# INVESTIGATION PROCESS

## Eliminating and Reducing Recurrence of Accidents and Abuse


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# Preface

This Booklet explores some of the standardized procedures by which an agency conducts an administrative investigation of "ungovernable incidents" or other situations as warranted. The authors use the term "ungovernable incidents" throughout this booklet to reflect a variety of situations for which an investigation may be necessary. **In general, the most prevalent "ungovernable incidents" are also those for which many states have specific regulations.** These include serious incidents and/or allegations of abuse of people receiving support.

The booklet provides guidance in addressing situations occurring at all types of organizations including nonprofit, for profit, voluntary, and privately operated agencies. Therefore, some terms used in this document have been intentionally broadened on scope to include a wider definition.

### Director
The CEO, President, or Executive Director of a private or voluntary agency.

### Agency
An organizational entity of a private or voluntary nature.

### Investigator
Individual(s) designated by the agency Director to conduct an investigation. The investigator should have specialized training to fulfill that role.

### Investigation
The systematic collection of facts for the purpose of the describing and/or explaining an incident or series of incidents.

### Interviewee
The person being interviewed.

# Seven Key Components

## SEVEN KEY COMPONENTS TO REDUCE, DETECT AND PREVENT ABUSE AND NEGLECT

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| 1 | Screen | The agency makes the effort to determine the appropriateness of a prospective employee's experience in working with individuals served. This includes background screening to identify and verify any previous charges of abuse and neglect brought against a prospective employee. The agency also screens individuals receiving services to determine whether the individual can be adequately supported with the programs provided. |
| 2 | Train | Once hired, a new employee must complete a thorough orientation, followed by a training period that addresses each individual's service plan to ensure quality care. Employees should also attend regular trainings regarding abuse, neglect and preventative strategies. Training should include reporting requirements and procedures for detection, intervention and prevention. Individuals in the program should be taught to recognize and identify signs and symptoms of neglect among their peers. They should also be informed of ways in which they and their family members can support detection and prevention efforts. |
| 3 | Identify | The agency creates and maintains a proactive approach for identifying incidents and occurrences that contribute to abuse and neglect. |
| 4 | Prevent | Review of specific incidents will help detect and prevent the occurrence of abuse and neglect. Approaching each incident as a lesson learned will create constructive feedback and positively influence necessary policy changes. |
| 5 | Protect | The safety of the individuals served and staff is the number one priority of an organization. It is also crucial to take necessary steps to protect individuals from abuse and neglect during an investigation of such allegations. |
| 6 | Report & Investigate | Put measures in place that facilitate and assure consistent reporting of abuse and neglect. Timely, thorough and objective investigation of all allegations of abuse, neglect or mistreatment is extremely important. |
| 7 | Respond | The agency should ensure the appropriate corrective, remedial or disciplinary action occurs in accordance with applicable local, state or federal law if investigations find the presence of mistreatment. |

*Source: CM's Appendix Q, Guidelines for Determining Immediate Jeopardy*

# The Investigation Process

Rather than assume there is a one-size fits all investigation process, we must realize that the differences in locations, situations, consumers and other factors will influence how an investigation is conducted. Accordingly, readers are asked to apply the information in this booklet to their specific situations. For example, suppose an individual in your agency has an injury and needs medical attention. If this document suggests you bring him/her to the nearest hospital for treatment to an on-site physician, then have the nearest physician examine the individual.

# Part I: Initial Actions

## Reporting Incidents

A good measure of a facility's general health is the effectiveness of its incident reporting and review process. Over time, the incident review process will reveal whether the facility is making progress in protecting people from harm. With an effective incident investigation and review process, the facility accepts responsibility for the actions of staff and residents as well as the obligation to correct a problem.

**If an ungovernable incident occurs, staff is responsible for:**

1. The safety of those involved.
2. Notification to the supervisor.
3. Completion of an incident report.
4. Documentation of the date and time of the incident and the names of all parties involved.

Staff is trained on how to identify and report incidents as defined by the applicable state and/or federal regulations. If an ungovernable incident occurs, staff needs to ensure the safety of those involved and then notify the supervisor, nurse and family contact, as outlined in the agency's policies and procedures. Ensuring safety may include calling 911 if emergency assistance is needed. Designated staff should conduct a thorough examination to check for injuries and complete an incident report as soon as possible.


The incident report should contain a factual and objective chronology of events. It should give specific details without speculating blame. The reporter or his/her supervisor should document the names of the doctor, nurse and any family members who were notified of the incident, as well as when they were informed and by whom. If the report contains medical information, a copy should be kept with the medical files and with the incident report.

## *Could This Happen at Your Agency?*

### Preventing Accidents at Adult Homes

In the Matter of Joseph Giacolone

#### BACKGROUND

Joseph Giacolone (a pseudonym) was born in Italy and attended grade school there. He never attended high school. He was a quiet man who never married and supported himself with a custodial job in a hospital.

In his early forties, Mr. Giacolone was diagnosed with Schizophrenia. His symptoms were controlled by medication, and he was able to lead a normal, albeit somewhat isolated life. Mr. Giacolone's first hospitalization was in 1981. Over subsequent years, he had several hospitalizations and went to live in an adult home. After his parents' deaths, he experienced periods of depression when he thought about them.

In his early sixties, Mr. Giacolone found it difficult to interact with the other residents at the adult home where he lived. His case manager sent him to a local day treatment program, but he found it difficult to function appropriately in that setting. Instead, Mr. Giacolone spent his days watching television. From case management notes, it didn't appear that any further attempts were made to engage him in any organized mental health treatment or even in the home's group activities.

## THE INCIDENT

On a crisp fall day, Mr. Giacolone woke early as was his habit. He ate breakfast and watched an hour of television. Prior to going outside for some fresh air, he stopped in the men's first floor community bathroom. From statements that Mr. Giacolone made later, it appeared he found some type of liquid in a bottle in the bathroom's wastebasket. What happened next is unclear, but Mr. Giacolone incurred severe chemical burns to his scalp, face, and right eye.

The home called 911, which activated the local emergency response system. Mr. Giacolone was sent by ambulance to a local hospital. The liquid was a caustic cleaning agent. He was admitted to the hospital for treatment of his injuries. He was discharged five days later and returned to the adult home. The on-site visiting nurse service provided follow-up care for about a week. However, due to the severity of his injuries and his need for a higher level of care, he was soon transferred to a nursing and rehabilitation center.

Four months later, he was still a patient at the center, receiving daily wound care. According to his social worker, Mr. Giacolone was in danger of losing the function of his right eye. He was diagnosed with Chemical Keratoconjunctivitis in the right eye and had a corneal scratch and sutures in his right eyelid. The injuries to his scalp and face were extensive. The treatment for those wounds included debridement and the application of salves and medications to promote wound healing. He was at increased risk for infection. Ultimately, his wounds might require skin grafts.

## INVESTIGATION RESULTS

The Commission's investigation into the incidents leading up to the accident concluded that Mr. Giacolone suffered severe chemical burns when he attempted to drink from the bottle in the wastebasket. If the bottle had been properly marked, disposed of properly, or if housekeeping carts were monitored at all times when in use or locked up when not in use, Mr. Giacolone's injuries could have been avoided. Furthermore, Mr. Giacolone's injuries could have been substantially reduced had a certified first aid responder, or other health care professional, properly flushed his burns with copious amounts of water.

## OUTCOME

Regulations that govern adult homes {18 NYCRR Section 487.11 (h) (5)} require that "Residents shall not have access to storage areas used for medications, cleaning agents, bleaches, insecticides or any other poisonous, dangerous or flammable materials."

As a result of the investigations, the home now requires that all housekeeping carts and cleaning agents be locked in the housekeeping closet while staff members are on break, at lunch, and at the end of the day. Additionally, all housekeeping and maintenance staff have been given training in the proper use and disposal of cleaning agents.

18 NYCRR Section 487.9 (a) (15) states, "At least one individual currently qualified by a recognized organization to administer basic first aid shall be on duty and onsite at all times." The home now posts the name of the person certified in first aid on duty during each shift at the front desk so that he/she may be contacted immediately.

# LESSONS LEARNED

The circumstances surrounding Mr. Giacolone's accident offer lessons to assist others in preventing tragedies of a similar nature in adult homes and other human service facilities.

## Does your agency, in its policies and practices...

- ☑ Provide training to both housekeeping and maintenance staff on the correct use, storage and disposal of all chemical cleaners, as well as paints, thinners, gasoline, etc.?
- ☑ Establish safety standards for staff to keep chemical cleaners and other caustic substances under their careful watch when in use, and instruct staff to lock these items when not in use, as required by regulation?
- ☑ Ensure that a person trained in first aid is available on every shift, and post the name and title of the person responsible for rendering first aid at the front desk during each shift?
- ☑ Make provisions for back-up should the designated first aid responder call in sick?

## Receiving the Verbal Report

Before beginning a formal investigation, someone in a managerial or administrative position needs to be notified of the incident. This person should visit the site to obtain first hand information, or he/she should document the reasons for not visiting the site. The supervisor at the site where the incident occurred should give the manager/administrator notification immediately. The supervisor should be prepared to inform the manager/administrator on duty of the time and place of the incident, the name(s) of the person(s) injured or otherwise involved and any medical treatment or other actions.

## Manager/Administrator's Role

The manager/administrator plays a very important role in the initial phase of the investigation process and has several specific responsibilities. When notified of an incident, the manager/administrator should first ask if any individuals were injured or believed to be injured in any way. If so, ensure that the injured person received medical attention. If he/she has not received medical attention, then he/she should be treated immediately. The following is a list of items/procedures that a manager/administrator is responsible for gathering.

