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Report of
an Investigation into the Failure to Protect
Residents of California's Developmental Center
from Physical Abuse

Note: When this report was originally published, we were known as Protection & Advocacy, Inc. (PAI). In October 2008, we changed our name from PAI to Disability Rights California.

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I. INTRODUCTION

Protection & Advocacy, Incorporated (PAI) is a private non-profit law corporation established to protect and advocate for the rights of Californians with mental and developmental disabilities. Under state and federal law, PAI has the authority to pursue legal, administrative, and other appropriate remedies to protect and advocate for the rights of eligible individuals and to investigate incidents of abuse and neglect when such incidents are reported, or if PAI determines there is probable cause to believe such incidents have occurred.

PAI began this investigation after the death of Joseph A. Bacaylan on January 14, 1992. At the time of his death, Bacaylan was a 29-year-old resident of Agnews Developmental Center (ADC). According to the Santa Clara County Medical Examiner's report, the cause of Bacaylan's death was a "stab wound of the chest and blunt abdominal trauma." The Santa Clara Police subsequently arrested Frank Vasquez, a psychiatric technician at ADC. The Santa Clara District Attorney's Office charged Vasquez with one count of First Degree Murder in the death of Bacaylan and one count of Felony Dependent Abuse upon another ADC resident. On August 4, 1992, Vasquez plead guilty to voluntary manslaughter in Bacaylan's killing and "no contest" to the charge of dependent adult abuse.

Between 1979 and 1985, Vasquez was employed at Stockton Developmental Center (SDC). While employed at SDC, he was the primary suspect in the beating of an SDC resident with profound mental retardation.

PAI's investigation focused on whether developmental center staff complied with the policies and procedures of the Department of Developmental Services (DDS), ADC, SDC, and the laws of the State of California governing reporting and investigation of dependent adult abuse.

On May 12, 1992, PAI released an interim summary of its ongoing investigation, observing in part that: "[B]ecause the failure to protect ADC residents from known or suspected abuse and neglect appears systemic in nature, remedial measures must address the need for institutional reform state-wide."

The purposes of this report are, to the extent possible in a public document, to set forth: (1) PAI's findings and recommendations for addressing systemic abuse and neglect; and (2) the facts underlying PAI's findings and recommendations.

PAI's five month investigation included:

Three weeks of intensive investigation at ADC and SDC interviewing direct care staff, supervisors, managers and administrators.

Interviewing personnel from the California Department of Health, Licensing & Certification Division (Licensing) and the Santa Clara County Long-Term Care Ombudsman's (LTCO's) Office.

Reviewing the abuse and neglect, and personnel policies and procedures of DDS, ADC, and SDC.

Reviewing the Santa Clara Police Department's crime reports regarding the death of Joseph Bacaylan.

Reviewing the Santa Clara Medical Examiner's reports regarding the death of Joseph Bacaylan.

Reviewing all ADC Special Incident Reports (SIRs) from Program 6, including Unit 632, for the year 1990; and all SIRs from Unit 632 for 1991 and the beginning of 1992.

Reviewing clinical records of 11 present and former Unit 632 residents.

Reviewing 1991 & 1992 Licensing reports for ADC, with a particular focus on Unit 632 reports.

Reviewing Licensing files for SDC from 1985 to present. Reviewing ADC and SDC personnel records regarding Vasquez.

Reviewing the SDC internal investigation report regarding the 1985 abuse incident at SDC which allegedly involved Vasquez.

Reviewing Unit 632 Daily Logs and Staffing Reports from June 1990 through March 1992.

Reviewing Unit 632 injuries and patterns of injuries.

PAI would like to thank the management and direct care staff of both ADC and SDC for their cooperation in this investigation. PAI especially wants to

acknowledge those staff members who stepped forward with courage and candor to expose the disturbing pattern of abuse and neglect that culminated in the death of Joseph Bacaylan on January 14, 1992.

II. EXECUTIVE SUMMARY

In recent years, public policy has given little attention to the investigation and reporting of physical abuse within California's developmental center system. That changed following January 14, 1992, when Joseph Bacaylan, a twenty-nine-year-old resident of Agnews Developmental Center (ADC), was killed by psychiatric technician Frank Vasquez. ADC is one of seven such state-run facilities serving more than 6,000 Californians with developmental disabilities.

PAI investigated the circumstances surrounding Bacaylan's death to identify what systemic problems, if corrected, would prevent such tragedies from occurring in the future.

PAI's investigation revealed that, despite numerous laws and policies aimed at protecting developmental center residents from physical abuse, residents remained at serious risk of harm because direct care and management staff repeatedly failed to comply with basic reporting requirements. In addition, because developmental center management and the Department of Developmental Services (DDS) have not given allegations of physical abuse the attention they warrant, effective strategies for preventing such abuse on a system-wide basis have not been implemented.

A Population At Risk

PAI's findings confirmed that developmental center residents with profound disabilities, such as the residents of ADC's Unit 632 where Bacaylan was killed, and numerous other residents injured, are at high risk for physical abuse. ADC failed to recognize and respond effectively to factors contributing to this risk, which include: (1) the nature of individuals' disabilities, and their vulnerability and isolation, (2) inadequate supervision and staffing, and (3) institutional dynamics such as fear of retaliation for reporting known and suspected abuse.

Inadequate Response to Life Threatening Emergencies

PAI's findings indicate that ADC failed to provide Bacaylan with basic nursing and medical care following his injuries. Direct care staff ignored significant changes in his behavior, including uncharacteristic lethargy and listlessness, for nearly two hours.

Once the stab wounds were discovered, Bacaylan did not receive basic emergency medical services. For example, despite obvious signs of shock—blue lips, shortness of breath, extreme agitation, and a dangerously low blood pressure—no one attempted to administer intravenous fluids or obtain a chest x-ray. Medical staff sutured the wounds before probing the depth of the wounds to discover that Bacaylan was bleeding internally. As a result, time and evidence were lost.

In addition, preliminary investigation by the hospital police was inadequate. For example, the hospital police made no mention of blood splatters on the ceiling and around Bacaylan's bed— obvious signs of suspected violent injury. Nor did hospital police gather other basic information, such as identification of potential witnesses.

Inadequate Reporting Practices

PAI's investigation revealed a repeated failure by ADC to recognize, report, and track individual cases of known and suspected abuse, as well as patterns of injuries potentially indicative of physical abuse, such as repeated bruising and abrasions. Even obvious and painful injuries such as penis lacerations and broken ribs went unrecognized and unreported. PAI's findings suggest an ongoing failure by ADC to report allegations of known and suspected physical abuse to mandated investigative and protective services agencies, including law enforcement.

Inadequate Personnel Practices

In addition to inadequate supervision of direct care staff, PAI's findings also revealed that developmental centers failed to take appropriate disciplinary action when staff was suspected of inflicting abuse. In 1985, for example, Vasquez was considered the "primary suspect" in the severe beating of a Stockton Developmental Center (SDC) resident. The incident was not reported out to any external agency, and no personnel action was taken. Moreover, personnel policies failed to ensure that individuals with a known history of poor performance and with questionable backgrounds would not be allowed to work in direct care positions. Although Vasquez had been determined "ineligible for rehire" by SDC, had a history of chronic absenteeism and adverse actions, and had been arrested and convicted

four times for driving under the influence, he was hired as a "transfer" at ADC anyway.

Recommendations

Based on these major findings, PAI recommends a number of specific actions to ensure more adequate reporting, investigation and prevention of dependent adult abuse within the developmental center system. PAI has discussed these recommendations with DDS, which has voiced support for the recommendations. DDS has already taken steps to implement some of these recommended actions.

A. Ensuring More Effective Reporting, Tracking, and Investigation of Allegations.

1. All developmental centers should have a uniform special incident reporting system which ensures that all injuries that may suggest physical abuse are identified and tracked. In reviewing the clinical records of Unit 632 residents, PAI investigators found that only 12% of the injuries potentially indicative of physical abuse resulted in the generation of special incident reports (SIRs). DDS should ensure that the definition of what constitutes a special incident is changed to implement this requirement. DDS should also ensure that a centralized, comprehensive system for the identification and tracking of special incidents is developed and implemented on a state-wide basis.

2. All developmental centers should have policies and procedures that ensure the reporting of dependent adult abuse to appropriate external protective and investigative services agencies. DDS should ensure that these requirements are carried out, especially the requirement that potential crimes be reported out to appropriate law enforcement agencies for investigation and disposition by the local district attorney's office. DDS should also ensure that all policies and procedures make clear that administrative responsibility for overseeing the investigation of abuse and neglect at developmental centers

does not include discretion over whether to comply with mandatory reporting requirements to external protective agencies.

3. All developmental centers should ensure that reporters of suspected and known abuse are supported and protected from retaliation. At ADC, a unit supervisor was "counseled" for cooperating with evaluators from the California Department of Health, Licensing & Certification Division (Licensing). Later, this same unit supervisor failed to act when observed physical abuse of a Unit 632 resident was reported to her directly.

B. Strengthening Oversight of Reporting and Investigation of Allegations.

1. DDS should periodically review the reporting rates of developmental centers for dependent adult abuse and neglect to detect possible signs of poor reporting practices. DDS should conduct on site reviews at all developmental centers which consistently evidence very low reporting rates.

2. DDS should develop a reliable protocol for checking the quality of developmental center investigations. This protocol should ensure that a reliable sample of all such investigations, including investigations of "unfounded" and "undetermined cases", are reviewed to ensure the quality of developmental center investigations. Investigations should be reviewed pursuant to a standard checklist which evaluates key indicators, including:

comprehensiveness and accuracy of initial special incident reports and final investigation reports;

prompt removal of the alleged perpetrator from direct care where indicated for the safety of the resident/victim or other center residents;

prompt initiation of an internal investigation and compliance with all external notification requirements; and

prompt securing, sketching, and photographing of the scene of the incident and conduct of physical exams, when appropriate.

C. Ensuring Basic Care and Adequate Preliminary Investigations of Abuse-Related Injuries.

1. ADC should modify applicable protocol and training to ensure that developmental center residents receive competent nursing and medical care for abuse-related injuries. Special attention should be given to strengthen direct care staff's observation skills. ADC should ensure that unit medical staff receives adequate training to identify and treat life- threatening conditions pending transfer to an appropriate acute care facility.

2. DDS should ensure that developmental center personnel, such as hospital police, receive adequate training to conduct preliminary investigations. If Bacaylan's injuries had not been so blatant and a Coroner's investigation initiated, the underlying abuse that caused his injuries might never have been discovered.

D. Enhancing Prevention Efforts.

1. All developmental centers should have hiring and personnel practices which adequately protect developmental center residents from foreseeably abusive direct care workers. Since Bacaylan's death, DDS has adopted new hiring policies which specify improved practices in these areas:

Mor
e thorough reference checks and sharing of information within the developmental center system;

procedures for processing and updating fingerprint requests and evaluating relevant negative information received from the Department of Justice; and

increased training of all managers and supervisors concerning abuse and neglect.

DDS should implement an effective mechanism for monitoring compliance with the new hiring policies.

2. DDS should show greater leadership in helping developmental centers recognize and respond to resident, employee and institutional characteristics which place developmental center residents at greater risk for abuse. DDS should develop more effective strategies for breaking the "code of silence" among staff and protecting those who report abuse and neglect from actual and perceived retaliation. On the day Bacaylan was killed, a staff person witnessed the ongoing beating, but did nothing to stop it.

III. INVESTIGATION

A. CIRCUMSTANCES SURROUNDING THE DEATH OF JOSEPH BACAYLAN

Joseph Bacaylan

Joseph A. Bacaylan, the son of Joseph and Gloria Bacaylan, was a 29-year-old man of Filipino descent. Around the age of three, Joseph, or "Jo Jo" as he was called, became severely disabled following a near drowning accident in the Sacramento River. After the accident, Bacaylan developed behavioral problems characterized by emotional withdrawal, extreme anxiousness and assaultive behavior. Upon admission to ADC on September 3, 1980, Bacaylan was a 17-year-old youth with profound mental retardation and possible schizophrenia. Like many ADC residents, Bacaylan was essentially nonverbal.

What follows is a summary of significant observations and information conveyed by ADC staff to PAI investigators directly and to the Santa Clara Police Department as set forth in their crime report.

Interviews with Staff Person No. 1 (SP#1)

According to SP#1, he first saw Vasquez struggling with Bacaylan at breakfast in the dining room on the morning of Tuesday, January 14, 1992. SP#1 did not think too much of this as Bacaylan did not like to go to the dining room to eat. SP#1 then saw Vasquez physically take Bacaylan down to the tile floor, putting Bacaylan on his back. While holding Bacaylan's wrists with arms extended into the air, Vasquez then came down on Bacaylan's neck with his knee. He remained on Bacaylan's neck area until Bacaylan was almost unconscious. SP#1 further stated that on this same date he "also saw Vasquez take [Bacaylan] to the floor, again putting [Bacaylan] on his back and grabbing his wrists, holding [Bacaylan's] arms

and hands up in the air. Vasquez would then drop to his knees onto Bacaylan's abdominal area."

SP#1 stated that on at least one occasion on January 14, 1992, he saw Vasquez escort Bacaylan into the cubicle next to where SP#1 was standing. SP#1 stated that he "heard noises which made him feel certain that Vasquez was more than likely hitting Bacaylan with possibly a closed fist about the torso area."

SP#1 told PAI investigators that he witnessed these events before 10:00 AM, at which time he had to leave the unit to help his wife with her car, and that he was gone until approximately 11:00 AM. SP#1 also related that he went to lunch from approximately 12:30 to 1:30 PM that day and that during that period Vasquez would have been the only direct care staff supervising the group of about ten patients, including Bacaylan.

The Santa Clara Police asked SP#1 if he felt Vasquez was physically abusing Bacaylan. He replied, "In my opinion he was." SP#1 also thought that Vasquez was in violation of ADC's policies and procedures regarding client abuse.

SP#1 stated that upon his return from lunch around 1:30 PM he noticed a significant change in Bacaylan's behavior. SP#1 stated that between the time SP#1 returned from helping his wife at 11:00 AM, and the time SP#1 went to lunch at 12:30 PM, Bacaylan "appeared to be very energetic and was very assaultive in behavior." SP#1 related that after lunch, Bacaylan appeared "to be somewhat listless with not much vigor. He appeared to be lethargic—almost as if he was tired or had no energy." When asked what he thought caused this change, SP#1 replied that "maybe Bacaylan had been medicated or even over-medicated" while SP#1 was away at lunch. SP#1 asked Vasquez if he had medicated Bacaylan and was told "No."

SP#1 did not notice any blood on Bacaylan's clothing that day.

At approximately 2:15 to 2:20 PM that day, Staff Person No. 2 (SP#2) came in early for the PM shift and asked SP#1 about Bacaylan's condition. SP#1 told him, "Well, he's good, but it's kind of weird. He's kind of too good." They further discussed Bacaylan's behavior because another client

came into the room, whom Bacaylan always attacked. Bacaylan, however, did not move. Both SP#1 and SP#2 commented that this was strange. SP#1 related that he and SP#2 were both looking at "Jo Jo" when Vasquez walked by. Then all three staff persons discussed Bacaylan's behavior, and Vasquez said, "He's probably just tired."

During his interview with the police, SP#1 was shown an entry in Bacaylan's records signed by Vasquez: "12:00 Jo Jo assaulted the staff and peers. Unable to redirect. Called into the physician and received orders for two-point wrist to waist soft ties to prevent injury to staff/peers." SP#1 was asked if this in fact occurred and he stated, "Jo Jo was never put in ties that day."

SP#1 was then shown another entry signed by Vasquez: "12:10 PM Placed in two-point wrist to waist soft ties for assault." SP#1 again stated that Bacaylan was never in any restraints that day. He was then shown an entry that stated on 1-14-92 at 1400 hours (2:00 PM): "Removed wrist to waist soft ties for ROM." This entry was also signed by Vasquez.

SP#1 reiterated that at no time was Bacaylan restrained on Tuesday, January 14, 1992, and that he could offer no explanation as to why Vasquez would put such entries into the chart.

Interviews with Staff Person No. 2 (SP#2)

SP#2 was assigned to the PM shift on Unit 632. He said that on January 14, 1992, he arrived for work at approximately 2:30 PM and had a discussion with SP#1 about "Jo Jo." Shortly before 3:00 PM, SP#2 saw Bacaylan coming out of the bathroom with his pants down. He told Bacaylan to pull up his pants and took Bacaylan back to his bed in the dormitory area. SP#2 then noticed a laceration on Bacaylan's right thigh and dried blood on his clothing. SP#2 immediately notified his supervisor.

SP#2 attempted to obtain vital signs from Bacaylan. He requested that Bacaylan take off the jacket and white T-shirt he was wearing. SP#2 noticed dried blood on the back of Bacaylan's T-shirt and found a second laceration on his back shoulder area. SP#2 noted that Bacaylan's skin was

grayish in color, and that Bacaylan was also cold to the touch and that he would not stay still.

According to SP#2, Bacaylan was then taken to the medical (examination) room on the unit where he was sutured by Doctor No. 1 (Dr.#1). SP#2 told interviewers that "the two wounds were clean cuts" and that he thought they were stab wounds. He did not, however, tell this to the physician suturing the wounds. SP#2 remembered other staff in the medical room talking about broken glass. However, because the wounds were without jagged edges, it was his opinion that they were not caused by glass. He also related that Bacaylan's pants had a cut in them slightly above the cut on the thigh. SP#2 also did not believe Bacaylan's injuries were caused by another resident.

