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Problems with abuse, neglect and cover-ups at Choate extend to other developmental centers in Illinois

Problems with abuse, neglect and cover-ups at Choate extend to other developmental centers in Illinois

Credit: Alex Bandoni/ProPublica. Source Images: Reporters' notes and the Illinois state government.

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Prompted by an outcry over abuse, Illinois proposed moving residents from Choate Mental Health and Developmental Center to similar facilities in the state. New reporting shows the problems at Choate are common throughout the statewide system.

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This year, Illinois officials announced what seemed like a solution to the outcry over abuse and cover-ups at a state-run developmental center: Downsize the facility and [move about half the residents elsewhere](#). Some of the roughly 120 relocated residents of the Choate Mental Health and Developmental Center would receive care in community settings. Others are expected to end up in one of the six developmental centers located in other parts of the state.

Gov. J.B. Pritzker and Illinois Department of Human Services Secretary Grace Hou said the plan would “reshape the way the state approaches care for individuals with intellectual and developmental disabilities.”

But a new investigation by Lee Enterprises Midwest, Capitol News Illinois and ProPublica has found that the problems at Choate extend to the other centers as well. People with developmental disabilities living in Illinois’ publicly run institutions have been punched, slapped, hosed down, thrown about and dragged across rooms; in other cases, staff failures contributed to patient harm and death, state police and internal investigative records show.

The Illinois State Police division that looks into alleged criminal wrongdoing by state employees investigates more allegations against workers at these seven residential centers than it does at any other department’s workplaces, including state prisons, which house far more people, according to an analysis of state police data.

It has opened 200 investigations into employee misconduct at these developmental centers since 2012 — most of them outside of Choate.

The state’s seven developmental centers, home to about 1,600 people, are situated from the bottom of the state at the edge of the Shawnee National Forest all the way north to the Wisconsin border. The oldest operating facility opened in 1873 and the newest one in 1987. They house dozens, and in some cases hundreds, of people with developmental disabilities in a hospital-like setting. These residents have a range of conditions: genetic, acquired from a problematic birth, or resulting from exposure to dangerous chemicals or from injury in childhood or adolescence.

As in other states, many of these facilities were built in small towns and rural areas. Today, they are short-staffed and at times chaotic and dangerous, according to a slew of reports and interviews with workers and advocates. This May, the safety concerns inside the developmental centers prompted a court-appointed monitor to urge IDHS to stop placing anyone covered by an expansive consent decree into any of the agency's developmental centers.

“Too many residents suffer physical injury, sexual assault and death to regard placement in such facilities as safe,” wrote Ronnie Cohn, the monitor and a New-York based expert on disability services, in a report that was prepared at the behest of a federal judge in ongoing proceedings.

Illinois is a stubborn outlier among states, continuing to funnel huge sums of money into institutional care. Many others have entirely shuttered or significantly downsized their state-run institutions. Illinois has about the same number of people living in them as do California, Florida, New York and Ohio combined. In Illinois, the lawsuit that led to the 2011 consent decree argued that the state had violated the civil rights of people with developmental disabilities by failing to offer enough options for community-based care. The next year, the state closed one of its centers and tried to shut another; that effort, to shutter the Murray Developmental Center in southern Illinois, failed in the face of union and community pushback. Now, the state is making space for 60 more residents at Murray, some of which will likely transfer from Choate.

“This is one of the most backwards states in the nation on everything we know how to measure when it comes to the care of people with developmental disabilities,” said Allan Bergman, a consultant from suburban Chicago who advises clients and governments across the U.S. on disability policies and programs.

We asked IDHS about the new reporting on issues within the state’s developmental centers. Agency spokesperson Marisa Kollias pointed out that the state had announced a broader review of every facility that IDHS operates as part of its response to [the reporting on Choate](#). She said in a statement that the state has worked to “identify the root causes of misconduct” and correct them. Among recent improvements, IDHS has appointed a new chief safety officer, held numerous trainings on how to report abuse and neglect and ordered more than 400 security cameras for installation across all of its facilities by the end of the year, she said.

Additionally, IDHS acknowledged shortcomings in the community care settings that operate under the agency’s oversight. Kollias said that the community system had been financially neglected by the prior administration and noted that Pritzker’s administration has successfully advocated for millions of dollars in new spending for these programs. Funding for home- and community-based care has roughly doubled what it was when Pritzker took office to more than \$1.7 billion, though advocates contend it’s still not enough after years of steep cuts.

State Police Investigations Rise

State police investigations of claims against staff at Illinois’ developmental centers are on the rise: Nearly 70% of them over the past decade were initiated since 2019, the year Pritzker took office.

Of the 200 state police investigations into employee misconduct over the past decade, 161 pertained to allegations of physical abuse and criminal battery; 25 to allegations of sexual assault and custodial sexual misconduct; and 10 to alleged criminal neglect of residents. Four were death investigations.

