REPORT OF

AN INVESTIGATION INTO THE DEATH OF LISA RUSSELL ON AUGUST 7, 1998

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

This report presents Protection & Advocacy, Inc.'s (PAI's) investigation into the death of Lisa Russell.[1] On June 23, 1998, Ms. Russell had a sexual encounter with Miguel Chase, a certified nurse assistant at the facility where Ms. Russell resided. As a result of that sexual encounter, Ms. Russell was infected with cytomegalovirus and died less than six (6) weeks later.

PAI releases this report as part of its ongoing educational efforts to:

- Improve the safety of people with developmental disabilities;
- Reinforce the mandatory reporting of abuse of dependent adults and the necessity for independent investigations of allegations of abuse by impartial investigators;
- Educate caregivers regarding the power relationship that exists between caregivers and clients which clouds the issue of consensual sex between staff and clients under their care; and
- Challenge the Department of Health Services, Licensing and Certification Program to recognize the serious, lasting and potentially life threatening effects of nonconsensual sexual encounters between facility residents and caregivers.

PAI is an independent, private, nonprofit agency that protects and advocates for the rights of persons with disabilities. Under federal and state law, PAI has the authority to investigate incidents of abuse and neglect of persons with developmental disabilities. 42 U.S.C. §§ 15001, et seq.; Welf. & Inst. Code §§ 4900, et seq.

PAI thanks Hillside House administrative and patient care staff for their cooperation with this investigation and commends them for the preventative measures they have taken since Lisa Russell's death.

PAI's Investigations Unit (IU) wishes to acknowledge Colette I. Hughes for her dedication and leadership of the IU and for her guidance in this report.

[1] Pseudonyms have been used throughout this report for all individuals' names.

II. EXECUTIVE SUMMARY

Lisa Russell was a 48-year-old woman with cerebral palsy and mild mental retardation. She was independent with many activities of daily living. Although she used a wheelchair, she required minimal assistance and supervision. She attended classes at a day program, working towards her goal of moving into an apartment with a friend.

On June 23, 1998, a certified nurse assistant (CNA) at Hillside House, Miguel Chase, invited Ms. Russell to have sex with him. She had refused his previous sexual advances. But, on this evening, she agreed. Chase told her the rendezvous plan. Later that evening, he wheeled her to a remote area of the campus, behind several outbuildings. He helped her out of the wheelchair and placed her on the grass. She had expected only kissing and fondling. But, instead, Chase lay on her and had sexual intercourse. On their way back into the building, Chase instructed Ms. Russell to keep their rendezvous secret. Nursing staff witnessed her return with Chase. Her hair was full of cut grass. There was mud, cut grass and light blood stains on the rear portion of her nightgown. Nursing staff checked her for injuries, but did not question Ms. Russell about what she and Chase were doing outside.

The following morning, Ms. Russell confessed their encounter. Hillside House administrators quickly interviewed Ms. Russell. She was not provided with an advocate or other support during the interview. Those conducting the interview were in positions of authority, including making decisions about the quality of her care and the fate of Chase. They asked leading questions, including questions that led Ms. Russell to state that the encounter was consensual. The answers that she provided in this interview were later relied upon by other independent investigators.

Within weeks, Ms. Russell was dead due to an infection that she most likely contracted as a result of the sexual encounter. While Chase was fired by Hillside House and lost his CNA certificate, he was never prosecuted.

PAI investigated Ms. Russell's death to determine whether Chase was arrested and prosecuted and what, if any, corrective action was initiated to protect residents from sexual encounters between staff and residents.

PAI's investigation determined that:

- Ms. Russell's death was proximately related to the sexual encounter with Chase;

- The facility failed to report the sexual encounter as dependent adult abuse;

- The facility's interview of Ms. Russell was improper and likely influenced other investigations;

- In the context of a caregiver-patient relationship, Ms. Russell's alleged consent to the sexual encounter is questionable; and,

- Any nonconsensual sexual encounter with a facility resident by a caregiver has the potential to cause significant injury and warrants a Class A citation by Department of Health Services, Licensing and Certification Program (Licensing).

III. BACKGROUND

A. VICTIMIZATION OF PEOPLE WITH DEVELOPMENTAL DISABILITIES

Studies estimate that upwards of 80% of women with developmental disabilities have been sexually assaulted (Sorensen, 1998, p. 2; Lumley & Miltenberger, 1997, p. 460). Persons with disabilities residing in institutions are two-to-four times as likely to be sexually abused as compared with those living in the community (Furey, 1994, p. 174). People with both mental retardation and a physical disability are the most vulnerable of all victims of sexual assault with disabilities (Sorensen, 2000, p. 2).

The vast majority of sexual abuse victims with developmental disabilities know their perpetrators and likely trust them (Lumley & Miltengerger, 1997, p. 460; Furey, 1994, p. 173). Direct care staff are the most likely perpetrators of abuse in facilities (McCartney & Campbell, 1998, p. 472). Persons with developmental disabilities are trained to follow their caregivers' instructions (Furey, 1994, p. 178). Compliance with caregivers may be overemphasized at the expense of lessons in assertiveness or independence, thus increasing the likelihood of being victimized by a caregiver (Tharinger, Burrows, Horton & Millea, 1990, p. 304). People with developmental disabilities are particularly vulnerable to abuse due to their dependence on caregivers, relatively powerless position in society, and lack of education regarding sexuality and sexual abuse (Kempton, 1993, p. 201; Tharinger, 1990, p. 305). In many of cases, the victims are unaware they are being victimized (Id., p. 199).