As SP#2 was escorting Bacaylan toward the medical room, Bacaylan collapsed after about five steps. Once in the medical room, SP#2 noticed that Bacaylan's breathing was shallow. At one point, staff tried to get Bacaylan to sit up on the examination table, but Bacaylan collapsed. Bacaylan then collapsed for the third time. At this point, Dr.#1 attempted to administer oxygen but Bacaylan resisted.

Interviews with Staff Person No. 3 (SP#3)

SP#3 gave essentially the same version of the above sequence of events as SP#2. He stated that after Bacaylan collapsed on the floor of the medical room of Unit 632, the physician ordered oxygen to be administered. SP#3 also noticed that Bacaylan's lips were blue. SP#3 dialed the hospital operator for an ambulance and the operator asked if he wanted paramedics. SP#3 asked how far away the hospital ambulance was and was told about two or three minutes; he declined the paramedics and the ambulance arrived shortly to transport Bacaylan to Unit 94, the infirmary at ADC, per Dr.#1's orders. This was at approximately 4:45 PM.

Interviews with Doctor No. 1 (Dr.#1)

Dr.#1 stated that he recalled receiving a phone call at approximately 3:30 PM on January 14, 1992, to examine Bacaylan because of lacerations to his right thigh and back that might require sutures. Dr.#1 proceeded to the

medical room on Unit 632. Bacaylan was brought into the examining room naked. According to Dr.#1, Bacaylan was accompanied by three staff persons and was resistive and combative.

Dr.#1 documented that the right thigh cut was approximately 2 centimeters in length and that on the upper left of Bacaylan's back was another laceration approximately 1-1/2 centimeters long. Dr.#1 also documented that he scrubbed both wounds of dried blood, administered a local anesthetic and closed the right thigh laceration with three sutures.

Dr.#1 said that Bacaylan was then turned over on his stomach and that he examined the wound on Bacaylan's back. Dr.#1 stated that he could not see how deep the wound was because Bacaylan was thrashing around. Dr.#1 stated that there was no fresh blood around either wound. Dr.#1 said that due to Bacaylan's moving around he was not able to obtain a blood pressure reading. Dr.#1 stated that he did listen to Bacaylan's chest with a stethoscope but could not hear any gurgling or noises within the lung to indicate to him that the cut to the upper back was deep enough to have caused bleeding into the lung.

According to Dr.#1, it took approximately 15 minutes to suture both wounds. During the procedure, Bacaylan's face appeared to be pale and his lips were turning blue. Dr.#1 again checked Bacaylan's chest, but believed that his lungs appeared normal.

Dr.#1 related that as the staff were assisting Bacaylan off the examining table, he collapsed twice and was placed on a sheet on the floor where Dr.#1 administered oxygen. Dr.#1 said that when this was done, some color returned to Bacaylan's face. However, his lips remained somewhat blue.

When Dr.#1 was asked if he ever probed the wound on Bacaylan's back to determine its depth, he responded that he had attempted to examine it more closely but was unable to do so because Bacaylan resisted.

Dr.#1 said that he performed a rectal examination to check for any blood. Dr.#1 stated that at 4:04 PM he observed "yellow colored stool covered

with black color." He also stated that Bacaylan's breathing was very shallow.

Dr.#1 said that he talked with Doctor No. 2 (Dr.#2) and ordered Bacaylan to be transported to Unit 94, the infirmary.

Dr.#1 was asked what would cause Bacaylan's blood pressure to be 80/40 (when he was admitted to Unit 94). He stated, "It could be some type of internal bleeding or a drug like Haldol or Mellaril, which are drugs for behavior control and in fact they are used to control psychiatric reactions and these are in fact medications that are being administered to Jo-Jo."

Dr.#1 related that later that evening he was informed that Bacaylan had died while being examined on Unit 94.

Dr.#1 was asked what he thought at the time had caused the lacerations to Bacaylan. Dr.#1 said that he was told that the wounds were possibly glass cuts from medication bottles that had been broken on the unit earlier that day. When asked what he thought they looked like, Dr.#1 stated that he thought the wounds had come from some sharp instrument as they were clean wounds. When asked why he didn't say something or enter his observations into Bacaylan's medical chart he responded that the doctors rely on the staff to tell them the causes of injuries.

Dr.#1 stated that there are not many knife wounds treated at ADC.

Dr.#1 was then questioned about a report prepared by him dated January 21, 1992, and entitled "RELEASE SUMMARY - DEATH." In this report Dr.#1 described the circumstances surrounding Bacaylan's death. He stated the cause of death as "Cardiopulmo- nary arrest of unknown etiology."

Dr.#1 was asked if, at the time he prepared this report, he was aware of the autopsy reports from the Santa Clara County Medical Examiner's office which confirmed that Bacaylan died of internal bleeding brought on by a stab wound to the chest and blunt trauma to the abdomen. Dr.#1 stated that he was aware of these facts when he wrote the release summary.

Dr.#1 was then asked why none of this was mentioned in his report. He responded that this was always done for "legal reasons."

Interviews with Doctor No. 2 (Dr.#2)

Dr.#2 related that on January 14, 1992, he was the physician on duty in the infirmary and received a phone call around 4:00 to 4:15 PM from Dr.#1 regarding Bacaylan. He stated that Dr.#1 informed him of Bacaylan's general condition and that Bacaylan had lacerations on his right thigh and back. Dr.#1 also told Dr.#2 that he thought this might be a case of over-medication.

Dr.#2 stated that he recalled Bacaylan arriving at approximately 5:00 to 5:15 PM on Unit 94, the infirmary (as opposed to Unit 96, in the same building, which is the acute care unit).

Medical records indicate that upon admittance to Unit 94 at 5:00 PM January 14, 1992, Bacaylan's vital signs were:

Pulse 84
Respiration 30
Pupils Reactive
Blood Pressure 80/40

Dr.#2 stated that Bacaylan fought him and his staff while they took his vital signs. Soon after arrival at the infirmary, Bacaylan stopped breathing. Dr.#2 stated that he attempted to use the Pulmonary Manual Resuscitator (Ambu-Bag) but it was not functional because a plastic fitting would not attach correctly. Dr.#2 stated that he immediately started cardio-pulmonary resuscitation (CPR). Dr.#2 also stated (and Bacaylan's medical records confirm) that an injection of epinephrine, not atropine, was administered.

Dr.#2 said that he could find no evidence of trauma to Bacaylan's body or any evidence of a collapsed lung. He did observe the sutured lacerations on Bacaylan's right thigh and back. He also remembered somebody telling him that the lacerations were possibly from broken glass.

Dr.#2 stated that in his 13 years at ADC he had never before treated a knife wound.

Dr.#2 stated that he pronounced Bacaylan dead at 5:43 PM and that notification was made to the Santa Clara County Medical Examiner's Office at 6:05 PM.

The hospital police were notified at approximately 5:49 PM and a hospital police officer responded to Unit 94 and wrote a case report. In this report, the officer wrote that upon his arrival, Dr.#2 was discussing the problems with the Ambu-Bag with another employee and that it was agreed that the fitting should be kept with the Ambu-Bag.

The officer further mentioned that the Coroner arrived to take possession of Bacaylan's body. The officer said that the Coroner took photographs of Bacaylan's body on Unit 94 and then took photographs of Bacaylan's clothing on Unit 632. The officer stated that the Coroner did note what were described as "small bruises" on Bacaylan's chest area, but he could not determine how fresh they were.

The hospital police officer stated in his report that he reviewed Bacaylan's sleeping quarters but did not mention any blood around or near the area.

Autopsy of Joseph Bacaylan

On January 15, 1992, an autopsy was performed on the body of Joseph Bacaylan at the office of the Medical Examiner for Santa Clara County. Report #92-014-013 states that the cause of death was a "Stab Wound of the Chest and Blunt Abdominal Trauma."

Dr. P., a pathologist, was asked to describe Bacaylan's injuries and, in particular, the chest wound. He described the wound as being "approximately one and one-half inches deep" and stated that "it nicked (cut) the left lung" and that "there was some bleeding around the left lung." Dr. P. further described the blunt trauma to the abdomen and said that he noticed some internal bleeding when he examined the body. Dr. P. said "there was also some bleeding on the interior of the abdominal cavity along the back side which eventually led (the blood) into the abdominal cavity."

In reference to the actual stabbing of the chest, according to Dr. H., also of the Coroners office, the chest wound should have been medically examined more closely because the left lung was nicked (cut) and was bleeding in the chest cavity. Dr. H. also commented that this injury, at a minimum, should have required an x-ray.

Dr. P. stated that his findings "showed that ribs number 7, 8 and 9 on the left side of the victim were broken and ribs number 8 and 9 on the right side of the victim were also broken."

Dr. P. commented on Bacaylan's chest injury and stated that a chest wound of this nature cannot be dismissed and sutured and that it has to be examined further (on the inside).

Dr. P. was then asked, "Is it safe for me to say that the victim slowly bled to death?" Dr. P. replied, "Yes."

Dr. P. then described the stab wound to Bacaylan's right thigh and stated that the instrument used to stab Bacaylan followed an upward motion (from just above the right knee stabbing in an upward motion toward the groin area) and was approximately 2-1/2 inches in depth.

Dr. P. further described the injuries within Bacaylan's abdominal cavity. He pointed out that there is a strong ligament adjacent to the liver and that it took a severe blow to tear this ligament. He stated that he located approximately 500 cc's of blood in the abdominal cavity and bleeding around the right kidney which totaled approximately 500 cc's of blood.

Interviews with the Special Investigator at ADC

The Special Investigator at ADC completed a report as part of his investigation into Bacaylan's death. In that report and in his interview with PAI investigators, the Special Investigator related the following information.

On January 14, 1992, he was on an assignment in the San Jose area and was notified of Bacaylan's death on Unit 94 at approximately 6:00 PM. The Special Investigator made phone contact with an ADC police officer and was advised of the facts surrounding Bacaylan's death as the officer knew

them. Because the ADC police officer apparently did not believe there was anything unusual about the death, the Special Investigator did not respond to the scene but instead gave the ADC police officer some instructions over the phone and went about his business. At approximately 9:00 PM, the Special Investigator talked by radio with the ADC police officer and asked if anything had developed that would require his coming into the hospital. The ADC police officer replied no, that the Coroner had come and gone.

The Special Investigator related that on January 15, 1992, at approximately 9:30 AM, the Coroner's Investigator came into his office and talked with him regarding Bacaylan's death. The Coroner's Investigator advised ADC's Special Investigator that he was there to conduct further investigation, as the autopsy revealed that Bacaylan might have died from extreme blunt trauma and the pathologist had found a large amount of blood in Bacaylan's stomach.

The Special Investigator and the Coroner's Investigator proceeded to Unit 632 and spoke with various staff members. Upon going to the sleeping area where Bacaylan had been the day before, they located blood splatters and smears in various places in the cubicle and corridor. The area was photographed by ADC's Special Investigator.

At approximately 2:00 PM, the Special Investigator met with the Executive Director of ADC, and advised her of the situation. They agreed to contact the Santa Clara Police and have them investigate a possible homicide. At approximately 4:00 PM, the Special Investigator contacted Sergeant Z. of the Santa Clara Police Department. Sergeant Z. and the Special Investigator then met on Unit 632 to begin the police investigation.

The Santa Clara Police investigated and Crime Report #285187, Case #9200664 was completed. As a result of their investigation, the Santa Clara Police arrested Frank Vasquez, a Psychiatric Technician on Unit 632, for the murder of Joseph Bacaylan.

On January 21, 1992, Felony Case #9202415, charging Vasquez with one count of First Degree Murder upon Bacaylan and one count of Felony Dependent Adult Abuse on another resident, was filed with the Santa Clara County Judicial District.

B. ANALYSIS OF INJURIES ON UNIT 632, AGNEWS DEVELOPMENTAL CENTER

Injuries of Unknown Origin
Patterns of Injuries Potentially Indicative of Physical Abuse
Severe Penis Lacerations of Residents Bacaylan and K.T.
ADC's Investigation of Lacerations
Inadequacies of ADC's Response to Penis Lacerations

Unit 632 is located on the bottom floor of a two-story stucco structure on the West Campus of ADC in Santa Clara, California. The unit, which houses a maximum of 41 residents, is licensed by the California Department of Health as an intermediate care facility for persons with developmental disabilities. The unit's average daily census for 1991 was 34 to 35 residents (28 to 29 males, 6 females). The unit is comprised of four groups of living quarters, arranged in an "H" pattern, with a centrally located nursing station. The residence is sparsely furnished. For safety reasons, pictures are bolted under plexiglass; furniture is chosen for structural integrity, durability, and easy cleaning.

Managed under Program 6, which focuses on behavior and social adjustment, Unit 632 serves individuals with severe developmental disabilities and behavioral problems. The program's goal is to "implement an individual habilitation plan that develops desirable and adaptive behavior enabling the individual to live, work, socialize, and enjoy leisure activities in a less restrictive environment."

Injuries of Unknown Origin

PAI investigative staff reviewed the clinical records of 11 Unit 632 residents (two former, eight current, and one deceased). From these records, which covered the time period from June of 1990 through March of 1992, a total of at least 209 injuries of unknown origin were identified. The total number of injuries from known and unknown origin was at least 295.

When comparing SIRs to injuries of unknown origin in the residents' clinical records, PAI investigators found that SIRs were generated less than 12% of the time such injuries were identified by PAI investigators. The persistent

failure to generate SIRs, either accurately or at all, is explained, in part, by ADC's vague definition of resident-related special incident, which is:

> *. . . any occurrence that is physically or psychologically harmful to an individual and/or is inconsistent with the individual's expected behavior or condition. Incidents which have minor consequences, such as superficial cuts and bruises due to the individual's condition or unusual behavior are not special incidents unless other factors add significance to the occurrence. (Emphasis in original.)*

PAI investigative staff also identified inconsistencies in the documentation of special incidents. For example, even though reviews of residents' clinical records indicated that the cause of certain injuries appeared to be unknown, staff nonetheless at times documented that such injuries were caused by a resident (i.e., "injury from another client"; "injury from a behavioral episode"; "aggressive act to self") rather than documenting that the injuries appeared to be of unknown origin.

Patterns of Injuries Potentially Indicative of Physical Abuse

The following classifications of similar types of injuries were taken from the 11 residents' clinical records and cross-referenced with available SIRs.

Penis/Scrotum Lacerations/Bruises

6/9/90, 0440: - Discovered client in shower, then observed "slightly bleeding sore/cut (difficult to distinguish) atop penis at base of shaft." Injury described as a bruise, approximately 1-1/2" wide around the penis with laceration of the top layers of skin, with some slight bleeding.

SIR - Open abraded area on penile base - totally discolored area below likewise noted.

7/27/90, 2200: - Cut (L) side of scrotum, appears approximately 1/2" in length; small amount of bleeding.

SIR - No corresponding SIR.

9/12/90, 2020: - Scrotum completely swollen, size of grapefruit. Penis dark, swollen. Scars and bruises all over back.

SIR - Abrasion in the left chest & left (illegible). Bruise in the inguinal area 10cm x 3. Genitalia - huge scrotum (the size of a big grapefruit). Dark color, with abrasion in the left scrotum also swollen in back of penis.

3/28/91, 2015: - Severe bruise on entire anterior aspect, shaft of penis. 2015 - Discovered by group leader at shower time to have a darkened bruised penis - origin unknown.

SIR - Penis is discolored; scrotum slightly swollen. Skin and subcutaneous tissue of dorsal penis - bruise (mild swelling & ecchymosis) about 4x7cm in size.

7/23/91, 1930: - 1-1/4" laceration on distal shaft of penis. 5 sutures.

SIR - Discovered at shower time by group leader to have a laceration with dried blood at head of penis.

8/15/91, 2000: - Blood in diaper discovered during preparation for shower; very large laceration across middle of penis (approx. 3/4" around, required 11 sutures).

SIR - Sustained a laceration around 2/3 penis circumference close to the base, one 1cm laceration near the big laceration & very superficial. Skin abrasion 1cm x 1/2cm. Wounds cleansed and repaired in 11 stitches (10 for big laceration & one for small laceration).

Injuries to Thigh/Pubic Area

7/11/90, 0400: - Large bruise to (L) (outer) thigh of client...Quite large with a great deal of discoloration.

SIR - No corresponding SIR.

1/1/91, 0800: - Upper inner (R) thigh, dark blue to purple bruise, approx. 1-1/2" wide at center and 2-1/2" long.

SIR - No corresponding SIR.

1/20/91, 2130: - Abrasions above pubic area. SIR - No corresponding SIR.

6/26/91, 2100: - Bruise on upper inner (R) thigh approximately 4" long and 2" wide. Skin unbroken and purple.

SIR - No corresponding SIR.

8/29/91, 0930: - Group leader reported abrasion, upper inner left leg (thigh). SIR - No corresponding SIR.

11/4/91, 2110: - Bruise on inner (R) thigh. SIR - No corresponding SIR.

Injuries to Chest/Abdomen/Limping

9/11/90, 0645: - Has assumed an unusual posture; is slowly ambulating about, doubled over at the waist. Group leader states that this has been observed over the past 2-3 days and feels that [resident] may be in some sort of pain.

SIR - No corresponding SIR.

7/22/91, 1005: - Limping, favoring (L) leg, unable to walk. Multiple superficial abrasions on both sides of (L) ankle, swelling on outer aspect of ankle. [At 2230, during showers: 4 abrasions (L) rib cage front.]

