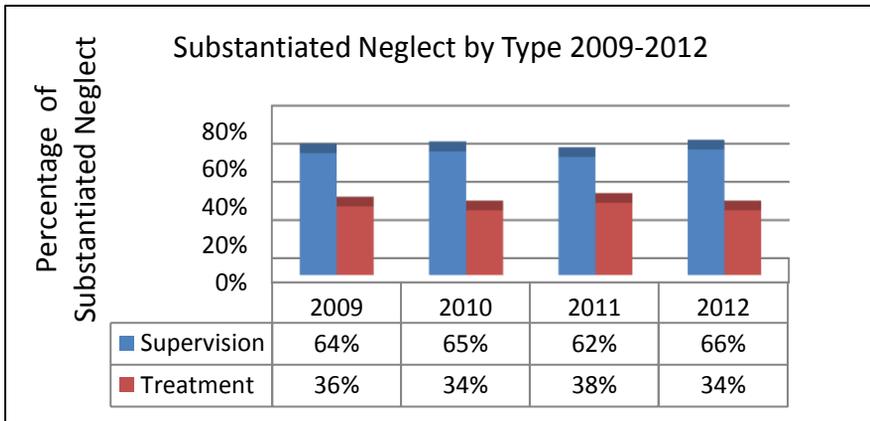


This would mean that in 2012, 20.03 people out of 1,000 would have an allegation of neglect reported. In 2012, there would be 11.6 people out of 1,000 with a substantiated MUI of neglect.

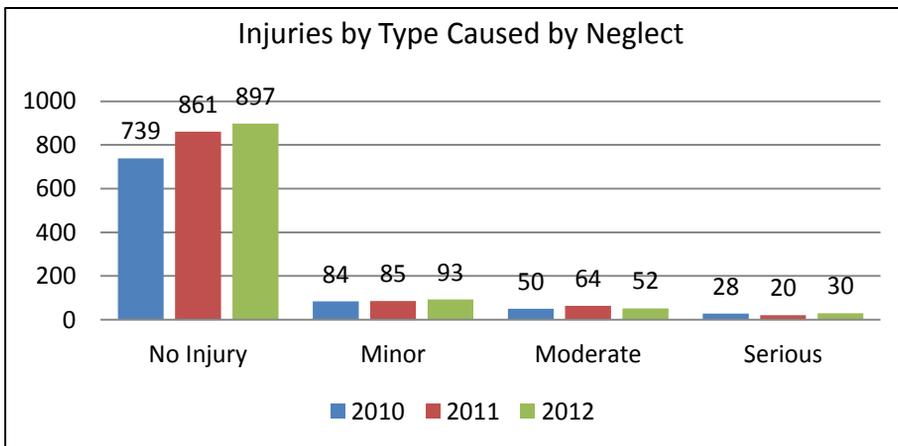
The chart below breaks down into a percentage the person(s) responsible for the substantiated MUIs:

	2009	2010	2011	2012
Staff	66%	70%	85%	83%
Family	16%	8%	8%	10%
Systems	11%	14%	7%	7%

Each individual’s plan outlines the services and supports needed to avoid specific risks. Neglect MUIs are broken into two main categories: supervision and treatment. For example, some individuals have a history of swallowing or inserting items that are dangerous and need someone to intervene. This person would need a supervision level to address that need. The other category of neglect MUI is a failure to provide treatment. An example of treatment would be an individual needs to be assisted in moving to avoid developing a pressure ulcer. The chart below shows the breakdown of substantiated MUIs for the last four years by supervision and treatment category.



The numbers of allegations filed, percentage substantiated, the rates per 1,000, and the percentages of supervision vs. treatment neglect have remained fairly consistent for the last four years. There has been a decrease over the last year in the number of individuals sustaining a moderate injury that have a substantiated MUI of neglect. As this chart shows the total number of injuries in substantiated neglect MUIs have decreased over the last year. Minor injuries have a slight increase, serious injuries have remained about the same and there is a decrease in the number and rate of moderate injuries.



Injuries are defined as the following:

Minor – Did not affect day-to-day activities, e.g., broken toe, fingers, sutures, splint, wrap.

Moderate – Did affect day-to-day activities, e.g., missed work, crutches, casts, adaptive equipment, bed rest.

Severe – Injury required hospitalization, off weeks from work.

None – no injury.

Serious Injuries resulting from Neglect

The following is a summary of some of the Neglect MUIs that involved serious injuries. Any case involving a death would be reviewed in detail by the Mortality Review Committee.

- Staff did not act when an individual was found unresponsive and waited 6 minutes before acting (checking vitals, initiating CPR) and calling 911, which resulted in a delay in medical attention. The individual subsequently passed away.
- An Individual makes an allegation that she was raped to her staff. No one seeks medical care for the individual or reports the allegation putting the individual at further risk she lives with the perpetrator.
- Staff did not monitor temperature of water, individual is covered in severe burns. There was a delay in medical attention and the individuals dies of burn related injuries.
- Individual was not provided with preventative medical screenings and care as outlined in their plan. As a result individual did not get the care required and this may have been a factor in the treatment of care.
- The individual's wheelchair was not properly tied down. The individual's wheel chair tips over and hits their head on the floor. The individual requires multiple stitches.
- The individual fell when being transferred because there was not adequate staff to assist with the Hoyer Lift. The individual suffered a broken leg.

Contributing Factors in Substantiated Neglect MUIs

Deliberately ignoring the individuals

The caregiver knows and callously disregards the needs of the individual so the caregiver is at fault. Instead of providing the supervision or treatment needed, they choose to do their own shopping, get drunk, text on their phone, leave the individual alone to go to another job, watch television, and an assortment of other things for their own personal enjoyment. The common element in these cases is that the caregiver completely ignores the individual and their needs. The caregiver may try to limit the individual's contact with others to cover up the neglect. There may not be a doctor or dentist appointment for years. The neglect may be accompanied by misappropriation, verbal abuse, and physical abuse. Some preventative measures for these cases involve criminal prosecution, removing the individual from their care, appointment of a guardian or a new guardian, respite care, and placement on the abuser registry.

Distraction / Complacency

These are the cases in which other people or things compete for the caregiver's attention.

- A person turns away to get an attends during hygiene and the individual falls.
- Supervision levels are not met because of the staff doing laundry instead.
- Certain safety steps are not taken or are not done in the right order.

Causes and Contributing Factors of Neglect

Distraction / Complacency

- Shortcuts are taken to speed things up in using lifts, bed rails, and wheelchairs or this equipment is not used at all.
- People are dropped off early/late with no supervision.
- Cases in which complacency is a factor involve experienced caregivers who become accustomed to nothing happening. The day in, day out schedule and how well everything is going, lulls them into not following the individual's plan.
- This would also include employees working multiple shifts without a break or rest so that fatigue becomes a factor. The overall schedule may not provide proper staffing .