B. LISA RUSSELL

Lisa Russell was a 48-year-old woman with cerebral palsy and mild mental retardation. For ten years, she lived at Hillside House, an intermediate care facility for persons with developmental disabilities (ICF-DD). She loved watching cooking shows on television and enjoyed doing crossword puzzles. She had a good sense of humor and looked forward to visits from University of California at Santa Barbara students with whom she liked to share stories and jokes.

Ms. Russell performed many activities of daily living independently. Although she used a wheelchair, Ms. Russell required minimal assistance and

supervision. She was working on her independent living skills and was planning to move out of Hillside House to share an apartment with a friend in the next few years. She attended classes three days a week at a day program and participated in programming activities at her residence, including outings and classes with her peers.

Prior to the incident underlying this report, Ms. Russell was in apparent good health. She took medication for some health problems and was able to identify her medications and to understand why they had been prescribed.

C. HILLSIDE HOUSE

Hillside House is a 59-bed ICF-DD located at 1235 Veronica Springs Road, Santa Barbara, California. Hillside House is a nonprofit corporation and is licensed by the Department of Health Services.

D. MIGUEL CHASE

Miguel Chase (Chase) was a CNA, employed at Hillside House beginning in January 21, 1998. Reportedly, Chase completed a three-month CNA training in 1997 at a convalescent home in Santa Rosa, California. He was issued a CNA certificate by the Department of Health Services on August 15, 1997. Chase reported on his Hillside House employment application that he had worked in health care since March 1995.

On January 20, 1998, Chase was hired by Hillside House as a full-time regular employee assigned to the evening shift (3:00 to 11:00 p.m.). He began his orientation the following morning.[2]

During the five-month period that he was employed by Hillside House, Chase was given four warnings about his work performance and was suspended from work once. Following the incident involving Ms. Russell, Chase was terminated from employment at Hillside House and his CNA certificate was revoked by the Department of Health Services.

[2] Studies of confirmed cases of abuse of persons with developmental disabilities show that the perpetrators of abuse in facilities are more likely to be male with direct care responsibilities, assigned to the second shift, and relatively new employees (McCartney & Campbell, 1998, p. 472; Marchetti & McCartney, 1990, p. 370).

E. CYTOMEGALOVIRUS (CMV)

According to the medical literature, CMV is a virus, in the family of herpes viruses (Crumpacker, 2000, p. 1586). Human CMV is the largest virus to infect human beings. Sixty to seventy percent (60-70%) of Americans living in many urban areas are infected. The clinical manifestations vary in people infected with CMV with most having no symptoms at all. In persons with an immune system incapable of fighting infections (immunocompromised), the disease is frequently fatal.

A primary CMV infection occurs when people not previously infected with CMV are first infected with the virus. After the primary infection, CMV can lay dormant in the human host for years. Secondary infections are a reactivation of the latent CMV infection.

A primary infection with CMV can produce a syndrome known as CMV infectious mononucleosis syndrome, characterized by fever, enlargement of lymph nodes, and atypical lymphocytes. One complication of this syndrome is inflammation of the middle layer of the walls of the heart (myocarditis).

IV. SEQUENCE OF EVENTS

On the evening of June 23, 1998, Ms. Russell was home at Hillside House. At some point in the early evening, Chase approached Ms. Russell and asked her if she was interested in having sex with him. This was not the first time that Chase had propositioned her. According to Ms. Russell, on at least two other occasions in mid-June, Chase invited her to have sexual relations with him. Although, she refused his previous advances, Chase's overtures made her feel, "good." He was the first, "nice guy to show interest."

On this particular evening, Ms. Russell accepted Chase's sexual proposition. He then instructed her to return to her bedroom and put on her nightgown. At approximately 8:35 p.m., Chase came to her bedroom door. She let him in. He pushed her outside in her wheelchair to an area behind one of the outbuildings. Chase helped her out of her wheelchair and placed her on the grass. They had sexual intercourse. After approximately ten minutes, he climbed off her and put her back in her chair. He then pushed her back to the main building. He asked her not to report the encounter. Ms. Russell later reported to law enforcement that she had not expected to engage in sexual intercourse with Chase. She was only expecting kissing and fondling. *"At the time, it felt like a good idea . . . Now I know it was stupid."*

Hillside House staff working that evening observed Ms. Russell coming into the building after hours with Chase:

> *At 9:00 p.m. CNA Baker noticed [Lisa] coming into [Hillside House] from outside of the residents [sic] lounge. [Lisa] was 'covered' [with] cut lawn (grass). [Lisa] denies falling out of [her wheelchair]. States 'I got out of my [wheelchair] and laid down on the grass.'*
>
> *[Miguel Chase] states [Lisa] 'was on the lawn.' Full body check [negative] for bruises or reddness [sic] or areas of swelling on back, arms, legs, head or[abdomen]. However her hair was full of cut grass, her nite gown [sic] was . . . full of cut grass, she had urinated and her nite gown [sic] has mud dirt was on the 'rear'*

portion of the gown. Also, it appears that [Lisa] has her menses, lite [sic] blood stains on the 'rear' portion of her nite gown [sic].[3]

Ms. Russell returned to her room and went to bed. Staff working that evening made no further inquiries.

