Sexuality and Developmental Disabilities: An Investigation of Sexual Incidents at Bernard Fineson Developmental Center

Clarence J. Sundram
CHAIRMAN

William P. Benjamin
Elizabeth W. Stack
COMMISSIONERS

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Preface

The fabric of this report is primarily monochromatic. It deals with one primary issue—the failure of the Bernard Fineson Developmental Center to protect its residents from harm. Specifically, this report describes the lack of supervision of residents which allowed numerous serious incidents to occur, and the failure of the incident reporting and review process to enhance the safety of residents by reducing the likelihood that the same or similar incidents will recur. Many incidents described herein were sexual: some involved incidents in which residents were forced into unwanted sexual activity by other residents; other incidents involved sexual activity in which one partner, according to the facility's own determination, was too mentally impaired to be able to give consent to the activity.

The case examples cited in this report portray a system which failed to comply with both the letter of the law (MHL §29.29) and the spirit of the Office of Mental Retardation and Developmental Disabilities' (OMRDD) incident reporting regulations (14 NYCRR Part 624) and in so doing left vulnerable residents unprotected, and kept from administrators, clinicians and direct care staff information essential to the responsible fulfillment of their duties.

The deficiencies were apparent over all four mandated incident management functions—the reporting, investigation and review of incidents and the implementation of corrective actions.

Specifically:

- Some serious incidents of forcible sexual assaults, attempted rape and sodomy were not reported either internally or externally to oversight and law enforcement agencies.
- Of those incidents which were reported, several serious ones were misclassified which lessened the scrutiny they received.
- Investigations of incidents were often cursory and closed prematurely, leaving unanswered questions and/or with conclusions not supported in fact.
- The Chair of the Incident Review Committee who reviewed all investigations, and the Committee as a body failed to question the adequacy of the investigations.
- There was no system in place to ensure the implementation of effective corrective actions.

There is, however, one thread in the fabric of this report which is a different color and it focuses the reader on questions regarding sexual activity among persons with severe or profound mental retardation.

Because the bulk of this report describes the mishandling of several tragic and shocking incidents, the reader might be tempted to view the consent issue only as a flashy distraction and dismiss it without consideration. Alternately, if the reader follows only this thread and loses sight of its place in the "whole cloth" of this investigation, (s)he may fail to recognize, as some facility staff did, the uncontestable obligation of the facility to keep residents safe.

Having fixed the consent issue in its proper context *vis a vis* this report, the Commission recognizes the need for a discussion of the issue of capacity to consent to sexual activity among severely mentally retarded persons. (See pp. 22-26)

It is evident to the Commission that, although OMRDD regulations are clear in defining as "sexual abuse" all sexual activity between clients and others, or among clients unless all involved clients are "consenting adults" (14 NYCRR Part 624.2(b)(2)), many staff appear not to understand the concept of

capacity to consent. Some facility administrators apparently have not resolved their own ambivalent feelings about physically non-coercive sexual activity involving persons who do not have the capacity to consent. Their ambivalence sends confusing messages to other staff about how they should respond to such sexual incidents among residents.

As a result of this confusion, lack of understanding or simply disagreement with the plain duty to report and investigate incidents which constitute "sexual abuse" as defined in the regulations, these duties were often not carried out by staff and administrators.

This report illustrates how the protections intended to be provided to residents of mental retardation facilities by state law and regulations are eviscerated when these duties are disregarded.

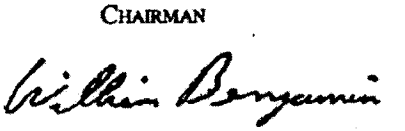
The Commission notes that in response to this investigation, the Commissioner of OMRDD has promulgated draft guidelines to assist facilities in clearly understanding their obligations to promote the ability of people in their custody to live as normal lives as possible, while at the same time protecting vulnerable people from harm. These draft guidelines forthrightly address the difficult and complex issues of determining when people with developmental disabilities lack the capacity to consent, thus triggering the protective role of the provider. They further assist providers in carrying out their obligations to provide care, habilitation, training and support services to enhance the autonomy and decision-making abilities of people with developmental disabilities.

The Commission recognizes that each of the issues addressed by OMRDD's draft guidelines may be disputed by some providers and advocates. It is precisely because of such anticipated controversy that, for years, there has been little official guidance to staff and programs on how to deal with seemingly conflicting values, sometimes with the types of consequences described in this report.

