

# Patient Abuse and Mistreatment in Psychiatric Centers:

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A Policy for Reporting Apparent Crimes To and  
Response By Law Enforcement Agencies

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NYS Commission on



QUALITY  
OF CARE

for the Mentally Disabled

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PROPOSED POLICY FOR REPORTING CRIMES INVOLVING  
PATIENT ABUSE OR MISTREATMENT TO LAW  
ENFORCEMENT AUTHORITIES

Introduction

A recent controversy over the lack of a timely report by a psychiatric center to local law enforcement agencies of an act of sodomy between two male patients has focused attention on the responsibility of a psychiatric center director to report apparently criminal behavior to appropriate law enforcement authorities.

The Governor's Office requested the Commission to study this issue and to recommend any changes in the laws or policies that are necessary or appropriate to fulfill the state's obligation to protect patients in its custody from abuse or mistreatment.\* In responding to this request, the Commission convened a working

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\*The Commission's efforts deal only with conduct that constitutes patient abuse or mistreatment whether committed by employees, fellow patients or others. We recognize that there may be a broader statutory obligation on the part of facility directors to report apparently criminal behavior that is unrelated to patient care, see 1975 Op. Atty. Gen. [Inf.] 210; People v. Klein 96 M. 2d 692, 410 N.Y.S. 2d 12, 15 (Sup. Ct., Suff. Co. 1978), aff'd on other grounds, 76 A.D. 2d 913, 429 N.Y.S. 2d 29 (2d Dept. 1980); see also, OMH Policy Manual §7700, subd. II, para. D [issued 7/16/79]. However, it is beyond the scope of this paper to address the broader issues.

group of individuals representing various facets of the criminal justice and mental health systems (Appendix A is a list of the individuals invited). The purpose of this working group was to assist the Commission in gaining a fuller understanding of the nature and dimension of the problem, and a better appreciation of the perspectives of the various segments of both systems as to what changes in law, policy or practice may be desirable.

In addition to the convening of the work group, the Commission undertook an investigation of the circumstances surrounding the act of sodomy and the lack of timely reporting to law enforcement agencies. The Commission also obtained and analyzed relevant OMH Policy and Procedures, as well as all incident reports of assaults from three psychiatric centers for the month of April 1985. We also reviewed the specific policies at these three facilities dealing with the reporting of possible crimes to law enforcement agencies.

The members of the working group were generous with their time and advice and greatly assisted the Commission in undertaking this effort. While we believe that the analysis and recommendations which follow represent a consensus of opinion of the working group, the Commission takes sole responsibility for the statements herein.

### Statement of the Problem

The Mental Hygiene Law provides that the director of a psychiatric center:

shall have the responsibility of seeing that there is humane treatment of the patients at his facility and shall investigate every case of alleged patient abuse or mistreatment. The director shall notify immediately, and in any event within three working days, the board of visitors of the facility and the mental health information service located in the same judicial department as the hospital, school, or institution of every complaint of patient abuse or mistreatment and shall inform the board and the mental health information service of the results of his investigation. If it appears that a crime may have been committed, the director shall give notice thereof to the district attorney or other appropriate law enforcement official as soon as possible, and in any event within three working days. (MHL section 7.21, subd. (b), emphasis added.)

The Mental Hygiene Law contains no further explanation of how the facility director's obligation to investigate is to be coordinated with an investigation into a possible crime by law enforcement officials, nor does it provide a standard by which a judgment that it "appears" that a crime may have been committed is to be made. Similarly, OMH policy and procedures do not assist in filling the void left by statute by providing guidelines for staff of psychiatric centers in determining when and what to report to law enforcement authorities (see, OMH Policy Manual §§7650, 7700).

In fact, these policies add to the confusion since they contain inexplicable omissions. For example, the policies define "Assaults," which are required to be reported immediately, in terms which are largely consistent with penal law definitions. But this term appears to only include conduct between patients.

"Patient Abuse" appears to cover conduct by staff against patients including physical abuse and sexual activity, but the policy does not require that such conduct be reported to law enforcement agencies. Neither definition specifically includes sex crimes, and thus the policy is silent on the reporting of such crimes to law enforcement agencies.

These factors contribute to the widespread noncompliance with the literal requirements of the law (see, Appendix B - Review of OMH Policies and Practices of Three Psychiatric Centers in Reporting of Assault Incidents, April 1985). This noncompliance results both from a substantive problem of facility directors determining "if it appears that a crime may have been committed," as well as a perceived practical problem of inundating district attorneys and law enforcement officials with a variety of conduct which is, strictly speaking, criminal, yet which is not perceived to be serious or worth prosecutorial resources. It is feared that the routine reporting of all such apparent crimes would result in a lack of police and prosecutorial response to more serious reports which warrant their attention. (See discussion infra, pp. 9-10.)

Some aspects of the legal responsibility to report are apparently clear to facility staff based on a common sense application of the law -- e.g., unambiguous evidence of a serious crime against a patient by a staff person should be reported. Other areas are apparently less clear. Where the conduct involved is less serious (e.g., simple assault), and/or a patient is the actor, facilities seem to have greater difficulty in

determining their legal obligations to report apparent crimes and have less inclination to report. For example, two patients may have been involved in a scuffle and one suffers a bloody nose. The act may be criminal assault or justified self defense. There may be a question of the legal competence of the assailant. Such possibilities present problems to facility directors in discharging their duty to report apparently criminal behavior to law enforcement authorities, at least partly because of confusion as to what role they play in making determinations over criminal responsibility or culpability for the crime, including the mental competence of the actor.

Perhaps the most difficult area for facility directors in carrying out their legal responsibilities to report apparent crimes is in the area of sexual behavior of adult patients. Unlike an assault, where the criminal act exists independent from the question of the criminal responsibility of the individual committing the act, the mental competence of the participants is critical to determining whether sexual conduct between adults constitutes a crime in the first place or is non-criminal consensual behavior.