Miscommunication or Lack of Communication

- There is an underlying false assumption on the part of the caregiver. Who is responsible for the individual's supervision level at the time of the incident?
- There is no clear method of transferring supervision between employees.
- The needed supervision level is not known in all settings.
- There is a failure to listen to the individual or those people in their lives that know them best. When someone describes the individual as not themselves, acting funny, or in pain, it is attributed to a behavioral issue. Discounting this information can cause a delay in getting medical attention.
- Gaps in implementing physician orders, getting and refilling medication orders, changing the medication logs, and giving the correct medication are sometimes issues of miscommunication.

Transitions

- Changing schedules or changes to where the person works or lives are always times of increased risk. There may not be the environmental supports in place at the new locations.
- Changing pharmacies has been a risk factor in many of the substantiated treatment neglect cases. The person may stay in the same location and still have changes.
- They do not have the proper equipment for these changes. For example, the lift straps no longer fits the individual correctly but is still used.
- There is no food processor to prepare the right dietary texture for the individual.
- There have been special events that cause a break in the individual's schedule: camp, Special Olympics, dances, and vacations. Even something as common place as going on and off a bus are times of transition.



Changes in caregivers can present an increased risk. When a family member dies, the new caregiver is not only learning how to care for the individual, but are attempting to work through the grieving process.

Lack of Action

The caregiver is trying to help the individual but lacks proper judgment. They see signs and symptoms of an emergency, but fail to call 911 immediately

Prevention:

1. Remove caregivers who, knowing the possibly tragic consequences, neglect individuals. The most egregious of these would also qualify for criminal prosecution for neglect.
2. Explore whether having a person assist the person with decision making would be appropriate.
3. Provide training to caregivers on individual's risk factors. Assure the caregiver has the tools to effectively intervene when there is a risk to health and safety.
4. Listen to the individual and to those who know them the best. Is this unusual behavior for them? Do not disregard their complaints of pain or injury as attention seeking. Advocate for the individual if a need is being unmet. Have a clear system of documenting and implementing continuing and changing medical needs.
5. Have all materials/equipment needed for the individual and for each task. Make sure all equipment is in good order and properly used by caregivers.
6. Build in a system of checks and balances to ensure medications are ordered, refilled, and taken properly.
7. Be aware of and plan for dangers during transitions (residential, day program, vacations, and respite).
8. Know and follow dietary textures and pacing – in all locations and on special occasions. Plan ahead.
9. Individuals that have specific medical needs should have caregivers that understand the signs/symptoms for that condition. Examples would be a heart condition, deep vein thrombosis (blood clots), diabetes, blood thinners, respiratory problems, and seizures. Call 911 immediately, if needed. Do not tie caregiver's hands with mandatory notifications prior to calling 911. If there is any doubt, call 911. Make sure caregivers are educated on the signs and symptoms of serious illness. Please see Health and Safety Alert –Health and Safety is Priority One.
10. Plans should be current and consistent across all settings. These should include clear expectations of how to respond to this individual and their unique needs.
11. Wheelchairs, lap belts, gait belts, shower chairs, van lifts, and other assistive devices and transfers should have a standardized best practice way used by all caregivers. Hands on training should be consistent with this simple and understandable best practice.
12. Plan for staffing difficulties. As much is possible, have experienced caregivers teach and mentor less experienced caregivers about the individual's needed services.

Systems Neglect

When an individual is neglected and the neglect is not the result of a particular person/people, a systems neglect is identified. A systems issue is a process that involves multiple components playing a role in the neglect. Some examples include:

- A person does not receive medication timely because the pharmacy thought the nurse was going to pick up the prescription. Yet the nurse believed the pharmacy was delivering the prescription. There was no specific policy outlining how this situation should be handled. Neither party was neglectful, however the individual did not receive his medications timely.
- An employee is assigned to be "eyes on" two individuals in the home. One individual runs out of the house and the employee goes to get them. While the staff is attending to the other individual, his roommate goes into the kitchen and eats a raw hot dog and chokes.

As a result, there was systematic changes that needed to be made to prevent this from occurring in the future. Prevention plans for systems issues involve policy changes, changes in procedures, training and oversight to effect positive changes.

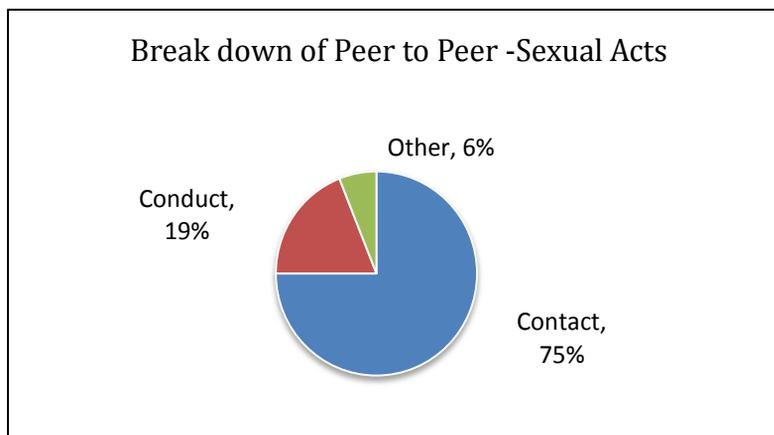
"Peer-to-peer acts" means acts committed by one individual against another when there is physical abuse with intent to harm; verbal abuse with intent to intimidate, harass, or humiliate; any sexual abuse; any exploitation; or intentional misappropriation of property of significant value.

Since 2007, peer to peer acts were separated from other MUIs that did not involve those receiving services. The different coding acknowledges the unique nature of having to serve and support both individuals. While not minimizing the injury and/or risk to the victim, it also acknowledges that immediate actions and preventative measures may be different. Peer to peer incidents are typically witnessed by a paid support provider and therefore have historically been substantiated at a higher rate than non-peer cases. Allegations of Peer to Peer acts were down in the areas of physical acts, sexual and verbal as illustrated by the chart below:

Allegation	2009	2010	2011	2012
Physical	1076	1234	1433	1366
Sexual	295	307	341	314
Verbal	187	236	397	346
Misappropriation	118	134	127	131

Analysis:

- Incidents involving Peer to Peer Sexual comprised 314 of allegations and 31% (96) of these were substantiated.
- The total number of substantiated sexual abuse MUIs has remained consistent in the Peer category. While it does show a slight increase, there has also been an increase in the number of individuals served from last year.



As defined in 5123:2-17-02, "Sexual contact" means any touching of an erogenous zone of another, including without limitation the thigh, genitals, buttock, pubic region, or, if the person is a female, a breast, for the purpose of sexually arousing or gratifying either person.

"Sexual conduct" means vaginal intercourse between a male and female; anal intercourse, fellatio, and cunnilingus between persons regardless of sex; and, without privilege to do so, the insertion, however slight, of any part of the body or any instrument, apparatus, or other object into the vaginal or anal opening of another. Penetration, however slight, is sufficient to complete vaginal or anal intercourse.

Peer to Peer Physical Acts

There were 942 cases substantiated at a preponderance level (it is more likely than not to have happened) in 2012. Last year the total peer to peer substantiation percentage was 71%, this year it is 69%. Peer to peer physical acts have historically been substantiated at a higher rate than cases of Physical Abuse. In 2012, males were involved in 63% of the Peer to Peer Physical Acts while females comprised 37%.

