



Disability Rights California

California's

system

protection and advocacy

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Senate Committee on Human Services Examining law Enforcement Practices within California State Developmental Centers

March 13, 2012

Testimony of Leslie Morrison, Directing Attorney Disability Rights California Investigation Unit

Thank you for the opportunity to address your committee today regarding our experience with the timeliness and thoroughness of the Office of Protective Services' (OPS) response to incidents of abuse, neglect, injury and death of residents at California's state developmental centers.

Disability Rights California is the agency mandated by federal law to protect and advocate for Californians with disabilities. One of our most critical functions is the investigation of abuse and neglect. Under federal and state law, Disability Rights California has the authority to investigate any incident of abuse or neglect of any person with a disability if the incident is reported to Disability Rights California or if Disability Rights California determines there is probable cause to believe the abuse or neglect has occurred.

Consistent with this authority, we have conducted over 500 investigations into alleged abuse or neglect of individuals with disabilities in state developmental centers and in the community. Most recently at the request of the Department of Developmental Services (Department), Disability Rights California, using our federal and state authority, has conducted a preliminary review of the incidents of abuse and neglect at state developmental centers identified in the recent media reports.

We know that people with disabilities everywhere are at a much higher risk of victimization and that the abuse response and criminal justice systems can be slow to respond. Each of us should be concerned about the abuse of California's most vulnerable residents and take every step possible to prevent abuse, and ensure the most effective reporting and comprehensive investigations possible. Our recommendations, which we discuss below, are designed to improve these systems both in the community and in the developmental centers.

Disability Rights California's Experience

Disability Rights California has long been focused on failures of the abuse response and criminal justice systems to responding to abuse, neglect and crimes against people with disabilities. In 2003, Disability Rights California released a report in collaboration with our partners under the federal Developmental Disabilities Assistance and Bill of Rights Act. Investigators, both in the community and in developmental centers, were criticized for their lack of expertise in conducting investigations involving victims with developmental disabilities. While community police have experience in conducting criminal investigations, they often lack expertise in interviewing victims with disabilities, including those with communication and cognitive impairments common among developmental center residents. Special investigators in developmental centers were criticized for lacking sufficient training and experience in criminal investigations. Authors called for the Legislature to make abuse and neglect of people with developmental disabilities a priority and to designate a lead agency to coordinate reform.

In 2005, Disability Rights California uncovered a series of suspicious lacerations to the genitals of five male residents at one developmental center. The injuries ranged in size from 1.5 to 8.0 centimeters and required between three and 20 sutures to close. The victims were primarily nonverbal and could not offer an explanation for how the lacerations occurred. Unwitnessed, staff were left to speculate about the cause. Delays in reporting only further hampered investigations. None of the victims received a sexual assault exam and none of the injuries were reported as possible victims of abuse. Disability Rights California called for the Department to ensure that injuries such as these were considered suspicious, warranting immediate reporting and investigation by OPS. The Department was asked to ensure that all medical and direct care staff were trained in their mandated abuse reporting duties and that OPS investigations probe abuse or neglect as a possible cause. The

Department was encouraged to develop their incident reporting system to detect suspicious trends.

In 2006, Disability Rights California issued a brief advisory, describing the sexual assault of a 38 year old man with a developmental disability who lived in the community and how inexcusable and unexplained delays by community police in interviewing the victim and gathering physical evidence ultimately undermined any hope for criminal prosecution. Disability Rights California again called for law enforcement to immediately and thoroughly investigate crimes against victims with disabilities and to partner with organizations and advocates serving people with developmental disabilities in their community to better serve this population.

Finally, in 2010, Disability Rights California investigated 12 cases of physical and sexual assault abuse of nursing home residents by care staff. The abuse ranged from punching or hitting in the face to repeated sexual assaults and allegations of rape. Even though all of the cases involved facts indicative of criminal abuse, most were handled not as criminal matters but as licensing or employment concerns. Nearly half of the cases were never reported to law enforcement. Reporting lagged for days; evidence was not gathered; investigations lagged or were never initiated; victims died while awaiting justice; and in at least one case, the assailant moved on to another care facility. This report again implored the Legislature to focus on protecting people with disabilities from abuse and ensuring prompt and thorough investigations of incidents of abuse.

Disability Rights California's Recent Audit of Deaths, Sexual Assaults and Suspicious Injuries to Developmental Center Residents.