SIR - No corresponding SIR.

8/8/91, 0800: - Favoring right lower abdomen; abdomen muscles very tight. Goes into the fetal position immediately when on his back.

SIR - No corresponding SIR.

8/26/91, 0800: - Scrapes to (R) side of rib cage. [On 8/31/91: Has fracture of the 8th rib. Left side of the chest, bruising and abrasions over the left chest wall.]

SIR - No corresponding SIR.

12/31/91, 1000: - Brought back to unit with noticeable limp. SIR - No corresponding SIR.

1/14/92, 1500: - 2 cm. laceration on (R) anterior thigh + a 1-1/2 cm. laceration on

(L) posterior chest (upper back). Client is very pale; agitated. Small bruise on (L) lower abdomen.

SIR - Two were generated; one upon discovery of injuries and one upon death.

Analysis of these injuries reveals a persistent failure to generate SIRs and to identify patterns of potential client abuse. In particular, the data shows that:

Twelve out of 18 (or 2/3) injuries had no corresponding SIR.

Twelve out of the 18 (or 2/3) injuries were directly to or near the genitals (six penis/scrotum injuries; six groin area injuries)

Four out of six groin area injuries were to the upper inner thigh, and three were specifically to the right thigh.

Thirty-three percent of the 18 injuries over this observed 26-month period occurred in July/August 1991.

Two out of three genital lacerations occurred in July/August 1991.

Severe Penis Lacerations of Residents Bacaylan and K.T.

Two disturbing injuries occurred on Unit 632 within a three-week period in 1991. Residents Bacaylan and K.T. received severe penis lacerations. These injuries shared remarkable similarities:

> Both lacerations were around the circumference of and in a straight line perpendicular to the shaft of the penis.
>
> Both lacerations appeared to be mechanical, or created by a sharp instrument, such as a knife or razor blade.
>
> Neither laceration had the accompanying signs of trauma associated with a bite mark.
>
> Both lacerations required multiple sutures.
>
> Both lacerations were discovered by PM staff when residents were undressed for their showers.

Bacaylan's Laceration

On July 23, 1991, at 7:30 PM, staff discovered a 1-1/4" long laceration around the shaft and towards the tip of Bacaylan's penis while preparing him for his shower. The injury, while no longer bleeding, required five sutures. Unit 632 staff described the injury to PAI investigators as being deep and around the head of Bacaylan's penis.

An SIR was generated, including notification of medical, managerial, and administrative staff. Action to prevent further occurrence, according to the report, was: "investigation of incident in progress. Bacaylan was administered first aid upon discovery of injury. Residence (Unit 632) Manager to follow up with Special Investigator/findings. Client to be monitored."

On the back of the SIR it was stated:

> *Two group leaders supervising (Bacaylan) and his peers. Injury discovered at shower time—with dried blood on his penis. Nothing reported or noted at change of shift by either the AM or PM shift. 1) AM shift supervisor made detailed*

> *search of bedroom and bathroom for sharp objects or dangerous exposed sharp closet parts, bathroom counter, etc. Nothing found! 2) Possibility that (Bacaylan) cut himself with top of pudding container?? 3) A certain peer in (Bacaylan's) group does bite and resulting wound is noted to appear as a "slice" or cut. Physician feels that this might be so. 4) Special Investigator notified.*

No photographs were taken of the injury. No references were made to the injury Bacaylan received to his genitalia only ten months earlier, in September of 1990, in which his penis was severely bruised and his scrotum was described as "the size of a big grapefruit."

Despite the injury, Bacaylan was prompted by staff to participate fully in all daily activities while the injury was healing. There was a noted increase in Bacaylan's agitation and assaultiveness. The sutures were removed after 11 days.

K.T.'s Laceration

On August 15, 1991, at 8:00 PM, just 23 days after Bacaylan's penis laceration was discovered, staff removed K.T.'s diaper while preparing him for his shower, and found old and fresh blood from two lacerations on K.T.'s penis. One laceration was very large and deep across the middle of his penis. That laceration traveled approximately three-quarters of the way around his penis and required 10 sutures; a more "superficial" 1 cm laceration next to it required one suture.

Unit 632 staff described the injury to PAI investigators as being "so severe that an artery was almost nicked" and "K.T.'s penis was almost in two pieces." Because of the depth and severity of the wound, three internal sutures were required. K.T. was treated by Dr.#1, then transferred to the acute medical unit, where he was treated by Dr.#2. While at the acute medical unit, K.T. was physically restrained to prevent further injury. The sutures were removed after 11 days.

An SIR was generated, including notification of medical, managerial, and administrative staff. Action to prevent further occurrence, according to the report, was:

> *Special Investigator notified of incident to help determine the kind of injury re: bite or laceration. After investigation is complete appropriate action will occur depending on those findings.*

No photographs were taken of the injury. No references were made to the injury Bacaylan had received to his penis only 23 days earlier.

ADC's Investigation of Penis Lacerations

In addition to the SIRs, notification was made to the families of Bacaylan and K.T. shortly after each injury was discovered, as required by policy. An inspection of all Unit 632 male residents' genitalia was conducted by a health services specialist on August 21, 1991. No further injuries were discovered.

An internal investigation of the penis lacerations by an ADC Special Investigator began on August 19, 1991. In questioning Dr.#1, the Special Investigator noted that even though Dr.#1 had treated numerous bite injuries, K.T.'s injury "did not appear to be of the type caused by biting, because there was no tissue damage or trauma to the underside or opposite side of the penis from the laceration." Additionally, Dr.#1 stated that "the laceration was clean, sharp, straight, whereas bite injuries are generally ragged and have somewhat of a crescent shape." Despite the facts mentioned above, according to the Special Investigator's report, Dr.#1 "did not think about this situation as being done by another person." Dr.#1 had been on vacation when Bacaylan's penis was lacerated, and was not told about it until he had completed suturing K.T.'s injuries.

Unit 632 staff, upon questioning by the Special Investigator, described the laceration on K.T.'s penis as being mechanical. According to the staff person who discovered K.T.'s injuries, the cut was "straight, clean, and deep . . . made by a knife or razor blade." A search was conducted around K.T.'s bedroom and in the shower room, but staff "were unable to even find

a remotely possible item." Additionally, K.T.'s diaper appeared to have been on him "for some time, because it was sagging which is characteristic of that type of diaper after hours of wear." Although K.T. could remove his own diaper "by pulling it off," this staff person was certain that "he could not replace it or put a clean one on properly if he had to . . . none of the other residents in groups #1 or #4 would have the ability or inclination to replace a diaper if there was one available."

In an interview with the Special Investigator, another staff person agreed that K.T.'s injury "in no way could have been a bite" and appeared to be a razor cut. This same staff person referred to Bacaylan's similar injury, which she described as "not a zipper cut, a bite with jagged edges, or anything like that. The cut was straight lined and there was no injury to the underside of the penis . . . after the doctor sutured the cut it may have looked like a bite, but not before." Both of these staff persons expressed the opinion that the penis lacerations to Bacaylan and K.T. could not have been inflicted by another client. Moreover, because of their disabilities, the other residents could not have replaced a diaper properly.

The Special Investigator was particularly concerned that he had not been contacted immediately upon discovery of K.T.'s penis laceration, or at all after Bacaylan's penis laceration, despite indications on the SIR form that he had been so notified.

After interviewing a total of seven staff (five direct care staff, all of whom worked the afternoon shift), the Special Investigator concluded:

> *It is the finding of this writer that the injuries suffered by (K.T.) and (Bacaylan) were intentionally inflicted by another person. That person is not believed to be a resident (client) of ADC. This belief is based on the fact that no weapon or implement was found that could have produced such wounds. It is further the belief that none of the individuals living on that residence are capable enough to procure, use and hide the type of weapon needed to produce such wounds. At this time there is insufficient evidence to show that any specific person is responsible for causing the wounds. Therefore it is my*

recommendation that this case be closed at this time and reopened if additional evidence becomes available.

Inadequacies of ADC's Response to Penis Lacerations

PAI could find no indication that these severe injuries were reported to any agency outside ADC. Under California law and ADC policy, as discussed more fully in Section E of this report, Licensing, the Santa Clara LTCO, and the Santa Clara Police all should have been contacted regarding Bacaylan's and K.T.'s penis lacerations. PAI investigators were told by program management that because the injuries did not recur, it was thought that perhaps the injuries had been inflicted by one of the unlicensed staff that had been interviewed by the Special Investigator, and who no longer worked on Unit 632. A female client who was identified as biting "in a very straight manner" was eventually transferred to another residence.

PAI investigators were told by Unit 632 staff that although penis injuries were not considered uncommon, the penis lacerations resulted in considerable confusion and apprehension among staff. All of the staff members interviewed related that none of the residents could have inflicted such injuries. Neither victim was likely to be self-abusive. K.T.'s records state explicitly that he is unable to button, snap, or zip his own clothing, due to his limited motor coordination. The confusion and apprehension among staff was compounded by the fact that Unit 632 staff saw no result from ADC's internal investigation.

A psychiatric technician who was interviewed by the Santa Clara Police after Bacaylan's death recalled that when she informed the Unit Supervisor of Bacaylan's scrotum injury on September 12, 1990, the Unit Supervisor responded: "I don't know if my day shift is beating these guys or you are."

In reviewing ADC's daily staffing logs for July 23, 1991, through August 15, 1991, PAI investigators found that 10 staff were present during the morning and afternoon shifts for both days on which these lacerations occurred. ADC's investigation of the incidents involved interviews with only four of the 10 staff members present both days and none of the staff from the morning shift, when K.T.'s injury most likely occurred.

C. PERSONNEL POLICIES AND PRACTICES RELATING TO THE EMPLOYMENT OF FRANK VASQUEZ

When Frank Vasquez was hired at ADC in 1990, he had a known history of poor performance as a psychiatric technician, including adverse actions for chronic absenteeism. He had been determined ineligible for rehire by SDC, another state facility. He also had a criminal record of arrests and convictions for driving under the influence dating back to 1984. ADC decided to hire Vasquez as a direct care worker anyway. As discussed later in this report, when Vasquez allegedly physically abused resident D.H., in August of 1991, no personnel action was taken against Vasquez.

Work History at SDC

Vasquez was hired for the position of Housekeeper at SDC on December 17, 1979, and was appointed to the position of Pre-Licensed Psychiatric Technician on September 20, 1982. On November 18, 1982, he was appointed to the position of Psychiatric Technician and remained in that position until December of 1985, when he was "separated" from SDC for being "Absent Without Leave" for a period of at least five days. Section 19996.2 of the Government Code states in part that, "Absence without leave, whether voluntary or involuntary, for five consecutive working days is an automatic resignation from State service, as of the last date on which the employee worked."

Incident of Alleged Client Abuse at SDC in 1985

On October 29, 1985, Vasquez was allegedly involved in an incident of client abuse on SDC's Unit 366. A 44-year-old resident with profound mental retardation was severely beaten. The incident was investigated by SDC hospital police, who filed an internal report.

Vasquez and a Unit Supervisor generated an SIR concerning this allegation of physical abuse. A Special Incident Brief was also prepared and sent to DDS in Sacramento.

The following is a summary of what took place based on the SIRs, the internal report completed by hospital police, PAI interviews with the reporting officer and witnesses to the incident, and resident W.F.'s medical records.

On October 29, 1985, at approximately 1:10 PM, two psychiatric technicians heard a loud scream. When they came through the door of the group room, they noticed W.F. in the corner holding his genital area in obvious pain. Vasquez was standing approximately three feet away from W.F. They asked Vasquez what had happened but got no response. At approximately 1:35 PM, blood was observed on the crotch area of W.F.'s pants. The victim was asked what happened and he replied "fell down." Vasquez then took W.F. back to the unit.

At approximately 2:00 PM on October 29, 1985, W.F. was examined by Dr. W. of SDC. According to the medical records, the patient was "found to have slow oozing of venous blood from urethra - probably 50 ml total. There is no evidence of injury other than very superficial laceration 8 cms length center of scrotal sack. There is no evidence of bladder distension. BP 120/74. Bleeding stopped."

The next entry, at 6:29 PM, reads in part, "cannot void [urinate] since 1530 this afternoon. Scrotum swollen, bruised. Post-trauma to urethra, scrotum." A decision was made to transfer the victim to San Joaquin Hospital for further treatment, where he remained until November 6, 1985. At the hospital, a catheter was placed in W.F.'s bladder.

Hospital police set forth the following conclusions in their report:

1. It was determined that the injury the victim received was of great force to have caused such an injury.

2. It is determined by the evidence presented that the injury occurred at the time that victim screamed. At which time the

victim was seen in the hallway holding his groin area and suspect 3 to 4 feet from victim.

3. It's determined that such injury could not have been caused by falling on a flat floor, especially when there were no objects in the hallway that victim could fall on.

4. Several clients who were thought to have the highest potential to inflict any kind of injury were interviewed but none were found with the coordination and ability to inflict such injury.

5. Evidence showed that the suspect was asked what happened but did not answer the staff.

6. It's my conclusion due to all the evidence and facts presented that Frank is the prime suspect and the only one with the ability to inflict such injury at the time victim screamed.

The recommendation section of the investigation report states: "Case be left open and sent to the executive director for his review and recommendation."

Despite the hospital police's investigative report and findings set forth above, the section of the report entitled "Comments by Executive Director" states: "The protective services investigation indicates injury may have been accidental."

SDC did not notify W.F.'s parents of the incident until December 16, 1985, nearly six weeks after the incident occurred. SDC did not report the incident to the Stockton Police Department nor to the San Joaquin District Attorney's Office. SDC took no disciplinary action of any kind against Vasquez relating to this suspected abuse.

During their investigation, PAI investigators learned that, at the time of the 1985 incident, SDC management held the following perceptions regarding the effectiveness of pursuing allegations of serious physical abuse:

1. SDC did not take the incident to the State Personnel Board because there was not enough evidence to support an adverse

action and, in their experience, the Board requires almost an "airtight case."

2. SDC did not report the incident to the Stockton Police or the San Joaquin District Attorney because there was not enough evidence to convict Vasquez and, in the past, they had not had much success in getting either the police or the District Attorney to take much interest in incidents occurring at SDC.

This backdrop helps to explain, but not excuse, SDC's failure to take appropriate personnel action and report apparent crimes to law enforcement. Developmental centers do not have the authority to determine the merits of a potential criminal action. That responsibility and authority belongs to the District Attorney alone. Developmental centers do have a responsibility to report allegations of serious physical abuse to external protective services agencies, including the police and the District Attorney—if only to create a record.

W.F. was seriously beaten on October 29, 1985. Because of the injuries inflicted, he required in-patient hospitalization. If SDC had reported this potential felony abuse properly, the individual responsible for committing it might have been arrested. The report, even without an arrest, might also have deterred the perpetrator.

Even assuming that SDC would not prevail in an adverse action before the State Personnel Board, SDC offered no explanation for why they took no non-punitive action, such as counseling or increased supervision, in response to the allegation. In fact, neither Vasquez nor

W.F. was moved off the unit following the 1985 incident.

Separation From SDC in 1985

On December 23, 1985, Vasquez was served with a "NOTICE OF SEPARATION FOR ABSENCE WITHOUT LEAVE (AWOL)" due to being AWOL for a period of at least five working days. His employee record card, which remained in his employee file at SDC, is stamped:

> *WOULD NOT REHIRE. REASON: Verification for 2 years [i.e., verification of his psychiatric technician's license]. This year he has failed to supply verification 5 times. He has also been AWOL 10 times for which he received a Formal Letter of Reprimand. He has very low rapport with his peers.*

Between December of 1985, when he was separated from SDC, and December of 1988, Vasquez worked in various jobs in the construction industry. Vasquez was employed as a Charge Nurse at a private psychiatric hospital from December of 1988 until March of 1990.

Work History at ADC

On July 16, 1990, Vasquez was hired as a psychiatric technician at ADC. His application for employment with ADC indicates the following about his previous employment as a psychiatric technician and reason for leaving SDC:

> *12-8-88 to 3-11-90 [Private Psychiatric Hospital], Charge Nurse;*
>
> *12-11-79 to 12-22-85 Stockton Developmental Center; Psychiatric Technician; Reason For Leaving: Wanted to go back to school.*

Despite a 4-1/2 year gap in time and the fact that Vasquez had been determined ineligible for rehire by SDC, his employment at ADC in 1990 was handled as a transfer.

PAI investigators interviewed the Personnel Officer for ADC. The Personnel Officer related that she was unaware of the specifics of hiring Vasquez. The Personnel Officer was shown Vasquez's employee record card from SDC and was asked if she was aware of the fact that Vasquez was not eligible for rehire at the time he was hired by ADC in 1990. She looked at the copy of the card and stated no, she was not aware of that fact. The Personnel Officer was also asked if she was aware of the fact that Vasquez had been convicted in the State of California four times between 1984 and 1988 for violating Sec. 23152 of the Vehicle Code, driving under the influence of alcohol or drugs, and that at the time of his employment at

ADC, Vasquez's California driver's license had been revoked. The Personnel Officer replied that she was not aware of those facts either.

PAI investigators also asked about the employment gap of three years on Vasquez's application (between leaving SDC and employment at a private psychiatric hospital). PAI was told that it was assumed that Vasquez would have been questioned about that employment gap during the hiring interview. It was further related that at the time of Vasquez's hiring, ADC was aware of the adverse actions for poor performance from SDC and that he had been "separated" from SDC.