To some extent at least, each of these situations calls for the application of judgment as to whether a specific set of facts rises to the level of a crime. Where there is a need for such judgment, there is not only room for differences of opinion and differing conclusions but a requirement for a fairly sophisticated knowledge of criminal law, criminal procedure and mental competency. This is particularly true in the environment

of a psychiatric center where the question of competence and mental capacity of the patients, who are either potential defendants in a criminal proceeding, or possible victims or witnesses, is inherently an issue. Determining the functional competence, e.g., to testify, to consent, to accurately report facts, etc., of individuals is among the most difficult and contested questions in both mental health facilities and in the criminal justice system.

As is clear from this statement of the problem, there may be a number of difficult questions to be confronted in determining if a crime has been committed. Indeed, the variety of fact patterns that may be encountered and questions about the competence of assailants, victims and witnesses, where relevant, could prove a veritable minefield, even for a skilled lawyer. At present, facility directors make these determinations about whether it "appears" that a crime may have been committed in the absence of clear guidelines or policy, or readily available legal advice, as best they can, influenced on occasion by the expressed wishes of patient-victims and/or concerns over the clinical condition of patients who may be witnesses, victims or defendants. In the process, they subject themselves to the constant risk of being second-guessed by victims, relatives, mental health professionals, law enforcement agencies, advocates and the media, should they make an erroneous judgment about what is in the patient's best interest or about what ought to have been reported.

The backdrop against which this problem of underreporting of apparent crime to district attorneys and local law enforcement authorities arises bears mentioning. The Commission has detected a strong undercurrent of frustration on the part of mental health professionals with the criminal justice system. A common perception of facility directors, supported to some extent by reports of actual experiences, is that when reports of serious criminal conduct are made to the police, often there is not a sufficiently timely and/or vigorous response in investigating the crime. If the police do conduct an investigation and forward the complaint to the district attorney, the cases are often given a low priority by the district attorney's office and may not be prosecuted altogether because of concerns over the competence and credibility of patient-witnesses or the competence of the patient-defendants. If the district attorney decides to prosecute such a case, frequently a patient-defendant is found unfit to stand trial and returned to the facility, essentially offering the facility no practical change in circumstances as a result of the reporting of the criminal behavior.

In the community of mental health professionals, dramatic instances of failures to prosecute serious crime have been widely disseminated, helping to engender attitudes that have down-played the importance of the statutory duty to report apparent crime.

This backdrop helps to explain, not excuse, the failure to report apparent crimes to appropriate law enforcement authorities.

### Discussion

There is a need for a statewide policy on the reporting of apparent crime that is clear and explicit for facility personnel to understand and apply, and that is sensitive to the need and capability of facility personnel to conduct internal investigations. However, to address the responsibility of facility directors to report apparent crime without concomitantly addressing what happens as a result of such reports is to leave the problem only half solved. Accordingly, the statewide policy should also encourage a close working relationship between the facility director and local law enforcement agencies while recognizing the constitutional and statutory responsibilities of law enforcement officials, and also leaving room for accommodation to the differing criminal justice policies and resource levels of various political subdivisions in which psychiatric centers are located.

It is therefore essential that the statewide policy permit both the mental health and criminal justice systems to discharge their respective legal duties in closer harmony, with a recognition and understanding of the essential differences in the roles of the respective officials.

Currently, under the literal terms of the Mental Hygiene Law, a facility director is given no discretion to decide not to report conduct which appears to be a crime. Such a literal interpretation finds support in an Attorney General's Opinion:

The director must report any evidence of a crime to an appropriate law enforcement official since it is for the law enforcement official to determine whether or not sufficient evidence exists to warrant prosecution or to conduct his own investigation in order to obtain additional evidence. (1975 Op. Att. Gen. [Inf.] 210, 211 (emphasis added))

The police and the district attorney, on the other hand, possess considerable discretion in the use of their investigative and prosecutorial powers following the reporting of an apparent crime by a facility director.

Thus, factors which a facility director believes ought to influence the decision of whether to pursue the investigation and prosecution of conduct in a psychiatric center, which appears to be criminal, should be called to the attention of the law enforcement officials who possess the power to exercise such discretion.

It readily becomes obvious that a close working relationship should be fostered to facilitate not only a more appropriate level of reporting of apparent crime, but more importantly, to elicit appropriate responses to such reports which take into consideration the objectives of both the mental hygiene and criminal justice systems. For example, input from the mental hygiene system may result in a higher priority being given to the vigorous investigation and/or prosecution of serious crime in psychiatric centers which victimize patients. At the same time, a fuller understanding by law enforcement officials of the realities of life in congregate care settings may cause them to view patient behavior, which may technically violate the penal

law, with the same discretion they would apply to such conduct occurring elsewhere in the community.

#### What Should Be Reported

Defining a precise line which separates the criminal conduct which victimizes patients from undesirable non-criminal behavior by staff, patients or others in a psychiatric center environment is not always easy. From the review of incident reporting practices at three psychiatric centers, it appears that facility directors err, if at all, on the side of not reporting behavior which may be criminal, partly out of a concern that strict adherence to a policy of reporting any apparent crime to local law enforcement authorities could lead to inundation of district attorneys and police in the localities in which psychiatric centers are located. In part, recognition of this practical problem has in the past resulted in the under-reporting of possible criminal conduct, particularly where the conduct does not involve serious physical harm to patients. Part of the reasoning for the lack of reporting of such "minor" criminal conduct is that such behavior is generally not reported when it occurs outside a psychiatric hospital; if reported, it is unlikely to provoke any response from the officials to whom it is reported; the time and resources devoted to such complaints would probably be disproportionate to any beneficial result that could be obtained; and entanglement in the criminal justice system for petty criminal conduct may be traumatic to patients without any realistic possibility of prosecution or other offsetting benefits. Perhaps most importantly, there is a concern that

reporting a large volume of minor criminal conduct may make it unlikely to get a prompt and vigorous law enforcement response when one is needed.

Care must be taken to retain a pragmatic approach to the relationships between the state psychiatric centers and the multitude of district attorneys and other state and local law enforcement officials who comprise the criminal justice system. Since the elements that enter into the exercise of police and prosecutorial discretion vary from jurisdiction to jurisdiction, based on local resources and policies, no single, uniform rule about the differential handling of serious and minor crime can be prescribed on a statewide basis although a framework for developing locally acceptable solutions can be suggested.