Early the following morning, the Director of Staff Development at Hillside House asked Lisa about what had happened the previous evening. Ms. Russell confided to her that she had gone outside with Chase and that they had engaged in sexual intercourse. The Director of Staff Development described their conversation:

The nurses were busy this am when I got here [at] 630 AM. In report I read & was told about incident report made last night ie: [Lisa Russell]. In passing [Lisa] in hallway, I asked [Lisa R]. "What happened last night" & her answer was "I don't want to get in trouble." I asked her, "why would she get in trouble" & her answer was "I don't want to get [Miguel C.] fired." I asked, why, what happened? [Lisa] said "[Miguel] & I had sex." I asked what does that mean [Lisa] & [Lisa] said "He put his penis into my vagina."

Hillside House did not notify local authorities, including law enforcement, adult protective services, or the local ombudsman, about Ms. Russell's allegations. Instead, at approximately 10:35 a.m., four Hillside House administrators interviewed Ms. Russell alone. The interview was taped. Those conducting the interview were in positions of power and authority within the facility. They ultimately made decisions about the quality of Ms. Russell's care and life, including her continued stay. They also determined the fate of Chase.

Some questions in the interview appeared to be compound and leading, suggesting particular answers. The following is a sample of some of the questions posed to Ms. Russell:

Hillside House: What it appears from something you said is that you may have had sexual intercourse or engaged in sexual activities with him.

Lisa: Yes . . .yes.

[3] The records from Hillside House show that Ms. Russell did not begin her menses that evening or for the remainder of June.

Hillside House: Yes? That is what happened?

Lisa: Yes.

Later,

Hillside House: Did you know you were going to go out and have sex? (pause) Or did you just go out for a walk?

Lisa: (pause) We went out to have it.

Hillside House: You went out to have it. So you knew before you went out there that you guys were going to have sex? Had you ever had sex with him before? No? Had you talked about it before?

Lisa: Yeah, but I never thought of that.

Hillside House: I'm sorry, I didn't understand you.

Lisa: He was just kidding, you know.

Later,

Hillside House: Did he force you to do this? (pause) . . .Did he force you? Did you at any time say no? Did you try to get up?

Lisa: No

Hillside House: No. Did he, um, did you think he kind of coerced you? Do you know what coerced means? It means kind of someone that's, even though you don't want to do something, they talk you into it.

Lisa: Uh-huh.

Hillside House: You know, like if I said, 'Oh, come on [Lisa], come on, go to Day Program, go do this . . .' and you don't really want to do it but you do it just so someone stops bugging you. Was that what happened? Or you really . . .?

Lisa: (interrupting) Yeah. Yes and no.

Hillside House: Yes and no

Lisa: Yeah.

Hillside House: He was bugging you about it, but then it kind of sounded like it might be good to you too.

Lisa: Yeah.

Later,

Hillside House: Okay [Lisa], when before you left, what happened to your underwears [sic] and your pants? What did you wear? Did you plan this ahead of time, because it was reported to me that you did not have underwears [sic] or bra on, all you got is a nightgown. Did you plan to dress that way before you left? You did. So you went with just nightgown?

Lisa: Um-hmm.

Hillside House: Just only nightgown she got before she left. She planned that.

Literature shows that persons with developmental disabilities are more suggestible and will answer what they believe the interviewer wishes to hear (Perske, 1994, p. 377). Ms. Russell was interviewed without the presence of an advocate or representative on her behalf.

At no time did the facility notify law enforcement. It was not until later that day when the triage nurse at the local hospital called the Santa Barbara County Sheriff's Department (Sheriff's Department) that law enforcement got involved. Law enforcement came to rely upon the statements made by Ms. Russell in the interview conducted by Hillside House administrators and other information that they provided to conclude that Ms. Russell had consented.

The staff determined that Ms. Russell consented to the sexual contact. It appears that administrators failed to appreciate Ms. Russell's impaired ability to refuse Chase's sexual advances in the context of their caregiver-resident relationship. The following excerpt is from an interview with PAI investigators:

PAI: And it [sic] was no doubt in your mind at the end of the interview with her that morning that this was a consensual act on her part.

Program Director: Definitely.

A little after noon that same day (June 24th), Ms. Russell was taken to Santa Barbara Cottage Hospital (Cottage Hospital) for a medical evaluation. No medical records exist of this emergency room visit.

The Sheriff's Department was contacted by the triage nurse at Cottage Hospital. Detective Foster was assigned to investigate the incident. He interviewed Ms. Russell and Hillside House administrators later that afternoon. It was the detective's initial opinion that Ms. Russell willingly had sexual intercourse with Chase. Ms. Russell was never examined by the Sexual Assault Response Team (SART) or any member of Cottage Hospital staff for evidence of a sexual encounter.

Later in the day, Hillside House staff described Ms. Russell as being fearful that Chase was waiting for her outside her room.

