A Series of Suspicious Genital Lacerations at One Developmental Center: Did DDS Respond Properly?

Protection & Advocacy, Inc.
Investigations Unit
433 Hegenberger Rd., Suite 220
Oakland, CA 94621
Tel. (510) 430-8033

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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.

Investigations Unit Staff:

Leslie Morrison, M.S., R.N., Esq.
Supervising Attorney (Oakland)

Charis Moore
Staff Attorney (Oakland)

Staff Acknowledgement for Editing and Production:
Emily Rose

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I. INTRODUCTION

Protection & Advocacy, Inc. (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, psychiatric and physical disabilities. 42 U.S.C. § 15001 et seq. and 10801 et seq.; 29 U.S.C. § 794e et seq.; Welf. & Inst. Code § 4900 et seq.

PAI learned of this series of incidents through routine monitoring of citations issued by the Department of Health Services (DHS). In September 2002, DHS issued a Class B citation to a California state developmental center stemming from the injuries sustained by Lenny M.[1] Based upon this incident, PAI queried the Department of Developmental Services (DDS) about how many similar incidents, involving genital lacerations or injuries, had occurred during the preceding five years at this facility. DDS reported four, and later five, similar injuries from November 1997 through November 2002. PAI initiated an investigation into each incident.[2] During the course of these investigations, a seventh incident occurred and was incorporated into PAI's inquiry.

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

> Publicize that significant genital lacerations to individuals with severe or profound cognitive impairments and without an adequate explanation of the cause may indicate possible physical or sexual abuse;
> Reinforce to mandated reporters the importance of fulfilling their reporting obligations;
> Prompt health care providers and mandated reporters to immediately notify designated investigators about injuries to persons with developmental disabilities that are characteristic of abuse or neglect;

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[1] To protect the confidentiality of the victims described in this report, pseudonyms have been used for the five residents.

[2] The earliest laceration incident (occurring in January 1998) was likely the result of a witnessed resident-to-resident assault and is not included in this report. PAI also did not include in this report a scrotal laceration, occurring in October 2002, resulting in five sutures. PAI could have, but elected not to pursue its federal and state authority to access to the records of this victim, despite the refusal of the victim's legal guardian to grant PAI access. See 42 U.S.C. § 15043(a)(2)(I)(iii); Welf. & Inst. Code § 4903(a)(4). This victim was in the same program as most of the other victims.

Urge health care providers and designated abuse and neglect investigators to consider abuse or neglect as a contributing factor to suspicious injuries and conduct prompt and thorough investigations, including consulting with community experts in abuse and neglect; and
In the case of injuries suggestive of sexual assault, advise health care providers to complete thorough sexual assault examinations with appropriate collection of evidence.

II. EXECUTIVE SUMMARY

PAI investigated five genital laceration incidents occurring at one state developmental center over five years. The injuries ranged in size from 1.5 to 8.0 centimeters and required between three and 20 sutures to close.[3] The victims resided in residences generally clustered in one program. The records indicate that all but one of the victims are nonverbal. Most require assistance with toileting. In each case, staff discovered the injuries while assisting with bathing or following toileting.

None of the injuries was witnessed. Staff members were left to speculate about the cause. No one could offer an explanation for how the lacerations occurred. Two of the injuries were never referred to investigators. Delays in reporting at least two others severely hampered investigations. There is no evidence that any of the victims received a sexual assault examination. None was reported as possible dependent adult abuse as required by the Elder Abuse and Dependent Adult Civil Protection Act. The causes of these injuries remain unknown.

According to PAI's experts, an injury of this kind to the genitals is unusual and suggestive of abuse, possibly sexual abuse, even in an institutionalized population and even with a population at risk for self-injurious behavior. All of the injuries were suspicious and should have been reported immediately to developmental center investigators or community law enforcement for investigation. Each of the victims should have received a thorough examination to reveal other signs of abuse. According to PAI's experts, the pattern of these injuries, occurring at one facility and clustered primarily in one program, is noteworthy. As the incidents occurred over time, their suspiciousness mounted, making each one more suspect than the previous one and reinforcing the need to investigate them as being the possible result of abuse or neglect.