***Request and record the following:***

- ❑ The location of the incident.
- ❑ The time and date of the occurrence.
- ❑ The name and medical status of anyone involved.
- ❑ The names and title of all employees who where on duty at the time of the incident.
- ❑ The name(s) of any employee who witnessed the incident.
- ❑ The name(s) of any resident who witnessed the incident.
- ❑ The name(s) and title of any visitor who may have been present during the incident.
- ❑ The name and title of the person reporting the information and a brief statement regarding the incident.
- ❑ If there is suspicion that a crime has been committed, direct the immediate vicinity of the ungovernable incident to be cleared of all people, unless the area must be used for care of individuals. Advise that any furniture and/or other items are to be left undisturbed until the manager or investigator arrives.
- ❑ All staff and witnesses should remain at the scene until the investigator has spoken to them. If it is the end of a shift, staff should be given incentives of overtime pay or comp-time to ensure their full cooperation.
- ❑ If misconduct by a staff member catalyzed the incident fellow staff may be tempted to distort or suppress the facts, and may seek cooperation from others in doing so in order to protect their friend. Separation of the staff is a practical means of reducing their opportunity to collaborate in this manner. Explain any known witnesses must be separated from each other, and the incident is not to be discussed with anyone until the interview process has ended.
- ❑ Do not overlook individuals served as potential witnesses. Depending on their communication skills, and cognitive abilities, they may be a very helpful source of information. Therefore, the manger should also ensure that they be separated to prevent possible distortion of their account of the incident.
- ❑ If appropriate, direct that color photographs be taken of any or other relevant items. Access to photographic equipment generally depends on agency policy. The manager or the investigator should have immediate access to such equipment.
- ❑ If a consumer was injured and was examined/treated by a physician, contact the physician as soon as possible to determine the nature, age, duration and probable cause of any injuries noted. This information is vitally important to the investigation of the incident.
- ❑ Notify the investigator and brief him or her on all information collected and action(s) taken. Time is of the essence, and the manger and /or the investigator should proceed to the scene immediately to follow-up in person on the orders for securing the area and testing the witnesses.

**QuickList**

### Manager/Administrator's Role

- ✓ Ensure the individual's immediate safety and well being.
- ✓ Request the preliminary information regarding who, what, when, where and how.
- ✓ Take immediate action relating to the scene of the ungovernable incident, which will facilitate an efficient and productive investigation.
- ✓ Make a preliminary assessment of the situation and notify the appropriate administrative personnel per agency policy.
- ✓ Make the appropriate and necessary administrative decisions on behalf of the agency regarding residents and staff.
- ✓ Visit the site to obtain firsthand information, including written statements from key persons present.

# Investigator's Role

This section outlines the initial actions a trained investigator should take. By following this action plan, the agency will be more likely to complete an investigation that is accurate, legally sufficient, and successful in revealing the cause of the incident and how it could have been prevented. Investigators who have any real or perceived conflict of interest are obligated to remove themselves from the investigation. Regardless of your agency's organizational structure, and the manner in which the investigators are assigned, these actions by the investigator are universal.

## ACTIONS UPON RECEIPT OF A REPORT

When asked to investigate an ungovernable incident, the investigator should confirm the following:

- ❑ The incident or Abuse Report Form is completed in accordance with the existing state regulations and agency policies.
- ❑ The location, date, and time of the incident has been documented.
- ❑ The victim's medical condition is known and recorded.
- ❑ The scene has been secured
- ❑ The names of all witnesses including consumers, staff, visitors, etc. have been obtained and witnesses have been retained and separated.
- ❑ The available physical evidence has been secured.

## ACTIONS AT THE SCENE

The investigator should proceed to the scene as promptly as possible. The longer the delay in arrival, the greater the possibility that physical evidence will be contaminated, and that witness' accounts will be distorted.

The investigator should collect and review all pertinent documentations related to the ungovernable incident (log books, clinical files, bed check list and staff assignments, etc.) The investigator must also determine if any other documents or records are needed. The order in which the investigator carries out the tasks below will depend upon the circumstances at the time. Rather than rely on memory, the investigator should use a notebook to record all information and findings during the initial stage.

## THE PHYSICAL SETTING & SECURING THE SCENE

Upon entering the area, the investigator must examine the entire scene, including the room(s), furnishings, and equipment, while taking care not to contaminate any evidence. The investigator should cover the following points with the on-site supervisor:

- ❑ Location of people and contents of the room before and after the ungovernable incident.
- ❑ Physical evidence discovered at or near the scene, such as blood or other spilled liquids, potential weapons, etc.
- ❑ The investigator is to ensure that "off limits" instructions are carried out.
- ❑ All furnishing and other objects should be left undisturbed and no one should "clean" the room of any debris (spilled liquids, body fluids, etc.) which could prove to be perceived as evidence.
- ❑ Staff should not bathe the victim or clean his or her clothing until told to do so by the investigator.

**QuickList**

### Who should be an investigator?

Certified investigators are people who have been trained according to your states' Office of Mental Retardation and/or Mental Health. Minimum qualifications should include:

- ❑ High school degree
- ❑ 21 years of age
- ❑ Satisfactory criminal background check
- ❑ Successful completion of state training protocols

Certified investigators should be required to take refresher classes every two to three years. Investigators should also be required to conduct a minimum of three investigations before being certified.

## VISUAL RECORDS

The investigator should take immediate steps to inspect and record the physical appearance and features of the scene where the ungovernable incident occurred. There are two main recording methods. The investigator should use both if the area contains significant physical evidence or is difficult to describe verbally. These two methods are:

### Photographs

See section entitled “photographic evidence.”

### A Sketch

The sketch can be “roughed out” after a preliminary examination of the site. Additions and refinements can be made as information is gathered during interviews. The investigator should carry a tape measure to aid preparing accurate sketches. If floor plans are readily available, the investigator can use them in place of a drawing.

**Both of these methods will help the investigator to do the following:**

- ✓ Depict all significant items and conditions in and around the scene.
- ✓ Establish a rough scale of distance and objective sizes.
- ✓ Prepare drawing to scale later.
- ✓ Show the placement of principle parties, objects, etc.
- ✓ Conduct witness interviews.

**Record the following data/information on each identification bag:**

- ❑ Date, time and location where an item was found and the identity of the person who found it.
- ❑ Date and time the investigator took custody of the items and from whom.
- ❑ Brief description of item
- ❑ Pertinent remarks regarding an item’s origin, connection with the incident, etc.
- ❑ Investigator’s signature.

### Sample Evidence/Security Bag

## PHOTOGRAPHIC EVIDENCE

Photographs are taken in order to:

- ✓ Provide a permanent record of fragile or perishable evidence (e.g., bruises)
- ✓ Clarify written reports
- ✓ Supplement notes and sketches
- ✓ Aid in identification

Color photographs provide the best evidence. Cuts, bruises or other visible injuries, are the most obvious and critical pieces of evidence to record by photograph. Such injuries should be photographed within one hour of incident.

It is best for an agency to possess at least one digital camera to take high resolutions photos of injuries. Photographs of injured individuals and the scene of the incident must be treated confidentiality. If the agency does not use a camera, it should hire a local photo service that is dependable and discreet.

**In order to protect the evidentiary value of all investigative photos, adhere to the following guidelines:**

- ❑ The object(s) in the photo must be relevant
- ❑ The photo must focus on a specific object or scene and accurately represent it.
- ❑ The photo should not appeal to emotions
- ❑ Take different views of the scene and make certain that the lighting is adequate for each photo.
- ❑ Use distance, mid-range and close-up photos to provide a better perspective.
- ❑ The photographer may need to testify about the date and time each photo was taken

**The best photograph may not be usable if it is improperly labeled, so caption every photo as follows:**

- ❑ Identify the subject.
- ❑ State the date and time the photo was taken.
- ❑ Identify the person talking the photo.
- ❑ Include a description/narrative (if needed).
- ❑ Identify the subject's name/status, and ID number.

Each state may impose different requirements regarding investigations of ungovernable incidents; the following are basic objectives that all administrative investigations should follow.

- ❑ To determine the facts of a particular ungovernable incident by complete a thorough review and analysis of all available evidence and witness statements.
- ❑ Use the results of the investigation to discover the conditions that caused the incident, and implement appropriate corrective actions that will aid in prevention.
- ❑ Provide accurate and detailed information to assist an agency in preparing for appropriate administrative actions. These include disciplinary (suspension, termination), non-disciplinary (training, counseling) or both depending on the results.

Provider agencies, regardless of population served, can use this information as a guide in conducting timely, accurate investigations that will yield corrective measures as well as documentation of efforts to recognized standards of care.

## INCIDENTS INVOLVING VIOLATIONS OF THE LAW

An ungovernable incident may involve a criminal act such as homicide, assault, arson, sexual assault, or theft. If the investigator suspects any sort of criminal activity, he/she should inform local law enforcement officials according to the agency's policy. The investigator may also seek advice from his/her agency's counsel.

If law enforcement becomes involved, the investigator should be prepared to brief the officer(s) upon arrival. The investigator and the police officer(s) should collaborate on a specific sequence for conducting the criminal and administrative investigations. The investigator will find it helpful to remember that the possibility of a crime presents many variables that law enforcement agents need to weigh, and this will influence their response.

Agencies may need to take prompt administrative action to ensure the well-being of the individuals in their care and staff following an ungovernable incident. They must also coordinate their actions with the local police and/or district attorney so that all parties can work effectively. This positive relationship will smooth both the criminal and civil investigation process

**What to do in cases where a crime may have been committed.**

- ❑ Consult with agency counsel and local law enforcement authorities
- ❑ Give full cooperation to law enforcement authorities and do not obstruct their activities
- ❑ If a criminal investigation is initiated, it may be advisable to wait for its outcome before taking punitive or other administrative actions
- ❑ Coordinate the agency's administrative and investigative actions within any criminal investigation.
- ❑ Comply with all regulatory, legal and agency policies regarding the healing of untoward incidents.
- ❑ Document all actions and conversations.

The subject of a criminal investigation is presumed innocent unless proven guilty "beyond a reasonable doubt." An administrative investigation makes the same assumption but requires only a "preponderance of evidence" (50% or more) to establish the individual's guilt. Since the higher levels of proof and more severe penalties rest with criminal investigations, it is often in an agency's best interest to wait for their outcome rather than if a person is found guilty in the administrative forum, which demands a less stringent level of proof.

# *Could This Happen at Your Agency?*

## Preventing Abuse Cover-Up

### In the Matter of Jesse Caron

## BACKGROUND

*[Note: All names are pseudonyms]* On the day after Christmas, Jesse Caron reported to his sheltered workshop, as he had for the past two years since moving from an institution to a community residence. On this day however, something was different. Mr. Caron's left eye was black and blue and almost swollen shut, and the white of the eye was completely bloodshot.

Concerned, workshop staff asked Mr. Caron what had happened. He told them a staff member from his residence punched him in the face on Christmas Eve. Workshop staff immediately called the director of Mr. Caron's residential program. The director arranged for a medical examination and commenced an investigation into the allegation of physical abuse by residence staff. The medical examination indicated that while the area around Mr. Caron's eye was severely bruised, the eye sustained no permanent injury. Mr. Caron reported to the agency's investigator, as he had to workshop staff, that he was punched by a residential staff member. He also requested to be moved to a new residence.