Shortly after the news of abuse and suspicious deaths of developmental center residents appeared in the media, the Department requested that Disability Rights California use our federal authority to conduct an immediate independent review of the Department's response to serious incidents in their facilities. Last week, we conducted a preliminary review, examining investigation records of suspicious or unexpected deaths, sexual assault allegations involving staff and serious injuries of unknown origin occurring in the past three years at all five remaining state facilities. To date, we have reviewed 74 deaths, 30 sexual assaults, and a random sampling of 20 serious injuries (focusing on those involving fractures, lacerations and genital injuries).

Our review was limited to the information contained in the Department's incident reports and investigation records. Some cases included portions of the residents' clinical records. Often the deaths included the county coroner's autopsy report. We thank the Department for providing us with such ready access to the records and endeavoring to obtain additional information upon request.

Based on the records that we reviewed, almost all of the cases were not suggestive of abuse or neglect. These facilities serve a fragile population of residents with complicated disability-related and medical issues. Many of the deaths were entirely attributed to serious, terminal medical conditions and, in fact, occurred not in the state facility but at local acute care hospitals where the resident was receiving medical care.

None of the deaths were suggestive of abuse. Five of the cases showed that negligent lapses in staff supervision directly or proximately contributed to the resident's death; three of which Disability Rights California had already thoroughly investigated. The Department produced information demonstrating that disciplinary action was taken against multiple staff in three of the cases.

A handful of others involved facts that suggested that quality of care or treatment concerns might be a proximate cause of the resident's death but, without a more thorough review of the resident's clinical records, it is premature to draw this conclusion. In some of these cases, investigators did not appear to sufficiently probe the possibility that neglect might be a contributing factor. For example, in one case, the individual died from an ulcer caused by a checker piece that he ingested at some earlier point in time. Investigators did not explore staff supervision in the preceding days to discern when he might have ingested the item and whether staff supervision or lack thereof could have prevented the event. In another case, a woman died of unrelated medical causes at the local hospital. But, several weeks into her hospital stay, hospital staff discovered that she had a broken femur. The OPS investigation did not attempt to determine the age the fracture to see if it might have occurred at the developmental center, and if so, how. It is unclear whether OPS investigators have the skills or knowledge to delve into complex medical questions of causation which might be more appropriately considered by the facility's clinical mortality review committee.

Most of the sexual assault allegations were reliably found to be false accusations, often quickly recanted. For example, one resident called OPS

directly and reported continuous sexual and physical abuse. OPS conducted an investigation, including sending items of her bedding and clothing to local law enforcement for semen detection (none was detected).

Nearly all of the victims were examined by medical staff at the developmental center shortly after the allegations surfaced and were found to have no evidence of injury. None of the victims were sent for independent sexual assault examinations. It is unclear if the facility medical personnel have the training and expertise to conduct sexual assault examinations and gather forensic evidence. Similarly, it is unclear of the skills and training of OPS investigators in conducting interviews with sexual assault victims. We have recommended that the Department consider partnering with local sexual assault response teams (SART) in the jurisdictions of each of their facilities to conduct these examinations for select cases, based on standard criteria recommended by the sexual assault team.

Disability Rights California was able to directly compare the responsiveness of local police and OPS investigators to sexual assault allegations in one jurisdiction. Coincidentally, Disability Rights California had just concluded a sexual assault investigation involving a woman with a developmental disability living in the community containing a state developmental center in which two female residents made similar allegations of sexual assault. In the community case, a patrol officer quickly responded but did not interview the victim when he realized that she was developmentally disabled. The case was assigned to the police detective who waited another week before meeting with the victim. In the developmental center case, OPS investigators interviewed both victims and the alleged perpetrator on the day of the allegations and proceeded with a thorough investigation. Neither case was referred to the District Attorney for prosecution.

Disability Rights California also reviewed a small number of randomly selected serious injuries of unknown origin. Injuries included fractures (including fractures to the spine and femur), genital injuries, black eyes, fat lips with loose front teeth, and large bruises. These cases almost universally involved victims whose disability precluded them from informing investigators how they sustained the injury. Most were nonverbal and had compromising medical conditions that put them at risk, such as osteoporosis, blindness, gait disturbances, or severe epilepsy.

These cases were promptly reported to OPS when they were discovered and investigators initiated investigations. It is unlikely that any of the injuries reviewed would have triggered any investigation if they had been reported to outside law enforcement. Disability Rights California again questions whether medical staff are sufficiently trained and experienced in conducting forensic examinations. OPS investigators relied heavily on the clinical findings in these examinations.

