In the Matter of Lisa Cohen

The Need for a Policy in the Developmental Disabilities Service System for Reporting Apparent Crimes to Law Enforcement Agencies

NYS Commission on
QUALITY OF CARE
for the Mentally Disabled

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PREFACE

In December 1985, the Commission issued a report calling attention to the need for a clear policy for reporting apparent crimes in psychiatric centers to appropriate law enforcement authorities as required by the Mental Hygiene Law (Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes to and Response by Law Enforcement Agencies). That report identified a problem of underreporting of crimes against patients, as a result of which patients were left unprotected by the Penal Laws of the State. Recognizing the complex factors that enter into a determination of whether a crime may have been committed, particularly in the context of a facility whose residents suffer from mental disabilities, the Commission also suggested the development of close working relationships between mental health and law enforcement professionals to develop practical and workable guidelines on a local level to implement mutual responsibilities.

This investigation into an allegation of sexual abuse of a mentally retarded woman indicates a need for similar actions in the State's developmental disabilities service system to ensure that vulnerable people are provided the full protection of the Penal Law. It also suggests a need for a broad-based training program for staff in this system to assist them in carrying out their obligations pursuant to the Mental Hygiene Law.

The findings, conclusions and recommendations represent the unanimous opinions of the Commission. A draft of this report was reviewed by the Commissioner of the Office of Mental Retardation and Developmental Disabilities. OMRDD's response to the Commission's recommendations are included in the report.

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Commissioner

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INTRODUCTION

On February 18, 1986 the Commission on Quality of Care for the Mentally Disabled (CQC) was informed by the Broome Developmental Disabilities Services Office (Broome DDSO) of an incident of alleged sexual abuse of a 22-year-old client by her stepfather which occurred on November 27, 1985. On February 24, the CQC requested a complete report of this incident and the response of the State-operated program where the client resides, Homer Folks Intermediate Care Facility (HF-ICF).

The material provided indicated that, following the complaint of the client to facility staff on November 29, 1985, the response of the facility was limited to consultation with the Mental Hygiene Legal Service (which advised that the actions alleged did not constitute a crime) and phone discussions initiated by her mother twenty days later. Despite the client's request to report her allegation to law enforcement authorities, no contact was made with the police or the District Attorney.

On March 16, 1986 CQC staff visited the HF-ICF to meet the client, Lisa Cohen*, review her treatment record, and interview HF-ICF staff. As her treatment record contained an indication of a previous history of sexual abuse by her stepfather, contact was established with the Tioga County Department of Social Services (DSS). On April 9, 1986 Tioga County DSS confirmed that, in

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*A pseudonym

1975, Lisa had been removed from her mother and stepfather's home due to neglect and sexual abuse by her stepfather. This information was conveyed to Broome DDSO's Director, Richard Thamasett, on April 10, 1986. Mr. Thamasett assured CQC that further contact between Lisa and her stepfather had been limited to supervised visits at the facility.

On April 20, 1986, CQC staff met with Lisa a second time to interview her regarding the alleged sexual abuse by her stepfather. Lisa readily recounted the incident and, during the interview, expressed her wish that her stepfather be punished for sexually abusing her. In a subsequent phone conversation on May 2, 1986, Lisa requested that the CQC assist her in reporting her allegations of sexual abuse to the police. On May 5, 1986, the next business day, Commission Counsel notified the Otsego County District Attorney's Office of the alleged crime.

BACKGROUND

Lisa Cohen returned to the HF-ICF from a three-day Thanksgiving home visit on November 29, 1985. That evening she told a direct care staff member that, during the ride home on November 27, her stepfather had repeatedly reached under her clothing and fondled her breasts and genitals although she told him to stop several times. The staff member documented the allegation in the staff observations/notes record, including Lisa's statement that she wanted to "get in touch with her

lawyer and have her stepfather kicked out of the house." (Lisa's request to contact her lawyer was apparently related to her previous contact with this attorney, appointed as her legal advocate during her childhood experience of sexual abuse by her stepfather.) The staff member also notified the HF-ICF program manager and a staff psychologist of the situation.