The policy that is formulated and applied should reflect the clear intent of the mental hygiene law, which expressly requires that the facility director must have every complaint of patient abuse or mistreatment investigated. If, in the course of such an investigation, there is "some credible evidence" that a crime may have been committed, the director should notify the district attorney or other appropriate law enforcement official. This threshold, which is consistent with the Attorney General's opinion cited earlier, should help separate the patently frivolous reports or allegations which cannot be substantiated from those where there is some evidence, upon which a reasonably prudent person can rely, to indicate that a crime may have been committed. In our view, it is thus necessary, in determining if it "appears that a crime may have been committed," to be able to

point to evidence which is credible to support such a threshold determination. This essentially means that, if in the course of an investigation, such a state of facts is established as would lead a person of ordinary care and prudence to conscientiously entertain belief that a crime may have been committed, the director should report it to local law enforcement agencies.

This policy has the virtue of discharging the State's constitutional obligations to protect residents of a psychiatric center from harm, c.f., Youngberg v. Romeo, 457 U.S. 307 (1982), as well as the duty of care for persons within the state's custody as imposed by the civil law of torts. By notifying appropriate local law enforcement authorities of possible criminal activity, the facility meets one of its legal obligations to residents by invoking whatever protections may be available to them through the application of the penal laws to behavior which may endanger their safety.

#### When to Report

From a reading of the Mental Hygiene Law, it seems clear that the Legislature contemplated that a facility director would immediately investigate every case of alleged patient abuse or mistreatment. Thus, the director bears a responsibility to conduct an investigation into every such allegation, although the conduct alleged may constitute a crime as well. However, if at any point in the investigation there is credible evidence to believe that a crime may have been committed, based on evidence that is then available, immediate notification to appropriate law enforcement officials is required. It should be noted that

by reiterating a facility director's obligation to investigate, we are not suggesting or envisioning prolonged delays in reporting. Rather the facility investigation will determine, as a threshold matter, whether a complaint is frivolous or entirely unsubstantiated, or is in fact supported by evidence which lends credibility to the complaint. In most cases, the "some credible evidence" standard could be met by statements of witnesses or physical evidence, or both. There may be infrequent instances in which the type of investigation required is more appropriately performed by a law enforcement agency in the first instance, either because of the seriousness of the allegation (e.g. homicide) or because of other factors that make immediate reporting necessary and appropriate even before a threshold determination is made. Where the conduct at issue is less serious, the facility investigation may proceed in greater depth before a determination is made of whether there is "some credible evidence" that a crime may have been committed.

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It should be made clear that the reporting of possible crimes to local law enforcement officials does not absolve the facility from further action. Unless specifically requested by law enforcement officials to defer its investigation, the facility should continue its investigation into the incident in order to take whatever preventive, corrective or disciplinary action as may be warranted. If, as a result of this further investigation the facility later concludes that the alleged perpetrator lacks the requisite competence to form a criminal

intent, or that participants in an apparent and reported sexual crime were in fact competent and consenting adults, this information should be promptly communicated to appropriate law enforcement authorities for their consideration. However, the decision as to what weight should be given to any evidence gathered by facility staff or to their professional opinions, is initially one to be made by law enforcement authorities and not mental health professionals. Should a district attorney decide to prosecute the case despite the additional information provided by the facility, the judicial system will be the ultimate arbiter of these issues.

Similarly, if the facility clinicians believe that involvement in the criminal justice system -- as a witness, a defendant or complainant-victim -- poses a serious risk to a patient's well-being, this opinion should also be communicated to appropriate law enforcement authorities for their consideration but should not be used as a justification for not making a report in the first place. It is simply not the role of the mental health system to make conclusive and binding judgments about criminal responsibility, the validity of defenses to possible criminal charges (e.g., self-defense, insanity, etc.) or the relative social value of prosecuting a particular crime. While prosecutorial decisions regarding these issues may well be guided by the advice and opinions of mental health professionals who are familiar with the clinical history of a patient, the responsibility for making such decisions lies within the criminal

justice system. Wayte v. United States, 105 S. Ct. 1524, 1531 (March 19, 1985).

The special difficulties posed by sexual conduct within an institution serving people with mental disabilities warrant recognition. Competent adults in open society, as well as in institutions, do not violate the penal laws by engaging in sexual relations. Where adult patients are found to have engaged in sexual relations, a facility should exercise particular care in ascertaining whether both parties were competent and consenting. If there is any reason to question the competence of either patient, the director should require that such patient be examined by a qualified psychiatrist, preferably one not employed by the facility, for the purpose of making such a determination, to assist the director in ascertaining if "some credible evidence" exists that a crime may have been committed. If there is no question as to the competence of both patients and both are found to have freely consented, a director can conclude that there is no reason to believe that a crime was committed and thus that no report to law enforcement agencies is necessary. However, such a decision and the reasons therefor should be appropriately recorded. If, on the other hand, following such an examination there is any doubt as to the competence of a patient to consent to sexual relations or that consent was freely given, and thus there is some credible evidence that the sexual conduct may be a crime, a report to law enforcement agencies would be required.

We recognize that in many instances the facts may not be completely clear as a result of a facility's investigation, and issues concerning patients' competence and the manifestation of the consent may present an unclear picture to a facility director. It is precisely because we recognize this inescapable reality that we deem it essential that a facility director have ready access to timely legal advice as to the course of action that ought to be followed given the specific information available as a result of the preliminary investigation. Such practical legal advice should be provided by OMH Counsel's Office. We recognize that, although contemplated by current OMH policy on Administrative Investigation of Major Incidents, the regular performance of such a function by OMH Counsel could increase its workload significantly, necessitating either an increase in resources or a reordering of priorities.

We also believe that close working relationships, based on mutual respect and trust, between police, district attorneys and facility directors would promote the easy exchange of information and the solicitation of informal consultations on the appropriate disposition of difficult cases.