In select cases, Disability Rights California questioned whether investigators sufficiently probed whether abuse or neglect was a possible cause. For example, one man was found to have a fractured clavicle. Care staff speculated that the resident may have tripped over a treadmill and fell on his shoulder. The record did not indicate consideration of other possible causes, including assault, or question the veracity of an unwitnessed fall as the likely cause, since most individuals would break their fall by quickly extending their arm, thus avoiding landing on their clavicle.

Incident reports confirmed that nearly all of the incidents were reported within minutes of being discovered to facility police. Records were less clear in documenting how quickly investigators were notified but generally investigations were initiated on the same or the following day. Investigations appeared to be comprehensive and showed a familiarity with facility record keeping, staff scheduling, facility work practices, and disability sensitivity that only augmented their thoroughness. In cases involving sexual assault and serious injuries, investigators consistently appeared to interview the victim, a positive practice not consistently attempted by outside law enforcement officers.

There was no documentation in the initial records we reviewed that any of the serious injuries were reported to outside law enforcement, as required by Welfare and Institutions Code §4427.5. As noted above, almost all of the deaths were referred to the county coroner, a division of the local Sheriff's Department. In all but two of the death cases, outside law enforcement declined to pursue the cases further. Approximately three of the sexual assault cases that we reviewed were referred to outside law enforcement; one was referred to the District Attorney. The Department has informed us that the required reports were made and subsequently provided these records but we have not had time to review these additional documents.

Our preliminary review showed considerable variability in the documentation by OPS, including when investigations were initiated by special investigators, when/whether local law enforcement was notified, the report's format, and consistent terminology for investigation outcomes. Facility management review and oversight of the incident reports often appeared cursory and not probing. They rarely directed clinical staff investigations to explore other avenues of review, including those to rule out abuse or neglect.

In Context with Larger System Issues

People with developmental disabilities are at disproportionately high risk of abuse, neglect, and criminal victimization. People with disabilities are four to ten times more likely to be victimized than people without disabilities. Individuals with an intellectual impairment are at the highest risk of victimization, with an estimated rate of criminal victimization over 10 times higher than people without impairments. People with disabilities are more likely to experience more severe abuse and for long periods of time. They are more likely to be victims of multiple episodes of abuse and involve a larger number of perpetrators.

The rate of sexual assault is two to ten times higher for people with disabilities when compared to people without disabilities. Eighty percent (80%) of women with developmental disabilities will be sexually assaulted at least once in their lifetime – that's 50% higher than the rest of the population. One California study found that 83% of women and 32% of men with developmental disabilities had been sexually assaulted. Another study found that nearly 50% of sexual assault victims with developmental disabilities were victimized 10 or more times. The risk of sexual assault is two to four times higher in an institutional setting than in the community.

Most frequently, the victim knows their assailant. It is most often someone who is responsible for services and supports related to the victim's disability – people the victims know and trust. One study found that the risk of abuse increases by 78% due to the vulnerability of people with developmental disabilities and their need for personal assistance services.

Homes and other residences are the most common setting for abuse, yet 80-95% of criminal abuse in institutions never reaches the authorities. Only 4.5% of serious crimes committed against people with disabilities get reported to law enforcement, compared with 49% for the general population. Seventy-one percent (71%) of crimes against people with

severe mental retardation are not reported. Three percent (3%) of sexual assault cases involving a victim with a developmental disability are reported, compared with between 16-28% for the general population.

Community police response to reported crime is lower if the victim has a disability. One study found that only 5% of crimes against people with disabilities get prosecuted compared with approximately 70% of crimes involving victims without disabilities. And when convictions occur, sentences are typically lighter, particularly in cases involving sexual assault.

Disability Rights California's Limited Notification of Incidents

As described above, Disability Rights California is the agency mandated by federal law to protect and advocate for Californians with disabilities, including investigating allegations of abuse, neglect and crimes against people with disabilities. Yet, we learn of these events mostly through serendipity. There are very limited circumstances by which incidents are required to be reported directly to Disability Rights California. Disability Rights California receives very few citations issued by the Department of Public Health to developmental centers (not more than two or three a year). Those we have received recently were issued months to over one year earlier. We have not received anywhere near the number of citations described in recent media accounts.