Mr. Caron was ambulatory, verbal, and independent in most activities of daily living. When refused a preferred activity, Mr. Caron would sometimes display inappropriate behaviors such as temper tantrums. These tantrums would often include verbal aggression (cursing, yelling) toward others, and property destruction. A plan was in place to address these behaviors through redirection, or escorting Mr. Caron to a quiet area. If escalation of these behaviors occurred, and Mr. Caron was unable to self-regulate, approved physical interventions were implemented in order to prevent Mr. Caron from hurting himself or destroying agency property. Mr. Caron did not have a history of being aggressive toward other people. According to a behavioral specialist who interviewed Mr. Caron following the allegation of abuse and reviewed his clinical record, Mr. Caron had no history of making false accusations.

## INITIAL AGENCY INVESTIGATION RESULTS

According to the agency's investigation, at approximately 4:00 p.m. on Christmas Eve, Mr. Caron asked to call a friend. The request was denied by the residence manager who believed Mr. Caron might attempt to invite himself to a Christmas party at a neighboring community residence. Disappointed, Mr. Caron yelled at the manager and stormed upstairs to his bedroom, and “thumping” sounds were soon heard. The residence manager asked fellow staff member, Mr. Romano, to check on Mr. Caron, who was found bouncing his basketball in his room. He appeared to be agitated. Mr. Romano escorted Mr. Caron downstairs to the residence's recreation room. The manager checked on Mr. Romano and Mr. Caron soon after their arrival in the rec room. Although the situation seemed under control, the manager asked the third staff member on duty, Mr. Philipson, to go to the rec room to assist Mr. Romano if he needed it.

Mr. Philipson reported that all was calm as he entered the rec room. Mr. Caron was sitting on a couch with Mr. Romano nearby. While Mr. Philipson’s back was turned working on files, he heard a scuffle. He turned to see Mr. Romano and Mr. Caron on the floor. Mr. Romano was asking Mr. Caron, "Why did you swing at me?" The two were struggling, with Mr. Romano attempting to restrain Mr. Caron's upper body. Mr. Philipson assisted by grabbing Mr. Caron's legs. After approximately 10 minutes of being held face-down on the floor, Mr. Caron calmed down and staff released their grasp, allowing him to stand. It was then staff noticed his eye was somewhat swollen. The residence manager was informed of the injury and contacted a nurse by phone. The nurse instructed them to apply ice to the injury.

## FACILITY INVESTIGATION CONCLUSIONS

During the facility's investigation, Mr. Caron maintained he was punched by a staff member. Staff, however, denied striking Mr. Caron. Mr. Romano, who claimed that Mr. Caron took a swing at him, initially stated that Mr. Caron's face hit the rec room door knob as he was being wrestled to the floor following the attempted punch. Mr. Philipson claimed he saw nothing, as he was busy working on files. Mr. Romano's statement, however, did not convince the facility investigator. Given the layout of the room, the location of Mr. Caron and Mr. Romano, and the testimonies of the residence manager and Mr. Philipson, (who stated the rec room door was closed) it was impossible for Mr. Caron to strike his face on the door knob. Furthermore, Mr. Philipson did not hear anything which sounded like a head hitting a door. Confronted with these findings, Mr. Romano changed his story. He told the facility investigator that it may have been possible that he struck Mr. Caron by accident while restraining him.

Troubled that he lied in his initial statements about the origin of Mr. Caron's injury, the agency transferred Mr. Romano to a different residence where he could be more closely supervised. However, the agency deemed there was insufficient evidence that Mr. Caron was the victim of abuse. Based on Mr. Romano's revised statement, the agency concluded that Mr. Caron may have been accidentally struck by some part of Mr. Romano's body while being restrained.

## A NEW INVESTIGATION

Upon receipt and review of the facility's investigation report, the Commission recommended the agency reopen its investigation, citing that:

- ✓ While Mr. Romano wavered in his version of incidents, Mr. Caron was steadfast in his claim he was punched by staff and had no history of making false accusations
- ✓ Staff neglected to secure appropriate medical attention for Mr. Caron as the severity of his injury became more apparent over the next two days
- ✓ The entire incident was precipitated by denying Mr. Caron access to a telephone, which was his right.

## THINGS TURN UGLY

When the agency reopened its investigation, Mr. Romano again changed his story. In this version, he claimed that after Mr. Caron swung at him and was restrained to the floor, Mr. Philipson kicked Mr. Caron three to five times in the head. He also stated that when swelling around Mr. Caron's eye was noted, the residence manager told him and Mr. Philipson to report Mr. Caron had struck his face on a door knob. With this new version, police were called in on the matter. In the ensuing investigation, Mr. Philipson denied kicking Mr. Caron. He also became more forthcoming about what he saw in the rec room.

According to Mr. Philipson, while Mr. Caron was sitting on the couch, Mr. Romano ordered him to lie on a floor mat, which had been used as place to calm down. Mr. Caron refused, and Mr. Romano pulled him up by his shirt. At this point, Mr. Caron swung at Mr. Romano, but missed. In reaction, according to Mr. Philipson, Mr. Romano punched Mr. Caron in the face and chest several times and both fell to the floor where a restraint was implemented. Mr. Philipson assisted by holding Mr. Caron’s legs. According to Mr. Philipson, when Mr. Caron was released and his injury was noted, Mr. Romano became afraid he'd lose his job. Both staff told the residence manager what had transpired, and the manager instructed them to report that Mr. Caron hit his face on a door knob. Upon interrogation, the residence manager confessed that he fabricated the door knob story to cover for Mr. Romano, who told him he had overreacted, punched Mr. Caron, and was afraid of being fired.

## RESOLUTION

Reinterviewed, Mr. Caron maintained, as he had in all previous interviews, that he was punched by a staff member. He denied that he was kicked, as Mr. Romano had most recently alleged. But, he could not name the staff member who punched him; he could only describe the car his assailant drove. The description matched the car driven by Mr. Romano.

Subsequently, the District Attorney's Office charged Mr. Romano with assault in connection with Mr. Caron's beating. He was fired by the agency for abuse, as were the residence manager and Mr. Philipson for their complicity in covering up the incident.

## A NOTE ABOUT LAW ENFORCEMENT

Early involvement with law enforcement authorities in abuse investigations can help the agency maintain objectivity, communicate to all parties the seriousness the agency attaches to the allegations and lead to a quick resolution.

# LESSONS LEARNED

The Jesse Caron case illustrates several lessons for both agency administrators and direct care staff. The first is the care which must be taken to objectively collect, analyze and weigh evidence in client abuse cases, particularly when it appears the only available evidence is the testimony of the victim and the prime suspect.

Throughout his ordeal, Mr. Caron maintained he was punched by a staff member. He had injuries consistent with his claim, and he had no history of fabricating stories or making false allegations. Yet he was not believed.

Instead, the agency chose to believe Mr. Romano - an employee who changed his initial "door knob" story when confronted with facts which proved it impossible. And while "buying" Mr. Romano's revised account that he may have accidentally made contact with Mr. Caron's face during the restraint, the agency clearly had reservations about Mr. Romano's veracity as evidenced by his transfer to a job where he could be watched more closely. Yet, administrators chose to believe his account over Mr. Caron's. It wasn't until external parties (the Commission and police) became involved that the truth was exposed, and the agency realized it had a far more complex problem involving abuse and conspiracy. No one wants to see abuse occur in their programs. Agency leaders, must take steps to ensure that this strong desire does not obscure their vision or prejudice their objectivity while investigating allegations.

Agency leaders have at their disposal a powerful tool to assist in this regard: the involvement of law enforcement authorities. New York State law requires agencies to report apparent crimes to police, and certain forms of abuse, particularly physical and sexual assaults. The early involvement of law enforcement authorities in abuse investigations can assist agencies in maintaining objectivity, communicate to all parties the seriousness the agency attaches to such allegations, and lead to the quick resolution of charges. A second lesson warranting reflection is the degree to which staff will go to "help" a fellow worker. There is a special bond among direct care staff. Few people are willing to do the jobs they take on, work the hours they put in, for the money they make. Their camaraderie enables them collectively to achieve what no one could do individually - provide quality care. It also provides a strong temptation to "cover" for a fellow worker who has erred.

As demonstrated by the Caron case, the worker who loses control, abuses an individual and conspires with others to cover his act, may be the first person to blame his peers for his own mistake. Direct care staff should consider the perils to their own careers and the health and well-being of the individuals they serve when tempted to cover for others.

Finally, a simple request, denied by staff, triggered a chain of incidents: assault, serious client injury, conspiracy, the termination of three employees and the arrest of one. All, perhaps, could have been avoided had Mr. Caron been allowed to exercise his right to make a phone call.

## Questions for Consideration

- ☑ Does the agency afford equal weight to the testimony of clients and staff in abuse allegations unless the scales are reasonably tipped by legitimate questions of credibility or other evidence?
- ☑ Has the agency cultivated relationships with police authorities to enlist their assistance in objectively investigating potential criminal situations and foster their understanding of people with developmental disabilities?
- ☑ While encouraging staff to report abuse, do agency policies recognize the special, and at times difficult, role of direct care staff and provide a means for staff to safely/anonymously report abuse? Do practices communicate that the agency will respond fairly to honest mistakes to improve staff's care-giving capacity? Or do practices promote a fear of reporting?
- ☑ Are staff sufficiently aware of client rights issues, not just as spelled out in law and regulation, but as also experienced in everyday situations, such as someone wanting to use a phone, have a visitor, or linger a bit longer at breakfast for a second cup of coffee? Is staff prepared to deal with conflicts over such issues without allowing them to escalate into physical altercations?



# Part II: Interviewing Process

## Obtaining the Witness's Account

This section focuses on obtaining information from witnesses, as they are considered the best source of information during an investigation.

### INTERVIEWS

Investigators should avoid simply collecting written statements from employees. Without follow-up questioning, employees may write that they do not know what occurred because they were not in the immediate area. They also might write what others told them, which would be hearsay, and not an accurate account of the incident. Personal interviews are essential to uncover the facts.

### SCHEDULING THE INTERVIEWS

The investigator should classify witness by category and decide the order in which he/she will interview each person. Based on the information available at this point, it should be possible to establish the following witness categories:

Victim. A resident, staff person, or anyone else reported to have been harmed by the ungovernable incident.

Primary/Secondary Witness. Any person present at the time the incident occurred.

Staff. Those who were on duty but not present at the time.

Others. Those who may have relevant information about the case.

Suspect. A person(s) whose acts or lack thereof may have caused or contributed to the ungovernable incident. The investigator should speak with this person after others have been interviewed. This discussion is likely to be an interrogation rather than an interview.