Even though Vasquez had a history of AWOLs and other performance problems, the decision was made to hire him because, according to ADC management, ADC had a hard time attracting employees. The major reason given for this difficulty was the high cost of living in the area.

Vasquez's personnel records from ADC indicate that in July of 1991 he was counseled by his supervisor for excessive use of sick time. The only adverse action in Vasquez's ADC personnel file is dated January 27, 1992, when he was terminated for allegations of client abuse in the death of Joseph Bacaylan.

Personnel Policies and Hiring Procedures

The Personnel Services Department of each developmental center is part of Administrative Services. The department is headed by a Personnel Officer who reports to the Administrative Services Director, who, in turn, answers to the Executive Director. According to ADC Administrative Directive #10-A-1:

> The Personnel Services Department of Agnews Developmental Center is established to plan, organize, administer, and supervise effective personnel policies, practices, and procedures so as to:
>
> a. Promote and coordinate recruitment of the best qualified personnel available.

In interviews with Personnel Officers at ADC and SDC, PAI investigators were told that the following is generally the procedure for hiring an employee in the position of Psychiatric Technician:

1. An application is filed with the personnel office.
2. The personnel office verifies the validity of the applicant's Psychiatric Technician License with the Department of Consumer Affairs and submits the applicant's fingerprints to the California Department of Justice (DOJ) for a criminal history check.
3. The applicant is interviewed by personnel from the program where he/she will be assigned to work.
4. Program personnel verify employment with two previous employers.
5. The employee is hired (prior to the return of the DOJ check).

The policy for employee finger printing and arrest notification is contained in DDS Policy #305 which in part states:

> *Developmental Center Police Officers, Special Investigators, Licensed Treatment Staff, and any other employees the Developmental Center deems necessary shall be cleared by the Department of Justice upon commencing employment and shall have any subsequent arrest reported by Department of Justice to the Developmental Center of employment.*

Criminal Record of Frank Vasquez

Prior to his employment with ADC, according to his California Department of Motor Vehicle records and Department of Justice records, Vasquez had been arrested and convicted on four separate occasions for driving under the influence, and, in 1988, his license had been suspended for four years.

Section	Violation Date	Conviction Date
23152(a) VC	01-20-84	03-01-84

23152(b) VC 05-12-84 10-02-84

23152(a) VC 02-19-87 03-22-88

23152(a) VC 02-13-87 04-04-88

Section 23152(a) of the Vehicle Code states: "It is unlawful for any person who is under the influence of an alcoholic beverage or any drug, or under the combined influence of an alcoholic beverage and any drug, to drive a vehicle."

At the time of Vasquez's arrest and conviction in 1984, Sec. 23152(b) of the Vehicle Code stated: "It is unlawful for any person who has 0.10 percent or more, by weight, of alcohol in his or her blood to drive a vehicle . . ."

Policies & Procedures Regarding Formal Adverse Actions

The policies relating to employee personnel files and adverse actions are contained in the DDS Administrative Manual, starting with Chapter 9000.

Adverse actions include:

1. Letter of Formal Reprimand
2. Suspension Without Pay
3. Demotion to a Lower Class
4. Reduction of Pay Within the Class
5. Dismissal from State Service

According to the personnel officers from ADC and SDC, Letters of Formal Reprimand are removed from an employee's personnel file automatically after a period of three years. This "expungement rule" is set forth in Government Code Sec. 19589, which states: "Letters of reprimand shall be removed from the personnel file of the State employee and destroyed not later than three years from the date the letters were issued." All other

adverse actions, unless there is a stipulation, remain in the personnel file forever. According to the State Personnel Board, such information includes, but is not limited to: attendance reports and related documents and legal investigatory files pending punitive (i.e., formal adverse) action. In the case of Vasquez, ADC knew of his prior adverse actions while at SDC, but hired him anyway.

D. ANALYSIS OF DEVELOPMENTAL CENTERS' REQUIREMENTS FOR RESPONDING TO ALLEGATIONS OF CLIENT ABUSE

Special Incident Reporting Requirements

In its July 29, 1991, Policy Memo #508, DDS explicitly recognizes that in order "to assure the best possible care, treatment and habilitation of individuals served in developmental centers", each developmental center must establish and implement a system for reporting to its management and to the State Developmental Centers Division special incidents "that threaten the well-being of [developmental center residents] and the effective operation of the developmental centers." Although DDS Policy #508 provides each developmental center with considerable discretion as to how it will identify and respond to incidents of abuse and neglect, at a minimum, Policy #508 requires each developmental center system to contain components which assure:

1. the safety of individuals living in developmental centers;

2. appropriate management awareness of investigations of each incident;

3. local corrective actions that lead to the prevention of future incidents of the same nature; and

4. prompt communication of information about possible system-wide problems such as death, rape, or possible litigation through special incident briefs sent to the Developmental Centers Division for departmental analysis.

Incidents that fall within the following general categories may be reportable by developmental centers as "Special Incidents" under DDS policy:

accidental injury aggressive
act to self aggressive
act to another client aggressive
act to staff
aggressive act to family/visitors
alleged client abuse
alleged violation of rights
complaint against facility contraband
criminal act death
event that endangers health or safety of client
fire
injury-unknown origin
injury-from a seizure
injury-from another client
injury-from a behavior episode
inappropriate sexual incident
intoxication
other (write in explanation)
overnight unauthorized absence
physician's order compliance error
possible litigation
pregnancy rape/sexual battery theft
withholding life support or do-not-resuscitate orders

The SIR is generated at the time a special incident is witnessed or discovered. Persons who witness or discover a special incident are usually direct care staff such as psychiatric technicians. Medical personnel may also enter documentation onto the form if the incident involves an injury

that requires their attention. The SIR form travels through unit and program management and then to administration.

Special Incident Brief Reporting Requirements

As noted above, certain special incidents must be reported to DDS in Sacramento via a "special incident brief." A special incident brief is defined as:

> *. . . a summary of an occurrence which creates unusual problems in develop- mental center operation or requires a statewide awareness of the need to correct operations of developmental centers. These occurrences have the potential to result in legal action involving the state or the department; in public concern or probable negative publicity or involvement of the Legislature or other public officials; or cause sufficient concern to the family or conservator of a client to also bring the occurrence to the attention of department administration.*

Special incident briefs must be transmitted by FAX to DDS within 48 hours following the incident. As noted earlier, a special incident brief was sent to DDS concerning the 1985 allegation of serious physical abuse upon SDC resident W.F. However, no adverse action was taken against the individual staff person who allegedly inflicted the abuse.

Executive directors at developmental centers have discretion over whether an incident is reported by special incident brief to DDS, except in the following instances, which must always be reported:

death
possible litigation
pregnancy
rape/sexual battery
withholding life support or do not resuscitate orders.

Special Incidents Defined

ADC defines a special incident as:

> *. . . an event or action of a person or any occurrence or attending circumstance which is unusual in that it has the potential to adversely affect the individuals served, the operation of the center, or does not fall within the framework of normal operating policy, current law, regulations, or accepted standards.*

A resident-related special incident is defined as:

> *. . . any occurrence that is physically or psychologically harmful to an individual and/or is inconsistent with the individual's expected behavior or condition. Incidents which have minor consequences, such as superficial cuts and bruises due to the individual's condition or unusual behavior are not special incidents unless other factors add significance to the occurrence. (Emphasis in original.)*

SDC defines resident-related special incidents more broadly than does ADC by requiring reports of "injuries, particularly those of unknown origin, resulting in significant tissue or organ damage (e.g., lacerations, bruises, abrasions, puncture wounds, etc.)." SDC also makes these injuries reportable to DDS through the special incident brief reporting process.

SDC has also developed a "user-friendly" manual of special incident reporting guidelines, with concrete examples of completed forms for the following hypothetical situations: alleged abuse; alleged sexual assault; chemical restraint; contraband; death of an individual; emergency mechanical restraint; fire; injuries of unknown origin; injuries causing major tissue damage/severing of body parts; suicidal gestures/attempts; suspected fracture; and unauthorized absence. SDC has also proposed a more comprehensive system for identifying and tracking client injuries by computer, which will be addressed later in this report.

ADC Special Incident/Abuse and Neglect Reporting Policies

ADC maintains several administrative directives pertaining to reporting and responding to potential client abuse. These policies explicitly provide that residents shall be protected from abuse, neglect, exploitation, and/or mistreatment by physical or psychological means by any employee,

volunteer, or visitor to ADC, and that such treatment is prohibited and will not be tolerated. Employees and volunteers are required to sign a statement that they have received, read and understand ADC's abuse and neglect policy. All staff to whom state-mandated reporting requirements apply must also sign a form which explains the mandated reporting requirements; the form is placed in their personnel files.

Staff responsibility for identifying, tracking, reporting and responding to abuse and neglect are delineated within ADC's Administrative Directives #10-A-9, #50-B-1 and #50-B-2. None of these policies, when read separately, fully details each staff member's individual responsibilities for reporting or investigating abuse or neglect. PAI investigators noted that in spite of, or perhaps in part due to, ADC's intricate reporting policies, the majority of staff members interviewed believed that once they reported known or suspected abuse to their supervisor, they were absolved of their reporting duties. ADC's polices are inadequate in that they:

fail to offer clear, step-by-step instructions delineating individual staff member responsibility;

create a false impression that reporting to Licensing, to the LTCO, or to the police is an administrative function only (as opposed to being the shared obligation of all staff);

fail to specify adequately the criminal penalties for inflicting abuse;

fail to set forth sufficiently medical staff's obligations to report injuries; and

fail to advise staff sufficiently that they will not be subjected to retaliation for reporting suspected abuse or neglect.

Further confusion was created by memos that seemingly contradicted existing directives. For example, an April 5, 1991, memo instructed staff that first line supervisors, not direct care staff, were responsible for completing protective agency notification forms. This memo was directly contrary to ADC's policy of having all staff sign statements, which are maintained in their permanent employment records, acknowledging their direct responsibility to report incidents of abuse or neglect.

Analysis of ADC's Special Incident Reports

ADC analyzes SIRs generated at ADC quarterly, and provides a written summary of trends to DDS. According to these summaries, there were a total of 945 reported special incidents facility-wide for 1990, and 507 for the first half of 1991. Of these reported incidents, the greatest number relate to client injuries, and a disproportionate number of incidents occurred on Program 6 and Unit 632. Specifically:

> 78% (739) of the reported incidents related to client injuries for 1990, and 71% (363) for the first half of 1991.
>
> 35% (258) of the reported injuries were from Program 6 for 1990, and 21% (77) for the first half of 1991. There were six programs at ADC in 1990, and seven in 1991.
>
> The total number of reported special incidents from Unit 632 comprised 8.88% (84) of all 1990 reported incidents facility-wide for 1990, and 14.5% (35) for the first half of 1991. There were 38 residences at ADC in 1990.

PAI's review of these summaries indicates that Program 6 had been identified as having at high number of special incidents relating to residents' health and safety. A need for intervention to diminish the number of Program 6 injuries and protect residents' health and safety had been identified and acknowledged by ADC administration and reported to DDS long before Bacaylan's death.

1990 SIR Summaries

In 1990, Program 6 had the highest percentage of reported special incidents in these areas:

> allegation of client abuse
> aggressive act to self
> suicide attempt
> aggressive act to staff
> unauthorized absence
> aggressive act from another client

sexual incident
property damage
behavioral episode
fire
unknown origin

In 1990, Program 6 also had the second highest percentage of injuries from reported special incidents in the following areas:

medication errors
aggressive act to another client
accident
seizure episode

1991 SIR Summaries

For the first half of 1991, Program 6 had the highest percentage of reported special incidents in the following areas:

suicide threat
aggressive act to self
unauthorized absences
aggressive act to another
sexual incidents
aggressive act from client
fire
behavioral episode
contraband
fracture
theft
injury resulting from aggressive act to other

In 1991, Program 6 also had the second highest percentage of injuries from reported special incidents in the following areas:

allegations of abuse
property damage
unknown origin

During 1991, Program 6 was reduced from eight units to four units, and the remaining units became Program 7.

Current Problems in Tracking Client Injuries

The existing special incident reporting process fails to meet minimum standards for identifying and tracking injuries indicative of abuse and neglect because it fails to:

ensure that SIRs are generated for all client injuries potentially indicative of physical abuse;

ensure that SIRs are generated consistently pursuant to objective, understandable criteria; and

ensure that critical information from SIRs and other sources concerning client injuries is tracked and analyzed in an effective, comprehensive manner.

As discussed earlier in this report, only a small number of injuries from unknown origin are reported accurately via the special incident reporting process. It also appears that the severity of injury does not always determine whether the injury is reported.

Patterns of similar injuries are missed when SIRs are not generated consistently, or not generated at all. An example of this is the pattern of bruising and abrasions on male residents' pubic and thigh areas that went unreported and untracked under the present SIR system on Unit 632.

The utility of reviewing SIRs under the present system is severely limited because there is no cross-referencing of other available significant data. A number of documents are already generated that, when cross-referenced with each other, would fill the gaps that exist within the present SIR system. These documents are not currently retained in any organized or centralized way, nor are they reviewed in a comprehensive, cohesive fashion.

Scattering of useful information across the facility is compounded by the fact that SIRs are not serialized or logged when they are generated, so there is no way of locating an SIR if it is misplaced.

The need for an improved system for tracking and identifying abusive trends and "high risk" situations within ADC and the rest of the developmental center system is compelling if individuals are to be protected from abuse and neglect.

Departure from Policy on Unit 632: the Abuse of D.H.

The following information and observations were related to PAI investigators and the Santa Clara Police Department.

On August 26, 1991, 11 days after the severe penis laceration of resident K.T., psychiatric technician Vasquez was assigned to pass out morning medications in the day room. At approximately 8:00 AM, another staff person observed Vasquez attempting to administer medications to D.H., who apparently not only did not comply with orders to approach the medication cart, but also was spitting the pills out after Vasquez physically deposited them into D.H.'s mouth. After two attempts to get D.H. to swallow the medications, Vasquez slapped D.H. with an open hand with such force as to cause D.H. to have a bloody lip. Additionally, Vasquez told the witness to these events to watch the medication cart; he then led D.H. into a back room. When Vasquez returned with D.H., he informed the witness that D.H. had taken his medications.

Later that day, D.H. was seen by this same witness taking his shirt off (which was unusual behavior for D.H.). The witness was alarmed to observe multiple bruises all over D.H.'s back. According to the witness, she informed a psychiatric technician about what she had observed. After this psychiatric technician observed the injuries, a decision was made to approach the unit supervisor.

Both the unit supervisor and Dr.#1 were called to observe the injuries. Dr.#1 apparently thought there was a possibility of a broken rib, and ordered an X-ray. The unit supervisor, reportedly visibly shaken and distraught, stated that she would arrange to speak with Vasquez.

According to the witness, when the unit supervisor discussed the options available in dealing with the matter, the unit supervisor stated that the witness could "press charges," which the witness understood meant

involving the police and testifying in court, or that the witness could let the unit supervisor "take care of it." The witness stated that she was fearful of losing her job or of causing Vasquez to lose his job. The witness opted to allow the unit supervisor to "take care of it." The following morning, the unit supervisor called the witness and Vasquez into her office. The unit supervisor then informed the witness that Vasquez had apologized for his behavior and stated that it would never happen again.

In their investigation of Bacaylan's death, Santa Clara Police were told repeatedly by staff that the residents of Unit 632, due to their disabilities and limited motor coordination, were incapable of formulating and implementing a sustained and deliberate attack. The majority of client-to-client injuries were also described by Unit 632 staff to PAI investigators as "hit and run," where residents would flail at each other and then run away.

According to another psychiatric technician, when she arrived for duty on August 26, 1991, she noticed that D.H.'s face was bruised, his ear was damaged, and he was leaning to one side as he walked. When she inquired about what had caused this, other staff informed her that

D.H. had "fallen." After D.H.'s x-ray was reviewed, it was determined there was a lateral fracture of the left eighth rib. Other psychiatric technicians, such as SP#2, stated that they were aware of rumors that Vasquez had inflicted the injuries on D.H. However, SP#2 told PAI investigators that he did not know whether the allegations were believable because ADC had taken no apparent action.

During the interview with Santa Clara Police, the unit supervisor stated that she could not recall any report to her that Vasquez had actually struck D.H., nor that there had "actually been a physical confrontation or attack and that it was never made clear to [the unit supervisor] by [the witness] that she had actually witnessed an actual attack by Vasquez on client [D.H.]." The unit supervisor stated that she was aware of D.H.'s broken rib, but did not connect the injury with anything that had been reported to her. The unit supervisor told police investigators, "I may be remiss in not documenting that incident and that's all I can remember."

In reviewing the incident with the unit supervisor, the Program Director, who did not become aware of D.H.'s fractured rib until after Bacaylan's death, stated that the unit supervisor said she "didn't report it because she was fearful--not of Vasquez but of how the incident would reflect on the residence and her staff."

D.H.'s injuries, though known by the unit supervisor, Dr.#1, and several direct care staff, were not reported via SIR or any other way. No investigation was conducted, either internally or by any outside agency. No documentation regarding notification of family or any other interested party could be located by PAI investigators.

No apparent attempt was made to keep Vasquez from having contact with D.H. and other vulnerable residents. On December 30, 1991, a chilling entry was documented in D.H.'s record by Vasquez: "[D.H.] was brought back to the unit with a noticeable limp." Fifteen days after this entry, Vasquez was arrested and charged with the beating and stabbing death of Unit 632 resident Bacaylan and with felony dependent adult abuse upon another resident.