On June 25, 2001, Ms. Russell was examined by the Hillside House physician, Dr. Shepard. He conducted a pelvic examination and took a vaginal culture. Following this examination, Dr. Shepard recommended that Hillside House advise Ms. Russell to leave Hillside House because of the sexual encounter. He wrote in Ms. Russell's records:

> *It is my impression that since she does not abide by the rules and [regulations] of [Hillside House] re [sic] day programs etc. and in view of the current situation, [Lisa] should be urged - (no [sic] forced) to leave [Hillside House] and find other living arrangements. There is no way to watch her 24 [hours] a day - and she seems to need constant survelliance [sic].*

Over the next weeks, Ms. Russell also became increasingly physically ill with spiking fevers. She was, "very drowsy," "nonverbal," and incontinent of urine. At one point, she asked to be taken to the hospital. "I don't want to stay here. I feel guilty of what happened." She remained at Hillside House.

Vaginal culture results showed that Ms. Russell had an infection. Antibiotics were ordered. She was given Tylenol for her fever.

On July 26th, the Hillside House doctor-on-call ordered Ms. Russell to be taken to the emergency room. Her condition had worsened. After refusing breakfast, she was found with her head between her knees, sweating profusely. Ms. Russell was admitted to the hospital and was ultimately diagnosed with CMV.

Ms. Russell remained in the hospital for six days. When she was discharged on July 31st, her attending physician stated in the discharge summary,

> *This patient's CMV mononucleosis likely represents a primary infection in a previously sero-negative patient. . . . Most likely the transmission was through sexual contact over the last month or so.*

She returned to Hillside House, still lethargic and feverish. The Cottage Hospital physician reassured Hillside House staff that Ms. Russell may feel ill and lethargic for three weeks. She advised them to treat her fever and pain.

Two days later, on August 3rd, Ms. Russell's temperature was 104.7°F. She was, *"verbally unresponsive, moaning and groaning only."* She was given Tylenol. Less than two hours later, her temperature had spiked to 106.5°F. By 11:00 a.m., Ms. Russell was too lethargic to swallow her morning medications. Staff called paramedics who transported Ms. Russell to the hospital.

When she got to the emergency department, she was unresponsive and lapsed into a coma. She was intubated and admitted. She remained unresponsive until her death. On August 7th, Ms. Russell's mother (Nancy) consented to removing her from life support. Ms. Russell died 15 minutes later. Cottage Hospital medical staff had not expected Ms. Russell to breathe on her own following extubation. Her final diagnosis was, "coma, unknown etiology." Nancy Russell requested an autopsy.

V. INVESTIGATIONS

A. SANTA BARBARA COUNTY CORONER'S OFFICE

An autopsy was conducted at Cottage Hospital by representatives from the Santa Barbara County Coroner's Office (Coroner's Office). As part of their investigation, the Coroner's Office reviewed Ms. Russell's Cottage Hospital medical record. The Coroner's Office Pathologist determined that the cause of Ms. Russell's death was, "[M]yocarditis of probable viral etiology," noting, "[A] history of a consensual sexual relationship was established with an employee of the facility."

B. HILLSIDE HOUSE

On the day that Ms. Russell reported her sexual encounter with Chase, Hillside House administration began an investigation. At about 2:30 p.m. on June 24th, three Hillside House administrators interviewed Chase. According to Hillside House records submitted to Licensing:

> *[Miguel] initially denied that anything had taken place between himself and [Lisa], providing confused and conflicting details of his actions that night. When asked why [the CNA on duty] and [Lisa] would report this if nothing had happened, [Miguel] stated 'Fuck. Yeah, I did. It was consensual. It was her idea."*

Later that same day, Hillside House notified Licensing. At no time did Hillside House notify law enforcement.

On June 24th, Chase was terminated from Hillside House for, *"resident abuse - had unprotected sex with female resident in his care while on duty."* The record indicates the basis of the termination was, *"breaking company rules, leaving work due to willful neglect, and resident abuse."*

C. SANTA BARBARA COUNTY SHERIFF'S DEPARTMENT

The Cottage Hospital triage nurse was the first to report the sexual encounter to law enforcement on June 24th. She called the Sheriff's Department when Ms.

Russell was taken to the emergency department for a pelvic examination. Detective Foster was assigned to the investigation.

Detective Foster interviewed Ms. Russell and Hillside House staff, including those administrators who conducted the in-house interview of Ms. Russell.[4] According to the Sheriff's Department report, Ms. Russell told Detective Foster that she did not want to prosecute Chase and, *"what would make her the most happy would be if this was the last time she had to talk about the case."*

Then, on July 1st, Ms. Russell called Detective Foster. She said that she had changed her mind and now she wanted Chase to be prosecuted for sexually assaulting her. She confessed to being afraid that Chase might return to Hillside House. She was afraid to go outside.

That same day, Detective Foster interviewed Chase by phone. Chase admitted that a male resident at a previous care facility had filed a complaint against him for, *"inappropriate sexual behavior."* Chase claimed that the accusation was false.

Chase told the detective that he knew it was illegal for him to engage in sexual relationships with clients. When asked why he had sex with Ms. Russell, he said, *"It was curiosity."* He said that he knew that it would cost him his job if his sexual encounter with Ms. Russell was discovered.