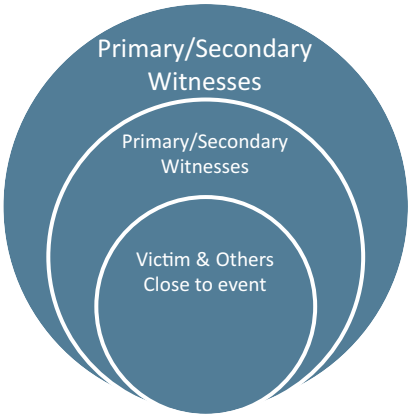
When determining the sequences of interviews, the investigator should visualize the witnesses as occupying different points on an "expanding circle" of incidents and circumstances. At the center of the circle are the victim and those nearest to him/her at the time of the incident. The investigator should interview these people first, while their recollections are fresh.

Next, he/she should interview others who were in the general vicinity at the time of the ungovernable incident, such as a staff person who was near the incident site .

The investigator may also wish to interview people who were not in the immediate area at the time of the incident, but who may have information that supports or refutes specific theories of the case. Examples include:

- Staff with knowledge of an individual's cognitive abilities, physical condition, behavior history, etc.
- Other supervisory staff familiar with work records of employees closest to an incident
- Human resources employees who can provide information and background on all employees involved.

## THE INTERVIEWING CIRCLE




## PREPARING FOR THE INTERVIEWS

Once the investigator has categorized the witnesses and decided the sequence if the interviews, he/she must find an appropriate setting and establish objectives.

Interview Location: Select a site with a relaxed atmosphere that will promote candid and private discussions. An interview should not be disturbed by telephone calls, loud background noise, or people coming and going. Take the time to locate a private office or other area that will be free from interruptions. If a discussion is to take place at the scene of the incident, make sure that normal activity in or near the area is minimized. The investigator should be sure that no other actual or potential witnesses or associated parties will be able to overhear or observe the interview.

Interview Objectives: The investigator should set specific objectives for each discussion based on information about the interviewee's connection with the case. For example:

- Confirming a person's presence at the scene when the ungovernable incident occurred.
- Confirming or ruling out any possible motive to suppress or distort the facts of a case.
- Learning about others who were present during the ungovernable incident, or who had an opportunity to observe part or all of it.
- Learning about eyewitnesses' work records, attitudes and behaviors.

Interview Assistance: It is highly recommended to have another management representative present for some, or all of the witness interviews. This person can assist by taking notes while the investigator concentrates on the witness. In deciding whether or not the assistance is needed, the investigator should consider the following guidelines.

- ☑ If the investigator wants a management staff member to attend the interviews, he/she should first ask the manager about his or her relationship with each witness. If the investigator detects significant positive or negative bias toward those who will be interviewed, another person should be chosen.

- ☑ If a witness objects to another party's presence and the investigator determines that the grounds for the objection are valid then the request should be accommodated.

## CONDUCTING THE INTERVIEW

The Opening: The investigator should be aware that a witness is more likely to be cooperative in a positive atmosphere. The investigator should try and develop a relationship with the witness from the onset of the interview.

The investigator should begin each interview with a cordial, sincere greeting and follow up with his/her full name, job title and organizational unit. Introduce the management representative and explain the reason for his/her presence. Depending on agency policy and the circumstances, it may be advisable to tape-record interviews. If this is to be done, inform the witness beforehand, and give him/her a copy after the interview upon request.

**The investigator should state the following:**

- The investigator represents the Director and has been authorized to investigate an ungovernable incident on his or her behalf.
- Any information provided will only be shared with management to the extent required for full and fair investigations.
- Advise the interviewee that he/she should refrain from discussing the content of the interview with others
- Ask the interviewee to indicate his or her full name, job title, work assignment, length of service, immediate shift supervisor, etc.

**Some interviewing tips for the investigator include:**

- The investigator should attempt to place the interviewee at ease by spending a few moments discussing the person's job and length of service at the agency. Address the situation to be discussed when the interviewee's initial anxiety has subsided
- The investigator should continue to show interest in an interviewee's personal concerns without allowing an interviewee's responses to stray significantly from questions asked.
- The investigator should keep the conversation as informal and relaxed as possible, without becoming overly familiar or personal.
- Maintain good eye contact throughout the interview.
- The investigator should avoid the use of legal or bureaucratic sounding language (e.g., Victim, subject, perpetrator, etc.)

**QuickList**

### Getting off to a good start

Here are some tips for a successful interview.

- ❑ Keep the atmosphere informal, but not overly friendly.
- ❑ For the record, establish the identity, role, title, etc. of everyone present.
- ❑ Emphasize the need to maintain confidentiality and that information will be shared only as necessary.
- ❑ Take the time to get acquainted before introducing the reason for the interview.
- ❑ Use everyday language and encourage the interviewees to do the same
- ❑ Above all, collect as much pertinent information as possible and avoid creating an adversarial or stressful atmosphere.

The investigator should remember that an interview is not an adversarial encounter and that the interviews can be very helpful in the instigation process. Staff members can become nervous and upset at the thought of being interviewed, and the interrogator should behave in ways that will reduce the staff's concerns and discomfort

## THE DISCUSSION

There are two interviewing techniques for exploring an interviewee's knowledge of an ungovernable incident. These are the Free Narrative and Direct Examination. The Free narrative is the interviewee's description, in his her own words, of what occurred. A direct Examination consists of a series of specific questions designed to help the interviewee to relate a complete account of incidents in an orderly and logical fashion. Both techniques have place in the interview process and are more fully discussed below.

## An Investigator should learn to be a good listener...

Free Narrative: An interview usually begins with the "free narrative" technique. This method is very important in evaluating a witness's credibility. The interviewer gives each witness a frame of reference that includes the date, times and incident of interest to the investigator, and asks each witness to tell what happened in his or her words. The investigator interrupts only when necessary to keep the witness "on track" or ask that major details be clarified. When a management representative or second investigator is present, he/she can take extensive notes while the primary investigator focuses on the interview. If only one investigator is present, there are two reasons why he/she should limit note taking to the basic essentials during this phase. First, it is extremely hard to listen and write effectively at the same time, and second, a witness will be more at ease if the investigator's attention is clearly focused on what he or she has to say.

...an interview is not an adversarial encounter...

**The investigator should consider the following points during an interview:**

- ☑ Everyone reacts differently to emotional and physical stimuli and this can effect the validity of the information provided.
- ☑ Lighting, distance or physical limitations such as impaired sight or hearing may cause a witness to describe or interpret incidents inaccurately.
- ☑ An interviewer must be alert for personal motives that may cause a person to give misleading information.

Direct Examination: Direct examination is designed to reveal who, what, when, where, how and why. This is the backbone of any investigation. Despite its name and strategic approach, direct examination is a subtle technique, and the investigator should rely on the following guidelines.

- ☑ Build a foundation for each area to be explored. For example, the investigator can begin with question that will place a witness at the scene of the incident. Questions should move from general to specific points. For example, the progression might be:
    - Were you on duty at 9:00pm?
    - What were you doing at 9:00pm?
    - Was anyone else present?
    - Who?
    - Where was Billy at the time?
    - Where was Suzie?
    - What did you hear?
    - What, if anything, did Sandy do?
    - How did Sandy react?

- ☑ When nearing crucial points in witness accounts, the investigator should ask questions that help a witness paint a detailed picture of what was seen, heard and done. The investigator wants the person to essentially freeze incidents frame by frame. To continue the previous example:
    - How far away were you?
    - How was the lighting in the hallway at that moment?
    - Who was present in the dining room?
    - What did Sandy say?
    - When did you move to another area?
    - Who was present?

The investigator should try to judge a witness' ability to recall incidents and tailor questions accordingly. Most people will not readily remember an incident with the level of detail that is being sought. Some will respond readily to the refresher questions outlined above, while others will have difficulty doing so even if they are doing their best to cooperate. The investigator can help them by identifying points. For example, if a witness recalls that a hallway was noisy, the investigator should ask the witness to focus on what was heard. These associations may bring out a flow of detail, which the witness mentally "filed away" as unimportant at the time. Another good technique is for the interviewer to ask the witness what the last thing he/she remembers seeing or doing followed by leading the witness back to the incident by asking questions in reverse order.

The investigator should avoid the use of "leading questions" or those that suggest a specific response. For example, when a witness has not stated that Joan, or anyone, hit an individual, the investigator should not ask, "How many times did Joan hit the individual?" The investigator needs to be certain that the information the witness provides is not generated or influenced by what the investigator suggests. The investigator needs to probe, not prompt. A witness's mind has probably recorded a host of visual and verbal data of interest to the investigator. It is the investigator's task to help the witness remember that data completely and express it clearly.

The investigator must also try to separate facts that a witness knows firsthand from conclusions or inferences that may have been made. In the previous examples, the witness may mix facts, conclusions and inferences on response to the same questions. For example:

**Q.** "What did Sandy do after Suzie called a name?"
**A.** "Sandy pushed Suzie into the wall" (Direct observation)

**Q.** "After the incident, what did Bob do?"
**A.** "He called the mid-level supervisor and reported It."

**Q.** "Did you hear or see Bob make the phone call?"
**A.** "No, but that's what Bob should have done - that's what we are supposed to do in such cases" (inference)

Such inferences and conclusions may be reasonable and are often correct, but they do not meet the strict criteria for factual, "first-hand" information. While the investigator cannot immediately add them to the fact pattern, he/she should use in the future interviews. For example, based on the previous interview, the investigator would follow up with Bob directly.

The investigator needs to be wary of quantitative estimates such as time, distance, and room sizes offered by a witness. Most people have trouble making these judgments. An effective technique is to verify each response against a known object or quantity. For example:

**Q.** "How far were you from Bob?"
**A.** "Approximately 30 feet."

**Q.** "Compare the distance with the size of this room."
**A.** "From me to the wall."

*"The investigator must also try to separate facts...from conclusions or inferences..."*

The instigator may find that the actual distance is only half that of a witness's original estimate. The points of verbal estimates are frequently inaccurate. If these estimates are not verified, they can significantly distort an investigation. Physical factors that may affect a witness's observations should be explored. Examples include:

Eye Sight: Does a witness wear corrective lenses? If so, was the witness wearing them when he or she observed the incident?

Lighting: Was the lighting sufficient for a witness to have seen clearly what he or she reporting?

Distance: Having reviewed a witness estimate as discussed before, can the investigator rule out confirms possible distortion of the incidents reported?

Obstructions: Did a witness have a clear, unobstructed view?