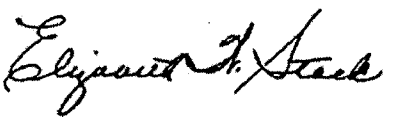
We commend the Commissioner of OMRDD for her willingness to bring this issue out into the open and to try to find the right balance between respecting rights to privacy and self-determination and clearly protecting vulnerable people from harm and exploitation.

The findings and conclusions of this report represent the unanimous opinion of the members of the Commission. A draft of this report was shared with the Office of Mental Retardation and Developmental Disabilities. The actions taken by OMRDD and Bernard Fineson Developmental Center are summarized at the end of the report.

Clarence J. Sundram
CHAIRMAN



William P. Benjamin
COMMISSIONER



Elizabeth W. Stack
COMMISSIONER

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Staff Acknowledgements

Project Director

Betty Jane Chura

Investigators

Gladys DeJesus-Tuccillo
Stephen Hirschhorn
Jerry Montrym
Corinne Romanotto
Pamela Williams

Production

Christine Blackman
Marcus Gigliotti

Background

In response to an allegation by the mother of a mentally retarded adult resident of Bernard Fineson Developmental Center that her son Mark[1] was being sexually victimized by one or more other male residents, the Commission conducted an investigation into this allegation and reviewed, in general, the Corona Unit's[2] handling of the sexual activity of residents on the sixth and seventh floors. These residents are generally the most active and skilled persons living at the site, although the functioning level of residents varies considerably on each floor. This is particularly true of the sixth floor where some residents are diagnosed as mildly retarded and others as profoundly retarded, and where some residents are quite fluent and others are nonverbal.

Staff had been instructed to view sexual activity as a private matter and not to record it in ward logs. CQC staff also learned that 13 of the 24 sexually active residents on the sixth and seventh floor were receiving sexual education or counseling, that condoms were not available because no one was teaching residents how to use them, and that the clinical staff had not determined which residents were capable of consenting to sexual activity and which were not.

At the time of this initial review, January, 1989, the facility was aware that some residents were sexually active with each other and, in one instance known to CQC, with partners in the community. The facility maintained that these sexual experiences were appropriate, for the most part, because those persons involved had developed a relationship or at least did not object to the activity.

Commission staff attempted to ascertain who, if anyone, could have forced himself on Mark. This prompted a more generalized inquiry aimed at determining what staff knew of the residents' activities and what measures were taken by the facility to protect residents from sexual advances. When asked to indicate which residents were sexually active, staff gave widely varying answers to this question. This was explained, at least in part, by a senior facility administrator's remarks that staff had been instructed to view sexual activity as a private matter and not to record it in ward logs. CQC staff also learned that 13 of the 24 sexually active residents on the sixth and seventh floor were receiving sexual education or counseling, that condoms were not available because no one was teaching residents how to use them, and that the clinical staff had not determined which residents were capable of consenting to sexual activity and which were not.

In response to the Commission's concerns that the lack of safeguards to protect vulnerable residents who could not consent to sexual activity and the risks of sex with multiple partners were not being assessed and

[1] All residents' names used in this report are pseudonyms.

[2] Bernard Fineson Developmental Center is located at three sites in Queens, New York. The three sites are the Hillside Unit, the Howard Park Unit and the Corona Unit.

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- ❑ training additional clinicians in the Sexual Awareness Program;
- ❑ increasing the number of residents in sexuality counselling;
- ❑ engaging a trainer from Planned Parenthood to teach condom use; and
- ❑ determining for each of the residents his/her capacity to consent to sexual activity.

A follow-up CQC review in August, 1990 revealed that many of the corrective actions had been implemented. Significantly, all capacity determinations had been made, condom training had been conducted, and sex education and training had been made available to more residents. However, problems surfaced during this and a subsequent review on January 15, 1991 when CQC staff asked for copies of incident reports of incidents of a sexual nature to evaluate how they were being handled. When they were told that there was only one such incident, CQC staff probed further and learned from staff of two other serious incidents discussed later in the report -- one involving Debra Miller and Michael Evans and the second involving six unsupervised residents. The facility's handling of these incidents led Commission staff to undertake on January 30 a review of the incident reporting and review process.

State Law and OMRDD Regulations

A well-functioning incident review system brings to light problems and investigates their causes so that program managers can take effective corrective measures to minimize the risk of recurrence of the same or similar events.