The cause and contributing factors continue to improve in their level of detail and thoroughness. Even those MUIs that now conclude without a known cause or contributing factor(s), have determined with more specificity what happened. The team in many of these cases have explored what factors were ruled out and documented what steps have worked/not worked. The common causal factors have remained consistent over the last three years. This list of common factors is not offered to condone or to in any way suggest that the victim is to blame. It is offered to try and trace back the root causes and prevent future incidents.

Aggressors are aggravated by the perceived actions of the other individual:

- *Thinks that individual has stolen, taken, broken their property*
- *Being "bossy"*
- *Talking loudly, asking a lot of questions*
- *Taking over their work at home or the workplace*
- *Touching them – even accidentally*
- *Talking about their relationship with ex-boyfriends/girlfriends*
- *Won't let them sleep;*
- *Radio, television, music choices*
- *Other individual came into their room or personal space*
- *Joking or horseplay misinterpreted*

Aggressors are frustrated and stressed about other things:

- *Grief over loss of family member*
- *Change to schedule/routine*
- *Worried about future medical appointment*
- *Worried about going on trips/visits*
- *Loss of liked staff member*
- *Not being able to attend event*
- *Not able to have specific food/drink*
- *Not having fulfilling work*

Aggressor feels excluded and seeks attention:

- *Staff is paying attention to someone else*
- *Not able to sit with others at lunch*
- *Boyfriend/Girlfriend break up or paying attention to someone else*

Aggressor specific reasons:

- *Communicating pain/discomfort*
- *Mental health issues*
- *Alcohol usage*



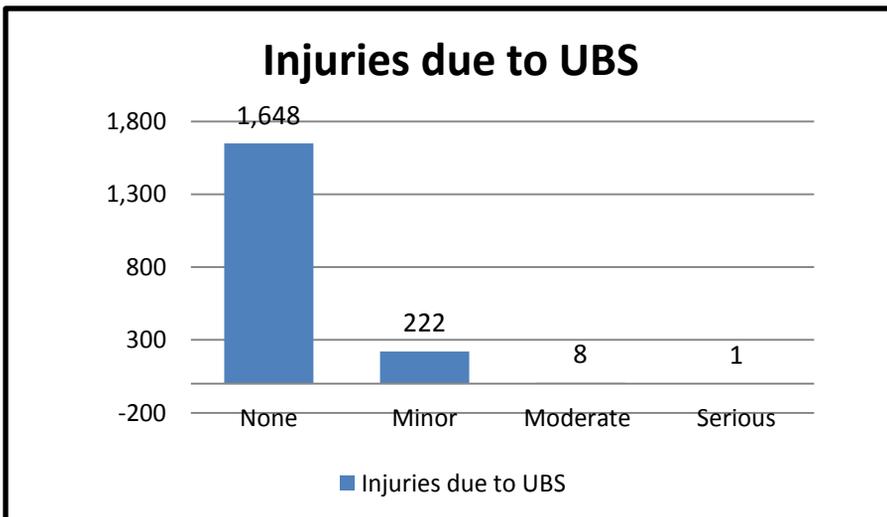
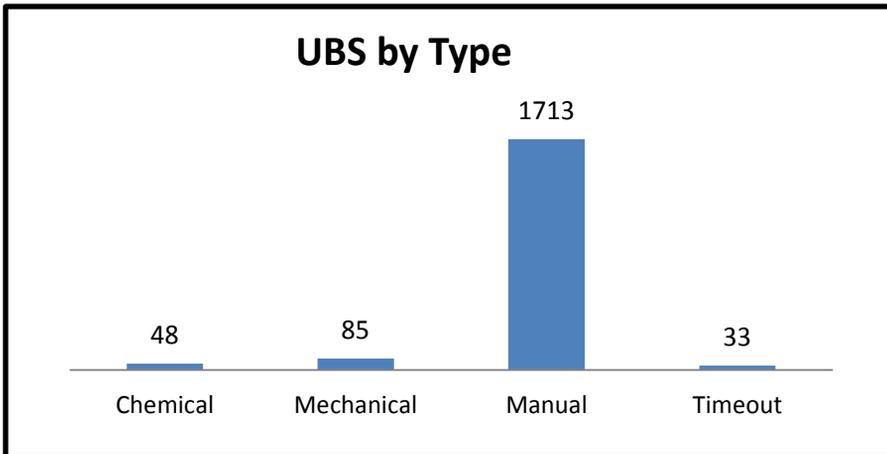
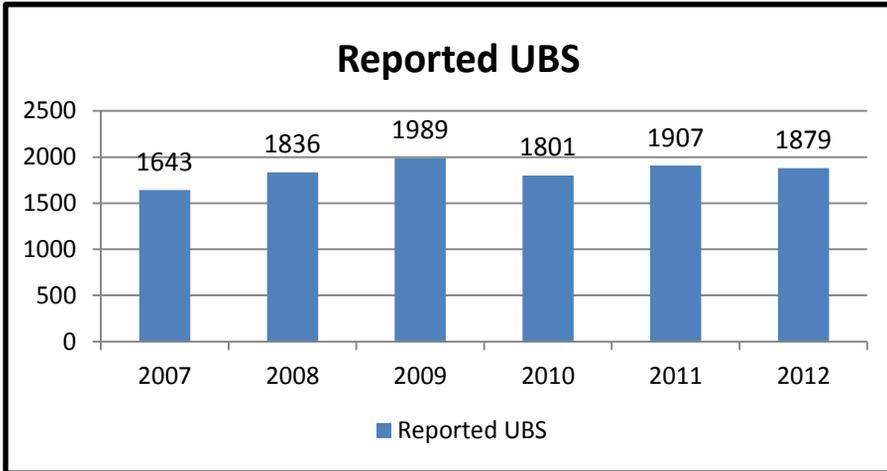
Prevention of Peer to Peer Acts

Preventing Peer to Peer Acts can be a challenge. Below are some actions that were successfully implemented over the past year to prevent in the reoccurrences of these incidents.

- *Counseling for aggressor;*
- *Communication Assessment; equipment*
- *Changes to Behavior Support Program;*
- *Medication changes;*
- *Law enforcement speaking with aggressor;*
- *Move either to another room/house*
- *Additional supervision;*
- *Different lunch/break times;*
- *Change transportation or seating on bus/van;*
- *Securing property;*
- *Set times to use phone, watch tv, radio;*
- *Buying additional televisions;*
- *Increased exercise;*
- *Staff communication;*
- *Apology by the aggressor;*
- *Informal Mediation between the peers;*
- *Personal Space training;*
- *Advocacy Training.*

Unapproved behavior support. "Unapproved behavior support" means the use of any aversive strategy or intervention implemented without approval by the human rights committee or behavior support committee or without informed consent.

In 2012, there were 1879 reported unapproved behavior supports, the majority of which were manual restraints. There was no reported injuries in 88 % of all unapproved behavior supports implemented as reflected below.



Injuries are defined as the following:

Minor – Did not affect day-to-day activities, e.g., broken toe, fingers, sutures, splint, wrap.