Initially, the Sheriff's Department concluded that no crime had been committed because Ms. Russell had allegedly consented to the intercourse. But later, the Sheriff's Department changed its conclusion and found that Chase had committed dependent adult abuse, in violation of Penal Code section 288(c)(2).

Detective Foster told Chase that the case would be forwarded to the District Attorney's office to determine whether to bring charges. But the Sheriff's Department did not refer the case to the District Attorney's office for prosecution prior to Ms. Russell's death. Once she died, the case was closed and no referral was made. According to the Sheriff's Department report, dated August 12th:

[4] The Sheriff's Department records indicate that this interview occurred on June 25, 1998. Hillside House staff reported to PAI investigators that this interview was conducted on June 24, 1998.

The listed victim in this case died of natural causes on 8-9-98 [sic]. This case had not been forwarded to the District Attorney's office for prosecution prior to the victim's passing away unsuspectingly.

Chase was never charged with the sexual assault of Ms. Russell.

D. DEPARTMENT OF HEALTH SERVICES

Hillside House reported the incident to Licensing on June 24th, the day that Ms. Russell reported the incident. On July 2nd, Licensing conducted a complaint investigation. That investigation included interviewing Ms. Russell, Chase and Hillside House staff, and reviewing Ms. Russell's records and Chase's personnel file.

Chase's personnel file revealed that, during his five months of employment, he was given four warnings and one suspension for poor work performance. One warning was based on Chase, *"inappropriately touching [a female patient], kissing her cheeks, hugging her to his waist."* A second allegation of inappropriate sexual touching was unsubstantiated following an investigation by facility administrators and Licensing.[5]

Licensing found the allegation of sexual intercourse between Chase and Ms. Russell to be, *"[s]ubstantiated."* A Class B citation was issued on July 9, 1998.[6] Hillside House was cited for:

- fail[ure] to ensure that this developmentally disabled client was protected from sexual and mental abuse. This violation has a direct or immediate relationship to the health, safety, or security of the client.

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[5] Research shows that staff persons who have committed abuse previously are also more likely to be repeat offenders (McCartney & Campbell, 1998, 472).

[6] Licensing issues one of the following citations based on the nature of the injury resulting from a violation:

- Class AA - When there is direct proximate cause of death of a resident; penalty range from $5,000 - 25, 000.
- Class A - When there is either imminent danger that death or serious harm would result to a resident or substantial probability that death or serious physical harm to a resident would result; penalty range from $1,000 - 10,000.
- Class B - When there is direct or immediate relationship to the health, safety, or security of residents other than class A or AA violations; penalty range from $100 - 1,000.

Health & Safety Code §§ 1424(c), (d) & (e).

Hillside House was fined $800, but the fine was waived.[7] Licensing stated the following reasons for the minor penalty assessment:

1. ***The probability and severity of the risk which the violation presents to the patient's mental and physical condition.*** *The probability and severity of risk to this resident are moderate, due to her mental retardation and dependence on staff.*

2. ***The patient's medical condition.*** *The resident has cerebral palsy and is developmentally disabled, resulting in weakness and lack of coordination of her limbs.*

3. ***The patient's mental condition and his or her history of mental disability or disorder.*** *The resident is mildly mentally retarded and is depressed.*

4. ***The good faith efforts exercised by the facility to prevent the violation from occurring.*** *The facility was aware of this employee's excessive familiarity with female clients, and he had been counseled about this before. However, they continued to allow him access to female clients and did not terminate his employment until after this incident.*

5. ***The licensee's history of compliance with regulations.*** *The facility has had one substantiated complaint in the past year, and no citations have been issued in that time."*

In late August 1998, following Ms. Russell's death, Hillside House received a deficiency from Licensing for failing to notify them of Ms. Russell's death.

On September 25, 1998, the Department of Health Services revoked Chase's CNA certification.

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[7] The criteria considered when assigning a penalty amount include:
1. The probability and severity of risk that the violation presents to the resident's mental and physical condition;
2. The resident's medical condition;
3. The resident's mental condition and history of mental disability or disorder;
4. The good faith efforts by the facility to prevent the violation from occurring; and
5. The facility's history of compliance with regulations.

Health & Safety Code §1424(a).

E. PAI'S INVESTIGATION

On October 27, 1998, PAI initiated an investigation into the death of Lisa Russell. PAI's investigation included:

- Reviewing Ms. Russell's records from Hillside House for the time period of June 1997 to August 1998.
- Reviewing Ms. Russell's medical records from Santa Barbara Cottage Hospital for the time period of July 26, 1998, to August 1998.
- Reviewing Sheriff's Department report on the June 23, 1998, incident.
- Reviewing Sheriff's Department report on Ms. Russell's August 7, 1998, death.
- Reviewing Coroner's Office investigation report on Ms. Russell's August 7, 1998, death.
- Reviewing Coroner's Office autopsy report on Ms. Russell's August 7, 1998, death, and all related documents, including laboratory reports.
- Reviewing Licensing's investigation report on the June 23, 1998, incident, and all related documents.
- Reviewing Licensing's statement of deficiencies regarding Ms. Russell's death.
- Reviewing Department of Health Services Enforcement Unit investigation report on the revocation of Mr. Chase's CNA certificate due to the June 23, 1998, incident.
- Reviewing documents from Ms. Russell's Tri-Counties Regional Center file relating to the June 23, 1998, incident and her August 7, 1998, death.
- Reviewing Mr. Chase's Hillside House personnel file.
- Reviewing Hillside House policies and procedures on abuse reporting and abuse investigations prior to and after the June 23, 1998, incident.
- Interviewing six Hillside House staff members in June 1999.