No action was taken by HF-ICF officials until three days later, December 2, 1985, when a social worker met with Lisa who related the incident and, according to a clinical summary note of their meeting, expressed her wish to call her lawyer and have her stepfather arrested. At some time between December 2-4, a social worker consulted with a representative of the DDSO, regarding this situation.

HF-ICF officials elected not to notify the police as requested by Lisa, but instead decided to consult with the Mental Hygiene Legal Service (MHLS). On December 4, 1985, the social worker informed a MHLS principal officer of Lisa's allegation and request to bring charges against her stepfather. According to clinical notes of the social worker, the MHLS principal officer, who is not an attorney and did not consult an MHLS attorney, offered the opinion that there might be little legally that could be done, and indicated that he would try to meet with Lisa "within the next few weeks." In a memo of December 16, 1985 to the social worker, the MHLS principal officer confirmed the conversation with her and wrote, "This allegation, as it was

presented to me did not appear to constitute a crime." He also wrote that Lisa should not be encouraged to believe that her stepfather would be arrested based on her allegation, but that she should not be prevented from calling the police. (It should be noted that telephone access at HF-ICF is supervised by staff. Lisa could not have contacted police without approval and assistance from HF-ICF staff.)

HF-ICF took no other action relative to Lisa's accusations from the time of the December 4 contact with MHLS until December 18, when Lisa's mother telephoned the Social Worker about the alleged sexual abuse. The social worker's clinical summary of this conversation reported that the mother had agreed Lisa was telling the truth. She reportedly told the social worker that her husband was often "inappropriate" with her friends and, in the past, had been inappropriate with Lisa. The mother requested that Lisa not come for home visits because of her husband's actions, and strongly expressed her preference that Lisa not pursue the matter legally.

Two days later, on December 20, Lisa's mother telephoned the social worker to inform her that she no longer believed Lisa's allegation, as she had confronted her husband and he had denied sexually abusing Lisa. The mother expressed her belief that Lisa was trying to break up her marriage so that Lisa could live with her. The social worker noted in the summary of this contact

that the mother again expressed her desire that Lisa not pursue legal action, warned that she would no longer communicate with Lisa or send a Christmas package if her wishes were disregarded, and indicated that she did not want Lisa to visit at her home for any reason.

On December 19, - twenty days after the allegation had been made - the social worker completed an Incident Report, OMRDD Form 147. The incident was reviewed by the Deputy Director Clinical, who concluded on January 3, 1986 that "all communication was appropriately arranged by staff."

FINDINGS

1. THERE WAS NO INVESTIGATION BY HF-ICF OF THE INCIDENT OF ALLEGED SEXUAL ABUSE BY LISA'S STEPFATHER TO ESTABLISH LISA'S COMPETENCY OR THE CREDIBILITY OF HER ALLEGATIONS, IN SPITE OF KNOWLEDGE OF ALLEGED PAST INCIDENTS OF SEXUAL ABUSE BY HIM WHICH HAD RESULTED IN LISA'S BEING REMOVED FROM HIS HOME. NO NOTIFICATION OF THIS POSSIBLE CRIME WAS GIVEN TO ANY LAW ENFORCEMENT AGENCY BY EITHER HF-ICF OR BROOME DDSO AS REQUIRED BY § 13.21 SUBD (b) OF THE MENTAL HYGIENE LAW.

No detailed statement of the allegation was recorded and no attempt was made to corroborate the details of Lisa's charges. Most significantly, HF-ICF officials did not pursue information from Tioga County DSS regarding a previous history of sexual

abuse of Lisa by her stepfather, despite reference to such history contained in the treatment record and known to the program director and the social worker.

No clinician familiar with Lisa was either asked to or evaluated such crucial variables as her competence to allege sexual abuse by her stepfather, family dynamics which were relevant to such allegations, Lisa's general reputation for veracity, or other clinical assessments which reflected on the credibility of Lisa's allegation about her stepfather. Thus, without careful review of Lisa's 1975 removal from her mother and stepfather's home, without clinical evaluation of Lisa's credibility and/or competence to allege sexual abuse, and without review of the details of Lisa's charges or consultation with OMRDD Counsel, HF-ICF officials determined that this incident should not be reported to law enforcement authorities and warranted no further investigation.