One of the means by which Disability Rights California learns of incidents of abuse and neglect is through the regular review of citations and deficiencies issued by the Department of Public Health to health care facilities. The Department of Public Health redacts citations of incidents involving victims with either psychiatric or developmental disabilities, essentially distributing an entirely blacked document aside from basic demographic information about the facility cited. The Department of Public Health readily agrees that Disability Rights California has the authority to access unredacted citations through our access authority. However, they require that we go through the repetitious process of submitting a written request for an unredacted copy of each redacted citation that we receive. Not only is this process timely, burdensome, and unnecessarily wasteful of resources for both Disability Rights California and the Department of Public Health but it significantly delays our notification of critical incidents of abuse and neglect. Several of our recommendations to this committee are targeted at expanding the direct reporting of critical incidents of abuse and neglect to Disability Rights California.

Disability Rights California's Recommendations

We are acutely aware of the high rate of victimization of all people with disabilities. Therefore, some of Disability Rights California's recommendations encompass reform beyond those focused on issues in developmental centers. This hearing is an opportunity to develop systemic reform that will protect people with developmental disabilities living in developmental centers as well as in the community.

I. Recommendations for the Department

1. Do not shift the responsibility for investigating abuse and neglect in developmental centers entirely to local law enforcement.

Disability Rights California has reservations about turning the responsibility for investigating incidents in developmental centers entirely over to the local law enforcement. Our experience has shown that local investigators are often loathe to investigate cases in facilities and often lack the skills and training to interview people with developmental disabilities. Furthermore, many of the incidents thoroughly investigated by OPS would not rise to the level typically triggering local law enforcement involvement.

2. Require the Department to refine the critical incidents reported to the local law enforcement agency.

Currently the Department is required to report to local law enforcement all resident deaths and serious injuries of unknown origin.¹ The Department currently is not required to report allegations of sexual assault. The Department's incident reporting policy however does not distinguish minor from serious injuries. The category of injuries is very expansive and includes abrasions/scratches requiring treatment beyond first aid; bites; bleeding; any bruising 5 cm or greater in diameter; any injury involving the head, breast or genital; burns; dislocations; fractures; lacerations; puncture wounds; and more. Inundating local law enforcement with reports of minor injuries may temper law enforcements' response to critical incidents warranting their immediate attention and expertise.

¹ See Welf & Inst. Code § 4427.5.

Certain critical incidents, including sexual assault allegations, must be immediately referred to outside investigators with better training and more recent experience in evidence collection and forensic interviewing. In many cases, collection of physical evidence is critical to bringing a successful prosecution or taking any disciplinary action against an assailant. Local law enforcement are best positioned to perform these vital functions.

In consultation with abuse experts, the Department should refine standards for evaluating which cases are referred. Minimally such cases must include all sexual assaults where there is evidence of staff involvement and injuries which abuse experts recognize as being suspicious of abuse or neglect.

3. Ensure that medical staff in developmental centers maintain competencies in detecting signs of possible abuse and immediately refer those victims to trained forensic medical examiners.

Medical personnel must be able to recognize indications of abuse or neglect so the cases can be referred to trained independent forensic examiners. This is particularly important in cases of alleged sexual assaults and serious suspicious injuries of unknown origin, particularly where the victim's history does not match the clinical findings. Sexual assault victims must receive SART examinations consistent with the standard protocols, not merely medical exams by facility physicians.

We recommend that the Department consider partnering with local SART teams in the jurisdictions of each of their facilities to conduct these examinations for select cases, based on standard criteria recommended by the sexual assault team.

4. Ensure that OPS resources are dedicated to investigating incidents suggestive of abuse, neglect, and crime.

The Department should continue its efforts to require all staff to report all incidents of known or suspected abuse or neglect but refine the system so that investigatory resources are dedicated to matters which are suggestive of abuse, neglect, or criminal conduct. For example, it may be unnecessary for OPS to as fully investigate deaths occurring in acute care hospitals which are entirely attributed to the resident's known terminal medical condition and for which abuse and neglect are not suspected. This will help ensure that resources can be deployed to investigate the most serious allegations of abuse and neglect.

The Department should consider refining the system so that investigatory resources are dedicated to matters strictly within the investigator's expertise or are promptly referred to the appropriate investigative or oversight entity. This includes considering whether it is effective to use OPS investigators to delve into complex medical questions of causation which might be more appropriately considered by the facility's clinical mortality review committee. The Department must then ensure that mortality review committees sufficiently probe whether abuse or neglect was a secondary or proximate cause of an incident, even for those cases primarily attributed to a more immediate cause. In some instances this will require assistance of outside experts. For example, deaths caused by sepsis in a resident with an untreated urinary tract infection or chronic kidney problems; or the death of a developmental center resident in a local hospital death directly caused by pneumonia following emergency surgery for bowel obstruction.