Section 29.29 of Mental Hygiene Law requires the Commissioners of the Offices of Mental Health and Mental Retardation and Developmental Disabilities to ". . .establish policies and uniform procedures for their respective offices for the compilation and analysis of incident reports." The OMRDD incident reporting regulations articulate more fully the responsibility of state-operated and certified programs to implement a system of incident management which ensures the reporting, investigating, reviewing and correcting and monitoring of untoward events. The review of incidents is to be conducted by a standing committee convened regularly for that purpose. The purposes of the incident review system are to "enhance the quality of care provided clients and to ensure that they are free from mental and physical abuse." A well-functioning incident review system brings to light problems and investigates their causes so that program managers can take effective corrective measures to minimize the risk of recurrence of the same or similar events.

The OMRDD regulations define incidents according to their nature and seriousness and establish special reporting procedures for the most serious. For example, all serious reportable incidents and all allegations of client abuse must be reported to the OMRDD immediately by phone or other appropriate method, and a completed Incident Reporting Form must follow within 24 hours. Leaves without consent, serious injuries requiring a hospital or infirmary stay of 24 hours or more, any possible criminal act on the part of a client and any allegation of client abuse are examples of serious reportable incidents. Client abuse includes all sexual activity except between consenting adults. Any allegation of client abuse must also be reported to the Commission on a completed Incident Reporting Form within 72 hours of discovery.

Methods

To ascertain whether incidents were being reported on incident report forms and forwarded from the units to the facility administration, the first and necessary step in the process, Commission staff read the records of approximately 60 percent of the residents of the sixth floor of the Corona Unit, reviewed the ward logs and tracked the untoward events identified in these documents through the incident reporting and review process for the previous six months. These investigative actions, taken over a two day period, revealed that the incident review functions were not implemented as required by OMRDD Regulations, Part 624.

Overall, the incident review system evidenced a failure to appreciate the seriousness of several incidents, leading to non-reporting or misclassification which resulted in circumvention of a rigorous review; substantial inadequacies in the investigation of some incidents and the failure of the Incident Review Committee (IRC) to identify these; and the absence of a mechanism to ensure that corrective actions are implemented and are effective. While these deficiencies were evidenced over a variety of types of incidents, they were particularly noticeable in incidents involving sexual activity among the residents.

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* * * *

The Commission's visits over the preceding 24 months focused, in large part, on the protection of residents not able to consent to sexual activity and encouraged the facility to evaluate the capacity to consent to sexual activity for each resident for whom this was questionable. The treatment teams completed an assessment sheet usually at the time of the individual's annual program review which indicated whether the resident was sexually active, whether this activity was appropriate and whether the person had the capacity to consent.

It is important to note that the OMRDD regulations governing incident reporting (14 NYCRR, Part 624) define sexual abuse, in part, as "any sexual activity between clients and others or among clients... *unless the involved client(s) is a consenting adult.* Sexual abuse includes any touching or fondling of a client directly or through clothing for the arousing or gratifying of sexual desires." The regulations further require that all such allegations are to be reported, investigated, reviewed by the Incident Review Committee and acted upon in an appropriate manner to safeguard the well-being of clients and to bring the matter to closure.

Further, all such allegations must be immediately reported to OMRDD and followed up in writing on Form OMR/147A, Allegation of Client Abuse. They must also be reported to the Commission pursuant to the Mental Hygiene Law (§45.19).

The definition of sexual abuse cited above derives from Penal Law, Article 130 which defines various sex crimes including rape, sexual misconduct, sodomy and sexual abuse. The law specifically notes that *lack of consent* is an element in each of these offenses. It states that a person is deemed *incapable of consent* when he is "less than 17 years old or mentally defective or mentally incapacitated or physically helpless." In defining a person who has a mental defect, the law notes that such a defect or disease renders the person "incapable of appraising the nature of his conduct." It explains this phrase further as requiring "an ability to understand the physiological nature of the sexual act and its consequences and an ability to understand and appreciate how such conduct will be regarded in the framework of the societal environment and taboos to which a person will be exposed. . .." (*People v. Easley*, 42 NY2d 50, 56 (1977))

Thus, by reference to the capacity assessments, one could determine when sexual activity between residents was the choice of two consenting adults and when it constituted "sexual abuse" as defined by OMRDD regulations because one or both of the partners was not capable of consent. According to the then Director of Quality Assurance, individuals were considered sexually active if they *sought out* a sexual partner or if they engaged in sexually self-stimulatory behavior in public settings. Thus, persons who were *only* unwilling or non-objecting partners in sexual incidents were not noted as sexually active.