2. THE MHLS RESPONSE TO THE NOTICE OF LISA'S ALLEGATION OF SEXUAL ABUSE WAS INADEQUATE AND INCLUDED INACCURATE ADVICE TO BROOME DDSO STAFF. PRIOR TO PERSONALLY COMMUNICATING WITH LISA AND WITHOUT CONSULTING MHLS'S OWN ATTORNEY, THE MHLS PRINCIPAL OFFICER INCORRECTLY ADVISED THAT THE STEPFATHER'S ALLEGED ACTIONS DID NOT APPEAR TO CONSTITUTE A CRIME. HE ALSO INDICATED THAT LISA SHOULD NOT BE PROHIBITED FROM REPORTING THE ALLEGATION TO THE POLICE BUT DID NOT UNDERTAKE TO ASSIST HER IN SO DOING.

In a telephone conversation with CQC staff on May 15, 1986, the MHLS principal officer acknowledged that he had been accurately informed of Lisa's allegation by the social worker on December 4, 1985, and indicated that he had concluded at that time the alleged actions by the stepfather did not constitute a crime because no sexual penetration of Lisa was described. This error* was not corrected by December 16, 1985 when he confirmed his opinion in writing to the social worker.

3. DESPITE FACILITY AND OMRDD POLICY REQUIRING THE COMPLETION OF AN INCIDENT REPORT WITHIN 48 HOURS, NO INCIDENT REPORT WAS FILED UNTIL 20 DAYS AFTER THE ALLEGED ABUSE BECAME KNOWN.

The initial contact with MHLS was made five days after the allegations were first reported by Lisa on November 29, 1985. Having been advised by MHLS by telephone on December 4, 1985 that "there may be little legally that could be done," (emphasis

*The Penal Law (§ 130.00 subd. 3.) defines "sexual contact" as follows:

> 3. "Sexual Contact" means any touching of the sexual or other intimate parts of a person not married to the actor for the purpose of gratifying sexual desire of either party. It includes the touching of the actor by the victim, as well as the touching of the victim by the actor, whether directly or through clothing.
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> Sexual contact without consent constitutes the crime of Sexual Abuse in the third degree, a misdemeanor. If such contact is by forcible compulsion, it constitutes sexual abuse in the first degree, a felony. (N.Y. Penal Law, § 130.55, 130.65)

ours) and in writing on December 16, 1985 not to prevent Lisa from reporting the incident to the police, the Broome DDSO neither reported the alleged sexual abuse as Lisa requested, contacted her previous legal advocate as Lisa also requested, nor sought more conclusive legal advice from MHLS, from OMRDD Counsel or from other legal resources. An incident report was not filed until December 19, 1985.

CONCLUSIONS

Section 13.21(b) of the Mental Hygiene Law imposes upon directors of developmental centers the responsibility to give notice to the district attorney or other appropriate law enforcement official "if it appears that a crime may have been committed." While the HF-ICF clients may no longer physically reside in a developmental center, their care, treatment and protection continues to be the responsibility of the facility director in his/her role as director of the DDSO (which operates the ICF). This responsibility creates a duty of the director to report conduct that may constitute a crime against a client in such a residence. When the investigation of an incident (required by OMRDD Policy and 14 NYCRR Part 681.4) reveals credible evidence to believe that a crime may have been committed, appropriate law enforcement officials should be notified. (See Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes to and Response by Law Enforcement Agencies, December 1985.)

The investigation conducted by the CQC revealed that there was credible evidence, known to the staff of the DDSO, for them to believe that a crime may have been committed and that, therefore, a report should have been made to appropriate law enforcement agencies, particularly in light of the expressed wishes of the client. Facility staff corroborated basic elements of Lisa's statement which established the opportunity for the events to have occurred as Lisa described, to wit, that on November 27, 1985, Lisa was picked up by her stepfather to ride alone with him to her mother's home for a Thanksgiving visit. No information was revealed by the CQC investigation which would suggest that Lisa's allegations could not or did not occur as described, with the single exception of the stepfather's reported denial of the allegations of sexual abuse.