Of those cases, 22 led to convictions, almost all of them for abuse.

A spokesperson for the state police said the agency could not speak to the reasons for the increase or for the disparity in the volume of cases from IDHS facilities that it handled in recent years as compared with Illinois Department of Corrections prisons or other agency workplaces.

But Kollias, the IDHS spokesperson, said the department views the increase in state police investigations “as an improvement in accountability at the facilities.” She also noted that most cases did not lead to convictions.

Both the numbers and interviews show how difficult it is to pursue charges, even when investigations get underway. In the facilities outside of Choate, between 50% and 99% of residents have disabilities that are diagnosed as “severe and profound”; some of those individuals are nonverbal and unable to communicate in traditional ways. Investigative records show instances of employees failing to report abuse or working together to hide it, or a general reluctance on the part of state employees to share information with investigators. Even when there’s a conviction, state police investigators are not always able to fully determine what happened.

For instance, among the more recent physical abuse cases where a conviction was secured is one from Shapiro Developmental Center in Kankakee, a small industrial city on the outskirts of suburban Chicago. In 2020, a patient was found with U-shaped markings and dark bruising on his chest, back, arms, legs and genitals.

A nurse examined his injuries but dismissed them as a rash from medication. A physician who examined him the next day had a different take: She believed the markings were consistent with someone striking the patient with an object, such as a belt or cord. The U-shaped markings looked like they could have been from a belt buckle, she told investigators.

Police interviewed multiple employees who worked the night shift, but they offered little information. The patient was unable to provide police specific details of the incident. He was only able to tell them a female worker “beat the hell” out of him on the night shift by striking his genitals with an unknown object.

The patient’s treatment plan notes that he needs help managing behaviors that include irritability, agitation and outbursts. One employee admitted to police that she had slapped the patient across the face that evening after she had directed the patient to stop a problematic behavior and he told her to “shut up, bitch.” But the worker denied she was responsible for any of his more serious injuries. No one else came forward with any information.

The worker pleaded guilty last year to misdemeanor battery and received 12 months of court supervision. She was fired from Shapiro, but neither state police nor IDHS’ inspector general were able to determine the cause of the patient’s more extensive injuries.

Peter Neumer, the IDHS inspector general, said his department regularly encounters cover-ups at facilities across the state, which prompted him to push for a new legal measure enhancing the penalty options against those who attempt to stonewall or obfuscate investigators. [Pritzker recently signed it into law](#).

The state police reports are not the only cause for concern. The inspector general receives and investigates all allegations of resident abuse and neglect. Some of those result in recommendations for civil penalties against employees, up to termination, and suggestions to address systemic failures. The most serious cases, where criminal misconduct is alleged, are also passed on to the state police.

Between 2013 and 2022, the inspector general investigated nearly 4,000 allegations from the developmental centers — with the most recent five years seeing a 45% increase in allegations compared with the earlier part of the decade.

There are also safety concerns documented in records from the Illinois Department of Public Health, which responds to complaints because it is responsible for ensuring compliance with Medicaid and Medicare regulations.

These records show that in addition to the abuse cases, residents have suffered from life-threatening mistakes and oversights by employees.

At Mabley Developmental Center, in the small north-central Illinois town of Dixon, a patient drank from a bottle of toilet bowl cleaner. The inspector general found that a worker had neglected the patient, who died of cardiac arrest three days later.

At Ludeman Developmental Center in Park Forest, in south suburban Cook County, a resident who was supposed to be closely supervised left the facility without permission and was later found walking barefoot across a busy six-lane street. In a different elopement case, a Ludeman resident suffered hypothermia after he went outside, unbeknownst to staff, one early fall morning when the temperature was in the 30s, wearing only a diaper and sat in the wet grass.

At Kiley Developmental Center in Waukegan, on the Wisconsin border, staff locked a disruptive patient in his room using a bedsheet tied across his door, an unauthorized form of restraint, according to health department inspection records. That same facility accidentally allowed an employee who the inspector general had previously found had abused a patient to return to work for two months before anyone noticed, according to staff interviews with health department surveyors. The worker has since been fired, according to a statement from IDHS.

Critical Staffing Shortages

This rise in allegations of violence and neglect comes amid significant staffing shortages, leading employees to work unsustainable and potentially dangerous overtime hours, according to an analysis of overtime records and interviews with more than a dozen employees at four facilities.

As of February, about 200 employees at developmental centers statewide — about 5% of the workforce — were unable to perform the job they were hired for pending the outcomes of abuse and neglect allegations with the state police or inspector general’s office. Most of them were on paid leave, including some who had been on paid leave in excess of two years. Others had been reassigned from their regular duties, and a small number had been suspended without pay pending the outcome of criminal court cases against them.

Neumer, the inspector general, said his office has prioritized working through cases more quickly to reduce the amount of time employees are out on leave. But in cases involving law enforcement, the inspector general cannot proceed with its internal investigation until a criminal case concludes, he said. Some cases linger for years with state police or prosecutors’ offices.