According to the Director of Quality Assurance, clinicians' reluctance to determine that residents lacked the capacity to consent stemmed from a concern that such a determination would lessen the avenues of sexual expression open to residents so assessed.

In some cases when clinicians were apparently not comfortable in making an absolute determination of capacity, they equivocated, noting that a resident is "not always" capable of giving consent or that the person is capable "with counseling." According to the Director of Quality Assurance, clinicians' reluctance to determine that residents lacked the capacity to consent stemmed from a concern that such a determination would lessen the avenues of sexual expression open to residents so assessed. In response to such concerns, the facility modified the original assessment form several times. The revised form includes more descriptive/narrative information related to the person's decision-making skills, self-awareness, social awareness and self-direction. Among the information included in this assessment is a description of how the person expresses his/her feelings, to what extent the person can discriminate between friendship and intimacy, and whether the person is capable of benefitting from sexuality counseling or education. The assessment concludes with two questions: Does this person demonstrate the ability to consent to sexual activity; and, does this person demonstrate the ability to protect himself/herself against the unwanted sexual advances of others?

This latter question is an attempt to broaden the determinants of consent to allow the treatment team the flexibility to find "consent" in

"non-objection." While well-intentioned, as this report will later detail, the equivocations in the facility's treatment of the issue of consent contributed significantly to a failure of staff to recognize the victimization of vulnerable residents.

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As noted, prompted by these preliminary findings of the January 15 review, which suggested the possibility of systemic and serious incident reporting and investigation failures, four CQC staff visited the facility on January 30 and 31, 1991. The results of this review revealed that some serious or unusual incidents, often involving sexual activity, were not reported as incidents, were inadequately investigated and reviewed, sometimes circumventing the IRC altogether, and corrective actions to ensure that vulnerable residents were protected were consequently not forthcoming. Furthermore, for those incidents which were reviewed by the IRC, there was no mechanism in place to ensure the implementation of corrective actions. The following cases illustrate these points.

Reporting and Classification Deficiencies

THE COMMISSION'S REVIEW REVEALED THAT SEVERAL SERIOUS INCIDENTS WERE NOT REPORTED, EITHER INTERNALLY OR TO THE APPROPRIATE OVERSIGHT AND LAW ENFORCEMENT AGENCIES, AND OTHERS WERE MISCLASSIFIED, SHORT CIRCUITING THE REVIEW PROCESS.

Case #1

On October 19, 1990, Debra Miller and Michael Evans (both in their mid-twenties) left the dining room together after lunch unnoticed by staff. They were found shortly by a safety officer in a stairwell after they inadvertently tripped the intrusion alarm. Debra was naked while Michael was fully clothed. Michael, moderately mentally retarded, verbal, relatively street-wise, and known to be sexually active with several other clients, initially told the safety officer that nothing had happened. During this exchange, he was observed stuffing Debra's panties behind a pipe behind the stairwell door. Program staff examined this area and found many pairs of underwear there (some labeled, some not) belonging to several female residents.

Upon learning of the incident three months after it had occurred, CQC asked the facility to report the incident to the police since, by Bernard Fineson's own determination, Ms. Miller did not have the capacity to consent to sexual activity.

Both Ms. Miller and Mr. Evans were examined by a physician. No semen was found on either of them and Debra evidenced no signs of trauma. At the time of this exam, Michael informed the physician that he had had sexual relations with Debra on that day and often in the past. In response to this admission, Debra, who is profoundly mentally retarded and non-verbal, was seen by a gynecologist. He ran tests for syphilis and gonorrhea, took a pap smear, performed an exam for the presence of sperm, and placed Debra on birth control pills. The test results available three days later showed no sperm, ruled out gonorrhea and syphilis, but chlamydia was suspected. Erythromycin was ordered for Ms. Miller, but no further tests or cultures were ordered to verify or rule out chlamydia.

Upon learning of the incident three months after it had occurred, CQC asked the facility to report the incident to the police since, by Bernard Fineson's own determination, Ms. Miller did not have the capacity to consent to sexual activity. Mental Hygiene Law §7.21(b) charges the facility director with the responsibility to notify the district attorney or other appropriate law enforcement officials as soon as possible, and in any event within three working days, when it appears that a crime may

have been committed. The facility agreed and the police came but would not accept the report.