We therefore suggest that OMH policies and procedures direct facility directors to meet with local district attorneys and police chiefs to develop working guidelines on the reporting of apparent criminal activity within psychiatric centers to satisfy both legal requirements and yet adapt to the practicalities of limited law enforcement resources. On the basis of discussions held during meetings of the working group between representatives

of the law enforcement community and mental health officials, we believe that district attorneys and local law enforcement officials would welcome such an opportunity and recognize the value of such a dialogue with an important segment of their community. What is contemplated is that working relationships will be developed at the local level between facility directors and local law enforcement authorities with a goal of fulfilling mutual responsibilities. While mental health professionals would keep their obligation to report possible criminal activity to law enforcement authorities, in the exercise of police and prosecutorial discretion, differential handling of major and minor crimes could be established. This might require, for example, that minor crimes (to be defined jointly) be routinely reported by forwarding copies of incident reports, with the facility to retain primary responsibility for investigation/correction of the problem, while serious offenses (again, to be defined jointly) would be promptly reported by telephone to the law enforcement agencies to exercise a right of first refusal over the investigation. In this working relationship, the issue of whether reports are made to the police, the district attorney, or other law enforcement agency could also be addressed, based on local preferences or established roles.

The development of such a working relationship would also help to clarify the reasonable expectations that a facility can have when serious crimes are reported to law enforcement authorities. Of particular importance in making this relationship work are assurances of a prompt law enforcement

response to a request for an investigation; sensitive handling of the investigation to minimize disruption of the facility routine, to avoid needless anxiety on the part of patients and staff, or adverse effects on staff morale; respect for clinical considerations regarding patients' status; and vigorous prosecution of crime within facilities when warranted.

The value of leaving to the police and prosecutors the primary responsibility for dealing with criminal activity that occurs within mental hospitals has recently been articulated by mental health professionals:

Several factors may make the prosecution of the mentally ill assailant morally acceptable and at times morally preferable. First, filing a complaint makes the fact that a violent act has occurred part of the public record. Second, initiating prosecution allows a judge or jury to attribute responsibility for the violent act (an area outside the strict purview of professionals).

Third, a policy of initiating prosecution should tend to diminish violent acts by patients who may be able to control themselves. Fourth, since judges and juries appropriately are inclined to sentence recidivists more harshly than first-time offenders, making the information about previous assaults available will tend to cause violent individuals to be sequestered from society longer than they otherwise might be. That may make society somewhat safer.

In summary, we believe that professionals may have a duty to initiate charges in cases where a serious assault has occurred. That is true even when the assailant has an intercurrent and serious psychiatric illness.

Phelan, Mills & Ryan, Prosecuting Psychiatric Patients for Assault, 36 Hosp. & Comm. Psych. 581, 582 (June 1985).

RECOMMENDATIONS

We recommend that:

- (1) OMH should establish and promulgate specific Policies for Reporting Crimes Involving Patient Abuse or Mistreatment to Law Enforcement Authorities. These policies should clearly specify the duty, as set forth herein, of a facility director to report behavior where there is some credible evidence that a crime involving patient abuse or mistreatment may have been committed whether by patients, employees or others. In this connection, OMH should provide facility personnel with guidelines assisting them in the investigation of possible criminal behavior and in differentiating criminal from non-criminal behavior as it relates to the most commonly encountered problem behaviors. The Policies should specifically address the particular problems encountered in dealing with sexual conduct between adult patients in a psychiatric hospital. OMH should also provide facilities and special investigators with further elaboration and such training as needed to understand the application of the law and policy on the reporting of crime to law enforcement agencies.
- (2) The OMH should encourage facility directors or their designees to solicit legal advice from OMH Counsel's Office in determining their duty to report specific behaviors that may constitute a crime. OMH Counsel should provide specific advice on a course of action to be followed in the

particular factual circumstances presented. If additional resources are necessary to provide readily accessible legal advice to facilities in such circumstances, such resources should be made available to enable a regular working relationship to develop between the Counsel's Office and the psychiatric centers.

- (3) OMH should promulgate a policy requiring facility directors to make every effort to establish a working relationship with district attorneys and other local law enforcement agencies to facilitate the development of operational guidelines on a local level. OMH should also provide such technical assistance as may be needed to help develop local working relationships which recognize the mutual responsibilities of both parties and which suggest procedures for the differential handling of major and minor crimes as defined at the local level. The Association of Chiefs of Police and the District Attorneys Association should similarly encourage their members to initiate and maintain open communications with mental hygiene facility directors. We strongly encourage regular meetings between appropriate local law enforcement agencies and facility directors to facilitate the development of such a working relationship.