The staffing issues go well beyond those who are being disciplined. Across the state, about 570 jobs at developmental centers — more than 14% of positions — are unfilled.

AFSCME Council 31, the union that represents most workers at these 24/7 facilities, issued a report in December criticizing the state’s use of forced overtime to address chronic understaffing and raising alarms about its impacts on workers and residents.

In at least one case at Kiley, staffing shortages may have contributed to a patient’s death.

In February 2022, an individual with a known swallowing disorder was supposed to be closely monitored while eating. But on this day, a worker went home sick, leaving her unit short-staffed. While no one was watching, the resident choked and died, according to a report by the Illinois Department of Public Health. A worker told public health investigators that records were fabricated at a supervisor’s request to make it look as though the facility had provided proper supervision.

The inspector general’s investigation into the incident is ongoing, and the employees who were involved remain on leave. IDHS said in a statement that in response to the health department’s findings, Kiley staff received training on “providing sufficient direct care staff.”

That was the second time in two years that a patient at Kiley with a known swallowing disorder choked to death while eating unsupervised. In a 2020 case, according to a report by the inspector general, the man may have been dead for several hours before anyone noticed and called for help.

Kollias, the IDHS spokesperson, said that staffing shortages in health care are a nationwide problem and that the state has taken steps to more quickly fill positions. Contract staff are filling in at every center to ensure required staffing levels for each shift are met, she said.

Conditions Are “Beyond Dire”

In some of those facilities, employees have raised alarms to their higher-ups, as a security chief at Choate had done before the state took action to address problems there, email records obtained under a Freedom of Information Act request to IDHS show.

This January, Matt Comerford, a Mabley employee, sent an email to Hou, the IDHS secretary, seeking her immediate attention to conditions he described as “beyond dire.” In his letter, he said that patient injuries — including black eyes and, in one case, an open head wound that required 13 staples — could not be accounted for, and he accused staff, including administrators, of stonewalling investigators.

“It has become normal for staff to never seem to know anything about these injuries,” wrote Comerford, the facility’s business administrator. He concluded his letter by saying that he believed speaking out put his livelihood at risk. “But the risks of not speaking out are far too great for me to remain silent.”

Mabley’s clinical services director, Patricia Fazekas, a longtime employee who resigned in May, wrote about similar concerns in an “exit” survey obtained by the news organizations.

“The system is broken and they know if they complain they will be retaliated against,” she said of staff. If one were to visit Mabley, they would “witness abused and neglected individuals being cared for by verbally abused and neglected staff.”

In March, James Zarate, an assistant director at Kiley, emailed a different senior IDHS official, telling her that residents’ well-being was in jeopardy in that facility, as well. Kiley staff, he wrote, are receiving “little guidance or training” and the facility is “operating with a shortage of staff which is being exacerbated by a toxic work culture.” Six other Kiley employees, who spoke with a reporter on the condition that their names be withheld because they still work there, similarly expressed that staffing issues and mismanagement had created a problematic work environment that put residents and employees at risk of harm.

The department said that the concerns the employees raised in their emails were passed on to the appropriate oversight bodies, and that IDHS is “independently investigating the claims and will address issues fully and appropriately.”

Both Comerford and Zarate, who do not know each other, faced disciplinary action shortly after sending their emails and additional complaints to various oversight bodies.

The department said the disciplinary decisions it made against the employees were unrelated to their emails and complaints. Zarate, a new hire, was terminated as a “probationary discharge” after six months on the job. His final performance review said he had failed to perform his job duties satisfactorily, such as by not ensuring that staff completed tasks in a timely manner or seeking input from his superiors. He was specifically admonished because subordinates had reported to health department surveyors that a staffing crisis resulted in residents not receiving “active treatment.”

“Mr. Zarate has made this an acceptable response when not meeting expectations, resulting in a possible IDPH citation,” the performance review stated.

The department didn’t dispute that staffing challenges exist, but in a statement to the news organizations, it said such a response was problematic because “essential services are expected to be provided to residents despite staffing challenges.”

Zarate declined to speak for this article.

Comerford was placed on paid administrative leave for 10 weeks, then suspended for 20 days without pay. Paid leave, the department said, is not punitive. As for the suspension, a disciplinary letter from the department said Comerford had, among other alleged infractions, raised his voice and cursed during a meeting and took a call on his private cellphone. The department said he had, on multiple occasions, displayed conduct unbecoming of a state employee and failed to perform job duties in an accurate and timely manner.

In a statement, Comerford said that “a well-worn page of the DHS Mabley playbook is to discredit and defame those who address systemic injustices against the most vulnerable population.” He said that the department had lied about, exaggerated or taken out of context many of the circumstances that led to the claims against him. The department said Comerford had the ability to challenge the discipline and did not do so. “He served his disciplinary time and has returned to work,” IDHS said in a statement.

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