Moderate – Did affect day-to-day activities, e.g., missed work, crutches, casts, adaptive equipment, bed rest.

Serious– Injury required hospitalization, off weeks from work.

None – no injury.

Causes and Contributing Factors to Unapproved Behavior Supports:

- Staff not following preventative measures because they believe the intervention will not have the suspected outcome
- Lack of training on plans
- Power Struggle
- Staffing
- Staff not trained on how to deescalate situation
- Lack of Management Support
- Antecedents are not identified or recognized

Prevention Planning:

- Proactive interventions to protect health & safety BSP
- Quality Training
- Incident reporting – address the concerns at its earliest onset
- Debriefing- Why or what lead to the incident?
- Team meetings/prevention
- Management follow through/supports
- Assessments
- Environment
- Staff Coverage
- Administrative Oversight
- Respectful Interactions

**Positive Culture Initiative**

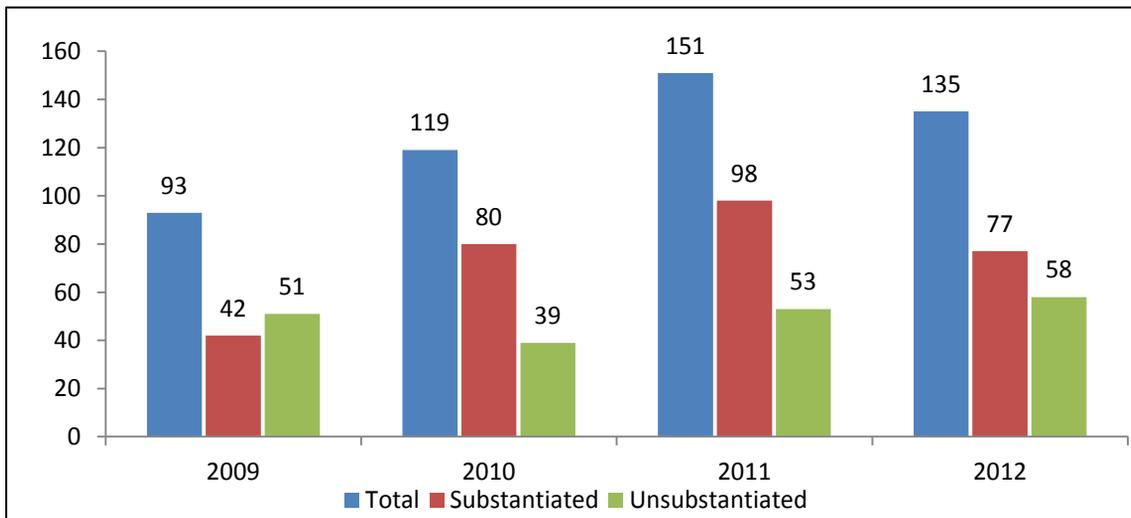
Learn more about creating a Positive Culture Initiative at <http://dodd.ohio.gov/pci>

A positive culture is an intentional way of supporting all people within our communities that focuses on creating healthy relationships and acknowledging the unique gifts that each brings to those relationships. It is about making the shift in thinking away from power, control and coercion in language and actions, and toward affirmation, unconditional acceptance and encouragement.

There are three different definitions of Failure to Report with three different evidentiary standards. The criminal offense of Failure to Report contained in Ohio Revised Code Section 5123.61, which can either be a misdemeanor or a felony depending on the severity of the offense. Criminal offenses must be proven beyond a reasonable doubt. The Abuser Registry definition is found in R.C. 5123.50. It requires clear and convincing evidence and also considers extenuating factors in certain cases. The major unusual incident (MUI) definition in Ohio Administrative Code 5123:2-17-02(C)(13)(e) is the broadest of the three definitions and only requires a preponderance to substantiate. The MUI definition is that a:

Mandatory reporter has reason to believe that an individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse (including misappropriation) or neglect and does not immediately report it to law enforcement or the county board. For individuals served by developmental centers reports must be made to law enforcement or the department.

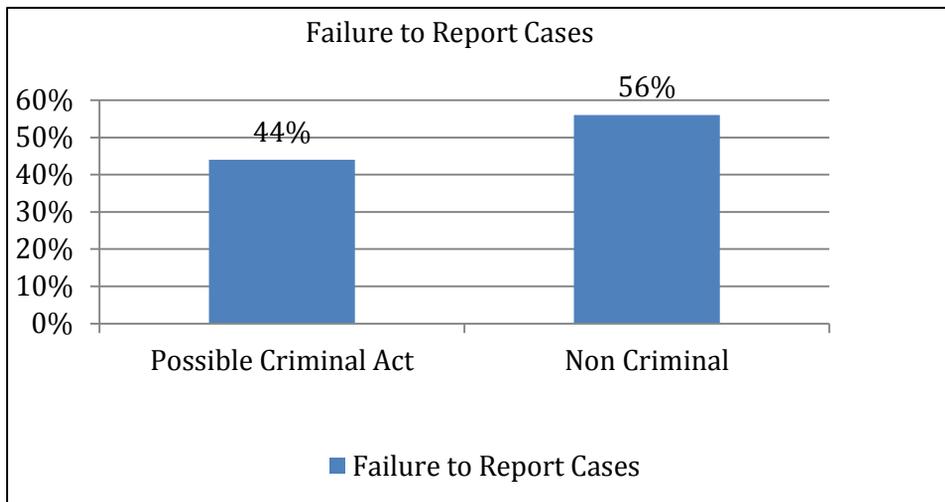
The substantiation rate for Failure to Report was 57% in 2012 which is a decrease of 8% from 2011.



A review of the substantiated cases shows that there were various reasons given by the person for failing to report:

- They were afraid for their job, themselves, or their family.
- They had become accustomed to reports or seeing neglect or violence.
- Lack of recognition of abuse/neglect.
- The victim always “cries wolf” so they are not believed.
- The victim is not seen as a victim, they are seen as difficult to work with.
- They are friends with abuser- don’t want to get them in trouble.
- The abuser is going through a rough time – it was a one time event.
- Someone else will report it – they are required to so I don’t have to tell anyone.
- Miscommunication of who will report abuse/neglect. They are new and hesitant to report anything.
- Want to report to specific person who is not there – on vacation, different shift.
- Discount individual’s allegation; attribute injuries/behaviors to something else.
- Didn’t want to alienate family/guardian; they might pull individual from services.

In 2012, in 57% of the substantiated cases, the failure to report was considered a possible criminal act and law enforcement was contacted. Law enforcement conducted the investigation in 8 of the 77 (10%) of the cases. Many times the abuser would be described as “rough” or “mean” to everyone – individuals and staff alike. Other staff may even be afraid of what he/she would do if they told.



There were times when the mandatory reporter did not want to follow the known reporting procedure and instead called someone else that they trusted – a co-worker, a family member, or a supervisor on another shift. There were very few cases in which there was a true miscommunication of who was going to report the allegation. More likely is that there were multiple mandatory reporters and no one reported it. Some even tried to explain that - I thought the abuser would report it themselves.