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Appendix A

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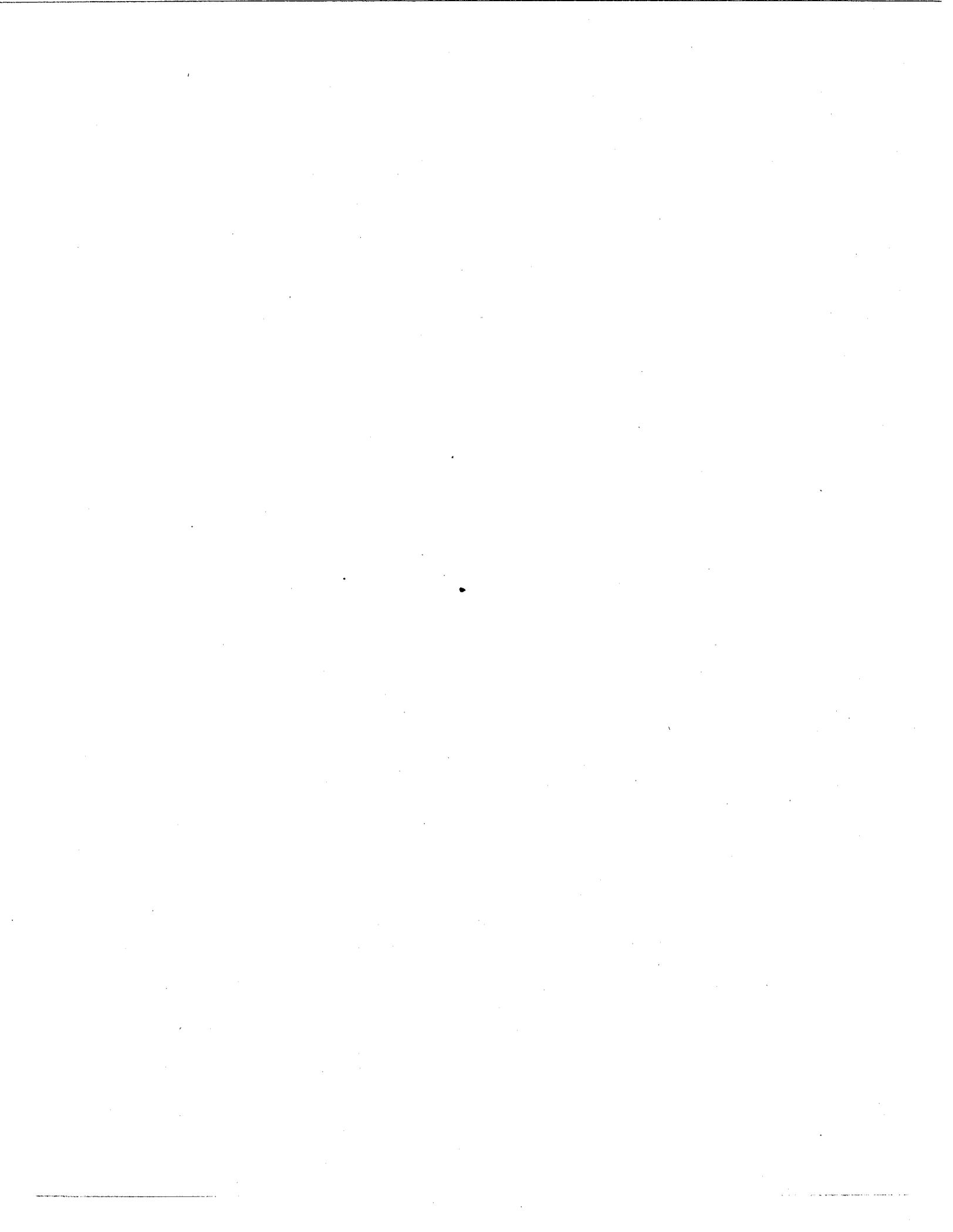
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REVIEW OF POLICIES AND PRACTICES  
OF THREE PSYCHIATRIC CENTERS IN  
REPORTING OF ASSAULT INCIDENTS

INTRODUCTION

Commission staff undertook a review of the Office of Mental Health's (OMH) policies and practices relative to notifying law enforcement officials of patient-related incidents which may be criminal in nature.

In this endeavor, Commission staff reviewed OMH's incident reporting policies<sup>1</sup> to assess the adequacy of guidance offered therein to facility directors regarding their responsibility under Section 7.21(b) of the Mental Hygiene Law to report apparent crimes to law enforcement authorities. Additionally, Commission staff secured and reviewed the incident and investigation reports of 136 incidents which occurred at three adult psychiatric centers in April 1985 and which were classified by the facilities as "assaults."<sup>2</sup> These were reviewed to determine the nature of the incident and whether law enforcement authorities were in fact notified as required by OMH policy. Finally, Commission staff also reviewed any facility specific

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<sup>1</sup>New York State Office of Mental Health Policy Manual, Section 7650.

<sup>2</sup>As will be discussed, OMH policies require that law enforcement authorities be notified immediately of incidents classified as assaults.



policies which the three facilities may have developed on the issue of reporting possible crimes.

The findings of the review are presented in the following sections:

- (A) Office of Mental Health Policies; and
- (B) The Practices of Three Facilities.

#### FINDINGS

##### (A) Office of Mental Health Policies

Section 7650 of the OMH Policy Manual establishes a process by which facilities are to report and investigate incidents which have an adverse affect on any patient. The objectives of the incident reporting process, according to the Manual, are to protect all patients from abuse, mistreatment or neglect by staff, other patients or visitors, and to identify dangerous conditions which cause accidents.

The incident reporting policies outline, in a step-by-step fashion, the actions to be taken by various facility staff -- from the person who discovers the incident and initiates an "incident report" (OMH Form 147) to the facility director who, among other things, notifies external parties, including law enforcement authorities -- in the reporting and investigation of incidents and the implementation of corrective action to prevent the recurrence of similar incidents.

In reviewing the OMH incident reporting policies, it was found that they offer insufficient guidance to ensure that all possible patient-related crimes are reported to law enforcement officials.

The OMH policies define eleven types of incidents (See Attachment 1 for definitions). Among the types of incidents defined are: abuse or mistreatment (which pertain to staff actions/omissions relative to a patient); assault (an intentional or reckless attack on a patient where there is clearly a victim and an aggressor and either impairment of physical condition, substantial pain, substantial risk of physical injury or death, or serious disfigurement); patient fight (an altercation between patients where there is no clear aggressor or victim); escape; medication error or reaction; accident; self-abuse; and various types of deaths (sudden, accidental, etc.). The OMH policies also dictate external reporting requirements (a matrix outlining external reporting requirements by type of incident is presented in Attachment 2). As indicated in Attachment 2, law enforcement agencies should be immediately notified of all incidents classified as assault and escape and certain incidents resulting in death.

In comparing OMH's definitions of incidents and the requirements for external reporting, it appears that not all incidents of a possible criminal nature are required to be reported to law enforcement agencies. For example, while all assaults must be reported to law enforcement officials, incidents of abuse are not required to be reported. This appears to be a significant omission in that the definition of "abuse" encompasses an array of employee behaviors which may constitute crimes, including physically attacking a patient and engaging in sexual activity with patients.

A second flaw in the policies which potentially impacts on reporting possible crimes to law enforcement agencies is their silence on sexual encounters between patients and the issues of consent and capacity to consent. Such encounters, although they may violate the Penal Law, do not always meet the OMH definition of assault. The policies' failure to address the topic of patient-to-patient sexual encounters and the attendant issues of consent and capacity to consent, which distinguish whether such encounters are criminal in nature, creates the possibility that potentially criminal behaviors are neither investigated by the facility nor reported to appropriate external parties.

Finally, the policies regarding the reporting of certain deaths to law enforcement officials are also confusing in that homicides, suicides, suspicious and/or sudden deaths are to be reported to law enforcement officials in New York City only.