## SPECIAL WITNESS CATEGORIES

Reluctant Witness: The previous information has focused on the cooperative witness who simply needs help in recalling specific details of an incident. The investigator will also encounter witnesses who intentionally evade the issue. Their behavior may range from an outright refusal to answer questions, to providing vague or conflicting recollections of details they should know. These individuals are classified as reluctant witnesses. The reasons for such behavior include the following:

- A reluctance to share information about a coworker because of uncertainty about what actions an administrator might take based on the information
- A belief that it is not appropriate to help management and those investigations are intended to blame an allegation of abuse on one or more employees, even if no one is guilty of misconduct
- A witness is friendly with another staff member and feels he/she may become a target of discipline
- A witness believes he/she may be disciplined for causing or contributing to the situation.
- A witness failed to intervene in a particular situation and does not want to become a target of discipline

The last two conditions can create difficulties for the investigator. Information obtained from such witnesses may place them in a target category, thereby changing the interview to an interrogation. More information is provided about interrogations later in this booklet.

# *Could This Happen at Your Agency?*

## A Study in the Need for Improved Communication Concerning Individuals with Developmental Disabilities. Case #8

In the Matter of Noah Paul

### BACKGROUND

"Noah Paul" was born in 1916. Diagnosed as having a severe Intellectual Disability, Mr. Paul lived in State institutions most of his adult life. In the mid-1980s, he was placed in the family care home of "Mrs. Alex".

Family care is one of New York's oldest community-based care programs for people with developmental disabilities. Families open up their homes and hearts to care for individuals who are unable to live independently, but do not require the structure or supervision offered in community residences or intermediate care facilities. Family care homes are sponsored by state-operated or licensed agencies whose staff train the family care provider, and visit the home monthly to assess conditions, monitor client needs, and offer the provider additional training or assistance, if needed. Staff of the sponsoring agency also provide case management and advocacy services on behalf of the family care client.

Mrs. Alex's home was sponsored by the developmental center in which Mr. Paul had resided for decades. Mr. Paul moved into Mrs. Alex's home with two other gentlemen with a developmental disability and did well over the next ten years. He attended a day program on a regular basis and enjoyed its routine activities as well as community outings and vacations.

The most recent psychological assessment indicated that Mr. Paul was a friendly, good-humored individual with the ability to speak in one or two word phrases. It was noted that he tried hard to please others responded well to positive reinforcement such as praise, and encouragement.

According to the psychological assessment and Mrs. Alex, Mr. Paul was independent in most self-care tasks. However, he needed assistance with personal hygiene and meal time, as he had a tendency to eat too fast. Although ambulatory, Mr. Paul required supervision to travel in his neighborhood and to his day program.

Overall, the psychological assessment indicated Mr. Paul's cognitive abilities had been regressing since his last complete triennial assessment due to the aging process. (Mr. Paul was 77 years old at the time of this most recent assessment.)

Despite his advanced years, Mr. Paul was in good health and suffered no major life-threatening illnesses during his years in family care. During his most recent annual physical examination, it was discovered that Mr. Paul had an elevated prostate-specific antigen, indicative of possible prostate cancer. Appropriate consents were secured to perform a biopsy and further treatment if cancer was diagnosed.

## HOSPITAL ADMISSION

While preoperative tests (e.g., blood work, EKG, etc.) were being scheduled on an outpatient basis, Mrs. Alex noticed that Mr. Paul's right leg was swollen and red. She took Mr. Paul to the emergency room of a local hospital where he was examined and diagnosed with having an infection. Mr. Paul had picked at his leg and developed a sore. He was placed on oral antibiotics, and Mrs. Alex was advised to bring Mr. Paul back to the hospital if the swelling and redness did not resolve or worsened. Several days later she escorted Mr. Paul back to the emergency room as the swelling and redness had worsened, and he now had several leg ulcers. Mr. Paul was admitted to the hospital with a diagnosis of cellulitis of the right leg. He was started on intravenous antibiotics and skin soaks.

According to Mrs. Alex, at the time of Mr. Paul's admission she informed nursing staff of his need for supervision while eating as he had a tendency to eat too fast. There is no record of this conversation in the hospital's nursing notes. A note entered by a nutritionist on Mr. Paul's second day in the hospital indicated that he needed "assistance with feeding," but reportedly, this indicated that his food should be cut for him, not that he should be supervised while eating.

It was decided that while Mr. Paul was hospitalized, he would undergo the remaining preoperative tests and the planned prostate biopsy. However, after the noon meal was served on his third hospital day, a nurse's aide found Mr. Paul in bed unresponsive with no vital signs. A code was called and the responding team found that Mr. Paul's oral cavity was full of food.

Mr. Paul was successfully resuscitated and transferred to the Intensive Care Unit where it was determined that he choked on the food.. He was placed on a respirator and treated for aspiration pneumonia. He also developed congestive heart failure. Mr. Paul's sister was consulted. He was placed on a Do Not Resuscitate status with his sister’s consent. Mr. Paul passed away.

# LESSONS LEARNED

Mr. Paul's death was directly related to a protocol which either his caretaker did not adequately communicate to hospital personnel, or hospital staff did not sufficiently appreciate. While Mr. Paul did not have a history of choking, his eating habits required reminders to slow down. His tendency to eat at a fast rate put him at risk for choking. His caretaker claimed she communicated these facts to hospital personnel. Direct support professionals are responsible for providing 24 hour-a-day long-term care for the people they support. These professionals know the individuals in their care far more intimately than hospital staff occasionally entrusted with the well-being of individuals for a brief period of time and a very specific purpose.

How does one ensure that hospital staff is sufficiently aware of the total needs of an individual entrusted to their care? How does one ensure that those special needs are appropriately attended to by hospital staff? And what does one do, if they are not?

In Mr. Paul's case, his caretaker of ten years reportedly told hospital staff about his supervision requirements regarding meals. She also informed staff of the agency which sponsored her home about Mr. Paul's hospitalization. Although she received reports on Mr. Paul's medical status, and relayed the information to her sponsoring agency, she did not assess whether Mr. Paul's need for supervision while eating was appropriately addressed, nor did staff of the sponsoring agency.

In response to Mr. Paul's unfortunate death, the developmental center sponsoring Mrs. Alex's family care home (and more than 70 other family care homes serving nearly 140 clients) put a process in place to assure answers to the above questions - questions which all agencies face when their clients are hospitalized or temporarily in another's care.

## Protocols Put in Place

- A special form, or profile, is completed on each client living in family care highlighting the individual's unique needs and special considerations in such areas as activities of daily living, mobility/ambulation, adaptive equipment, known allergies, behavioral issues, etc.
- Should the individual require hospitalization, a copy of the profile will be given to the hospital at the time of admission, and staff of the developmental center will be alerted to the hospitalization.
- A staff member from the developmental center's medical service will then visit the individual in the hospital to assess the overall care and attentiveness to special needs and, if needed, initiate discussions with hospital staff as to what steps will be taken to ensure special needs are met, including the assignment of one-on-one staff. The developmental center's hospital liaison staff member will maintain ongoing contact with the hospital during the course of the admission, and the developmental center's chief medical officer can be called upon if additional advocacy efforts with the hospital are indicated.

These protocols are worthy of consideration by all agencies. The developmental center sponsoring Mrs. Alex's family care home had these procedures in place for the community-based group homes and intermediate care facilities it developed in the last 20 years. It had not, however, applied the protocols to the family care modality, which has existed in New York State since the 1930s. This in itself is a lesson that care agencies continually revisit and review how well they communicate with hospitals and advocate on behalf of individuals entrusted to another party's care.



Consumer Witness: Often a consumer will be the only available eyewitness in a case where an employee's actions may have caused the situation. The investigators should become informed of the individual's communication skills. Ideally, a licensed psychologist or psychiatrist will perform the evaluation, especially if sworn testimony is needed.

Like any other potential witness, a consumer should be separated from others who were involved in or observed the situation. The consumer should be sequestered with a staff person he/she trusts, in a place where he/she will comfortable. This staff person is not to discuss with the situation with anyone.

## Key Consideration

Do not overlook people who are non-verbal, whether witnesses or victims, as a source of information. People may posses many communication skills including signing, using a communication board etc. Whether the investigator or another person does the questioning, the investigator should be present to guide the questioning.

It may be prudent to videotape interviews. If this is impractical, the interviewer should write or dictate a complete set of notes to document what he was learned from the witness. For example, a statement that the accused employee has been "out to get me" would require corroboration before being accepted as fact. The investigator is not to attempt to have an individual sign a statement if he/she cannot comprehend the contents of the statement.

Often a consumer will not know the investigator and it may be necessary to enlist the aid of someone the consumer knows and trusts. This person, who may be a clinician or other staff person, must understand thoroughly the need for confidentiality.

Clinical and other Staff Witnesses: Promptly after interviewing a consumer, the investigator should review his/her clinical records and speak with the clinical staff responsible for implementation of his/her service plan. Areas that the investigator should explore these clinical and program staff includes:

- ☑ Factors that might impede the individual's ability to communicate and perceive the events that occurred, for example, processing time.
- ☑ The consumer's relationship with his/her peers as well as staff members. Of specific concern are interactions with the person or persons who are or may become the target of disciplinary action.
- ☑ Has the consumer previously complained about care or treatment received? Were these complaints investigated? What were the results?

*It should be noted that the investigator should obtain assistance from an "objective" or neutral interpreter when interviewing any person who does not speak read or write English or has a hearing impairment.*

Supervisory Witnesses: Investigators should talk with supervisors in order to record any information that the supervisor may have about the ungovernable incident. It is also important to become acquainted with the facts and circumstances of the staff's reliability and credibility. The investigator should advise the supervisor that the discussion's primary purpose is to gather facts regarding a situation, not to make judgment about the staff's general performance.

**The subsequent supervisory discussion is to cover the following:**

- A supervisor's general impression of an employee witness, including overall work performance, reliability and relationships with coworkers.
- An employee's specific responsibilities, job description and training record
- Relationships between supervisor and staff
- An employee's relationship with the individuals served and/or other staff involved in the ungovernable incident, including any indication of hostility or bad feelings among them.
- Any previous oral or written counseling delivered by the supervisor to staff and any prior disciplinary action
- A supervisor's assessment about an employee's general reliability and credibility

A supervisor who is close to his/her staff may find it extremely difficult to accept the possibility that a staff member has engaged in such misconduct. Consequently, his or her attitude toward the investigator could vary from full cooperation to open resistance. It may be necessary to remind the supervisor of the agency's absolute obligation to protect the welfare of the people they support and to fully investigate any circumstances that may affect their well being. The investigator must stress that his or her responsibility is to gather facts.

## THE INTERROGATION

The interrogation may reach a point where the available evidence leads one to believe that an employee, through his/her actions or failure to act, may be culpable for the incident under review. If the investigator has evidence that casts suspicion on a particular employee, he/she can no longer conduct a simple interview with that employee. Any further discussions between the investigator and the target will occur in a more formalized setting called an interrogation.