Separate from investigations conducted by OPS, every incident report also must be critically and thoughtfully examined at each level of program management and administrative review to ensure a sufficiently probing investigation and to prompt swift corrective action to minimize the likelihood of a similar incident. Program managers and facility administrators bring a different understanding and perspective to incidents than OPS and have the authority to immediately implement changes in practice or the environment. For example, a restraint related injury might be reviewed by OPS for abusive or improper application of the restraint device while clinical managers may recognize the necessity to swiftly review and revise a resident's program or behavior plan to implement additional restraint alternatives or to consider whether restraints can be safely used with the resident.

5. Require the Department to augment their incident data reporting system to detect patterns of abuse and neglect.

The Department maintains an incident reporting procedure for "special incidents"² involving any regional center client, not just developmental

² Special incidents include: cases in which a consumer is missing and the vendor or long-term health care facility has filed a missing persons report with law enforcement; reasonable suspected abuse or exploitation; reasonable suspected neglect; serious injury or accident; certain unplanned or unscheduled hospitalization; the death of any consumer;

center residents. This system would be enhanced by developing a process of regular “data mining” by dedicated, trained staff, for the purpose of identifying trends or suspicious patterns of incidents in developmental centers or with particular vendors or providers (day programs, transportation service providers, residential care providers). The Department should use the identified trends to swiftly develop systemic reform or to require regional centers to ensure reform by regional center vendors. This might include directing a secondary investigation into the trend or developing or revising an existing policy or a treatment protocol to ensure future incidents are swiftly identified and addressed. For example, if the Department detects a pattern of genital lacerations in one facility or a series of deaths associated with bowel obstruction, they should immediately take corrective action to prevent future incidents. A refined system should clarify the responsibility for reviewing serious injuries which are not witnessed so that possible abuse or neglect is detected.

The data should be mined by facility and provider and incorporated into annually reviews of vendor performance and at the time when vendor agreements are renewed. Critical incidents should trigger immediate notification to other regional centers using the vendor and might indicate the need for an immediate review of the provider and/or suspension of the vendor agreement.

6. Require the reporting of all unexpected or suspicious deaths and sexual assaults of developmental center residents which involve staff to the state Protection and Advocacy agency.

Protection and Advocacy agencies (P&As) are granted broad access to information pertaining to the death of a person with a developmental disability.³ The only mandated reporting to P&As currently required are those deaths or serious injuries occurring during or related to the use of seclusion or behavioral restraint.⁴ Currently, we do not routinely receive reports of non seclusion or restraint abuse or deaths of residents in developmental centers. We also do not currently receive notification of sexual assaults. We recommend that the Department be required to report these incidents directly to the P&A no later than the close of the business day following their discovery.

cases in which a consumer is the victim of a crime; and unusual occurrences reportable to licensing. Cal. Code Regs. tit. 17 §54327.

³ See Welf. & Inst. Code § 4903(e)(2).

⁴ See Health & Safety Code § 1180.2(e).

II. Recommendations for Local Law Enforcement

1. Require local law enforcement to partner with OPS to conduct investigations into critical incidents referred by OPS.

Local law enforcement officers often lack expertise in interviewing victims with disabilities. They are unfamiliar with the culture and practices of developmental centers that might prove invaluable in determine if abuse or neglect was involved – things like daily routines, resident monitoring, record keeping, emergency procedures, and general and individual resident disability accommodations. OPS officers know who to talk to and where to get the information. Partnering with OPS staff who are familiar with the policies and practices in developmental centers will augment law enforcement's investigations of critical incidents.

2. Ensure that local law enforcement officers maintain competencies in interviewing and investigating cases involving victims with developmental disabilities.

Many officers and investigators in local law enforcement agencies lack experience and are uncomfortable interviewing people with developmental disabilities. These interviews may take more time or periodic breaks and may require several interview sessions. Victims may require assistive communication devices or the presence of familiar individuals. The officer may need to modify his/her language or manner of communication to be understandable to the victim.

Law enforcement should maintain liaisons and partner with organizations and advocates serving people with developmental disabilities in their community. Regional centers may be available to assist with interviews or to conduct training to law enforcement regarding working with people with developmental disabilities.

The Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) is mandated to provide trainings to local law enforcement and prosecutorial personnel in investigating and prosecuting crimes against dependent adults and elders, and to representatives from the Adult Protective Services and long term care ombudsmen in evaluating and documenting criminal abuse against dependent adults and elders. BMFEA should ensure it satisfies its

obligation to provide this training, particularly in those jurisdictions that do not have designated staff with expertise in the area of dependent adult and elder abuse. We encourage the Department to ensure that OPS representatives from each developmental center attend these trainings.

III. Other Systemic Recommendations

- 1. Amend the Mandated Abuse Reporting Act to require that all known or suspected abuse and neglect involving residents of long term care facilities in the community be immediately reported to law enforcement and the long term care ombudsman.**

The language in the Mandated Reporting Act that permits reporting of known or suspected abuse or neglect “as soon as practicable” is vague and invites reporting delays. This language should be deleted. Mandated reporters must be required to report all incidents immediately.

Mandated reporters in community settings are offered the option of either notifying the long term care ombudsman or law enforcement of complaints about abuse and neglect in long term care facilities. It is essential that mandated reporters no longer be permitted to fulfill their reporting obligation by only notifying the ombudsman. Most incidents of abuse rise to the level of possible criminal conduct and should be treated as crimes and reported to local law enforcement. Permitting reports of possible criminal conduct to be made to lay investigators reduces the gravity of the offenses and delays or even precludes the collection of evidence critical for prosecution.

- 2. Ensure that the state Protection and Advocacy agency ready access to unredacted Department of Public Health citations involving people with disabilities.**

To fulfill our federal mandate to investigate incidents of abuse or neglect of any person with a disability, it is critical that the state P&A promptly receive all citation reports unredacted. For purposes of abuse or neglect investigations, P&As are granted broad access to “examine all relevant records” including “reports prepared by an agency charged with investigating reports of ... abuse, neglect, injury, or death.”⁵ Separate from our investigations authority, P&As are also entitled to access “information in reports prepared by ... entities performing certification or licensing

⁵ See Welf. & Inst. Code § 4903(b)(2).

reviews.⁶” Requiring P&As to jump over bureaucratic hurdles to get ready access to this information when the victim has a psychiatric or developmental disability is unnecessarily time consuming and may jeopardize the prompt initiation of an investigation. P&As should be provided unredacted copies of all citations within 10 days of their issuance by the Department of Public Health.

3. Develop a coordinated system to examine the larger issue of abuse and neglect of people with disabilities.

Given the extent of the issues identified, we recommend that the Legislature require the development of a coordinated system to address the issue of abuse and neglect of people with disabilities in all settings. Since California’s criminal justice and disabilities systems do not provide a clear picture of the incidence of abuse, neglect, and victimization of people with disabilities, we recommend beginning by developing a uniform statewide data collection system which captures information about the incidence of violence against people with disabilities. Victim disability information should be captured in abuse reporting forms used by law enforcement, Adult Protective Services, the long term care ombudsman and others in the abuse reporting and criminal justice systems. Outcome data on crimes reported should be collected, documenting the results of law enforcement investigations, referrals for and outcomes of prosecutions, and judicial determinations. Getting baseline information of the scope of the issue and particular problematic areas is a good place to start developing focused reform initiatives

We recommend that the Legislature designate one agency with the authority and responsibility for spearheading the focus on abuse and neglect of people with disabilities and coordinating reform measures. The Department of Justice, within which is housed the BMFEA, may be well situated to assume this role and assure a coordinated system of services that will significantly reduce the risk of victimization and unequal access to justice for victims.

4. Develop a system for reporting and tracking abusive care staff.

California currently requires many care staff to clear a fingerprint background check before being hired or as a term of continued employment. This system matches an applicant’s fingerprints with criminal conviction records. But, given how few cases are referred for prosecution and the even smaller number resulting in a criminal conviction, this is a woefully inadequate means of ensuring abusive staff

⁶ See Welf. & Inst. Code § 4903(c)(1).

are precluded from working with people with disabilities. California should develop a system for the reporting and tracking of care staff with allegations of abuse substantiated by the Department of Public Health, the Department of Developmental Services, the Department of Mental Health and other state oversight agencies, including those not resulting in a criminal conviction.

Ideally, the system would include a centralized database where employers could report staff who were terminated from employment because of a substantiated claim of abuse. This system would allow the tracking of unlicensed staff for whom no licensing entity or certification board is providing oversight. To ensure due process, the system should include an appeal process for care staff to challenge their entry into the database. The database would be searchable by all prospective employers in a variety of care settings - from skilled nursing and assisted living facilities to in-home care.