- Interviewing Enforcement Unit Investigator from Department of Health Services regarding criminal background checks for CNAs.

- Touring Hillside House to view and photograph Ms. Russell's bedroom, the facility, and the outdoor area in which the June 23, 1998, incident took place.

- Consulting with John Swartzberg, M.D., an expert in infectious diseases.

- Consulting with members of the Alameda County Medical Center Sexual Assault Center.

VI. FINDINGS AND CONCLUSIONS

A. MS. RUSSELL'S DEATH WAS PROXIMATELY RELATED TO THE SEXUAL ENCOUNTER WITH CHASE.

The medical evidence shows that Ms. Russell had a primary, acute CMV infection that ultimately caused her death from viral myocarditis. PAI's medical expert, Dr. Swartzberg, concluded that Ms. Russell's CMV infection was most likely transmitted sexually and within the few weeks prior to her death. Dr. Swartzberg based this opinion upon Cottage Hospital laboratory tests and the time frame in which the symptoms developed. Serologic tests taken on July 28th showed that Ms. Russell had a high immunoglobulin G (IgG) and immunoglobulin M (IgM) antibody levels. High levels of both IgG and IgM antibodies strongly suggest that the primary viral infection occurred within the last several months. The atypical lymphocytes in her blood were characteristic of a mononucleosis syndrome caused by CMV, Epstein-Barr virus, or Toxoplasma gondii. The latter two syndromes were eliminated by serologic tests. Dr. Swartzberg felt that the care provided by medical staff at Cottage Hospital was within the professional standard of care and was not a contributing factor to her death.

Based on the history of Ms. Russell's recent sexual intercourse with Chase and in the context of no other reported sexual activity or blood exposure, Dr. Swartzberg concluded that Chase infected Ms. Russell with the CMV and that this infection developed into the myocarditis that caused her death.

> *It's my opinion, [Ms. Russell] was acutely infected with CMV from her sexual encounter [with Chase] and that this accounted for both her first hospitalization and her second hospitalization and it accounted for her death from myocarditis.*
>
> *It is apparent from the data that I reviewed that [Ms. Russell] acquired an acute infection, what we call a primary infection of CMV, and that the only source that I can entertain was the sexual transmission. . . . Furthermore, the temporal relationship between the time that she had sexual intercourse and the development of the symptoms is consistent with acute CMV. . . . It is temporally consistent with that and there is no other apparent way she could have been infected.*

B. HILLSIDE HOUSE FAILED TO REPORT THE DEPENDENT ADULT ABUSE OF MS. RUSSELL AS REQUIRED BY LAW.

Studies show that 80-85% of criminal abuse of residents of institutions is never reported to the proper authorities (Sorensen, 1998, p. 4). Staff are reluctant to come forward with charges for fear of reprisal or retribution from facility administrators (Id.). Administrators may be reluctant to report violent crimes because they can lead to negative publicity, questions about their competence, damage their careers or even lead to losing their jobs (Id.).

The Elder Abuse and Dependent Adult Civil Protection Act is intended to correct the problem of under-reporting. Pursuant to this act, California care custodians of dependent adults are required to report to the local ombudsman and/or local law enforcement any incidents that reasonably appear to be physical abuse or neglect. Welf. & Inst. Code §§ 15600, et seq. Physical abuse includes sexual assault. Welf. & Inst. Code § 15610.63(e). Consent by the dependent adult is not an exception to the reporting requirement. Welf. & Inst. Code §§ 15630, et seq. The sexual encounter between Ms. Russell and Chase constituted dependent adult abuse.

Hillside House staff working on the evening of June 23rd had a duty to question Ms. Russell about what happened when she returned to the facility in a disheveled condition accompanied by Chase. Once the incident was disclosed, staff at Hillside House were required to report it to the authorities. Welf. & Inst. Code § 15630. A timely report by Hillside House likely would have permitted law enforcement to interview Ms. Russell and other witnesses first and in a neutral, impartial manner. Hillside House administrators acted improperly by failing to report the sexual encounter to proper authorities. Instead, they conducted a leading and suggestive interview of Ms. Russell, the content of which was later relied upon by other, independent investigators and local law enforcement. It was the triage nurse at Cottage Hospital who reported the incident to local law enforcement.

C. THE FACILITY'S INTERVIEW OF MS. RUSSELL WAS IMPROPER.

When Ms. Russell reported the incident, Hillside House administrators decided to interview Ms. Russell, rather than contact the appropriate authorities. Ms. Russell did not have an advocate or representative present to support her or protect her interests. During the course of the interview, different individuals posed questions.

The staff present during the interview were all in positions of authority within Hillside House. They would make decisions about Ms. Russell's continued stay at Hillside House, her home for the past ten years. They made decisions about the quality of services that she received. They also would decide the fate of Chase, including if he would continue to work in proximity to Ms. Russell at Hillside House. The context of being interviewed alone by individuals in positions of power undoubtedly influenced the answers that Ms. Russell provided.