Prevention measures included:

- Developing on-call procedures to recognize reports of abuse.
- Providing staff with a 24-emergency line to access supervisory support.
- Many times the person who failed to report was fired.
- Even in cases with only one person who failed to report, many providers chose to train all staff in the home or agency about being a mandatory reporter.

Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., Heimlich maneuver, cardiopulmonary resuscitation, intravenous for dehydration).

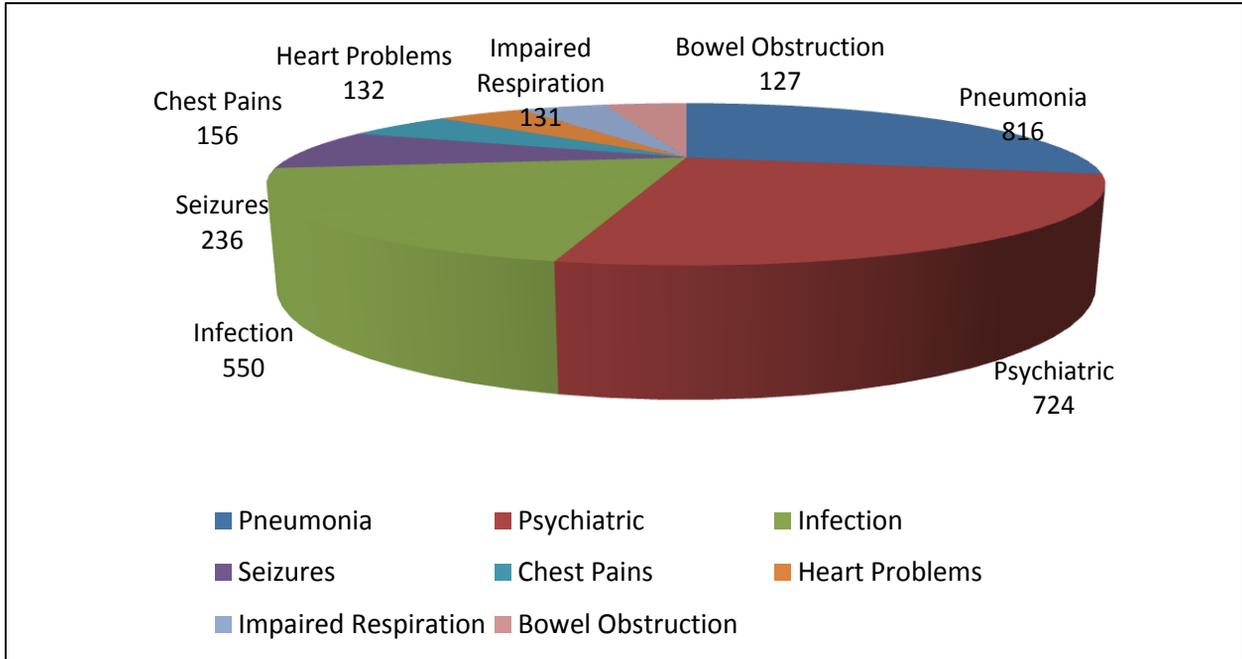
- There were 667 medical emergencies reported in 2012 which reflects an increase from 631 in 2011.
- Choking-Use of Heimlich and Back Blows were used 290 and 54 times respectively during 2012. These interventions were successful in all but 9 incidents in which an individual died as a result of choking.
- Dehydration continues to be one of the leading causes of medical emergencies with 85 reported MUIs in 2012 which is an increase of 20 from the previous year. Individuals who do not swallow well are particularly likely to refuse fluids or indicate fear when they get them, often resulting in dehydration. Dehydration is also likely when staff or family try to restrict fluids to prevent incontinence, not realizing that lack of fluids can contribute to constipation and increased seizure frequency, not to mention drug toxicity and other health problems.

The chart below provides the number and type of medical emergencies.

2012 Medical Emergencies	Count
Abdominal Pains	2
Allergic Reaction	8
Altered State	1
Back Blows	54
Blood Pressure	2
Blood Sugar Levels	38
Bowel Obstruction	1
Chest Compressions/CPR	12
Chest Pains	4
Dehydration/Volume Depletion	85
Emesis (vomit, diarrhea)	16
Heimlich Maneuver	290
Impaired Respiration	29
Infection	16
Ingestion-PICA	5
Kidney	3
Other	24
Placed Item in Orifice	0
Pneumonia and Influenza	5
Seizure	13
Tube Issues	57
Unexplained Bleeding	2
Total	667

"Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a condition that is specified in the individual service plan or nursing care plan indicating the specific symptoms and criteria that require hospitalization.

The Major Causes of Unplanned Hospitalizations in 2012 were:



There were 4,348 unplanned hospitalizations in 2012 which is a decrease of 2% over the previous year. As in the past, unscheduled hospitalizations represent the largest category of all reported MUIs at 23%. Unplanned psychiatric hospitalizations account for 644 (15%) of all unplanned hospitalizations while medical hospitalizations make up 3,704 (85%).



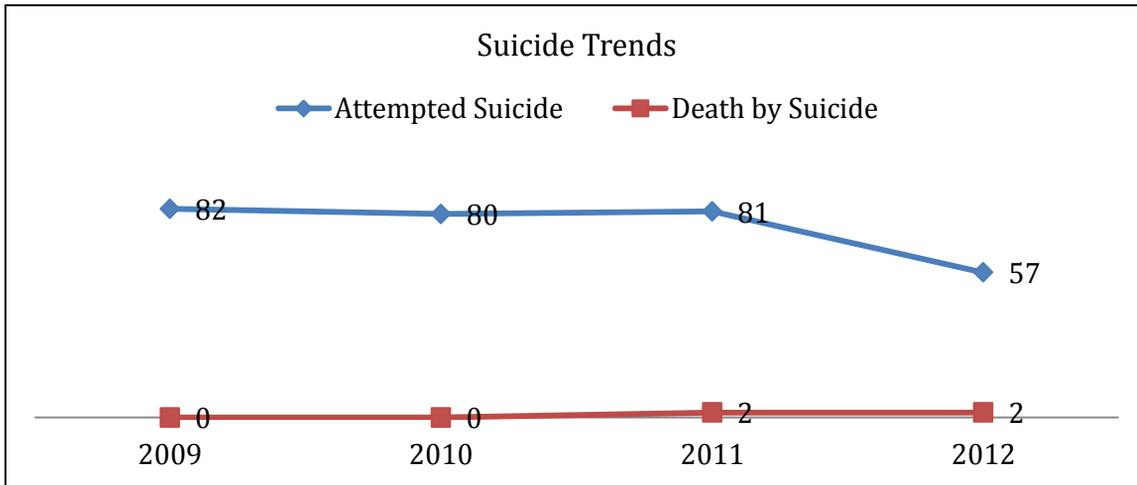
Unscheduled Hospitalizations account for 23 % of all MUIs