PAI investigators noted that seven months before D.H. was injured, the unit supervisor had received a counseling memo that was forwarded to her personnel file because ADC had received a "Statement of Deficiencies" as a result of a conversation the unit supervisor had with Licensing Evaluators. The memo stated: "In view of the facts surrounding your comments, you did address the issues pertaining to the deficiency. In consideration of the fact that it was not your intent to incriminate or malign the Center, I find it necessary to give you this counseling memo . . ." The memo also instructed the unit supervisor to refer to a memo issued January 3, 1991, which ordered all staff to refer inquiries from Licensing to ADC's Administration and required that a Program Director or Department Head be present during all employee interviews with Licensing evaluators. In essence, the unit supervisor was disciplined for being forthcoming and cooperative with Licensing evaluators. This punishment, in turn, may have contributed to the unit supervisor's reluctance to report subsequent incidents.

E. MANDATORY REPORTING OF ABUSE TO OUTSIDE AGENCIES

Criminal Penalties

California law establishes criminal penalties for the infliction of pain and other abuse on dependent adults by their caretakers. Penal Code Section 368.

Hospital administrators, as well as physicians, have a duty to report injuries inflicted by a deadly weapon or injuries inflicted in violation of any criminal law of this state. Penal Code Sections 11160, 11161. As noted earlier, when the penis lacerations were discovered, no such reports were made.

California Law Regarding Reporting Dependent Adult Abuse

Mandatory reporting requirements also exist for reporting dependent adult abuse to external protective services agencies. Welf. & Inst. Code Sections 15600-15637. Individuals who reside in intermediate care facilities for the developmentally disabled, such as those individuals on Unit 632, are dependent adults for purposes of the reporting statute.

Under the statute, all known and suspected physical abuse must be reported. Every "care custodian" must report when that person either: (l) has observed an incident that reasonably appears to be physical abuse; (2) has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury clearly indicates that physical abuse has occurred; or (3) is told by a dependent adult that he or she has experienced behavior constituting physical abuse. ADC violated this statute repeatedly. For example, ADC failed to report the known and suspected abuse of D.H.—which included a slap to the resident's mouth with enough

force to cause bleeding, and multiple bruises across the resident's back indicative of physical abuse.

"Care custodian" is defined broadly and includes administrators as well as direct care employees. Persons who do not work directly with dependent adults as part of their official duties, including members of support staff and maintenance staff are exempted from the reporting requirement. Welf. & Inst. Code Section 15610.

Under the statute, developmental centers are permitted to establish "internal procedures to facilitate reporting, ensure confidentiality, and apprise supervisors and administrators of reports, provided that these procedures are not inconsistent with the Welfare and Institutions Code reporting requirements." Welf. & Inst. Code Section 15630(e). (Emphasis supplied.)

The report, which in Santa Clara County is to be given to the county's LTCO's Office, must be made "immediately or as soon as possible by telephone" as well as in writing within two working days. The report must include, among other things, the names of the individuals believed to be responsible for the incident and their connection to the victim. Welf. & Inst. Code Sections 15630(a)(1) and (2)(G).

Requirement to Report to Licensing

Licensing relies on ADC to self-report "unusual occurrences" which are defined in the California Code of Regulations Title 22 Section 76551 as: "Occurrences such as epidemic outbreaks, poisonings, fires, major accidents, deaths from unnatural causes or other catastrophes and unusual occurrences which threaten the welfare, safety or health of clients, personnel, or visitors . . ."

ADC policy requires that the following incidents be reported to Licensing:

unusual/unexpected deaths
serious suicide attempts
allegations of abuse/neglect in or out of the center that involve a minor serious fracture/injuries resulting from accidents or abuse

unauthorized absences when the individual is known or suspected to cause harm to self or community
arson
penal code violations
serious conditions at the Center that might cause harm/danger to the individuals (i.e., explosions, floods, fires, generator failures lasting a significant period of time, etc.)
burns
pregnancies, self-abortions, rapes, sexual offenses (involving minors)
outbreaks or undue prevalence of communicable diseases
other unusual occurrences; things that are out of the ordinary.

Licensing is conducting an ongoing investigation of ADC. It has issued numerous citations for violations and has assessed fines. The fines will not be paid, however, because both agencies share the same state budget, and are state agencies.

Interview with Long-Term Care Ombudsman (LTCO)

PAI investigative staff was told that the practice in Santa Clara County is for the LTCO's office to rely on the findings of the special investigator and not to conduct independent investigations of dependent adult abuse at ADC. It was related that an exception to this practice would be drawn if LTCO were to receive a referral from non-staff (for example, a family member) regarding alleged abuse or neglect at ADC.

PAI investigators were also told that for the year 1991, the Santa Clara LTCO received approximately 13 to 15 referrals from ADC.

It should be noted that unlike Adult Protective Services (APS) and law enforcement agencies, the LTCO coordinator is not required to make further reports to the other two-thirds of the trinity of protective services agencies (in this case, APS and law enforcement). However, the LTCO coordinator "may report the instance of abuse to the county adult protective services agency or to the local law enforcement agency for assistance in the investigation of the abuse if the victim gives his or her consent." Welf. & Inst. Code Section 15630(h). (Emphasis supplied.)

The LTCO coordinator, in coordination with Licensing, is, however, required to:

> *immediately report by telephone and in writing within two working days to the [B]ureau [of Medi-Cal Fraud in the Office of the Attorney General] any instance of neglect occurring in a health care facility, which has seriously harmed any patient or reasonably appears to present a serious threat to the health or physical well- being of a patient in that facility. Welf. & Inst. Code Section 15630(h).*

Interview With Adult Protective Services (APS)

PAI investigators interviewed a supervisor from the Santa Clara County APS. PAI was told that ADC is considered a long-term care facility and that the LTCO has jurisdiction. The supervisor referred to All County Letter #90-109 from Sacramento Adult Services Branch, dated November 1990, which directs all APS offices to refer all reports regarding individuals in long-term care facilities to the LTCO.

PAI was also informed that about two years ago, an employee from ADC called APS asking for clarification on the reporting requirements. As a result, an APS supervisor met with ADC staff, who told the supervisor that there was an agreement with the LTCO office that ADC would do its own investigations. When the APS supervisor expressed concern about the apparent conflict of interest, ADC staff related that there was no conflict because the Special Investigator "worked under the jurisdiction of the Attorney General and was a peace officer."

Memorandum of Understanding Between ADC and Santa Clara Police Department

ADC property falls under the jurisdiction of two local law enforcement agencies, the Santa Clara Police Department and the San Jose Police Department. There are Memorandums of Understanding (MOU) between ADC and both of these agencies concerning referrals of abuse that may be criminal in nature.

The MOU between ADC and the Santa Clara Police, dated June 21, 1991, reads in part:

> It should be understood that any services provided by the Santa Clara Police Department to the Agnews Developmental Center are at the request of the Hospital Administrator. To clarify the services that will be provided by the Santa Clara Police Department, the following policy will be utilized:
>
> 1. *Misdemeanors -- Any Misdemeanor will be handled by the Agnews Uniformed Officers. Follow-up investigation will be handled by the Senior Special Investigator who will be responsible for obtaining formal complaints. Nothing in terms of reports or statistics etc., will be forwarded to the Santa Clara Police Department.*
> 2. *Felony Property Crimes -- Will be handled with the same procedures in misdemeanor cases.*
> 3. *Felony Crimes Against Persons -- All felonies against a person, such as: murder, assault, rape, robbery, etc., will be investigated by the Santa Clara Police Department. In these situations the responding ADC Uniformed Officers or the Senior Special Investigator (SSI) will secure the crime scene and identify potential witnesses, pending arrival of a Santa Clara Police Department unit…*
>
>   *EXCEPTION -- Assaults occurring between clients (individuals who live and are treated at ADC), except homicides or great bodily injuries, will be investigated by the SSI. These include sexual assaults…*
>
> 7. *Arrestees - - The Santa Clara Police Department will continue to book prisoners arrested by Agnews Developmental Center Uniformed Police personnel or the Senior Special Investigator.*

This MOU was signed by both the Chief of Police of the Santa Clara Police Department and the Executive Director of ADC.

Although this MOU requires that the Santa Clara Police Department be notified of all potential felonies against ADC residents, there was no notification made to the Department of the penis lacerations or other known physical abuse on Unit 632 in Summer of 1991. According to staff, ADC refrains from making referrals to law enforcement or to the District Attorney because these entities are reluctant to take cases where the victim is developmentally disabled. This perception by ADC management does not excuse it from fulfilling its obligation to report crimes against residents. In addition, as pointed out earlier, reporting crimes to law enforcement agencies is not just for purposes of prosecution. Creating a record of allegations and arrests is an important objective underlying the reporting requirements.

F. INTERNAL INVESTIGATIONS OF CLIENT ABUSE AT DEVELOPMENTAL CENTERS

The developmental centers' internal investigatory system, as demonstrated earlier in this report, has not resulted in adequate internal investigation of client abuse nor ensured that known and suspected physical abuse is referred to appropriate external protective services agencies, including law enforcement. This is, in part, due to the fact that DDS and the individual developmental centers have not adequately resolved the conflict of interest dilemma they face in conducting investigations of themselves. If this conflict cannot be resolved adequately, the responsibility for investigating abuse should be given to an independent investigatory agency.

Policies and Procedures for Investigating Potential Abuse

Department of Developmental Services

DDS requires that investigative services be available within each developmental center 24 hours a day. Each developmental center has an assigned Senior Special Investigator, who operates under the direct supervision of the Executive Director. When the Special Investigator is not available (as discussed more fully below) hospital police are responsible for conducting abuse and neglect investigations.

Under the direction of the Office of Legal Affairs, DDS, is Special Investigations, which is responsible for:

> providing investigatory services for the Director and department staff of any activities that may constitute a crime;
>
> coordinating investigations with and providing advice to local law enforcement agencies on cases concerning persons with developmental disabilities; providing consultation to departmental staff on employee protection and crime prevention;
>
> providing special investigation coordination and guidance with the depart- mental centers' investigations.

Agnews Developmental Center

According to Administrative Directive #50-B-1, all allegations of abuse and neglect must be investigated by the Special Investigator and all investigations must be conducted in a manner that meets these requirements:

> must be initiated within 24 hours of the report of the incident;
>
> must include a physical examination as part of the preliminary investigation; and
>
> verbal or written results of the preliminary investigation must be available to the Executive Director within five calendar days of the reported allegation.

The duties of ADC's Senior Special Investigator include primary responsibility for investigating all residents' deaths, allegations of abuse or mistreatment, and criminal activity which occurs on ADC's grounds. The Senior Special Investigator is also responsible for appearing as a witness in court or in State Personnel Board proceedings resulting from investigations.

ADC's policy requires that all relevant factors be taken into account in evaluating the conduct of employees who may be responsible for abuse and neglect. Factors to be considered in determining appropriate case disposition include: (1) the circumstances and behavioral characteristics of the individuals involved; and (2) the possible consequences of failure to intervene in a particular incident.

Administrative Directive #50-B-1 explicitly states that:

> At the conclusion of the investigation, if it is determined that the allegations are unfounded, the employee involved will be returned to regular duties, and any written material will be purged from the employee's official personnel file. . . Any allegation from any source and most importantly from individuals served of abuse, mistreatment, exploitation, or neglect that is substantiated by investigation shall result in prompt administrative or adverse action against the employee involved. If there is sufficient evidence obtained to substantiate criminal violation, the case shall be immediately referred by the Senior Special Investigator to the Executive Director and the Santa Clara County District Attorney's Office for appropriate action. (Emphasis supplied).

In addition to conducting investigations, ADC's Senior Special Investigator is responsible for periodically providing staff with training on how to recognize and report abuse and neglect. The Senior Special Investigator also maintains a supply of child and dependent adult reporting forms, and is available for consultation, upon staff request, on how to fill out these forms.

Authority for Internal Police Investigations at Developmental Centers

The authority for internal police investigations at Developmental Centers is set forth in Welf. & Inst. Code Sec. 4493:

> *The hospital administrator of each state hospital may designate, in writing, as a police officer, one or more of the bona fide employees of the hospital. The hospital administrator and each such police officer have the powers and authority conferred by law upon peace officers listed in Section 830.38 of the Penal Code. Such police officers shall receive no compensation as such and the additional duties arising therefrom shall become a part of the duties of their regular positions. When and as directed by the hospital administrator, such police officers shall enforce the rules and regulations of the hospital, preserve peace and order on the premises thereof, and protect and preserve the property of the state.*

This discretion to designate employees as hospital police officers in no way relieves developmental centers of their mandatory obligations to comply with dependent adult abuse reporting requirements to both the LTCO and appropriate police agencies.

PAI investigators noted that it is standard practice in developmental centers to hire Senior Special Investigators who have completed police officer standard training and have experience as law enforcement officers. Despite this training, ADC's Senior Special Investigator did not interview the AM staff concerning K.T.'s injuries, despite indications that K.T.'s injuries likely occurred during that shift. PAI investigators also found inaccuracies in the sequence of events in the Senior Special Investigator's report on Bacaylan's death.

Conflict of Interest Dilemma

Developmental centers, as with other agencies responsible for investigating themselves, face an inherent conflict of interest: the role of being potentially liable for the injury inflicted, and the responsibility for investigating the alleged abuse.

ADC staff related to PAI investigators that there have been only five or six cases referred to the Santa Clara County District Attorney's office over the past six years. Because final disposition of investigations is, in practice, presently controlled by developmental center administration, administrators face a challenging dilemma. Because referring an incident for prosecution or investigation by an outside agency may be viewed as evidence of substandard managerial performance, there is a strong incentive to handle serious problems of abuse through internal channels only.

This conflict of interest dilemma has not been resolved appropriately within the developmental center system. The current responsibility given to Executive Directors at developmental centers to oversee internal investigations has been interpreted incorrectly as providing discretion over reporting certain incidents "out of house." Two glaring examples of this are: (1) SDC's failure to report the 1985 alleged assault in which Vasquez was the "primary suspect"; and (2) ADC's failure to report the potentially felonious acts inflicted upon Bacaylan and K.T., even though it had been determined that none of the residents could have caused the penis lacerations. The reporting requirements under California's criminal and dependent adult abuse reporting statutes are mandatory, not discretionary.

Role of the Hospital Police in the Investigation of Client Abuse

All developmental centers have their own police department, called Hospital Protective Services. At ADC, the department consists of a Chief of Police and five officers. Organizationally, the hospital police are located within Administrative Services. The Chief of Police reports to the Administrative Services Director, who in turn, reports to the Executive Director.

As noted earlier, when the Special Investigator is not available to investigate abuse and potential crimes upon developmental center residents, that responsibility is carried out by the hospital police. PAI's investigation revealed that the hospital police are not adequately trained to investigate incidents of serious abuse, including those criminal in nature. Consequently, developmental center residents are subjected to an unnecessary risk of harm. DDS should ameliorate this risk by ensuring

adequate training and appropriate reporting of all potential crimes to responsible law enforcement agencies.

Laws Regarding the Hospital Police

Welfare and Institutions Code Sec. 4491 states:

> *The hospital administrator shall be responsible for preserving the peace in the hospital buildings and grounds and may arrest or cause the arrest and appearance before the nearest magistrate for examination, of all persons who attempt to commit or have committed a public offense thereon.*

Welf. & Inst. Code Sec. 4493 gives the Hospital Administrator at a developmental center appointing authority to confer peace officer powers and authority as defined in Penal Code Sec. 830.38 and arrest authority as defined in Penal Code Sec. 836.

Training Required By Statute Penal Code Sec. 832 states:

(a) Every person described in this chapter as a peace officer shall satisfactorily complete an introductory course of training prescribed by the commission on Peace Officer Standards and Training. On or after July 1, 1989, satisfactory completion of the course shall be demonstrated by passage of an appropriate examination developed or approved by the Commission. Training in the carrying and use of firearms shall not be required of any peace officer whose employing agency prohibits the use of firearms.

(b) (1) Every peace officer described in this chapter prior to the exercise of the powers of a peace officer, shall have satisfactorily completed the course of training described in subdivision (a). (2) Every peace officer described in Section 13510 or in subdivision (a) of Section 830.2 may satisfactorily complete the training required by this section as part of the training prescribed pursuant to Section 13510.

(c) Persons described in this chapter as peace officers who have not satisfactorily completed the course described in subdivision (a), as specified in subdivision (b), shall not have the powers of a peace officer until they satisfactorily complete the course.

(d) Any peace officer who, on March 4, 1972, possesses or is qualified to possess the basic certificate as awarded by the Commission on Peace Officer Standards and Training shall be exempted from this section.

The training described in this section is introductory by definition and only qualifies the successful candidate to a Level III Reserve Officer competency. Penal Code Sec. 832 training is presently only 24 hours long, and does not prepare the officer for the duties of routine patrol or that of a custodial officer.

In contrast, a police officer, deputy sheriff or marshall, also peace officers in the State of California, complete a course of training almost 1,000 hours long. There is no comparison in the training and experience between a hospital police officer and a police officer employed by a municipality or a deputy sheriff employed by a county.

The inadequacy of hospital police training is a problem that has already been recognized by state authorities. In 1991, the State of California Department Of Mental Health appointed an ad hoc committee to investigate the quality of training received by Hospital Protective Services personnel. The committee specifically found that:

Officers do not receive adequate vocational training in the areas of:

i. Criminal investigations - ability to accomplish investigative duties and responsibilities associated with being the first officer in discovering or responding to the scene of a crime; and crime scene protection and chain of evidence.