The questions were asked in a manner that appears to have influenced Ms. Russell to state that she had consented to the sexual encounter. Some of the questions asked were leading, including questions about Ms. Russell's willingness to go with Chase. Ultimately this interview contributed to conclusions by law enforcement and other investigators that Ms. Russell consented to the sexual encounter. This conclusion precluded Ms. Russell from receiving a sexual assault examination, which may have revealed physical evidence of the sexual encounter or use of force.

The initial interview of a victim is best executed without suggestion or bias, as it is the best opportunity to capture the facts, as recalled by the victim. It helps those investigating to elicit from the victim their uninfluenced description of the incident. This first interview begins to cement a description of the incident in the minds of investigators and the victim.

In this case, this first opportunity to document Ms. Russell's true account of the incident was lost when she was interrogated by the facility's administrators who were not impartial and may not have been specifically trained to conduct interviews of potential sexual assault victims. Had trained law enforcement been involved in this initial interview, it would have more likely been impartial and non-coercive. Questions by law enforcement would have more likely conformed to standard interview techniques. Early law enforcement involvement would more likely have revealed and preserved relevant evidence, including physical evidence had Ms. Russell received a SART examination.

D. IN THE CONTEXT OF A CAREGIVER-PATIENT RELATIONSHIP, MS. RUSSELL'S ALLEGED CONSENT TO THE SEXUAL ENCOUNTER IS QUESTIONABLE.

While the record indicates that Ms. Russell willingly went outside with Chase, whether she consented to Chase's advances is questionable. The question will forever remain unanswered in part due to the power imbalance inherent to

every caregiver-resident relationship that clouds the issue of consent. While consensual sexual relations are possible between a caregiver and a resident, this issue is very complex and difficult to readily discern, for both the victim and those investigating the allegation of a sexual assault.

During its investigation, PAI consulted with members of the Alameda County Medical Center Sexual Assault Center, some of whom have specific expertise in the counseling and treatment of persons with developmental disabilities who have been victims of sexual assault. According to these experts, the nature of a caregiver-resident relationship is inherently unequal because the caregiver has more power and control. Like sexual harassment in the workplace, the perpetrator holds a position of power or authority. Victims may feel powerless to resist the propositions of the perpetrator for fear of retaliation, whether directly stated or implied by the nature of their relationship (Furey, 1994, p. 178). A caregiver has authority over the resident's lifestyle, from simple activities of daily living to whether the resident will be permitted to remain in the care setting and the quality of that stay. The resident is captive and at the mercy of the caregiver. This is supported by Dr. Shepard's note that suggests that Ms. Russell should be discharged as a result of the sexual encounter with Chase.

This dynamic in the caregiver-resident relationship may compromise the ability of the resident victim to voluntarily consent to sexual advances by the caregiver. The resident may feel direct or indirect pressure to cooperate with the caregiver's sexual propositions. The difference in power between a resident and caregiver acts like an unspoken form of coercion. If the resident conceals the abuse, she may curry favors, adding to the quality of their life in the facility. If the resident refuses the caregiver's advances, the resident may fear retaliation, a reduction in the level of privileges, or a lessening of attention from a care provider (Id.).

Any sexual activity may be abusive or, at least, exploitive when one of the parties lacks the information necessary to give consent (Lumley & Miltenberger, 1997, pp. 459, 461). Researchers observe that people with developmental disabilities typically lack experience in dating and mating or formal sex education. (Id.) Without relevant sex education, an individual lacks the foundation to satisfy the legal criteria for distinguishing between a consensual[8] sexual act and sexual abuse (Parker & Abramson, 1995, pp. 257-258). Many have little to no exposure to

[8] Consent is defined as, "a positive cooperation in act or attitude pursuant to an exercise of free will. The person must act freely and voluntarily and have knowledge of the nature of the act or transaction involved." (Parker & Abramson, 1995, pp. 257-258).

information about sexual abuse (Tharinger, et al., 1990, p. 305). This lack of knowledge about sexuality and intimate relationships increases the vulnerability of persons with disabilities to sexual overtures from others (Furey, 1994, p. 174).

At least one study concluded that investigators are confused about the issue of consent. This study found that investigators are likely to focus on the issue of volition alone rather than considering both the victim's ability to understand the nature and consequence of the sexual act ("informed") and his/her ability to understand and use volition ("consent") (Parker & Abramson, 1995, pp. 261-262).

Additional factors unique to persons with developmental disabilities make them more vulnerable to abuse. Experts point to a lifelong dependency on caregivers. Many are educated early on to be compliant at the expense of lessons in assertiveness or independence (Tharinger, et al., 1990, p. 304). Victims with cognitive disabilities may feel guilt about not complying with their caregiver's demands, in part due to their dependency upon the caregiver (Kempton, 1993, p. 202; Furey, 1994, p. 178). Additionally, some strive to be accepted and to have friends in the "normal population" (Tharinger, et al., 1990, p. 305). Researchers conclude that this desire for acceptance makes persons with developmental disabilities more vulnerable to coercion (Id.).