The chart below represents the reasons for hospitalizations from 2005-2012

	2005	2006	2007	2008	2009	2010	2011	2012
Abdominal Pains	154	199	97	78	67	58	59	39
Abnormal Blood Levels				20	45	111	62	51
Absent Pulse	4	2	1	3	1	3	2	0
Allergic Reaction	17	19	10	10	9	13	13	11
Altered State	234	215	178	158	122	106	89	87
Baclofen Pump Issues							4	8
Blood Clots				25	57	61	48	50
Blood Pressure	0	23	60	66	58	38	53	48
Blood Sugar Levels	89	91	55	56	50	50	41	61
Bowel Obstruction	130	136	117	115	119	137	127	135
Body Temperature Variat.								17
Cancer						29	18	29
Chest Pains	315	306	160	165	169	158	156	157
Decubitus Ulcer	0	0	0	0	0	0	5	5
Dehydration	235	212	112	116	103	93	91	98
Edema	0	0	0	0	0	0	9	14
Emesis	298	289	165	136	108	112	80	82
Gallbladder	48	42	24	224	38	47	47	41
Headache	0	0	0	0	0	0	4	5
Heart Problems	35	2	86	80	135	141	132	107
Impaired Respirations	440	378	199	173	149	205	131	117
Infection	584	564	391	388	513	661	550	572
Ingestion - PICA	9	13	1	4	10	10	7	20
Kidney	74	79	33	40	64	69	76	81
Med Error	10	4	0	0	2	3	0	0
Observation-Evaluation						159	218	243
Other**	1110	1212	573	605	756	159	464	501
Placed Item in Orifice	4	1	1	2	5	3	1	0
Pneumonia	1001	943	563	632	817	701	816	697
Seizure	482	465	224	269	256	235	236	253
Shunt	0	1	2	7	18	15	7	7
Stroke	59	43	46	40	29	36	23	35
Syncope						12	29	29
Tube Issues	41	64	34	38	25	68	46	55
Unexplained Bleeding	111	102	22	72	66	90	35	47
Unknown	23	14	6	4	0	0	0	0
Psychiatric	1144	1134	570	614	643	698	724	644
Totals	6651	6553	3730	3940	4434	4320	4424	4348

**Other reasons for hospitalization include: elevated temperature, elevated blood levels, surgery, etc.
The MUI Unit will continue to make changes to the Incident Tracking System to capture specific data for hospital admissions.

In 2012, there were 57 attempted suicides reported and 2 individuals died as a result.



Mental health conditions can affect anyone, including people with developmental disabilities. Some signs may include:

- Changes in sleep patterns - excessive sleep, little or no sleep, or interrupted sleep
- Changes in appetite - a lack of appetite or being fearful of food and inspecting or refusing food
- Excessive worry – constant and excessive talk about particular daily events, repetitive behavior rituals to either ensure or prevent an event
- Excessive anger – being threatening or hostile to others, appearing to be angry at strangers, anger that is excessive for the situation
- Excessive happiness – being excessively happy over a period of time, having grandiose thoughts and ideas
- Excessive sadness – having a depressed mood over a period of time that is not related to loss or grief, a loss of interest in pleasurable activities, talking about death or hurting oneself
- Hearing voices – staring to the side or corners and appearing to be involved in a conversation, covering ears
- Seeing things that are not there – covering eyes, brushing unseen material off body
- Change in cleanliness habits – refusing to bathe and shower or bathing and showering excessively
- Bruises or cuts – accidental or purposeful self-harm

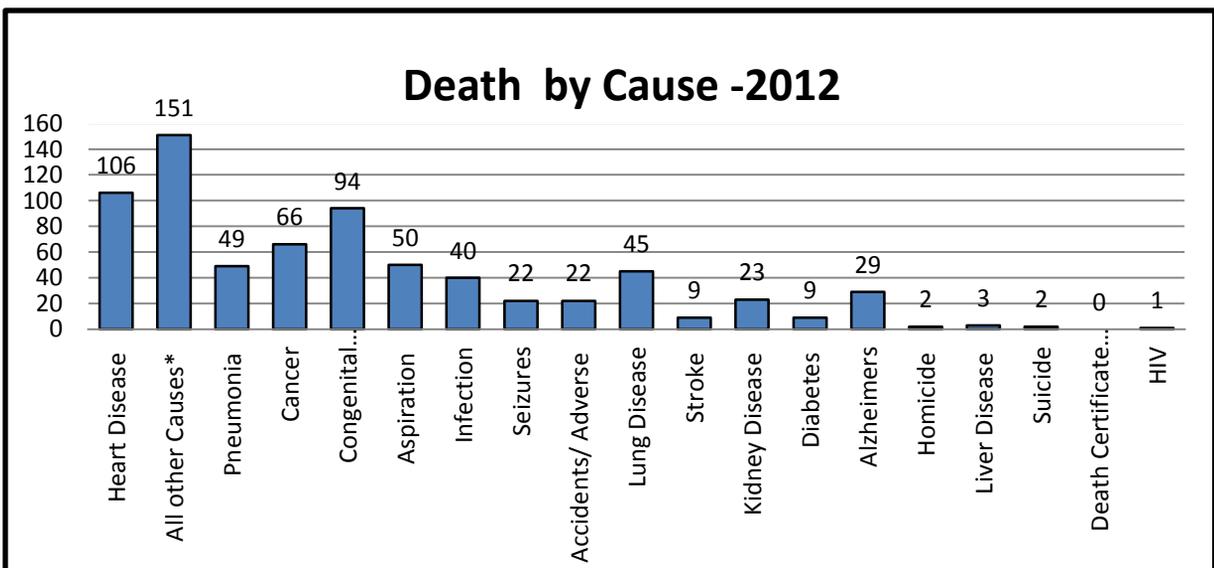
Some of the Causes and Contributing Factors of Suicide Attempts were:

- Chronic Pain
- Loss (of family member, staff, relationship, job, home)
- Refusing to take medications as prescribed to treat depression/illness
- Isolation
- Not having someone to communicate their feelings with

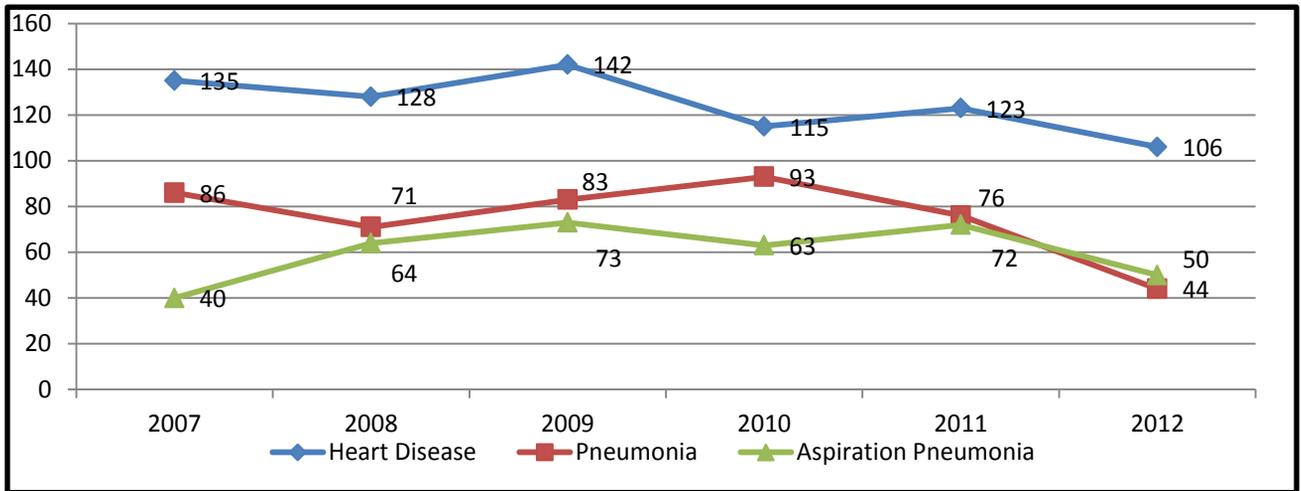
Take any suicidal talk very seriously. It's not just a warning sign that the person is thinking about suicide — it's a cry for help.