Two separate sources of information established a history of inappropriate sexual activity by the stepfather, consistent with Lisa's allegation. First, Tioga County DSS reported that sexual abuse by the stepfather had led to a Family Court order removing Lisa from the residence of her mother and the stepfather. Evidence used at the hearing which led to Lisa's removal included sexually explicit photos of Lisa taken by him. Second, Lisa's mother acknowledged to the social worker that he had behaved in a sexually inappropriate manner with female friends. These two sources of information demonstrate that the stepfather may have been both capable of, and predisposed to, sexually abusing Lisa.

In addition, CQC staff reviewed Lisa's treatment record as a means of evaluating her credibility as a source of allegations and information. This review focused on Lisa's competence to understand and communicate the events alleged, and her previous record as a source of information.

Lisa's record indicated that she has been diagnosed as borderline mentally retarded, with a recent measured IQ of 74. An October 1985 psychological evaluation noted that Lisa's independent living skills were quite sophisticated, and that she had demonstrated appropriate judgement regarding the presence of danger and was able to independently travel downtown. The 90 day psychological review completed December 27, 1985 did not include any reference to maladaptive behaviors such as lying or making false accusations of sexual abuse. The record did describe two incidents of consentual heterosexual behavior with another client at the HF-ICF, which Lisa described during a personal interview as pleasurable and acceptable to her. Overall, the treatment record strongly indicated that Lisa was competent to allege sexual abuse and that she had no previous history of maliciously or falsely making such allegations.

As noted, section 13.21(b) of the Mental Hygiene Law requires a report to law enforcement authorities "if it appears that a crime may have been committed." It is reasonable to conclude that the State owes no less a duty to persons in its custody in community residential facilities than in developmental

centers. The Legislature has recently recognized this duty of operators of community-based facilities by enacting Chapter 79 of the Laws of 1986, which amends section 16.13(b) of the Mental Hygiene Law, as follows:

> (b) Making such reports as are necessary to provide notification to the district attorney or other appropriate law enforcement official and the commissioner or his authorized representative as soon as possible, or in any event within three working days, if it appears that a crime may have been committed against a client receiving services from such provider, and such other reports, uniform and otherwise, as are required by the commissioner or his authorized representative with respect to its operations. Information obtained by the commissioner from the records of clients receiving services shall be kept confidential in accordance with the provisions of this article.

Even in the absence of a clear statutory requirement for reporting an apparent crime, under the circumstances present in this case, a report should have been made to appropriate law enforcement agencies.

RECOMMENDATIONS

1. The Commission recommends that the Office of Mental Retardation and Developmental Disabilities develop and disseminate a clear policy to guide both State and voluntary service providers on their responsibility to report allegations of crimes which may have been committed. This policy should delineate who bears such responsibility, the standards and process by which these decisions should be made, including the standard to be used in the determination "that a crime may have been committed," and appropriate time frames for required actions. Periodic training relative to this policy should be regularly offered to both OMRDD and voluntary service providers.

Commissioner Webb responded in an October 24, 1986 letter stating:

> The development of a policy statement regarding suspected criminal activity is ongoing as identified in my March 5 correspondence to you. At this time, the proposed policy is undergoing final internal review. We will share this with you for your review and comment in the immediate future. OMR will follow the release of this policy statement with training opportunities for all state-operated and certified programs.

2. In addition, the Commission suggests that OMRDD direct facility directors to meet with local district attorneys and police chiefs to develop working guidelines on the reporting of apparent criminal activity within developmental centers and community facilities, both to satisfy legal requirements and yet be adaptable to the practicalities of limited law enforcement resources. (See Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes to and Response from Law Enforcement Agencies, December 1985.)

The OMRDD responded:

> Your suggestion that the B/DDSO directors meet with local law enforcement officials to develop working guidelines is included as an element in the above-referenced policy statement. To date, two DDSOs have held such meetings and their experiences have been incorporated in the refinement of the above policy statement.