## INTERROGATING THE TARGET

An interview becomes an interrogation if the facts indicate that an individual's actions or lack thereof caused the incident. Interrogation procedure must conform to the agency's policies. Consult with the agency's Human Resources personnel to confirm that policies are current and accurate.

# Part III: Written Statement

## The Purpose of the Written Statement

A written statement records a witness's observation and action regarding an ungovernable incident. If taken correctly, the statement accomplishes the following objectives:

- It gives each witness a written format in which to review and affirm the details of his/her verbal account.
- It helps the investigator understand and summarize the facts and circumstances that the witness stated.
- It may be used in a subsequent administrative proceeding to refresh a witness's recollections, establish the circumstances of an investigation, and to prevent a witness from recanting his/her account of the situation.

### PRELIMINARY WRITTEN STATEMENT

Upon learning of an allegation of abuse or other ungovernable incident, one of the manager/administrator's first actions is to obtain written statements from employed witnesses. These preliminary written statements represent the manger's sincere effort to obtain information at the earliest possible time, when employee's memories are at their best. Often the manger/administrator does not attempt to evaluate these preliminary written statements, but collects and gives them to the assigned investigator. The investigator will proceed based in part on the information they contain.

Each state, agency and investigator may use a different format for employee statements. To improve consistency in collecting and presenting information, some agencies have developed standard forms. These forms are an outline for documentation of data (e.g., name, title, shift, date prepared, etc.) and some of the basic examination questions of who, what, when, where, why, and how.

Agencies that use standard forms have indicated their preliminary written statements are far more informative than statements prepared without the benefit of standard forms.

### COMPLETED WRITTEN STATEMENTS

The investigator should write a complete statement of the interview.

#### Techniques Used When Obtaining Written Statements

Investigators can use one of two basic techniques when taking written statements. These differ according to who writes the statement. Either the investigator or the witness will write the statement. During the interview, the investigator should make brief notes on the information the witness discloses. At the conclusion of interview, the investigator will either write completed sentences which will become the witness's statement, or repeat the witness's words to the witness and have him/her write those words in a document and this will become the written statement. In either case, statements should always be written in the witness's words.

### THE USE OF WITNESS'S VOCABULARY

Encourage the witness to talk in his or her own words. This will establish that he/she is familiar with an incident and is not simply responding to questions. Use the witness's grammar and vocabulary. A written statement is more credible, and can be given greater evidentiary weight, if its language and style are those normally used by the person. This will also eliminated grounds for a later claim that he/she did not understand portions of the written statement.

Prepare the statement using the first person pronoun ("I") because it is the witness's first-hand account of an ungovernable incident. Before transcribing the information, the investigator should carefully review with a witness the facts and circumstances the witness has given. This will reduce the need for corrections and changes as the writing proceeds. The statement should respond to the essential questions of who, what, when, where, why and how. It is imperative that the written statement includes all of the details of the witness's recollections.

Under ideal conditions and with unlimited resources, the written statement will be prepared and typed after the interview so that both the interviewee and the investigator can sign it. It should be double-spaced so it will be easy to insert corrections.

## Crucial Tip

When all corrections have been made, ask the witness to sign the last page, noting the date and time of signature. In case of a multi-page document, the witness should sign the bottom of each page. This will establish that there were no page substitutions after the document was signed. The investigator should also sign the statement and include the date and time of his or her signature. Whether the statement was typed or handwritten, the investigator should retain the signed original and give the interviewee a copy on request.

### FORMAT OF THE WRITTEN STATEMENT

Include the following information in the heading:

- ☑ The witness's name and relationship to the agency (e.g., employee, consumer, visitor, etc.)
- ☑ The location, date and time of preparation.
- ☑ For employees, include job, shift work, location and immediate supervisor.
- ☑ For consumer, include residence. Prepare consumer written statements only for consumers who can read and comprehend such statement.
- ☑ For persons who are neither consumer nor staff, include place of employment and relationship, if any to the consumer.

# Part IV: Investigative Report Writing

The Investigative Report is the primary vehicle by which all of the information obtained during the investigation is shared with management and other oversight or regulatory agencies. State and private agencies depend on clear and accurate reports so they can determine an appropriate course of action. To serve that purpose, the investigative reports should do the following:

- ☑ Advise agency management of what actually occurred with respect to the ungovernable incident as best as can be determined through the investigation.
- ☑ Provide management with a bias for informational decisions, both short and long-term, with respect to persons or other factors.
- ☑ Recommend appropriate corrective actions, which would prevent future similar occurrences.

# When Investigations Miss the Basic Facts. Case #19

In the Matter of Alanis Petty

## BACKGROUND

"Alanis Petty" was 35 years old and 7 1/2 months pregnant when she walked from the passenger waiting area of a Long Island railroad station and had lain down in the path of an oncoming train. She died instantly, and the fetus could not be saved. Based on eyewitness accounts, the death was clearly a suicide. Just several hours earlier, Ms. Petty had eloped from the psychiatric unit of a local hospital. Police officers, aware of the elopement and responding to a report of a suicide, identified the body at the train station as Ms. Petty's. The police notified the hospital, which in turn reported the death to appropriate external parties and commenced an investigation into the incident.

The facility's investigation revealed no deficiencies in the care provided to Ms. Petty:

- ☑ She had been admitted to the hospital one week prior with symptoms of depression and suicidal ideation.
- ☑ Within days her mood improved, and she denied thoughts of suicide.
- ☑ On the day of death, she left her unit for an outing with a group of patients and staff. She got on an elevator ahead of the group, and the elevator doors closed quickly, and she absconded.
- ☑ Police were promptly notified of the elopement.

But one question nagged Ms. Petty's family, and Commission staff who reviewed the facility's investigation report: How could a 7 1/2 month pregnant woman get ahead of her group and vanish so quickly?

## ALANIS PETTY

Ms. Petty's first known psychiatric hospitalization occurred when she was in her mid-20s. According to records of that hospitalization, she had a long history of psychiatric difficulties and sporadic outpatient treatment. Her hospitalization was precipitated by poor sleep patterns, anxiety, hyperactivity, pressured thoughts and a total inability to function.

During her nearly three-week hospitalization, Ms. Petty was diagnosed as having bipolar disorder, manic type. She was prescribed Lithium, which had good results. She was discharged to her home, where she lived with her husband and had plans for outpatient care with medication therapy and monitoring.

In the years following, Ms. Petty worked part time, and she and her husband had a son. Her psychiatric difficulties continued, and she was reportedly seen by a number of private physicians who at various times prescribed Lithium, Prozac, Elavil, and Ativan. According to family members, Ms. Petty's manic phases usually occurred in summer months and were manifested in provocative dress and hypersexuality.

During one such episode in the summer before her death, Ms. Petty left her husband and seven-year-old son to live with an ex-boyfriend. By the fall of that year, Ms. Petty was pregnant. She was also the target of her boyfriend's physical abuse. Ms. Petty left his domicile and returned to her husband and son.

Although reconciled with her family, Ms. Petty faced a number of stressors. Deeply religious, Ms. Petty was reportedly ostracized by her church community over her infidelity. She faced legal proceedings involving her boyfriend over paternity and abuse issues. Although reunited with her husband, she carried another man's child and was ambivalent about having the baby.

By the spring, the stressors took their toll. Ms. Petty had difficulty sleeping, felt depressed, overwhelmed, anxious, and suicidal. She went to the hospital seeking psychiatric help.

## MS. PETTY'S LAST HOSPITALIZATION

Upon arrival at the hospital's emergency room, Ms. Petty recounted her past and more recent history including the stressors in her life, her depression, self-denigrating ruminations, and her thoughts of suicide.

Ms. Petty was given diagnoses of R/O depression and R/O bipolar disorder. For the first several days, she was placed on a heightened level of supervision. This was discontinued as Ms. Petty denied suicidal ideation. She did, however, voice concern about being a burden on her family, or spending the rest of her life in an institution. At various points, she seemed sad.

According to the records and commission interviews with staff, considerable attention was given to providing Ms. Petty psychotropic medications, and this issue was discussed between her psychiatrist and OB/GYN physician. Lithium, which had worked well in the past, was considered, but ruled out due to the potential danger to the fetus. Other, less potentially harmful, psychoactive agents were deemed desirable, but Ms. Petty refused them as she was concerned about their impact on her pregnancy.

Ms. Petty reportedly wished that birth could be induced early so she could begin taking psychotropic medications, but this was contraindicated by her physicians.

During her one-week hospitalization, Ms. Petty enjoyed several outings off her locked unit, accompanied by staff and, on the day before her death, her husband. The outings occurred without incident. According to her husband, when she was last with him, Ms. Petty gave no indication or suggestion of what would transpire the next day. While Ms. Petty was allowed off her unit accompanied by family or staff, her psychiatrist did not believe she should be allowed unescorted leaves.

## THE INCIDENT

On the day she died, Ms. Petty woke and participated in the unit's activities. According to staff she was talkative, socialized with peers, and seemed happy. One of the activities that morning was planning and preparing the midday meal. Patients would plan the meal and volunteer to serve in groups; shop for the food, do the cooking, and clean up when the meal was over. Ms. Petty volunteered to go on the shopping expedition and to help in the cleanup after the meal.

Ms. Petty and one other patient were chosen to accompany three staff, (two women and one male staff) to the local supermarket to purchase the meal's ingredients. Careful examination of what next transpired revealed that Ms. Petty did not get ahead or run away from the group. She was left alone while off the locked ward.

In planning the shopping trip, the three staff agreed that the male staff member would take Ms. Petty and the other patient from the second-floor locked ward and wait by the elevator area. In the meantime, one of the female staff went to another unit to pick up a cellular phone required to take on all outings. The other female was going to complete some paperwork. They all agreed to meet by the elevator.

The male staff member accompanying Ms. Petty and the other patient left the locked unit and went to the elevator to wait. When a long period of time had passed and neither of the other two staff showed up, the male staff member told Ms. Petty and the other patient to wait while he went to look for his coworkers.

The male staff person left the two patients by the elevator and proceeded to the unit where the cellular phone was kept. He rang the bell but no one answered. Using his keys, he opened the door and entered the unit to look for his colleague. He estimated that he left the two patients alone at the elevator for mere minutes. He found his colleague. Together, the two staff returned to the elevator area but found only one patient. Ms. Petty was gone. The remaining patient reported that while they were left alone, an elevator came and Ms. Petty boarded it, and left.