Inadequacies of the Hospital Police Investigation into Bacaylan's Death

When Bacaylan died, the preliminary investigation did not include the gathering of basic information. For example, there was no mention of blood

splatters on the ceiling and around Bacaylan's bed—obvious signs of suspected violent injury—still evident almost 24 hours later, even after the area had been cleaned up by the janitorial crew.

The hospital police report did not contain any statements from individual witnesses who last saw Bacaylan alive on Unit 632, or even their names for purposes of follow up or interviewing. The report did not mention why Bacaylan was sent to the Infirmary, his physical condition, or how he got there. These facts raise serious questions as to whether hospital police are equipped to investigate client abuse adequately.

Problems with the Hospital Police System

The hospital police system operates in a similar manner at all seven developmental centers. Some problems with this system are:

1. Hospital police are under the direct supervision of hospital administration and have no independent authority to implement policy or set up security procedures. As a result, administrators with little or no experience in law enforcement or security measures establish policy in these very critical areas.

2. Under the present system, hospital administration has the authority to start or stop an investigation or security measure. Hospital administration does not have the experience or education upon which to make such decisions.

3. Hospital police, while classified as peace officers, do not have appropriate training, experience or education to act as peace officers for purposes of investigating allegations of serious client abuse in developmental centers.

Because of these problems with the hospital police system, developmental center residents are being placed at unnecessary risk of harm.

G. BARRIERS TO IDENTIFYING AND RESPONDING TO CLIENT ABUSE

Description of Unit 632, Residents and Staff
Institutional Dynamics
Institutional Barriers to Reporting Abuse
Barriers to Reporting of Abuse by Staff
The "Silent Accomplice"
Characteristics of Abused Residents
Characteristics of Abusive Employees

Description of Unit 632, residents and staff

Research in the area of abuse of residents demonstrates that the frequency of abuse is widespread and may be a common part of institutional life. Pillemer & Moore (1989), in their survey of institutional staff, found that 10% of staff self-reported that they had personally committed acts of physical abuse within the last year. The most frequent type of physical abuse reported by other staff members was the excessive use of restraints. Pushing, shoving, grabbing, or pinching a patient was the second most frequent type of physical abuse observed and reported by other staff members. Pillemer & Moore, "Abuse of Patients in Nursing Homes: Findings from a Survey of Staff" (1989) 29 The Gerontologist.

A review of the research literature addressing institutional abuse indicates that contributing factors include: isolation and vulnerability of residents with developmental disabilities; institutional dynamics; and reluctance of staff to report suspected and known abuse.

Residents of Unit 632

Entrance criteria for becoming a resident of Unit 632 are:

physical capacity to and need to acquire basic to advanced skills in bathing, dressing, and toileting;

capacity to eat meals with a spoon and capacity to learn to serve self and use all utensils;

potential to acquire life skills while decreasing high frequency of severe/- undesirable behaviors.

Program 6 entrance criteria include:

ability to walk or be self-mobile in a wheelchair and ability to translocate from bed to chair;

no major chronic health conditions requiring skilled nursing interventions;

the physical capacity to translocate independently 100 yards to various areas and be able to attend a minimum of five hours daily activity;

ability to benefit from training in domestic, vocation, recreation or community skills while decreasing maladaptive behaviors.

Exit criteria include referral to a less restrictive residence or program:

when independence in domestic skills permits, or;

when life skills training can be acquired elsewhere only with minor interruptions.

Staff of Unit 632

The residents of Unit 632 are served by a number of professional, licensed, and unlicensed staff. Daily direct care is handled primarily by licensed psychiatric technicians, unlicensed or pre-licensed psychiatric technician trainees, and unlicensed hospital workers. At the time of PAI's investigation, there were approximately 30 regularly assigned staff members, rotating on three daily shifts. Shifts are: 6:30 AM to 3:00 PM (day shift); 2:30 PM to 11:00 PM (afternoon shift); and 10:45 PM to 6:45 AM (night shift). Communication among staff regarding residents' progress occurs during shift overlap.

Mandatory staff to client ratios, according to program management, is 1:8 during morning and afternoon shifts and 1:16 during the night shift. ADC adopted the ratio of 1:5.5, based on the needs of Unit 632 residents. Actual ratios, however, according to Unit 632 staff, range from 1:5 to 1:11, depending upon factors such as unscheduled absenteeism.

Primary responsibilities of direct care staff include: providing organized programming for the care, treatment and development of residents, including attendance at meetings for evaluation of residents' progress; assisting residents with daily living routines and household tasks; monitoring residents' physical condition; administering medical treatments; observing, documenting, and maintaining reports of residents' progress; escorting residents to activities and appointments; and providing a safe and therapeutic environment.

Direct care staff are supervised by licensed shift supervisors, who coordinate daily general and psychiatric nursing care. The unit is managed by the unit supervisor, who, in turn, is supervised by the Program Director. The responsibilities of these managers include: recruitment, assignment and evaluation of residence personnel; assuring that units meet with applicable standards, policies, laws and regulations; and investigation of special incidents.

Institutional Dynamics

Vulnerability and Isolation of Residents

These two factors--the extreme vulnerability of institutionalized persons with mental retardation due to their disabilities, and their relative isolation from the community--have been identified as exacerbating the problem of abuse in public residential facilities. It should be pointed out, however, that abuse and neglect of persons with developmental disabilities is by no means limited to large public institutions such as developmental centers. Relative isolation and extreme vulnerability also contribute to the risk of harm for residents of non- public facilities in the community.

Research has shown that maltreatment by abusers is inhibited by the presence of relatives and friends. Marchetti and McCartney, "Abuse of Persons' With Mental Retardation: Characteristics of the Abused, the Abusers, and the Informers" (Dec. 1990) 28 Mental Retardation. The residents of Unit 632 are isolated, not only because of their limited verbal ability, but also because contact with family and loved ones is minimal or non-existent.

Inadequate Personnel Practices

The importance of screening potential direct care staff adequately is well established:

> *The background and experience of applicants for direct care positions are given only cursory screening, and a potential candidate's temperament is not examined. As a result, persons with low frustration thresholds and explosive personalities are not screened out. See, e.g., Sundram, "Obstacles to Reducing Patient Abuse in Public Institutions" (Mar. 1984) 35 Hospital and Community Psychiatry.*

As discussed in Section C of this report, ADC did not sufficiently screen or adequately utilize the information available concerning Vasquez's prior substandard employee performance and criminal record.

As pointed out by Licensing: "In addition to the facility practice of continuing to employ numerous staff with poor work histories as direct care givers for the mentally retarded and developmentally disabled, the facility does not necessarily disqualify staff from this work for criminal activity." DDS hiring practices should help ensure that individuals who pose a potential threat of abuse will not be hired by or transferred to other developmental centers as was the situation with Vasquez.

Inadequate Supervision and Staffing

ADC needs to provide more active and ongoing supervision of direct care staff on the units in order to positively effect the quality of care provided. "There is now ample evidence that supervising ward staff members by merely organizing regular meetings away from the environment of the living group is ineffective for improving the quality of residential care for mentally retarded individuals." Seys & Dukes, "Effects of Staff Management on the Quality of Residential Care for Mentally Retarded Individuals" (1988) 93 Am. J. on Mental Retardation.

The importance of reliable staff has also been emphasized in the literature:

> *The reliability of 'hands-on' employees, those who spend the majority of their work day in direct contact with the residents, is particularly critical because of the immediate impact when familiar staff are present. . . When assigned staff are absent, others need to take their place, either by 'floating' from a different work area or by overtime for staff from the previous shift. Floating usually brings in unfamiliar staff who cannot be expected to provide the same quality of care as those who are experienced and familiar with the residents. Overtime usually is not voluntary, which can result in a fatigued employee. Briggs, "Reducing Direct-Care Staff Absenteeism: Effects of a Combined Reinforcement and Punishment Procedure" (June 1990) 28 Mental Retardation.*

Unscheduled absenteeism has been an ongoing problem on Unit 632. When Vasquez was hired at ADC, he had a known history of chronic absenteeism, but was nonetheless assigned to Unit 632.

Working Conditions

Other factors contributing to institutional abuse are the working environment, the residents' challenging behaviors and need for daily assistance, low job prestige, and perceived staff powerlessness within the institution.

Rusch et al. pointed out that ". . . many living skills that may require staff involvement are unpleasant. Because caretakers dislike such duties, physical abuse of residents may result if the unpleasant duties become too frequent." Rusch, et al., "Abuse Provoking Characteristics of Institutionalized Mentally Retarded Individuals" (1986) 90 Am. J. of Mental Deficiency.

Institutional Barriers to Reporting Abuse

During its investigation, PAI noted four factors at ADC that have been identified in the literature as contributing to failure to report incidents of abuse:

1. different perspectives on the part of the facility administrators and residents/- advocates on the issue of control over treatment and control over efforts to remedy maltreatment;

2. low volume of reporting directly from residents;

3. lack of consensus on what acts or omissions by facility staff require protective intervention;

4. inherent difficulty in determining that harm to a resident occurred as the result of particular staff member(s) specific acts or omissions. Rindfleisch and Bean, "Willingness to Report Abuse and Neglect in Residential Facilities" (1988) 12 Child Abuse & Neglect.

Because facilities such as developmental centers are closed environments, it has been suggested that institutional abuse is much like abuse that occurs within a family:

> *Institutions' responses to (abuse allegations) may include reactions similar to those manifested in families identified or accused of abuse: denial, cover-up action, or defensive behavior. The motivations for 'avoiding' the problems are also similar. The accused will fear punishment or reprisal, want to protect reputations and careers, try to cover the deed to serve the long-term needs of the social unit (family or institution), and be unwilling to acknowledge the presence of internal factors that lead to . . . abuse. Durkin, "No One Will Thank You: First Thoughts on Reporting Institutional Abuse". (1982) Child & Youth Services.*

These reactions were illustrated by the unit supervisor's behavior in responding to the abuse of resident D.H. One direct care staff member made the analogy directly, stating that the removal of other staff members from the unit after Bacaylan's death was like "being violated, like a family member has been taken." Even though the institutional environment has been likened to a family, it has been suggested that institutional environments differ from the family in the following significant ways:

> *(1) care and treatment are provided in socially sponsored environments; (2) these environments are operated by paid persons who are not related to the residents; (3) care and treatment are carried out in environments that are formally organized; and (4) such environments are usually professionally administered and administrators typically regard themselves and their staff members as part of a solution and not as part of a problem. Rindfleisch and Bean (1988).*

Sundram (1984) has observed:

> *. . . there are powerful factors at work in the state hospital system to hinder prompt reporting of severe patient abuse by employees as well as by patients. These factors include the facility director's attitude toward employees charged with allegations of patient abuse; perceptions of staff about the even handedness of the disciplinary system as applied to professional and direct care staff; and the effectiveness of the disciplinary machinery in punishing alleged abusers. Sundram (1984).*

Barriers to Reporting of Abuse by Staff

According to the Office of the Inspector General's (OIG) 1990 survey regarding abuse in skilled nursing and intermediate care facilities, 51% of the respondents believed abuse is "sometimes or rarely reported." Contributing factors, identified in that survey according to the respondents, and by ADC direct care and management staff interviewed by PAI include:

> basic fear of losing one's job;
> the sense of loyalty shared among staff members; fear of retaliation by the facility or peers;
> fear of fines or penalties;
> fear of bad publicity; and
> lack of clear or sufficient facts;

When it came to physicians' failure to report, the OIG survey respondents gave the following reasons why physicians may fail to report:

lack frequent involvement with residents;
concern with immediate treatment, too busy, or do not recognize abuse; identify with the staff and their problems in coping with residents;
are apathetic;
do not possess sufficient facts;
believe the incident has already been reported; may be unaware of their requirement to report.

Durkin (1982) pointed out that staff's reluctance to report may also be driven by a "desire to avoid becoming involved in what is usually a messy business at best, or may reflect attitudes regarding the system . . . which may be ineffective or bureaucratic." Furthermore, per Sundram:

> *. . . the employee who is an innocent witness to an incident of patient abuse is faced with a terrible choice: he can do nothing about it and become a silent accomplice, subject to disciplinary sanctions himself for failure to report the incident, or he can report the abuse, risk the wrath of and perhaps reprisals from the abuser, and face ostracism by fellow employees who do not approve of his action. The likelihood of discovery in the former instance is not great, but the negative effects of the latter course of action are likely to be real and immediate." Sundram (1984).*

The "Silent Accomplice"

SP#1, who was on duty with Vasquez when Bacaylan was beaten and stabbed to death, became a silent accomplice after allegedly witnessing Vasquez physically abuse Bacaylan several times that day. SP#1 stated that his own fear of Vasquez prevented him from reporting the abuse. In fact, it was not until SP#1 received a call two days later saying that he needed to provide a written statement to the unit supervisor, that SP#1 decided to come forward to the police.

Visibly shaken, SP#1 detailed to the police blows that matched the injuries that contributed to Bacaylan's death. He described that Vasquez, on two or three occasions, held Bacaylan's wrists outstretched on the floor and pressed his knee into Bacaylan's neck almost to the point of Bacaylan's

losing consciousness; and that Vasquez jumped with both knees on top of Bacaylan's abdominal area. SP#1 also stated that he "heard noises which made him feel certain that Frank Vasquez was more than likely hitting 'Jo Jo' with possibly a closed fist about the torso area." Despite this, SP#1 did not attempt to intervene or stop the abuse, nor did he come forward until 48 hours after the abuse occurred.

SP#1's failure to intervene or report promptly is an example of the compelling forces against reporting abuse within the institutional environment. PAI investigators also note SP#1's ability to distinguish, from behind a partition, the method of force (closed fist) and area of the body to which the blows were administered (torso area).

Characteristics of Abused Residents

Rusch, et al. (1986) analyzed what common characteristics were shared among individuals with mental retardation who had been victims of abuse within the institution. They found that abused residents:

> exhibited more aggression and self-injurious behaviors;
> tended to be younger;
> had fewer independent living skills; had less verbal ability;
> had more ambulation ability.

A review of clinical records reveals that residents of Unit 632 possessed all of the above characteristics.

Characteristics of Abusive Employees

Pillemer found that "staff persons should be more likely to maltreat patients if they are poorly educated, male, aides rather than nurses, less experienced . . . and undergoing job burnout." Pillemer, "Maltreatment of Patients in Nursing Homes: Overview and Research Agenda" (Sept. 1988) 29 J. of Health and Social Behavior.

It has also been found that (1) direct care nonprofessional staff such as psychiatric technicians commit and report abuse most often, (2) physical

abuse is the most frequent type of confirmed abuse, and (3) abuse is most often committed on the morming (AM) shift. Marchetti & McCartney (1990).

Pillemer & Moore (1989) also observed that "Staff who are burned-out, who are dissatisfied with their jobs, and who experience significant staff-patient conflict are at greatest risk of engaging in abusive behavior . . . staff who have negative attitudes toward . . . persons appear to be more likely to behave inappropriately toward them."

Many of the dynamics, barriers, and characteristics identified in the research and discussed briefly above which contribute to an abusive institutional environment were in existence on Unit 632 long before Bacaylan's death.

H. PROPOSED AND IMPLEMENTED CHANGES AT DEVELOPMENTAL CENTERS

Changes Proposed by DDS
Proposed and Implemented Changes at ADC Proposed Changes at SDC
Changes Proposed by DDS

A work group of a dozen people from DDS, department legal staff, and the seven developmental centers reviewed personnel policies. Improved personnel screening, hiring, supervision and training policies have been adopted which include:

centralized application process;

a ban on hiring until the entire hiring process is completed;

more stringent reference checks;

ongoing processing of job-relevant negative information received from the Department of Justice;

improved employee orientation and training concerning abuse and neglect; more effective management training for supervisors.

DDS is pursuing ways to speed up the process of checking prospective employees' criminal records. At present, it can take several weeks or months for the Department of Justice to complete such a check.

Additional DDS proposals include:

- increasing staff training requirements concerning clients' rights and abuse and neglect;
- developing more specific policies prohibiting discrimination, substance abuse and sexual harassment; and
- providing external peer review to enhance the quality of medical and nursing services.

Proposed and Implemented Changes at ADC

- more staff training on identifying, reporting and documenting abuse;
- a Special Incident Quality Assurance Review Team to review all injuries, SIRs and other documentation concerning clients' injuries;
- increased unannounced visits by management and administrative personnel on Unit 632 and appropriate follow-up with the Clinical and Executive Director;
- possibility of computerizing all SIRs;
- more peer review of clients' behavioral programs, nursing care and quality of medical care;
- hiring a full-time medical director and increased quality assurance for medical services;
- subjecting new employees to an FBI check, if appropriate, in addition to fingerprinting and DOJ criminal history check;
- requiring all managers and supervisors to attend seminars on recognizing and investigating abuse cases;
- lowered resident population of Unit 632 from 41 to 28;

special "Code Team" to respond to medical emergencies;

closed the infirmary;

increased training of acute unit staff in emergency medical procedures;

Unit 632 management and staff discussed the following changes with PAI investigators:

need for increased and more accurate documentation of resident injuries;

need for new leadership on the unit;

need for increased staffing minimums;

transferring staff to other units at their request;

need for increased contact between staff and management;

need for ongoing peer review by a developmental psychologist for clients' training and behavioral programs;

transferring some Unit 632 residents to other units so they can benefit from being around less behaviorally challenging peers.

Proposed Changes at SDC

As discussed more fully in the Findings, Conclusions and Recommendations under Section D, SDC has proposed a computerized investigation and SIR system. This system, as proposed, would allow the facility to record and track client abuse more effectively.