**(B) Reporting Practices of Three Facilities**

As previously discussed, OMH policies require that law enforcement authorities be informed of certain types of incidents. One such type of incident is "assault" which OMH defines as "an intentional or reckless physical attack on a patient where there is clearly a victim and an aggressor and there is at least one of the following:

- impairment of patient's physical condition;
- substantial pain;
- substantial risk of physical injury;
- a risk of death;
- serious or protracted disfigurement."

In order to obtain a better picture of reporting practices, Commission staff requested that three facilities forward for the Commission's review all investigative materials (OMH 147 and investigation report) pertaining to any incident which occurred in April 1985 and which was classified as "assault." (Such investigative materials offer a description of the incident, injuries sustained and external parties notified.)

(1) Overview of the Assault Incidents

As indicated in the table below, 136 incidents classified as "assault" occurred at the three facilities during the period in question. The types of incidents ranged from one patient hitting another patient with a pocketbook for no apparent reason to alleged sexual assaults. The best descriptor of the incidents is the seriousness of the injuries sustained.

Display of April 1985 Assault Incidents  
and the Nature of Injury and  
Police Notification

<u>Facility</u>	<u>Census</u>	<u>Number of Assaults</u>	<u>Number Resulting In:</u>			
			<u>No Injury</u>	<u>Minor Injury</u>	<u>Major or Suspected Major Injury</u>	<u>DA or Police Notification</u>
A	850	91	43	38	10	1
B	841	36	11	20	5	1
C	<u>154</u>	<u>9</u>	<u>3</u>	<u>5</u>	<u>1</u>	<u>0</u>
Total	1845	136	57	63	16	2

For analytical reasons, in reviewing the assault incidents, Commission staff created, on the basis of the extent of injuries sustained by patients as documented in the investigation reports, three classes of assault:

- Class 1: assaults resulting in no injury;
- Class 2: assaults resulting in a minor injury (i.e., a bruise, a reddened area, or superficial scratch with no notation of bleeding); and
- Class 3: assaults resulting in a major injury or suspected major injury; i.e., where there was bleeding, loss of consciousness, a fracture or suspicion of a fracture, or other serious injury as indicated by the need for x-rays or referral to a hospital.

Of the 136 assault incidents, 57 resulted in no injury.

Examples of these include:

- At Facility A, Patient A hit Patient B with a plastic cup because Patient B touched him. No evidence of injury was found on either patient.
- Also at Facility A, Patient C hit Patient D in the face when Patient D asked for a cigarette. No injuries were noted.
- At Facility B, Patient A alleged that Patient B slapped him on the left ear. No injuries were noted.
- Also at Facility B, Patient C pushed Patient D to the floor because Patient D would not give him a cigarette. No injuries were noted.

- At Facility C, Patient A attacked Patient B and hit her in the nose (for no apparent reason). No injuries were noted.

In the Commission staff's opinion, on the basis of the reports submitted, 63 of the assault incidents resulted in minor injury. Examples of these include:

- At Facility A, Patient A slapped Patient B because Patient B was loud. Patient B had a slight discoloration on her face.
- Also at Facility A, one patient started calling another patient names. The second patient then hit the first patient who sustained some swelling and slight discoloration over an eyebrow.
- At Facility B, Patient A provoked Patient B into a fight by pulling her hair. Patient A received scratches on her face and chest.
- Also at Facility B, Patient A went into Patient B's locker by mistake which started a fight between the two. Patient B sustained a superficial laceration on the chin.
- At Facility C, Patient A pushed Patient B for no apparent reason, causing her to hit her head. Patient B sustained a bruise on her head.

Finally, of the 136 assaults reviewed, 16 resulted in major injury or suspicion of major injury (as evidenced by the medical attention provided). Since these incidents will be referred to later in the report, a summary of each is provided below.

- Case #1 At Facility A, Patient A punched Patient B in the nose allegedly because Patient B made sexual advances towards him. Patient B was taken to a local hospital and found to have a broken nose.
- Case #2 At Facility A, Patient A had been on leave without consent (LWOC). The patient was returned to the facility by the police and later claimed that she had been raped while she was on LWOC.
- Case #3 At Facility A, Patient A attempted to kiss Patient B and Patient B punched him. Patient A received a bloody and swollen nose.
- Case #4 At Facility A, Patient A hit Patient B in the face several times and hit his head on the floor. Patient B was found to be semi-conscious and bleeding in his mouth. An emergency code was called, x-rays ordered (negative) and patient recovered.
- Case #5 At Facility A, Patient A claimed that another patient had "bothered" him sexually during the night and showed staff his bloody pajamas. A physical examination revealed a 3/4" by 1/2" rectal tumor/possible hemorrhoids which the physician indicated seemed to have been "mildly aggravated by rectal coitus."
- Case #6 At Facility A, Patient A for no apparent reason "slammed" Patient B's head into a wooden table twice. There was swelling and x-rays were ordered to rule out fracture. The patient did not bleed or lose consciousness and x-rays were normal.

- Case #7 At Facility A, Patient A attacked Patient B for no apparent reason. Patient B suffered a swollen hand and x-rays were ordered. No fracture was found.
- Case #8 At Facility A, Patient A claimed that Patient B attacked him in the bathroom. Patient A sustained a 1/2" laceration over the forehead with bleeding. No sutures were needed.
- Case #9 At Facility A, Patient A claimed that Patient B climbed into his bed and tried to undress him, so he started hitting him in the facial area. Patient B sustained a swollen cheek and received x-rays to rule out fracture.
- Case #10 At Facility A, Patient A claimed that Patient B sexually molested her (vaginal penetration with a finger). Patient A claimed that she wanted to press charges. The facility arranged for her to be seen at the Rape Crisis Center at a local hospital.
- Case #11 At Facility B, Patient A punched Patient B in the face causing a laceration, bleeding and some swelling.
- Case #12 At Facility B, Patient A attacked Patient B hitting him in the face and head. Patient B sustained a bloody nose.
- Case #13 At Facility B, Patient A (same person as Patient A above) struck Patient C above the eye. Patient C required five sutures at a community hospital to close the wound.
- Case #14 At Facility B, Patient A kicked Patient B in the knee. X-rays were ordered which revealed no fracture.

Case #15 At Facility B, Patient A claimed she was raped by Patient B. Patient A was sent to a local hospital for examination.