Chase was a caregiver at Hillside House. He was one of the staff who provided direct and indirect care to the residents. Ms. Russell may have felt powerless to resist his advances. According to statements that she made following the incident, Ms. Russell did not anticipate that they would have intercourse. It was only after Hillside House terminated Chase that Ms. Russell felt comfortable enough to admit that she had not consented and that she wanted Chase prosecuted for sexual assault.

E. ANY NONCONSENSUAL SEXUAL ENCOUNTER WITH A FACILITY RESIDENT BY A CAREGIVER HAS THE POTENTIAL TO CAUSE SIGNIFICANT INJURY AND WARRANTS A CLASS A CITATION BY LICENSING.

In this case, Licensing issued a Class B citation with an $800 penalty assessment. Ultimately, the penalty was waived because the facility had a history of compliance with state regulations.

The class of citation issued in this case suggests a failure to appreciate the serious harm a resident suffers following a nonconsensual sexual advance

by or encounter with a caregiver, whether or not the incident is technically a sexual assault. Because of the inherently coercive nature of any such sexual relationship, it should be treated as assaultive and abusive in licensed facilities until proven otherwise.

According to the literature, rape results in both long-term physical injuries and mental health consequences (Allen, 2001, p. S1). The psychological trauma in most cases is more severe than any physical injuries (Allen, 2001, p. S6). Clinical conditions include post-traumatic stress disorder, rape trauma and rape trauma syndrome[9]. Chronic and possibly deadly physical disease may be transmitted.

Research finds that reactions to sexual abuse in the population of persons with developmental disabilities are more severe than in the non-disabled population (Tharinger, et al., 1990, p. 307). However, there are limited therapeutic interventions offered to victims of sexual abuse who are developmentally disabled (Tharinger, et al., 1990, pp. 308-309). Mental retardation is generally an exclusionary criteria for psychotherapy. Traditional therapeutic interventions facilitating recovery from a sexual assault have not been researched in the case of a victim with a developmental disability (Tharinger, et al., 1990, p. 308). With little to no therapeutic intervention, victims may suffer serious and long-term harm.

The Class B citation issued to Hillside House indicates that Licensing failed to appreciate the serious harm that results to the resident following a nonconsensual sexual encounter with a staff member. Such an encounter violates his or her position of trust and authority in a manner that minimally places the vulnerable resident at risk of serious psychological and emotional trauma. Such incidents warrant Class A citations, at a minimum.

[9] Rape trauma syndrome describes the etiology and behavioral characteristics of stress and anxiety suffered by a victim following a sexual assault.

VII. RECOMMENDATIONS

A. ANY SEXUAL RELATIONS BETWEEN A FACILITY RESIDENT AND CAREGIVER SHOULD BE REPORTED UNDER ABUSE REPORTING STATUTES FOR AN INDEPENDENT AND IMPARTIAL INVESTIGATION.

All mandatory reporters must meet their statutory charge and report any incident that reasonably appears to be abuse, including reports from the victim, pursuant to the Elder Abuse and Dependent Adult Civil Protection Act. Welf. & Inst. Code §§ 15600, et seq. PAI recommends that every care facility regularly review these reporting requirements with their staff and institute measures to ensure compliance. At least one research study found that staff who have recently attended an inservice training regarding abuse reporting requirements are more likely to report an incident of abuse (McCartney & Campbell, 1998, p. 472). Inservice has been shown to be an important factor in increasing the reporting of abuse (Id.; Marchetti & McCartney, 1990, p. 367).

B. ALLEGATIONS OF ABUSE MUST BE INVESTIGATED INITIALLY BY INDEPENDENT INVESTIGATORS.

Following an allegation of abuse, one important initial intervention is to report the incident and preserve evidence. This is likely to include sending the victim for a physical examination for collection of physical evidence and preserving the "scene" of the abuse for independent investigators. Facility staff should not initiate interviews or evidence collection. Even well-intentioned and caring facility staff can unintentionally taint or destroy evidence. Potential witnesses should not be interviewed except by trained, independent investigators. All victim interviews should be conducted with an advocate for the victim present, unless the victim declines such representation.

C. LICENSING IS URGED TO CONSIDER CLASS AA OR A CITATIONS FOLLOWING INCIDENTS OF NONCONSENSUAL SEXUAL

ENCOUNTERS BETWEEN DEPENDENT ADULTS AND CAREGIVERS.

PAI urges Licensing to consider the serious and life threatening harm to victims of nonconsensual sexual relations between dependent adults and caregivers, whether or not the incident is, technically, an assault. Any such incidents should carry the presumption that they constitute serious abuse. If found to be nonconsensual, they warrant the issuance of a Class A citation, at the least.

D. PERSONS WITH DEVELOPMENTAL DISABILITIES SHOULD RECEIVE TRAINING IN SEX EDUCATION AND SEXUAL ABUSE PREVENTION.

In order to protect themselves from sexual abuse, persons with developmental disabilities must be trained in sex education and sexual abuse prevention. Staff should assist residents in making choices about sexual expression with the foundation of knowledgeable sex education, including information about recognizing a potentially dangerous situation, responding to abuse by verbally refusing and/or escaping the situation, and reporting the abuse situation (Lumley & Miltenberger, 1997, pp. 461-462).

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