IV. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. CIRCUMSTANCES SURROUNDING THE DEATH OF JOSEPH BACAYLAN FINDINGS AND CONCLUSIONS

ADC failed to ensure that Unit 632 staff exercised appropriate nursing care judgment.

ADC failed to recognize life-threatening injuries and provide necessary emergency medical treatment for Bacaylan.

ADC failed to recognize, communicate about and properly treat obvious knife wounds, which contributed to Bacaylan's death.

ADC failed to investigate the circumstances leading to Bacaylan's death properly.

ADC failed to ensure that Bacaylan's clinical record documented the cause of death accurately.

ADC failed to ensure that Unit 632 staff exercised appropriate nursing care judgment.

Direct care staff's failure to observe, evaluate, and respond to changes in Bacaylan's behavior and condition, denied Bacaylan his basic right to competent nursing services. Even though direct care staff noted significant, uncharacteristic changes in Bacaylan that indicated a clinical problem, staff did nothing until the knife wounds were observed nearly two hours later. The changes that staff observed but did not respond to included listlessness and lethargy. Staff even speculated that Bacaylan had been over-medicated.

ADC failed to recognize life-threatening injuries and provide necessary emergency medical treatment for Bacaylan.

ADC's failure to recognize life-threatening injuries and provide necessary emergency medical treatment for Bacaylan contributed to his death. Bacaylan was pronounced dead two hours and forty-five minutes after staff discovered his injuries. Despite the fact that the injuries were obviously caused by a sharp instrument, ADC medical staff failed to treat them as serious injuries. According to the Santa Clara County Coroner's pathologist, medical staff should have probed and x-rayed the wounds to

determine their depth. Time and evidence were lost as a result of the wounds being sutured.

When staff decided finally to transfer Bacaylan, the treating physician arranged for transfer to ADC's infirmary rather than the acute medical unit, which was in the same building. The treating physician did this despite the fact that Bacaylan was cold, clammy, had blue lips and a dangerously low blood pressure—all obvious signs of shock. Because ADC staff transferred and admitted Bacaylan to a unit that could not provide the level of care required, they effectively denied him access to life-saving equipment and services. Such emergency equipment and services included intravenous, cardiac monitoring and endotracheal tube placement capabilities. When Bacaylan stopped breathing after his arrival at the infirmary, a critical piece of medical equipment (Ambu-Bag) did not function.

ADC failed to recognize, communicate about and properly treat obvious knife wounds, which contributed to Bacaylan's death.

Direct care staff failed to notice and/or respond to multiple blood splatters on the walls and ceiling of Bacaylan's group living area. None of the staff present challenged the theory that the wounds were caused from rolling around on broken glass, even though the wounds, according to staff's own observations, were straight-edged as opposed to jagged, and inconsistent with the type of wound produced by broken glass. Direct care staff who discovered the injuries, and even suspected that the wounds were caused by a knife, failed to communicate this observation to the treating physician or anyone else in authority at the time. These failures contributed to improper diagnosis and treatment.

ADC failed to investigate the circumstances leading to Bacaylan's death properly.

ADC's preliminary internal investigation into Bacaylan's death by the hospital police was inadequate. The hospital police failed to make basic observations and gather critical information necessary to conduct a preliminary investigation. Even though ADC police reviewed the scene, they failed to note signs of obvious violence—such as the blood splatters on the ceiling and walls. At the time of the preliminary investigation, ADC

police conducted no interviews with Unit 632 direct care staff. Nor did ADC police note the names of potential witnesses for purposes of follow-up.

ADC failed to ensure that Bacaylan's clinical record documented the cause of death accurately.

The documenting physician charted Bacaylan's cause of death as "Cardiopulmonary arrest of unknown etiology" despite the documenting physician's knowledge of the Coroner's findings that Bacaylan died of internal bleeding caused by a stab wound to the chest and blunt trauma to the abdomen. This same physician informed PAI investigators that ADC preferred that reports be written that way "for legal purposes."

RECOMMENDATIONS

ADC should ensure that direct care staff receive proper training and supervision to render competent nursing care.

ADC should ensure that medical staff receive proper training and supervision to provide competent emergency care.

ADC should increase the competence of direct care staff to make, document and communicate objective clinical observations.

Appropriate licensing agencies should investigate the conduct of medical and direct care staff who may have violated their professional obligations to determine whether discipline should be imposed.

DDS should ensure that individuals who conduct preliminary investigations receive proper training.

DDS should ensure that the purported practice of placing misleading documentation in clinical records at ADC is further investigated and appropriate action taken.

ADC should ensure that direct care staff receive proper training and supervision to render competent nursing care.

Developmental center residents have a right to decent nursing care. This basic right was violated when direct care staff failed to observe and

respond to obvious changes in Bacaylan's condition and behavior and to carry out appropriate nursing interventions in response to those changes. ADC should modify applicable direct care protocol to ensure that basic nursing interventions are carried out and documented adequately in residents' clinical records. ADC should improve its employee orientation and ongoing training and supervision of direct care staff to ensure basic nursing care competence. Special attention should be given to improving basic observation skills and ensuring that appropriate standards are in place for taking and assessing vital statistics.

ADC should ensure that medical staff receive proper training and supervision to provide competent emergency care.

As discussed earlier, ADC failed to provide Bacaylan with access to basic emergency services including competent medical care. ADC should thoroughly review its emergency response protocols, policies, procedures and equipment to ensure that adequate life-saving services are provided at ADC or provided for by timely transfer to an acute care hospital in the community. During their employee orientation period, all medical staff should receive comprehensive training concerning the identification and treatment of life-threatening emergencies. Updated training and education concerning the provision of emergency medical services should occur on a periodic basis thereafter.

ADC should also strengthen its peer review capacity for evaluating and improving the delivery of emergency medical services. The newly hired medical director should exercise strong leadership and oversight in this critical area.

ADC should increase the competence of direct care staff to make, document and communicate objective clinical observations.

The repeated failure of direct care staff to make objective clinical observations concerning abuse, to effectively communicate clinical observations to other members of the interdisci- plinary team, and to document clinical observations thoroughly and accurately, has put ADC residents in considerable risk of harm. It is imperative that ADC ensure not only that direct care staff receive appropriate training in making good

clinical observations, but that direct care staff fully understand the necessity for openly and clearly communicating these observations to other staff members, including physicians who are also responsible for responding to abuse-related medical emergencies. ADC should also address, as discussed later in these findings and recommendations, the need to do everything possible to break the pervasive "code of silence" among staff members.

Appropriate licensing agencies should investigate the conduct of medical and direct care staff who may have violated their professional obligations to determine whether discipline should be imposed.

ADC should ensure that conduct relating to substandard medical care and failure by individual staff members to report abuse are referred to licensing agencies for investigation. The California Medical Board should investigate the medical treatment provided to Bacaylan and other injured Unit 632 residents to determine whether their physicians should be disciplined. A copy of this report has been forwarded to the Department of Consumer Affairs. According to the Department of Health Services, the Santa Clara Medical Association has been asked to conduct a peer review of these physicians' performance. The Association should forward its findings and recommendations to the California Medical Board for review.

Individual direct care and medical staff members who failed to intervene and report abuse should have their conduct investigated and should be subject to appropriate discipline by their licensing boards.

DDS should ensure that individuals who conduct preliminary investigations receive proper training.

Developmental Center personnel who are expected to conduct preliminary investigations into abuse, including possible felonies, must receive proper training. Time and evidence were lost as a result of inadequate investigation by the hospital police. If Bacaylan's injuries had not been so blatant and a Coroner's investigation initiated, the underlying abusive actions that caused his injuries might never have been discovered.

DDS should ensure that the purported practice of placing misleading documentation in clinical records at ADC is further investigated and appropriate action taken.

PAI investigators were told that ADC administration condoned the practice of failing to document the causes of known death-related injuries accurately in clinical records "for legal reasons." If this is accurate, those responsible should be prosecuted for violations of Penal Code Section 471.5 (falsification in records), a misdemeanor, and potentially Penal Code Section 134 (preparing false documentary evidence), a felony. A copy of this report has been forwarded to the Office of the District Attorney for Santa Clara County.

DDS should ensure that all developmental center administrators understand the requirement and the importance of accurate documentation in residents' clinical records. DDS should also ensure that the policies and procedures of all developmental centers, particularly those pertaining to abuse, serious injury and death, are reviewed and modified as needed to ensure that all medical staff and management understand this requirement and its implementation. DDS and ADC should also ensure that the conduct of this physician, in failing to document Bacaylan's injuries accurately, is fully investigated, and appropriate personnel action taken.

B. INJURIES ON UNIT 632, AGNEWS DEVELOPMENTAL CENTER FINDINGS AND CONCLUSIONS

ADC failed to recognize and respond to patterns of injuries potentially indicative of physical abuse.

ADC failed to emphasize that repeated incidents of abuse and injuries were not considered "routine."

ADC failed to supervise and manage Unit 632 adequately.

ADC failed to recognize and respond to patterns of injuries potentially indicative of physical abuse.

ADC did not recognize and respond to an alarming pattern of injuries on Unit 632 that indicated possible physical abuse. PAI's investigation

revealed serious and unexplained injuries that shared similar characteristics. Examples include the series of penis injuries, including lacerations, and the series of injuries from unknown origin, including repeated injuries to the groin area, ribs and abdominal area of several residents.

Even when ADC investigated serious injuries such as the penis lacerations internally, and determined that the injuries could not have been caused by another resident, ADC failed to institute measures to protect residents from further harm, and failed to fulfill its mandatory obligation to report such potential felony abuse to the LTCO, Licensing and the police. ADC apparently assumed that the perpetrator was no longer on the unit because "It didn't happen again."

ADC failed to emphasize that repeated incidents of abuse and injuries were not considered "routine."

ADC permitted repeated incidents of abuse and injuries to be considered "routine", thus allowing the causes of such harm to be ignored and residents to go unprotected. Regardless of the cause of the injuries, ADC had an obligation to protect its residents from harm— whether such harm was caused by the residents themselves or by staff. The individuals on Unit 632 were foreseeably at high risk for injuries, in part due to their known behavioral problems, which at times included aggressive acts to self and others. ADC took inadequate measures to address this risk. Erroneous assumptions persisted that clients were harming each other, despite the nature of the injuries incurred and the unlikelihood that the clients were capable of inflicting such injuries.

Although many Unit 632 residents exhibited aggressive behaviors, staff repeatedly told the Santa Clara Police and PAI investigators that the residents, because of their multiple disabilities, including poor motor coordination, were not physically capable of carrying out the sustained, forceful attacks necessary to cause injuries such as the penis lacerations and multiple bruises which indicated beating-type injuries. Staff repeatedly described client-to- client assaults as "hit and run", where residents would flail at each other usually with an open hand and then run away.

ADC failed to supervise and manage Unit 632 adequately.

In addition to its failure to respond appropriately to resident injuries, ADC failed to address inadequate staffing, despite knowledge of the nature of the clients on Unit 632, and the known problems of scheduled and unscheduled absences. PAI investigators noted that even though the overall staff-to-client ratio on Unit 632 met the minimum requirements (1:8) most of the time, during the normal course of the day, one staff person would be left to supervise 10 or more residents. This occurred on January 14, 1992, when Bacaylan was beaten and stabbed to death. Vasquez was the only direct care staff person with the 10 residents in Group 2 for almost two hours.

The level of care required to provide basic nursing care to individual residents (such as diapering) or to maintain direct contact with a resident who is being restrained, also reduces the number of staff available to supervise the group. In such situations, the number of potential staff witnesses to abusive acts decreases, while the opportunity for abuse increases.

RECOMMENDATIONS

DDS and ADC should redefine what constitutes a special incident.

DDS and ADC should re-evaluate the practice of grouping aggressive and otherwise behaviorally challenging residents together.

DDS and ADC should redefine the functions and roles of unit and program managers to give staff active and ongoing supervision directly on the units. DDS and ADC should implement strategies to decrease unscheduled staff absenteeism.

DDS and ADC should redefine what constitutes a special incident.

DDS and ADC should modify the definition and criteria for what constitutes a special incident to ensure that staff identifies and tracks any and all client injuries that indicate potential physical abuse. The present definition of what constitutes a reportable resident-related special incident is too vague. The definition should be modified to ensure that all injuries that suggest

physical abuse, whether "superficial" or not, are considered "significant" and identified, tracked and documented properly. The existing definition contains no specific objective criteria for determining what injuries are "expected" and have "minor consequences." This has contributed to the dangerous assumption that repeated incidents of abuse and injuries are "routine" and thus "expected."

DDS and ADC should re-evaluate the practice of grouping aggressive and otherwise behaviorally challenging residents together.

The practice of grouping clients with aggressive and otherwise challenging behaviors together on the same unit seems to increase the number of injuries caused by residents and desensitize staff to the frequency and severity of injuries. The phenomenon was demonstrated on Unit 632, where injuries were considered "routine." Consequently, such injuries went unrecognized and unreported. Because staff expected residents to harm themselves or others, they erroneously assumed that injuries were related to these expected behaviors even when they had no objective evidence to support such an assumption.

Aggressive and otherwise challenging behaviors require additional attention from staff. When such behaviors require intervention, the quality of supervision for the remaining residents is negatively affected. In addition to increasing the likelihood of assaults from other residents and staff, the practice of grouping aggressive and otherwise behaviorally challenging residents together denies residents the benefit of a calmer and safer environment, and the opportunity to learn from the constructive behavior of peers.

DDS and ADC should redefine the functions and roles of unit and program managers to give staff active and ongoing supervision directly on the units.

DDS and ADC should review the functions, roles and training of management thoroughly and modify them to provide more active and ongoing daily supervision and evaluation of direct care staff. Merely increasing the number of staff to perform routine care does not necessarily result in higher quality of care. Effective, ongoing management practices, such as guidance, prompting, and immediate feedback within the care

environment, increase the quality of care provided to residents. This kind of "active" supervision should also decrease the likelihood of abusive staff behavior towards residents.

Management should carry out unannounced visits throughout the facility, particularly on residences with identified health and safety problems such as Unit 632. Management and all supervisors should receive specialized training in providing constructive feedback and ongoing evaluation of the quality of care being provided by direct care staff on the units.

DDS and ADC should implement strategies aimed to decrease unscheduled staff absenteeism.

Decreasing unscheduled staff absenteeism is a crucial administrative function due to absenteeism's negative impact on the quality of resident supervision and care. Management should develop a system to reinforce reliable attendance and progressively discipline absenteeism.

In an interview with PAI investigators, ADC staff underscored the importance of staff quality, as opposed to quantity. A direct care supervisor who had worked at ADC for nearly 20 years revealed that if he could change anything in the institution it would be that "the staff interacts positively on an ongoing basis with the clients instead of one another."

C. PERSONNEL POLICIES AND PRACTICES RELATING TO THE EMPLOYMENT OF FRANK VASQUEZ FINDINGS AND CONCLUSIONS

SDC failed to ensure that suspected physical abuse by Vasquez was referred out for investigation and disposition by the proper authorities and appropriate personnel action taken.

DDS and ADC failed to ensure that direct care applicants and employees were subject to appropriate personnel practices.

SDC failed to ensure that suspected physical abuse by Vasquez was referred out for investigation and disposition by the proper authorities and appropriate personnel action taken.

SDC failed to follow its own policies and procedures and the laws of the State of California by not taking appropriate personnel actions or referring for investigation the suspected beating of a resident by Vasquez in 1985. Even though there was considerable evidence to suggest that Vasquez was responsible for the 1985 beating of W.F., SDC failed to refer the matter to local law enforcement for prosecution or initiate an adverse action against Vasquez. Final case disposition of the 1985 incident by SDC's Executive Director portrayed investigatory findings inaccurately. Even though an SDC police officer's report gave step-by-step conclusions that Vasquez was the "prime suspect and the only one with the ability to inflict such injury . . .", the Executive Director's final comment was: "The protective services investigation indicated injury may have been accidental."

SDC did not even remove Vasquez from direct client care pending investigatory findings, thus permitting continued access to vulnerable residents.

DDS and ADC failed to ensure that direct care applicants and employees were subject to appropriate personnel practices.

DDS and ADC jeopardized the health and safety of ADC residents by failing to utilize appropriate hiring and screening practices. At the time Vasquez was hired, ADC knew about yet ignored Vasquez's history of adverse actions for chronic absenteeism and an obvious misstatement on his application regarding the reason for his "separation" from SDC.

ADC could not show that large gaps of unaccounted-for time in Vasquez's previous work history were addressed during the hiring process. ADC also failed to notice or obtain Vasquez's personnel card from SDC, which clearly stated that SDC would not rehire Vasquez and why he was ineligible for rehire. Adequate communication between the facilities would have underscored the seriousness of Vasquez's past performance problems including the fact that SDC had designated him as "not eligible for rehire."

ADC also failed to obtain or consider significant Vasquez's four arrests and convictions in the State of California for driving under the influence of

alcohol or drugs, which ADC would have seen upon review of Vasquez's records from the Department of Justice.

RECOMMENDATIONS

DDS should ensure that developmental centers refer all suspected crimes against residents by staff to outside authorities for investigation.

DDS should ensure that staff persons suspected of physical abuse are subject to appropriate discipline.

DDS should implement new hiring and personnel practices to protect residents.

DDS should ensure that developmental centers conduct stringent background screening on all potential direct care employees

DDS should ensure that developmental centers refer all suspected crimes against residents by staff to outside authorities for investigation.