Case #16 At Facility C, Patient A hit Patient B with a "round house punch" in the left eye over a cigarette dispute. Patient B had "edema and tender left orbit" and was taken to the hospital for x-rays to rule out facial fractures.

(2) Compliance with Requirements on Notifying Law Enforcement Agencies.

The review of the 136 assault incidents indicated that the rate of compliance with existing OMH policies requiring that law enforcement authorities be immediately notified of assault cases was low, as indicated in the table on page 5. Of the 136 incidents classified as assault, one was reported to law enforcement agencies by the patient/victim. This case involved the patient who claimed she was raped while on LWOC (Case #2 previously discussed). The patient reported the allegation to the police while she was still on LWOC. The police in turn brought her to a local hospital where she was examined and then returned to the psychiatric center. Interestingly, neither the police nor community hospital staff informed the psychiatric center of the patient's allegations and treatment. It was upon return to the psychiatric center that the patient informed facility staff of the events which occurred while she was on LWOC. The facility then contacted the local hospital and verified that the patient had been examined and treated as a possible rape victim.

Of the remaining 135 incidents classified as assault, only two, or slightly more than 1 percent, were reported by the facility to law enforcement officials. The two cases which were reported were:

- Case #1, discussed in the previous section, in which a Facility A patient broke a second patient's nose in response to the second patient's homosexual advances; and
- Case #15, also discussed earlier, in which a Facility B patient claimed that she had been raped by another patient.

One possible explanation for the low rate of reporting assaults to law enforcement officials is the incongruity between the OMH policy definition of "assault" and the Penal Law's definition of criminally assaultive or reckless behavior. Although the OMH policies require that all "assaults" be reported to law enforcement agencies, assault, as defined in the OMH policies, includes behaviors which may not be criminal.

Essentially, the OMH definition of assault, which includes actions which result in substantial risk of physical injury, goes beyond the Penal Law's definitions of assault or reckless endangerment which require actual physical injury or a substantial risk of serious physical injury. Thus, OMH's requirement that all "assaults" be reported to law enforcement agencies would result in the reporting of non-criminal behavior. However, in spite of the OMH policy requirement, 57 incidents in our review which resulted in no injury but were classified as

assault by OMH (apparently because they presented a substantial risk of physical injury) were not reported to law enforcement authorities.

While the incongruity between OMH's definition and reporting requirements and the Penal Law's definition of criminal behavior may have tempered to some degree the facilities' reporting practices, this does not explain the facilities' failure to report incidents which met both the OMH definition of "assault" and the Penal Law's definition of a crime. Of the 136 incidents reviewed, 79 resulted in physical injury. In 16 of these cases the injury appeared to be major and either impaired a person's physical condition or, most likely, caused substantial pain. Only two of these 16 were reported to law enforcement authorities. Examples of the incidents not reported include:

- Case #4 in which a Facility A patient was beaten to the point of semi-consciousness.
- Case #5 in which a Facility A patient claimed he was sodomized by another patient and a physician verified anal penetration.
- Case #10 in which a Facility A patient claimed she was sexually molested and requested to press charges.

(Facility A's internal investigation into this incident revealed that the incident should have been reported to the police and that its staff was remiss in not doing so. As it turns out, the patient was taken by staff to a community hospital for examination and the staff

there notified the police. The patient then declined to press charges.)

- Case #13 in which a Facility B patient was transferred to a community hospital for five stitches above the eye after being punched by a repeatedly violent patient.
- Case #16 in which a Facility C patient was sent to a community hospital for x-rays to rule out facial fractures after being punched in a dispute over a cigarette.

### (3) Limitations of Facility Specific Policies

Aside from departures from OMH's incident reporting policies, the assault incidents reviewed also exemplify departures from and pitfalls in the facilities' own incident reporting procedures regarding the notification of law enforcement officials.

For example, a Facility A 4/1/85 directive indicates that, when the safety office is informed of a serious incident, a safety officer will respond to the scene and, if it appears that a crime has been committed, will notify police. Facility A's policies define serious incidents as abuses, assaults, escapes, etc. But the directive and policies fail to identify who will notify the safety office and when.

Of the 91 assaults which occurred at Facility A -- which by Facility A's definition constituted serious incidents -- there is evidence that safety officers responded to only three. In one case (Case #1 involving a patient who broke another patient's nose) the safety office was notified of the incident six hours

after it occurred and then contacted police. In the second case (Case #10 in which a female patient claimed she was sexually molested by another patient and expressed a desire to press charges) a safety officer was notified, responded to the scene, but was told by staff that it was unnecessary to contact the police as that would be done by the community hospital once the patient was transferred there. Finally, in the third instance (not discussed earlier) a safety officer responded to the scene of an "assault incident" which was reclassified to a "patient abuse incident" only to be told that it was a clinical matter and his assistance was not necessary.

In short, although Facility A's directive indicates that safety officers play a key role in ensuring police notification of possible crimes, in practice, based on the 91 incidents, it appears that safety officers either are not called or fail to respond to serious incidents such as assaults. If they are called, they are called late and are at times dissuaded by staff from notifying law enforcement authorities of a possible crime.

Facility B's policies are also somewhat flawed with regard to reporting possible crimes to police. Facility B's policies vest the responsibility for determining whether a particular incident should be reported to the police with the Director or the Administrator on Duty (AOD). The policies, however, differentiate between serious and non-serious incidents. While the policies categorically define certain incidents such as patient abuse by an employee, death or homicide as serious, other incidents such as assaults are classified as serious (and thus

brought to the Director's attention) or non-serious (and not brought to the Director's attention) based on the seriousness of the injuries sustained. Yet the policies contain no operational definition of serious injury. Case #13, for example, was classified as a non-serious assault, despite the fact that the patient, who was attacked by a repeatedly violent patient, was brought to a community hospital and received five sutures above the eye.

In short, Facility B's policies do not guarantee that all assaults will be reviewed with an eye toward determining whether the police should be notified.