The two staff and the patient walked to the first floor to look for Ms. Petty, but did not find her. They returned to the unit and reported what occurred, which triggered a building search with no results. Police were notified. Several hours later, and 15 miles away, Ms. Petty was struck by the train.

## DISCUSSION

The incidents the day of Ms. Petty's death were well documented in staff statements given to the facility immediately after the incident. However, these statements were not considered by the facility in its review until the Commission reaffirmed the statements in subsequent interviews, and confronted facility administrators with the evidence. While the facility in its internal review focused on the complexities of Ms. Petty's clinical (i.e., psychiatric, medication, and OB-GYN) care and concluded that all was appropriate (a conclusion supported by the Commission) it failed to examine more practical matters. The mechanics of her escape, the adequacy of her supervision, and the implications concerning supervision of patients in the future. Without addressing these issues, it was concluded that Ms. Petty eloped when she got ahead of her group, but received adequate care.

Upon receipt of the Commission's findings, the facility re-examined the incidents surrounding Ms. Petty's elopement and death. It agreed that material aspects concerning Ms. Petty's elopement and death were not carefully examined, and in the future, its Quality Assurance Committee would explore all aspects of ungovernable incidents.

Additionally, while acknowledging that staff erred in judgment by leaving Ms. Petty alone, the facility indicated it had no policies to guide staff conduct in such matters. As such, it revised its policies to ensure that physicians approving patient participation in off-ward activities also indicate the level of supervision the patient requires while off-ward. The facility also revised its policies to ensure that all equipment and staff required for an outing be assembled on the unit before patients leave on the outing.

## LESSONS LEARNED

All ungovernable incidents offer potential opportunities for learning and preventing the occurrence of similar incidents. In Ms. Petty's case, the facility appropriately looked at critical clinical issues. Her suicide potential, her medication management, her recent behavior and mental status, and concluded her death was unpredictable and suggested no quality of care issues. Blinded by these heady issues, however, the facility failed to examine more practical factors. How did Ms. Petty leave the facility? Why was she left alone? What does this mean about supervision of patients on future outings? The facility's eyes were opened to these realities only after an external party intervened. If an outside source had not analyzed the situation, staff would not have received the policy guidance they needed on future outings, and patients would have been left vulnerable.

All facility administrators and staff should ask themselves to what extent their quality assurance mechanisms are eye-opening vehicles, or canes to assist in navigating a half-seen world.



## Types of Reports

Investigative findings will generally be presented as follows:

Oral Report: These reports appear through-out the investigation. The investigator uses them to keep the Director or designee up-to-date on any findings that require a management decisions or action. Example:

- Identification of any condition adversely affecting the welfare or safety of individuals served.
- Identification of a person or persons strongly suspected of abuse or involvement in an ungovernable incident.

Interim Written Status Report: These occur on an as needed basis. During the course of an extensive investigation, it is advisable to commit the findings to writing on a regular basis such as weekly or bimonthly. Interim reports serve three purposes:

- They provide agency management with chronological updates on the investigation progress.
- They offer the investigator a solid foundation on which to base the final written report.
- They can also make it easier for agencies to meet certain regulatory requirements. For example, some states require agencies to provide them with monthly reports on the status/results of investigations into serious reportable incidents or allegations of abuse.

Final Written Report: The final written report must serve as the investigator's formal record of his/her methodology, findings, conclusions and recommendations. As such, it must be a comprehensive history of the completed investigation.

## Format of a Written Investigation Report

While there is no universal design for investigation report, the following format is suggested for a final investigation report.

Issues/Incident/Allegation: This section should include a brief statement of the incident under investigation and a summary of the factor(s) that may have caused or contributed to it.

Background History: In this section, give the description and general background of each consumer, staff person, or other principle involved in the investigation. Include enough information to give a reader who is unfamiliar with the individuals a thumbnail sketch of each one.

Investigative Process Protocol: The investigator will use this section to describe the investigation process followed, and list the name and title of every person interviewed/interrogated and the dates of all discussions. The investigator will also list any records or documents reviewed, and any physical evidence examined.

Factual Findings: The investigator will provide a chronological summary of all facts discovered during the course of the investigation. This section represents the "meat" of the investigation and is often written in a brief numbered or bulleted fashion. Investigators indicate this is the easiest and most organized way to write, and readers find it easier to follow than lengthy paragraphs.

Conclusions: Investigators should base their conclusions on the Factual Findings section of the report.

The ideal report: The ideal report will answer any outstanding questions, particularly about the "who, what, when, how and why" of the incident.

Recommendations: Any recommendation should be presented in a broad manner. For example, "Seek appropriate administrative action for the infraction committed by employee Johnson," is better than "employee Johnson should be fired." As another example, "Agency should change bed check frequency from current 60 minute to 30 minute intervals," is usually not as suitable as, "Agency should review their policy regarding the maximum time intervals between bed checks."

## Maintenance of Investigation Report

It is important to remember that confidentiality is critical in each investigation. All materials related to an investigation report (witnesses' statements, physical evidence, pictures and diagrams, etc.) are to be maintained in a private and secure place. A locked file cabinet would meet this requirement. Please refer to your state's requirements for the length of time and any other special provisions regarding the retentions of investigation reports and related confidential documents.

# *Could This Happen at Your Agency?*

## A Recreational Accident. Case #31

In the Matter of Lester Banks

### THE INCIDENT

On a rainy morning, the last Saturday of summer, Frank Orvis was driving to the group home where he worked. As he turned onto the group home's street on the final leg of his journey, he pulled behind a 15-ton delivery truck. His dashboard clock indicated it was 8:30.

Mr. Orvis followed the truck, going the posted 30 MPH limit. As the vehicles neared the group home, Mr. Orvis noticed a person in a black hooded sweatshirt on a bicycle in the residence's driveway. The bicyclist was riding down the 100-yard driveway, and pedaled directly into the side of the oncoming truck. The truck was unable to stop in time to avert collision.

The bicyclist, Lester Banks, was one of the group home's residents. He suffered massive head trauma in the accident and died two days later in a local hospital. The truck driver, who had a spotless driving record, was not cited for any violations of the Vehicle and Traffic Law in what proved to be a truly tragic accident.

### BACKGROUND

Lester Banks was a 24 year-old man who was diagnosed with a mild intellectual disability. Since the age of eight, he had lived in a variety of out-of-home placements, including foster care, psychiatric hospitals and group homes, due to his explosive and impulsive behaviors. His mother, who also had a developmental disability, was unable to manage his behaviors. His behaviors included fire-setting, running away, threats of suicide, and violent temper tantrums. Mr. Banks was also diagnosed with atypical psychosis, conduct disorder and adjustment disorder. Medically, Mr. Banks enjoyed relatively good health. He did, however, have a profound hearing loss in one ear and required glasses to correct his vision.

When he was 19, Mr. Banks was placed in an out-of-state residential program. At the time of placement, Mr. Banks displayed daily episodes of aggression, property destruction, and other anti-social behaviors. Within the next four years, these behaviors dissipated, and Mr. Banks, was referred to a group home on Long Island. The group home served seven individuals.

According to the home's records, Mr. Banks was a high-functioning individual. He was independent in most areas of self care, had a great sense of humor, and tended to socialize more with staff than his fellow residents. He enjoyed riding a mountain bike which he owned, writing letters to friends, and keeping a journal of his daily activities and desires. Journal entries detailed his fondness for staff, as well as his life goals: living in his own apartment, learning to drive a car and getting a "bigger and better job."

Most telling about Mr. Banks were comments offered by staff during interviews following his fatal accident. More than one staff person said they were not sure whether Mr. Banks was a staff person or a resident when they first met him. One staff member described him as a "peer," another described his interactions with Mr. Banks as "more of a friendship than a staff/resident relationship." Another, who was his primary counselor in the residence, said Mr. Banks was "bright and aware that he was different from his roommates...that's why it was difficult for him to receive help from professionals...he thought he was just like staff, and staff often treated him like a staff member."

While in the group home, Mr. Banks did not display the aggressive behaviors which had marked his earlier years. He was employed in a supported-work program at a local department store. In addition to fostering his vocational goals, his most recent service plan focused on skills that would advance his quest for more independent living: banking, cooking, and basic academic and travel skills.

Although he was very independent and had seemingly conquered his earlier challenges to self-regulate when agitated, Mr. Banks tended to show poor safety awareness. He would periodically leave the group home without telling staff, or while with a group of residents out on shopping trips, leave the group and wander off on his own. On one occasion, while waiting alone in the house van for a staff person, who had left the keys in the ignition, Mr. Banks started the vehicle, threw it in gear, and attempted to drive himself. Driving erratically, Mr. Banks came to rest on the front lawn of the residence. No one was injured.

Just months before his death, Mr. Banks left the house without permission and rode his bike. He was not wearing a helmet. He had travelled several miles on heavily trafficked streets to a bank in town. He withdrew some money and returned home.

## INVESTIGATION FINDINGS

Like the police investigation into Mr. Banks' fatal accident which found no wrong-doing on the part of the truck driver, administrative investigations cleared group home staff on duty that morning of any culpability. The administrative investigations, however, found other problems in the group home's operations which set the stage for the Saturday morning tragedy. These included:

- Unclear expectations as to the conditions under which Mr. Banks could ride his bike
- A lack of clear policy and procedure on the use of recreational vehicles, such as bikes and skateboards
- The absence of an up-to-date comprehensive service plan for Mr. Banks, which would inform all staff of his need for supervision
- The failure to formally communicate critical incidents involving Mr. Banks for review, and possible modifications of service delivery plans.

In the absence of formal communication channels among staff (via service planning and incident reporting processes), residence staff relied heavily on "word-of-mouth" as a primary communications channel. As an independent and high-functioning individual, Mr. Banks was often the source of information about incidents involving him.
Interviews with staff after the accident revealed that Mr. Banks' bike riding abilities were questionable, and that staff had differing understandings of what level of supervision he required while riding.

While some staff believed Mr. Banks was an able bicyclist, others stated he was "spastic" and "unstable" on the bike.

Following the incident wherein Mr. Banks rode to town unbeknownst to staff and not wearing his helmet, a staff member counseled him on the dangers of his actions. This staff person also wrote in Mr. Banks' program book that Mr. Banks "is not to ride his bike unless a staff member is present...He must wear a helmet at all times...The problem being, in the past he has taken his bike and left home without permission...This is a potentially dangerous situation."

This incident was not formally reported and reviewed by the agency, and Mr. Banks' service plan was not updated to reflect his need of supervision with regard to bike riding.