DDS should ensure that developmental centers implement effective policies and procedures for reporting potential crimes and disciplining developmental center staff for allegations of abuse. PAI investigators heard repeatedly that developmental centers took no action to report potential crimes or impose discipline because law enforcement was unresponsive and actions before the personnel board too difficult. It is not the role of developmental centers to prejudge the merits of a potential criminal action. DDS should provide more direction and supervision to ensure compliance with mandatory reporting requirements, particularly those relating to reporting criminal dependent adult abuse.

DDS should ensure that staff persons suspected of physical abuse are subject to appropriate discipline.

DDS should ensure that developmental centers take prompt administrative action in response to allegations of abuse. This includes ensuring that its Office of Legal Affairs vigorously pursues actions before the State Personnel Board when allegations of serious abuse are made. In 1985,

when W.F. was severely beaten, SDC forwarded a special incident brief concerning the facts and circumstances surrounding the allegation to DDS. Nevertheless, no adverse personnel action was pursued against the alleged perpetrator. In fact, informal personnel action such as counseling or increased supervision was not even taken.

DDS should implement new hiring and personnel practices to protect residents.

DDS should ensure standard application of hiring practices throughout the developmental center system.

Past personnel practices have involved little more than a simple check of licensure and verification of past employment. As a result, the safety of residents has been jeopardized. Former and prospective supervisors should communicate more clearly, and should pay more attention to problematic work histories.

DDS must implement specific, uniform standards for the release of information among developmental centers and reference checks. DDS must also implement procedures for ensuring that developmental centers have obtained and evaluated this information. Following Bacaylan's death, DDS convened a task group and developed improved new hiring policies and procedures. DDS should now establish a mechanism for effectively monitoring implementation of these new personnel practices.

DDS should ensure that developmental centers conduct stringent background screening on all potential direct care employees.

Developmental centers should thoroughly investigate the backgrounds of individuals who may have any direct contact with residents before direct contact occurs and periodically thereafter. Developmental centers should review the results of DOJ and FBI checks before employees have any contact with residents. Current practice allows employees to work in direct care positions before the developmental center obtains background results from DOJ.

According to DDS and developmental center administration, it often takes weeks or months to receive results of criminal history checks from DOJ. DDS should negotiate an interagency agreement with DOJ to speed up the processing of such background checks. If negative job- relevant information is received from DOJ after employment has begun, management must evaluate the information and take appropriate action.

D. ANALYSIS OF DEVELOPMENTAL CENTERS' RESPONSE TO ALLEGATIONS OF CLIENT ABUSE FINDINGS AND CONCLUSIONS

ADC failed to ensure that its special incident reporting system identified high- risk situations and patterns of abuse.

ADC failed to ensure compliance with its own policies and procedures, and with state law regarding reporting and responding to abuse.

ADC failed to ensure that its special incident reporting system identified high-risk situations and patterns of abuse.

ADC's special incident reporting system failed to identify high-risk situations and track patterns of abuse. The existing special incident reporting system failed to ensure that special incident reports were generated consistently for all client injuries indicative of physical abuse. It also failed to ensure that critical information from special incident reports and other sources concerning client injuries was tracked and analyzed in an effective, comprehensive manner.

ADC failed to ensure compliance with its own policies and procedures, and with state law regarding the reporting of physical abuse.

ADC repeatedly failed to report significant resident injuries internally (via the special incident reporting process) and externally (via notification to outside protective agencies). When incidents were reported internally, ADC failed to analyze them adequately and take appropriate action to protect residents from further harm. As a result, dangerous conditions on Unit 632 were allowed to continue and unnecessary harm ensued.

ADC has several policies and procedures aimed at protecting residents from abuse and neglect. Although such policies and procedures are not entirely clear and comprehensive, line and management staff repeatedly ignored the most basic directives. For example, ADC failed to report the penis lacerations as a potential felony to the Santa Clara Police, as required by ADC policy and the MOU with the Santa Clara Police Department.

In another example, ADC failed to report and respond to the abuse of D.H. A staff member witnessed and reported to a supervisor an incident in which Vasquez slapped a resident with such force that blood came out of the resident's mouth. This staff member also saw Vasquez take D.H. alone into a room out of sight from other staff, and then later observed multiple bruises and abrasions on D.H.'s back. The unit supervisor, despite her knowledge of D.H.'s fractured rib, did not report the abuse. She stated that she was afraid the incident would reflect badly on the unit and her staff.

RECOMMENDATIONS

DDS and ADC should implement an information management system that identifies and tracks client injuries and special incidents.

DDS and ADC should revise policies and procedures to delineate clearly individual staff responsibility in reporting potential abuse.

DDS and ADC should ensure that all staff receive adequate training concerning preventing, recognizing, reporting and responding to abuse.

DDS and ADC should implement an information management system that identifies and tracks client injuries and special incidents.

DDS and ADC should assure implementation of an information management system that identifies and tracks client injuries and special incidents and that correlates other related useful information statewide in a comprehensive, effective manner.

SDC has proposed a more comprehensive special incident tracking system which merits consideration. In addition to special incident reports, the

proposed system would utilize other important information and enter it into a data system. The proposed system's tracking components include, but are not limited to: client name, investigation case number, date and time of incident/allegation, type of incident/allegation, location of incident/allegation, staff/client involved, witness of incident/allegation, finding of investigation (founded/- unfounded) and action to assist client (for example, an ID team meeting, etc.).

Additionally, the proposed system would track and cross-reference other relevant information including, but not limited to: SIR file, staffing assignment file, emergency interventions, quality assurance review file, medication error file, police services file and staff training file.

DDS and all developmental center administration should study this proposed system, attempt to improve upon it, and then implement a uniform, comprehensive system statewide for identifying, gathering, tracking and utilizing information concerning special incidents of abuse and neglect. Such an improved tracking and retrieval system could help reduce the number of serious incidents, identify those individual staff members responsible for them, and assist with meaningful planning at the departmental and developmental center levels.

DDS should ensure that any new system effectively identifies emerging patterns, such as injury clusters, as well as staff involvement in multiple incidents of abuse upon developmental center residents.

A more comprehensive, centralized system would, for example, be more likely to address failure to report an incident such as D.H.'s fractured rib because it would no longer depend entirely on the special incident reporting process.

DDS and ADC should revise policies and procedures to delineate clearly individual staff responsibility for reporting potential abuse.

DDS should ensure that ADC and all other developmental centers revise their policies and procedures to address individual staff responsibility in reporting and responding to potential abuse clearly and comprehensively. The likelihood of proper reporting is enhanced when all direct care,

management, professional and administrative staff have a clear understanding of their individual responsibilities. DDS should give special attention to requirements for reporting abuse to outside agencies such as the police and licensing. DDS also should give special attention to ensuring that all staff, including physicians, understand what criminal penalties may be imposed for failure to report and intervene in suspected and known physical abuse.

DDS should ensure that all administrative directives at both the departmental and center levels pertaining to neglect are modified to: (1) offer clear, step-by-step instructions delineating individual staff member responsibility and (2) sufficiently advise staff that they will not be subjected to retaliation for reporting suspected or observed abuse and neglect.

DDS and ADC should ensure that all staff receives adequate training concerning preventing, recognizing, reporting and responding to abuse.

Comprehensive training concerning preventing, responding to and reporting abuse and neglect should be a part of every employee's orientation. Follow-up training should occur periodically. This training should involve the review of relevant policies and procedures and their implementation. Such training also should employ the use of hypothetical situations, role playing, and other techniques that will help to sensitize staff to these issues from the perspective of the resident. Medical staff needs specific training so that they fully understand their professional responsibilities in identifying, treating, documenting and reporting suspected and observed abuse of developmental center residents.

E. REPORTING OF ABUSE TO OUTSIDE AGENCIES FINDINGS AND CONCLUSIONS

DDS and ADC failed to exercise sufficient leadership in protecting developmental center residents from abuse.

DDS and ADC failed to exercise sufficient leadership in protecting developmental center residents from abuse.

As discussed in this report, DDS failed to: (1) ensure the proper reporting of potential criminal abuse; (2) take appropriate personnel action against those responsible for inflicting abuse; and

(3) take sufficient precautions to protect direct care staff from retaliation for reporting abuse to outside agencies.

RECOMMENDATIONS

DDS and ADC should develop more effective strategies for increasing commitment to residents' well-being at all levels throughout the system.

DDS should develop and implement a policy to ensure that developmental centers report potential crimes against residents to local law enforcement agencies.

DDS and ADC should develop more effective strategies for increasing commitment to residents' well-being at all levels throughout the system.

Commitment to residents' well-being is strongly related to the willingness to report abuses. This commitment includes willingness to report despite threats to oneself, co-workers, or the facility. DDS and developmental center administrators are responsible for setting an example and showing strong leadership in upholding this kind of commitment.

DDS and the administration of all developmental centers should ensure that their individual and collective conduct makes clear not only that abuse of residents will not be tolerated, but also that those who report or expose abuse will be supported and protected from retaliation.

As discussed in Section D of this report, the unit supervisor on Unit 632 was "counseled" for revealing information to a Licensing inspector who was evaluating the care being rendered at

ADC. A written memorandum from the Executive Director of ADC stated that such communications with outside agencies should only occur in the presence of management. Although ADC administration reported to PAI that this memorandum has been misunder- stood and that the directive has

been withdrawn orally, the directive, to date, has not been withdrawn in writing. As discussed earlier, this same unit supervisor who was "counseled" for communicating potential deficiencies to a Licensing evaluator later failed to take any corrective action when observed potential felony abuse was reported to her.

DDS should develop and implement a policy to ensure that developmental centers report potential crimes against residents to local law enforcement agencies.

DDS should ensure that all developmental centers develop and implement clear procedures for reporting potential crimes against developmental center residents to local law enforcement. Developmental center administrators have, in practice, been exercising decision-making authority over whether allegations of criminal abuse and neglect will be referred out to appropriate law enforcement agencies. This is improper. The decision whether to prosecute belongs to the District Attorney not the developmental center. Developmental center administration has no authority to override the mandatory requirement to report potential crimes and physical abuse to external protective service agencies, including the police and the LTCO.

F. INTERNAL INVESTIGATIONS OF CLIENT ABUSE AT DEVELOPMENTAL CENTERS FINDINGS AND CONCLUSIONS

State mandated state protective agencies rely on ADC's internal investigations rather than conducting independent investigations.

DDS and the developmental centers have not responded appropriately to the conflict of interest they face in reporting out abuse.

DDS has failed to ensure the quality of developmental center investigations.

State mandated state protective agencies rely on ADC's internal investigations rather than conducting independent investigations.

Although obligated by law to investigate and protect dependent adults, state mandated protective agencies rely upon the findings from ADC's

internal investigations. An MOU between the Santa Clara Police Department and ADC allows ADC to conduct its own investigations into misdemeanor dependent adult abuse and neglect (circumstances other than those which product great bodily harm or death). This MOU specifically states that ADC should not forward reports or statistics regarding such incidents.

The LTCO office also relies on ADC's internal investigation rather than exercising its own independent judgement concerning alleged abuse and neglect of dependent adults.

DDS and the developmental centers have not responded appropriately to the conflict of interest they face in reporting out abuse.

DDS and the individual developmental centers have not adequately resolved the conflict of interest dilemma they face in conducting investigations of themselves. A strong incentive exists for executive directors to deal with incidents internally. For example, despite evidence presented in the internal investigation report that Vasquez was allegedly responsible for the physical abuse of a resident in 1985, the Executive Director at SDC dismissed the incident as a possible accident. SDC took no disciplinary action against Vasquez. SDC did nothing to protect other potential victims. The Executive Director apparently considered the matter resolved when Vasquez stopped coming to work. Vasquez was later hired by another developmental center—ADC.

DDS has failed to ensure the quality of developmental center investigations.

The hospital police system is inadequate in that it fails to ensure that abuse and neglect is investigated properly. While hospital police are required to conduct investigations in the absence of the Senior Special Investigator, such investigations are beyond the scope of their training and experience. As a result, the quality of these investigations, as in the case of the preliminary investigation into Bacaylan's death, may be seriously compromised.

RECOMMENDATIONS

DDS should ensure that developmental centers do not enter into inappropriate agreements that violate mandatory reporting requirements.

DDS should make it clear that developmental center administration does not have the authority to interfere with mandatory reporting requirements.

DDS should strengthen its oversight of developmental center investigations and reporting.

DDS should ensure that developmental centers do not enter into inappropriate agreements that violate mandatory reporting requirements.

DDS should ensure that developmental centers rescind and do not enter into agreements with protective services agencies, including the police, which may chill the independent investigation of abuse and neglect. The MOU the Santa Clara Police Department should be modified to ensure compliance with mandatory reporting requirements. Entities responsible for reporting and investigating dependent adult abuse should ensure that they are not improperly delegating their authority and responsibility through agreements or other practices. Appropriate representatives involved from ADC, police agencies (Santa Clara and San Jose both have police jurisdiction over ADC), the LTCO and APS should re-evaluate and coordinate their respective roles to protect ADC residents more fully. External mandated protective agencies have done little review or investigation of abuse at ADC, despite present legal requirements.

DDS should make it clear that developmental center administration does not have the authority to interfere with mandatory reporting requirements.

DDS should take effective precautions to ensure that administrative staff of developmental centers do not abuse their discretion in the disposition of investigatory cases. DDS and the administration of all of the developmental centers must exercise strong leadership in developing and implementing policies, procedures and other strategies for resolving the conflict of interest that exists in giving executive directors administrative responsibility

over the investigation of abuse and neglect. As discussed in this report, properly trained individuals who are free to refer cases to appropriate independent agencies should conduct police and investigatory activity at developmental centers. If the conflict of interest cannot be addressed adequately, the investigatory function should be removed from DDS and the developmental centers altogether and given to an independent agency.

DDS should strengthen its oversight of developmental center investigations and reporting.

DDS should periodically review the reporting rates of all developmental centers, as well as the nature of reported allegations, to detect possible signs of poor reporting practices. DDS should conduct on site reviews at all developmental centers which consistently evidence low reporting rates or absence of reporting of less serious allegations.

DDS should also develop a reliable protocol for checking the quality of developmental centers' investigations of dependent adult abuse. This protocol should ensure that a reliable sampling of all such investigations, including investigations of "unfounded" and "undetermined" cases are reviewed with a standard checklist. Key indications for review include:

comprehensiveness and accuracy of initial SIRs;

prompt removal of the alleged perpetrator from direct care responsibilities when indicated for the safety of the alleged victim and other residents; prompt initial investigation of the allegation;

prompt physical exams of victims, comprehensive physical exam reports, and color photographs of visible injuries;

prompt securing, sketching and photographing of the scene of the incident, as appropriate;

prompt compliance with all external mandatory reporting requirements; prompt interviews and appropriate signed, written statements for all witnesses and informants, alleged perpetrators, and alleged resident/victims; and comprehensive investigation reports.

G. BARRIERS CONTRIBUTING TO IDENTIFYING AND RESPONDING TO CLIENT ABUSE FINDINGS AND CONCLUSIONS

ADC failed to recognize and respond effectively to characteristics and institutional dynamics known to contribute to the incidence of abuse.

ADC failed to recognize and respond effectively to characteristics and institutional dynamics known to contribute to the incidence of abuse.

ADC failed to identify and effectively respond to resident and institutional characteristics known to increase the incidence of abuse. Vulnerability and isolation of residents, inadequate personnel practices, and inadequate supervision and staffing are factors known to increase the risk of abuse in large residential facilities such as ADC. All of these characteristics were evident on Unit 632.

Fear of losing one's job, fear of retaliation, fear of bad publicity, loyalty among staff, and avoidance of becoming involved were all behaviors identified by staff in their interviews with PAI investigators and demonstrated by their actions in response to resident injuries, including the circumstances surrounding Bacaylan's death.

RECOMMENDATIONS

DDS and ADC should develop effective strategies for addressing institutional dynamics that contribute to an abusive environment.

DDS and ADC should increase their capacity to identify at-risk residents and implement specific strategies to protect them.

DDS and ADC should increase their capacity to implement strategies for preventing abuse by employees.

DDS and ADC should develop effective strategies for breaking the "code of silence" among staff.

DDS and ADC should develop effective strategies for addressing institutional dynamics that contribute to an abusive environment.

Implementation of new personnel practices, the development of more effective strategies for diminishing unscheduled absenteeism and overtime, and more active routine supervision would address some of the factors that contribute to an abusive environment.

DDS and ADC should increase their capacity to identify at-risk residents and implement specific strategies to protect them.

Residents who are aggressive and self-injurious should have appropriate individualized behavioral plans. ADC should reconsider its practice on Unit 632 of grouping clients together on the basis of behaviors, because such grouping may create conditions that increase the likeli- hood of client abuse. If ADC continues to group residents this way, staff must receive ongoing specialized training and supervision to minimize the risk of harm.

DDS and ADC should increase their capacity to implement strategies for preventing abuse by employees.

Managers and supervisors should receive more effective training in identifying and responding to at-risk employees. They should give more attention to implementing supervisorial strategies for preventing abuse and neglect before it occurs.

DDS and ADC should develop effective strategies for breaking the "code of silence" among staff.

As noted earlier, commitment to residents' well-being is positively related to willingness to report abuse. There is a need for strong leadership in this area. Recognition of the phenomenon is the first step. Exposure of and education about underlying causes is an important next step. Had the "code of silence" among staff on Unit 632 not been so powerful, it is likely that Joseph Bacaylan would be alive today.