Facility C has no written policies describing how, when and by whom possible crimes are to be brought to the attention of law enforcement officials. In a letter to the Commission, the Director of Facility C indicated that some degree of violence is to be expected in the center, given the population, and that it would be clinically inappropriate to report each assault to the police unless it is serious. The Director indicated that allegations of rape or sexual assault would be reported to police (providing they are clearly not delusional claims by a patient) as would assaults which result in substantial injury. However, the director offered no definition of serious incident or substantial injury; nor did he indicate who makes the decision that an incident was serious or the injury was substantial.

Finally, it should be noted that the director indicated that Facility C has a working agreement with the local district attorney's office and appended a letter from the district

attorney's office. That letter, however, indicates that it is agreed that Facility C will notify the district attorney's office if any member of its staff has reason to believe a crime has been committed. The letter makes no reference to Facility C's using the seriousness of the incident or injury as threshold criteria for determining if there is reason to believe a crime has occurred or the process by which Facility C makes such determinations.

#### CONCLUSION

Section 7.21 of the Mental Hygiene Law confers upon facility directors the responsibility to provide patients humane treatment. Towards that end the law also requires facility directors to investigate allegations that such level of service has been compromised through abuse or mistreatment and to notify law enforcement officials, immediately or within three working days, if it appears that a crime may have been committed.

The OMH policies on the reporting of incidents to law enforcement agencies omit from the reporting requirements certain behaviors which may constitute crimes, such as physical or sexual abuse of a patient by an employee and non-consensual sexual encounters between patients. Facility practices on the reporting of such to law enforcement authorities deviate from the Office of Mental Health's policies, apparently with little Central Office oversight or monitoring. And, the policies developed by individual facilities on this issue vary from facility to facility and fail to ensure that appropriate facility staff will review potentially criminal incidents with an eye toward

determining whether law enforcement officials should be notified. Consequently, as indicated by this review, incidents which may constitute crimes are not always reported to appropriate law enforcement authorities.

Attachment 1.

DEFINITIONS

Abuse or mistreatment - a patient is abused or mistreated if any of the following occur:

- Neglect
- Physical Abuse
- Psychological or Verbal Abuse
- Misuse of Medication
- Misuse of Restraints or Seclusion

Neglect - A condition of deprivation in which patients do not receive sufficient, consistent and appropriate services, treatment, medication or nutrition to meet their fundamental and ongoing needs.

Physical Abuse - Any contact which causes or has the potential to cause injury. This includes but is not limited to: hitting, kicking, shoving, slapping, hurling, tickling, pinching, choking and any sexual activity between employee and patient.

Psychological or Verbal Abuse - Consists of degradation, humiliation or dehumanization of a patient and includes but is not limited to: verbal or gesture ridicule, screaming or shouting at patients.

Misuse of Medication - Medication knowingly prescribed or used incorrectly including medication used as a restraint apart from a treatment plan or documented emergency. Unexpected adverse drug reaction is not misuse of medication.

Misuse of Restraints or Seclusion - Restraint or seclusion used for a purpose other than to prevent a patient from injuring self or others. Refer to Section 7600, Restraint and Seclusion, of Policy Manual for details.

Accident - An unexpected event which causes injury to a patient. It may be caused by the non-deliberate actions of either the patient or another person, or by unsafe conditions.

Minor Accident - A slight injury to a patient not caused by another person or by unsafe conditions. It is an accident, such as a scrape or bruise, which does not require the immediate attention of a physician or treatment in the medical/surgical unit. Excluded are accidents, however slight, in which an employee may be culpable.

Assault - An intentional or reckless physical attack on a patient where there is clearly a victim and an aggressor and there is at least one of the following:

- impairment of patient's physical condition
- substantial pain
- substantial risk of physical injury
- a risk of death
- serious or protracted disfigurement.

Death from Unnatural Causes - Death which does not result from disease or organ failure unless the organ failure is caused by a source external to the body. Death from natural causes is not an incident unless it is sudden.

Sudden Death - Unexpected death from natural or unnatural causes and any death within 24 hours of admission.

Accidental Death - Death which results from unintentional or non-deliberate acts or actions. Such incidents may include but are not restricted to:

- Death following injury
- Death from asphyxiation (e.g., from choking on food).

Drug Reaction, Unexpected Adverse - An unexpected abnormal response to a proper prescription and administration of a drug.

Escape - A patient leaves without consent and is one of the following:

- Considered dangerous to self or others
- Unable to care for self
- Committed to the facility by order of a court pursuant to the Criminal Procedure Law or Family Court Act.

Medication Error- Non-deliberate error in prescribing or using medication. Unexpected adverse drug reaction is not a medication error.

Patient Fight - A physical altercation between two or more patients resulting in injury to at least one of the patients. There is no clear victim or aggressor.

Self Abuse - Deliberate self injury by a patient which is not a suicide attempt.



NEW YORK STATE  
OFFICE OF MENTAL HEALTH

POLICY MANUAL

Attachment 2.

DATE OF ISSUE: 2/28/79	SEC.: 7650
BY T.L.: 79-4	PAGE: 9 of 9
SUBJECT: Incident Reporting Notification Chart	

TYPE OF INCIDENT	NOTICES										
	Regional Office	Board of Visitors	Miss	Child Abuse Register	Commission on Quality of Care	Mental Hygiene Medical Review Board	Coroner/Medical Examiner	Local Law Enforcement Authorities	Office of Counsel	Bureau of Statistical Analysis	Health
Abuse or mistreatment	I W	I W	I W	I W If patient is under 10 yrs. old	W						I only gov
Accident or Injury	W	W	W								I If gov
Assault, or attempted homicide (does not include patient fights)	I W	I W	I W	I W If patient is under 10 yrs. old	W			I			I
Attempted Suicide	I W	W	W		W						I
Escape	I W	W	W					I			I
Medication error or unexpected adverse drug reaction	W	W	W								I If gov
Death, sudden, accidental, or within 24 hours of admission	I W	I W	W		I	I W	I	I New York City only			I
Death, under suspicious circumstances or from other than natural causes	I W	I W	W		I	I W	I	I New York City only			I
Homicide	I W	I W	I W		I	I W	I	I New York City only	I W		I
Suicide	I W	I W	W		I	I W	I	I New York City only		W	I

I - Immediate notification by phone or in person  
W - written notification by sending completed copy of Incident Report