There were 723 reported deaths in 2012 resulting in a crude mortality rate of 788 (per 100,000) compared with Centers for Disease Control preliminary 2010 data which was 798.7 for overall deaths in the general population. The following is a summary of data collected on deaths with individuals with disabilities in Ohio.

- Heart disease continues to be the leading cause of death for Ohioans with disabilities (14%) as well as the general population.
- The average age of the 723 individuals who died in 2012 was 50.42 years compared to the average populations life expectancy is 78.5 years (CDC).
- Pneumonia and aspiration pneumonia continue to make up the next largest causes of death.
- Men continued to have a higher mortality rate (53%) than women (47%).
- Individuals residing in a licensed facility had the highest mortality rate. Often individuals who reside in licensed facilities have higher medical needs.
- Incidents of cancer related deaths accounted for 9 % of all individuals who died in the system.
- Of the 723 reported deaths in 2012, there were 27 identified as adverse which include accidental, homicide, suicide. The chart pulls out suicide and homicide separately but all are considered Adverse Deaths. Adverse deaths accounted for 3.73 percent of all death reports. There was a slight decrease in adverse deaths over the past year.
- Falls accounted for 4 deaths in 2011 which is a decrease of 4 deaths caused by falls in 2010.
- In 2012, 9 people died due to choking. This was an increase of 3 from 2011.



Leading Causes of Death from 2007-2012



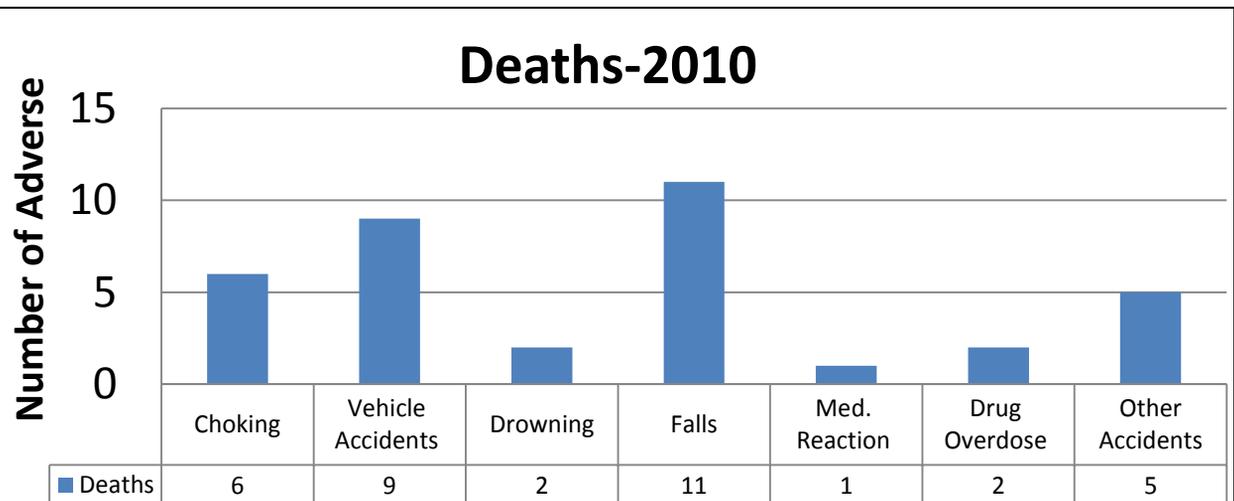
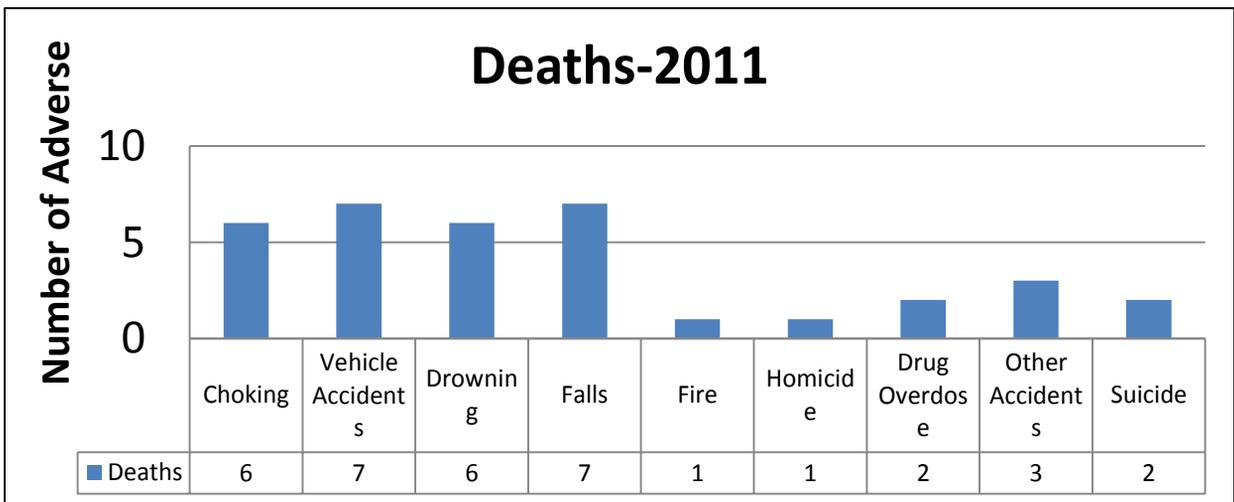
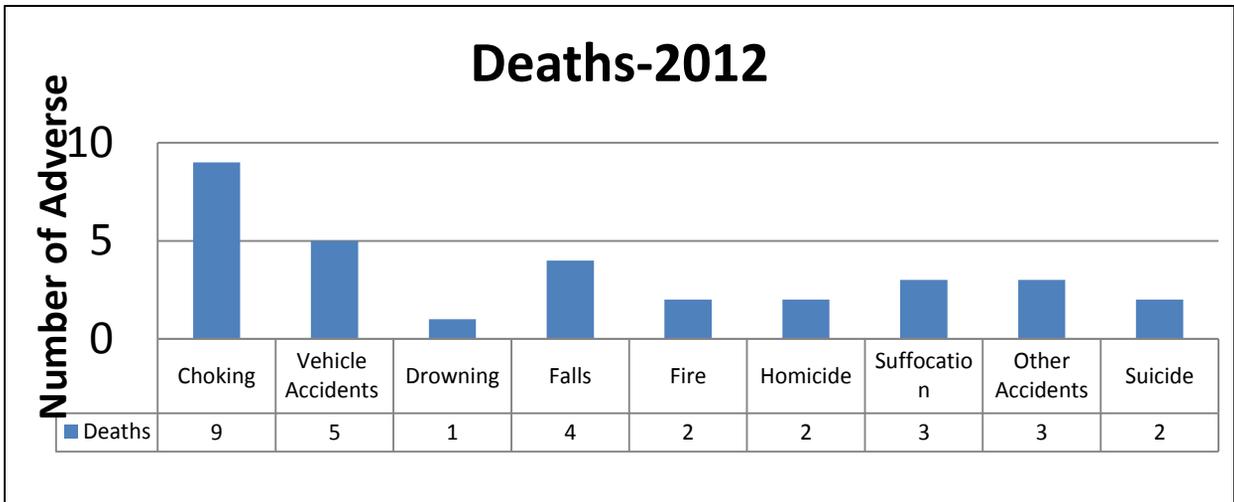
A three year review of the leading causes of death for Ohioans with disabilities served in our system.

