OFFICE OF THE INSPECTOR GENERAL		INVESTIGATIVE REPORT
Case No.	**Report Date**	**Investigator Name**
9518-0033	February 13, 2018	XXXXX
Facility/Agency Name		
Ludeman Developmental Center		
Facility/Agency Address		**Incident Location**
114 N. Orchard Park Forest, IL 60466		XXXXX

Allegation

On November 30, 2017, the Office of the Inspector General received a reported allegation of neglect from Ludeman Developmental Center. It is alleged that XXXXX failed to provide the required 1:1 supervision to individual XXXXX when he eloped from the facility with no shoes or coat on in 25 degree weather. During the investigation it was alleged that XXXXX was asleep when XXXXX eloped.

Synopsis

XXXXX was assigned to provide 1:1 supervision to XXXXX during 3rd shift on November 30, 2017. XXXXX denied leaving the house, at any time, during the shift but admittedly left XXXXX unsupervised to take a restroom break. During the break, XXXXX heard the door chime sound and assumed it was XXXXX leaving the house. After finishing up in the restroom, XXXXX, admittedly, failed to let the other staff working in the house, or the supervisor, know that XXXXX eloped. XXXXX denied being sleep, at any time, during the shift; however, she did not hear the door chime sound. XXXXX traveled by foot, wearing only pants, a shirt and socks, to the BP gas station, located approximately two miles from the facility, in 25 degree weather, where he was spotted by XXXXX, who was on her way to work. XXXXX refused to get into the car with XXXXX. Instead, he walked across the street to Walgreens. He went inside and ingested three bottles of pills that he took from the shelf. XXXXX was transported to St. James Olympia Fields Hospital and treated for a Tylenol overdose and suicidal ideations. He was transferred to Norwegian Hospital, where he received psychiatric treatment until he was discharged back to Ludeman DC, on December 12, 2017.

Findings

Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against XXXXX and unsubstantiated against XXXXX.

Recommendations

The Office of The Inspector General recommends the following: The facility ensures that the level of supervision documented in the Individual Service Plan and the Behavior Intervention Plan is accurate and cohesive. The facility should also notify XXXXX's guardian of any incidents as required by his ISP.