Commission staff also called the Deputy Commissioner of Quality Assurance for the Office of Mental Retardation and Developmental Disabilities (OMRDD) when they learned that an incident report had been completed and an investigation was begun, but the report was "pulled" before it reached the Incident Review Committee and was not reported to the OMRDD or the Commission. Reportedly the Treatment Team Leader and the Director of Quality Assurance, without reference to the consent capacity of the partners, had jointly decided that since sexual intercourse most likely had not been completed, no sexual abuse had occurred and, hence, no incident. They also reportedly were concerned about violating the residents' privacy.

Reportedly the Treatment Team Leader and the Director of Quality Assurance, without reference to the consent capacity of the partners, had jointly decided that since sexual intercourse most likely had not been completed, no sexual abuse had occurred and, hence, no incident. They also reportedly were concerned about violating the residents' privacy.

At the request of the Commission and of the OMRDD Deputy Commissioner for Quality Assurance, in mid-January 1991, the Facility Director re-opened and completed the investigation herself. This review concluded:

- There was lack of supervision of individuals in the dining room on October 19, 1990, as no one was aware that the two clients in question were missing.
- An OMR 147 incident report should have been completed and the incident should have been reviewed by the IRC. (This was subsequently done on January 17, 1991).
- A special team meeting should have occurred immediately following the initial investigation to discuss Ms. Miller's behavior and the team should have decided whether this incident warranted her being placed on birth control pills. The physician acted independently of the team in ordering birth control pills, and Ms. Miller's correspondent was not notified about the medications, as required, until January 17, 1991.

The Facility Director also concluded that there was no "coverup" of the incident by the actions of the Treatment Team Leader and the Director of Quality Assurance in short circuiting the reporting and investigative process.

The Facility Director noted that confusion over the meaning of capacity to consent to sexual activity contributed to the decision to not treat the situation as an incident. Although she had been determined not capable of giving informed consent to sexual activity because of the severity of her retardation, Ms. Miller was reportedly considered by some staff to be able to protect herself against unwanted sexual advances. It is this mind-set discussed earlier which explains to some degree the failure of the facility to view the incident as sexual abuse or an attempted sexual assault.

The Director's investigation also failed, as did the initial one, to pursue the questions raised by the pile of underwear in the stairwell and Mr. Evans' assertion that he had had sex with Debra in the past. No special precautions were taken to ensure that she and other residents

lacking capacity were protected in situations other than in or en route to the dining room.

Case #2

Similarly, in March 1990 Martha, who is profoundly retarded, non-verbal and, according to the facility, lacks the capacity to consent to sexual activity, was involved in a rape or attempted rape. Martha was heard screaming in her bedroom; staff pushed aside her barricaded bedroom door to find her naked with a naked male resident. Two other male residents looked on. The residents were dispersed and Martha was helped to dress. She was given no medical follow-up, no incident report was filed, no investigation ensued and the police were not called. The unit log for the day noted "no incidents or problems. . . ."

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When CQC investigators read the nursing notes several months after the event and brought the incident to the attention of the Director for Quality Assurance, the facility responded by conducting training on incident reporting policies and procedures. The male residents involved were also counselled.

Case #3

A similar failure to see the seriousness of a sexual incident and to appreciate the perspective of the victims is revealed in the facility's handling of a September 16, 1990 incident. On that date, six residents (4 males, 2 females) were found to have had their pubic hair shaved at the insistence of Michael Evans (who was involved in the sexual incident with Debra). Two of the four men had been involved in the sexual assault of Martha described above. The facility investigated the incident and learned that both of the women involved were coerced. Martha (the victim of the attempted rape) reportedly was held down by one of the male residents while the second resident shaved her pubic area. Christine reported that she was afraid not to cooperate because the day before Michael Evans had hit her in the eye in the presence of two staff. A BFDC psychologist who routinely interviews residents involved in incidents and who interviewed Christine came to the conclusion that she "consented to the shaving" even while acknowledging that the "consent" was forthcoming from fear of further physical attack. The investigator took no action to ascertain whether the blow to Christine's eye had been reported on an incident report and investigated.

When questioned as to why this incident was not considered an assault or sexual abuse and why it was merely classified as a reportable incident, which does not require notification to the OMRDD or to CQC, the Director of Quality Assurance stated that she did not view it as serious, in part, because the actions were more for experimentation than sexual purposes.

When questioned as to why this incident was not considered an assault or sexual abuse and why it was merely classified as a reportable incident, which does not require notification to the OMRDD or to CQC, the Director of Quality Assurance stated that she did not view it as serious, in part, because the actions were more for experimentation than sexual purposes. The Incident Review Committee accepted recommendations for corrective actions discussed later in this report which called for increased supervision of residents.