Ranking	2012	Counts	2011	Counts	2010	Counts
1	All Other Causes*	151	All Other Causes	201	All Other Causes	138
2	Heart Disease	106	Heart Disease	123	Heart Disease	120
3	Pneumonia	49	Cancer	76	Pneumonia	83
4	Cancer	66	Pneumonia	64	Cancer	66
5	Congenital Diseases	94	Congenital Diseases	70	Aspiration Pneumonia	61
6	Aspiration Pneumonias	50	Aspiration Pneumonia	40	Congenital Diseases	52

*Other causes of death in 2012 include: bowel obstruction, surgical complications or cause was not known at the time of this report.

Mortality Review Process:

- Each death undergoes a special review which includes standard elements related to the individual’s health and death compared with the death certificate or autopsy report.
- The Mortality Review Committee meets quarterly to review each adverse death and then any patterns related to deaths of Ohioans with developmental disabilities. The Committee makes recommendations on an individual case and system wide basis.
- Mortality Rates have remained fairly consistent over recent years as indicated by the data on the following slides.
- DODD partners with other state agencies in it’s review of Mortality cases.



(13) "Major unusual incident" (MUI) means the alleged, suspected, or actual occurrence of an incident when there is reason to believe the health or safety of an individual may be adversely affected or an individual may be placed at a reasonable risk of harm as listed in this paragraph, if such individual is receiving services through the MR/DD service delivery system or will be receiving such services as a result of the incident. Major unusual incidents (MUIs) include the following:

(a) Abuse. "Abuse" means any of the following when directed toward an individual:

(i) Physical abuse. "Physical abuse" means the use of physical force that can reasonably be expected to result in physical harm or serious physical harm as those terms are defined in section 2901.01 of the Revised Code. Such force may include, but is not limited to, hitting, slapping, pushing, or throwing objects at an individual.

(ii) Sexual abuse. "Sexual abuse" means unlawful sexual conduct or sexual contact as those terms are defined in section 2907.01 of the Revised Code and the commission of any act prohibited by section 2907.09 of the Revised Code (e.g., public indecency, importuning, and voyeurism).

(iii) Verbal abuse. "Verbal abuse" means purposefully using words or gestures to threaten, coerce, intimidate, harass, or humiliate an individual.

(b) Attempted suicide. "Attempted suicide" means a physical attempt by an individual that results in emergency room treatment, in-patient observation, or hospital admission.

(c) Death. "Death" means the death of an individual.

(d) Exploitation. "Exploitation" means the unlawful or improper act of using an individual or an individual's resources for monetary or personal benefit, profit, or gain.

(e) Failure to report. "Failure to report" means that a person, who is required to report pursuant to section 5123.61 of the Revised Code, has reason to believe that an individual has suffered or faces a substantial risk of suffering any wound, injury, disability, or condition of such a nature as to reasonably indicate abuse (including misappropriation) or neglect of that individual, and such person does not immediately report such information to a law enforcement agency, a county board, or, in the case of an individual living in a developmental center, either to law enforcement or the department. Pursuant to division (C)(1) of section 5123.61 of the Revised Code, such report shall be made to the department and the county board when the incident involves an act or omission of an employee of a county board.

(f) Known injury. "Known injury" means an injury from a known cause that is not considered abuse or neglect and that requires immobilization, casting, five or more sutures or the equivalent, second or third degree burns, dental injuries, or any injury that prohibits the individual from participating in routine daily tasks for more than two consecutive days.

(g) Law enforcement. "Law enforcement" means any incident that results in the individual being charged, incarcerated, or arrested.

(h) Medical emergency. "Medical emergency" means an incident where emergency medical intervention is required to save an individual's life (e.g., Heimlich maneuver, cardiopulmonary resuscitation, intravenous for dehydration).

(i) Misappropriation. "Misappropriation" means depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Ohio Revised Code, including Chapters 2911. and 2913. of the Revised Code.

(j) Missing individual. "Missing individual" means an incident that is not considered neglect and the individual cannot be located for a period of time longer than specified in the individual service plan and the individual cannot be located after actions specified in the individual service plan are taken and the individual cannot be located in a search of the immediate surrounding area; or circumstances indicate that the individual may be in immediate jeopardy; or law enforcement has been called to assist in the search for the individual.

(k) Neglect. "Neglect" means when there is a duty to do so, failing to provide an individual with any treatment, care, goods, supervision, or services necessary to maintain the health or safety of the individual.

(l) Peer-to-peer acts. "Peer-to-peer acts" means acts committed by one individual against another when there is physical abuse with intent to harm; verbal abuse with intent to intimidate, harass, or humiliate; any sexual abuse; any exploitation; or intentional misappropriation of property of significant value.

(m) Prohibited sexual relations. "Prohibited sexual relations" means an MR/DD employee engaging in consensual sexual conduct or having consensual sexual contact with an individual who is not the employee's spouse, and for whom the MR/DD employee was employed or under contract to provide care at the time of the incident and includes persons in the employee's supervisory chain of command.

(n) Rights code violation. "Rights code violation" means any violation of the rights enumerated in section 5123.62 of the Revised Code that creates a reasonable risk of harm to the health or safety of an individual.

(o) Unapproved behavior support. "Unapproved behavior support" means the use of any aversive strategy or intervention implemented without approval by the human rights committee or behavior support committee or without informed consent.

(p) Unknown injury. "Unknown injury" means an injury of an unknown cause that is not considered possible abuse or neglect and that requires treatment that only a physician, physician's assistant, or nurse practitioner can provide.

(q) Unscheduled hospitalization. "Unscheduled hospitalization" means any hospital admission that is not scheduled unless the hospital admission is due to a condition that is specified in the individual service plan or nursing care plan indicating the specific symptoms and criteria that require hospitalization.