Immediately following the bicycling-to-town incident, Mr. Banks' bicycle was put in a utility room and a lock was placed on it, thus limiting his unfettered access to the bike. However, the lock was needed for another purpose in the home and was removed, thus allowing Mr. Banks free access to his bike.

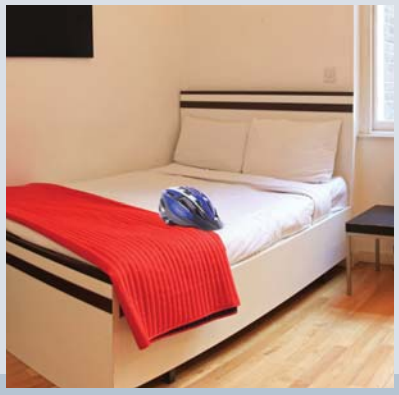
In the subsequent weeks, Mr. Banks routinely used his bike to ride up and down the home's long driveway as a form of exercise. All staff was aware of this, as Mr. Banks would post this early morning routine on his daily calendar of activities.

However, staff was not consistent in ensuring that Mr. Banks was supervised during this activity. Some believed Mr. Banks did not require supervision while riding in the driveway. Others were convinced it was OK by Mr. Banks himself who would report "I'm just going to get the newspaper at the end of the driveway."

During this early morning routine, Mr. Banks was periodically seen not wearing his helmet. When this was observed and Mr. Banks was reminded to put on his helmet, he would sometimes comply, or put his bike away, as he disliked wearing the helmet.

On the morning of his fatal accident, Mr. Banks told staff he was going to step outside for a "breath of fresh air." Staff was not aware that once outside, he began riding his bike. They also were not aware he was not wearing his helmet, which was found in his room after the accident.

It was estimated that Mr. Banks was outside for no more than 15 minutes when the accident occurred.



# LESSONS LEARNED

Questions linger about the more immediate factors contributing to Mr. Banks' accident. How able a rider was he? Did he see the truck coming? Was his impaired vision further compromised by rain on his glasses, or the hood of the sweatshirt he was wearing? Given his hearing loss, did the hood of the sweatshirt further impair his hearing? Could he hear the truck's horn? Was his judgment poor? Did he overestimate his, or the truck's ability to stop on rain-slicked pavement? Did he not notice anything, perhaps engrossed in thoughts of what the rest of Saturday held in store?

Some questions had haunting answers. If Mr. Banks had received the level of supervision one staff had prophetically indicated was needed, perhaps the accident could have been avoided. Had Mr. Banks worn his helmet, perhaps his injuries would have been less severe and he may have survived.

Honoring and fostering the interests of individuals supported are important roles played by service providers. There are also risks that should be weighed as appropriate or not. If a risk is appropriate for a specific individual, steps must be taken to ensure safety. Sometimes the risks associated with some of these interests are readily apparent, for example, risks associated with learning cooking skills, independent travel skills, or vocational skills in industrial settings.

Risks associated with leisure time or recreational interests, however, are often less obvious. It is crucial that staff and supervisors do not take an individual's independent skills for granted.

Lester Banks' death taught his agency that it did not pay sufficient attention to the recreational interests of clients in a way that would promote one's abilities and at the same time safeguard against harm. Had Mr. Banks engaged in serious maladaptive behavior, such as fire setting, assault, etc., as he had done in the past, it would have been amply documented, reviewed, and communicated to all staff. But, when he engaged in a seemingly healthy recreational activity but did so in an unsafe manner, it was not well documented, or communicated to all staff.

In response, the agency instituted policy reforms which are worthy of consideration by all agencies. Among the questions addressed by the agency which other providers should probe are:

- ☑ Does the agency assess and document individuals' safety awareness in regard to leisure activities such as bike riding, swimming, skate boarding and sports which may carry a risk of harm?
- ☑ Are levels of supervision for certain recreational activities agreed upon based on assessments of individuals' skills?
- ☑ Is there a universal understanding of what safety or protective equipment is required for different types of activities (e.g., helmets for bicycling, protective pads for skateboarding and ice skating, etc.)?
- ☑ Are recreational equipment and protective devices properly maintained and in good working order?
- ☑ Is equipment stored in such a way that access can be controlled, if necessary and proper use also promoted?

# Part V: Liability Concerns

Even an agency that meets the highest standards in conducting its investigations may find itself defending against a legal action related to an ungovernable incident. The plaintiff who files such suits usually claim the agency failed to meet a certain standard or fulfill a duty. There are common mistakes that providers make when dealing with incidents. These behaviors consistently pop up to support a plaintiff's arguments, and help them win lawsuits against provider agencies.

## Not Reporting in a Timely Fashion

Any incident or situation that endangers, or has the potential to endanger, a person's well-being or safety must be reported to the program administrator immediately upon discovery. All staff is responsible for doing so. With prompt notice, the governing body, executives, administrators, medical staff and supervisors can take corrective measures and prevent recurrence. Neglect is often charged for failure to act quickly. It's crucial that staff can demonstrate they reported any incident promptly, and that staff administrators, or other appropriate authority took immediate corrective action. The health, welfare and safety of people served are always top priority.

## Going Against Written Policies and Procedures

Policies and procedures should be reviewed annually by all staff. Agencies have written plans and/ or procedures on how to care for consumers, investigate incidents, and handle problem employees, etc. These written plans and procedures are important because one's actions will be reviewed based on them. If the agency's written procedure calls for staff to contact a doctor in a particular instance and a staff member contacted the nurse, a procedure has been violated. If the individual dies in the hands of the nurse, the plaintiff will allege it was because the agency did not contact a doctor, and he/she will have those polices and procedures as proof of neglect.

## Admitting to Liability in an Incident Report

It is understandable when a staff member feels guilty or remorseful if an individual in his/her care is injured. For example, when someone gets injured an employee may say "Oh it is my fault, I should have/could have done something differently." In context of a lawsuit, these statements will be considered admission of guilt and could be used to develop theories of liability against an agency whether it was really at fault or not. While it is important to decipher what caused the incident, it is not necessary to admit liability for it. There is a distinct legal difference between being sensitive to a person's injury and admitting to negligent acts. Encourage accurate reporting of the facts. Only after the investigation will all the facts be examined and a corrective action determined.

## Manipulating, Fixing or Adding to Existing Records

Rule of thumb: do not alter records. For example, an employee forgets to fill something in and adds it after the incident, or someone adds a fact to make the file clearer. Unfortunately, any file that has been manipulated is rendered useless by the courts. The perception is that any changes could be a cover-up for a wrongdoing. Most attorneys recommend that records not be touched at all. Existing and untouched documents are most effective for minimizing liability.

IF CHANGES MUST BE MADE TO A FILE AFTER AN INCIDENT, NEVER DELETE OR TAMPER WITH THE ORIGINAL INFORMATION. MAKE ADDITIONS OR CORRECTIONS ON A SEPARATE PIECE OF PAPER. THEY SHOULD BE HIGHLIGHTED AS AMENDMENTS, DATED AND SIGNED.

## Formulating Opinions without all the Facts

The main purpose of an incident review and investigation is to gather facts. The goal is to identify the cause of the incident so management can take steps toward prevention. The people closest to the incident should do the initial documentation. They must record the facts as quickly and clearly as possible.

### Failing to Investigate

Not investigating reported problems is a clear path to allegations of negligence. If an individual is found with bruises on repeated occasions and an investigation is not done and documented, this could easily be cause for claim of negligence. Good judgment and complete investigations of an incident are required to address incidents in a timely manner. No incident is too small to investigate. An investigation of minor incidents can prevent larger ones.

Researching of conclusions and forming opinions however, should be reserved for supervisors and trained investigators. Again it goes back to the strength of documentation. Suppose, for example, one of your consumers had a history of self-injury, and injured himself. A poorly trained investigator might assume that a staff member abused the individual. You would not want that inaccurate report to become a matter of record that would most certainly be used against you in a court of law.

# Summary

The task of providing services to people with disabilities is a very serious and difficult assignment. There are oversight agencies whose laws, regulations and standards impose demand for compliance on providers at every twist and turn. It is every provider's duty to deliver the highest standards of care. Despite all of the rules, regulations, policies, procedures, staff orientation efforts and in-service training intended to protect staff and people supported, ungovernable incidents can occur.

Every agency has a responsibility to learn from these incidents in order to prevent similar occurrences in the future. The best known way to meet that obligation is to understand the conditions that spawned the incident. The investigation process exposes that information, and the corrective actions that will promote prevention. This booklet was prepared to assist in conducting successful investigations that reveal both causes and deterrents.

# Notes

# Notes

# About Irwin Siegel Agency, Inc.

Irwin Siegel Agency, Inc. (ISA) is a leading insurance and risk management organization serving the Human Service field and insures service providers in 50 states and the District of Columbia. ISA continues to set the standards of quality, innovation and value when it comes to developing new programs that meet the dynamic nature of the Human Services field.

Our Risk Management Division continues to develop specialized resources to assist our customers in their endeavors to effectively manage risk and control losses. In conjunction with Chartis, we offer loss control training seminars and teleconferences that address important field related issues. We have also accrued an inclusive video lending library containing information on field related programs, including but not limited to; vehicle safety, workforce issues, stress management, medication administration, fire safety, self-determination, and working with challenging behaviors.

Not only does our Claim Department offer a caring and experienced staff, but also the claims offices with which we work are staffed with designated adjusters who have extensive training in the Human Service field and who are familiar with the unique coverage's and nuances of our policies. To supplement our adjuster base, we have a network of distinguished legal professionals who bring years of successful experience to the table, particularly with regard to those legal matters indigenous to the human service field.

## ARE YOU COVERED?

Some relevant products available through ISA include:

- Workers' Compensation Insurance
- Volunteer Accident Insurance
- Directors & Officers Liability Insurance
- HIPAA Coverage (Health Insurance Portability & Accountability Act)
- Employment Practices Liability Insurance

*Availability may vary by state*

# Resources

## SAMPLE OF AVAILABLE RESOURCES

### Printed Publications

- Workers' Compensation: Loss Control Program Manual
- Compliance and Ethics: A Guide to the Development of a Compliance Program
- Safety Committee: A Guide to the Development and Implementation of an Effective Safety Committee

### Flyers & Bulletins

- Preventing Slips, Trips, and Falls
- First Aid Kit: Requirements and Recommendations
- Keep Agency Data Safe

### Video Lending Library

- The Basics of Safe Lifting
- Safety Matters
- Safety Orientation and Accident Prevention

### Partner Programs

- Online Training
- Background Checks and Screening Services
- Vehicle Incident Monitoring

### And much more...

Contact our Risk Management Division
for additional resources and partner services

1.800.622.8272
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*10/2012*

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