Based upon its investigation, PAI finds that the injuries were suspect of abuse. The victims could offer no reliable explanation for how the injuries occurred. The suspected cause was inconsistent with the description of the injury. The victims should have received thorough medical evaluations, including sexual assault examinations to collect corroborating evidence if any existed. PAI's investigation found that staff failed to fulfill their mandated abuse reporting duties and alert investigative staff promptly to initiate an investigation. Furthermore, investigations did not sufficiently consider abuse as a possible cause.

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[3] In two cases, there was a second laceration of smaller size not included in these figures.

At PAI's request, in June 2003, DDS initiated a secondary investigation into the first six incidents, in consultation with the county District Attorney's office. These investigations found no evidence of physical or sexual abuse or a pattern of abuse. DDS did find that staff had failed to report injuries to investigators as required by facility policy and that, preceding the injury, staff failed to provide the victims with close supervision. In the cases that were investigated, DDS found the initial investigations were inadequate because they failed to gather evidence of the victims' individual circumstances and failed to interview medical staff to find a likely cause for the injury and to potentially rule out abuse.

PAI recommends that DDS:

Evaluate and modify its abuse and neglect training and reporting system to ensure that injuries like these do not escape the attention of staff;
Reinforce to medical and direct care staff, in the case of suspicious injuries of unknown origin, the need to perform thorough comprehensive physical examinations, carefully make a record of the injury and examination, and secure possible evidence;
Ensure that investigations into unusual and unexplained injuries suggestive of abuse include consideration that abuse or neglect is a possible contributing factor or direct cause;
Revise policies to ensure internal consistency and consistency with the Elder Abuse and Dependent Adult Civil Protection Act;
Scrutinize the abuse and neglect and incident reporting and investigation system and implement reform measures where indicated, including ensuring that staff:

- are adequately trained to recognize injuries that indicate possible abuse or neglect,
- fulfill their mandated abuse reporting obligations, and comply with all DDS and developmental center policies; and

Utilize the incident reporting system to detect trends, including infrequently occurring unusual injuries suggestive of abuse or neglect.

III. BACKGROUND

A. Abuse and Neglect of Adults with Developmental Disabilities

Experts agree that individuals with disabilities are at a disproportionately higher risk for abuse and neglect. (Petersilia et al., 2001). Conservative estimates are that people with disabilities are at least four times more likely to be victimized than people without disabilities. (Sobsey, 1994; Toronto Star, 1990). Individuals with an intellectual impairment are at the highest risk of victimization. (c.f., Sobsey & Doe, 1991). Victim risk factors include:

> social isolation,
> functional and cognitive impairments that limit their ability to recognize abusive behavior and verbally or physically defend themselves,
> communication limitations, and
> dependence on others to assist with personal care and activities of daily living.

(Sobsey & Varnhaggen, 1991).

Victims with cognitive impairments rely on others to identify and report suspected abuse or neglect. In the absence of established guidelines for detecting abuse or neglect of dependent adults with developmental disabilities, investigators and examining clinicians must identify and interpret complex and equivocal signs suggestive of abuse. Certain types of injuries are rarely accidental and should suggest possible abuse. Clinicians must be alert for these injuries and then conduct a thorough evaluation. In light of the increased risk of victimization and the challenges victims face in reporting abusive injuries, abuse or neglect must be considered as a contributing cause to suspicious injuries of unknown origin or cases in which the suggested cause does not match the appearance of the injury. After all, abuse and neglect of dependent adults is a crime.[4]

B. Department of Developmental Services

With an annual budget of over $3 billion, the Department of Developmental Services (DDS) is responsible for ensuring the coordination and provision of services and supports to over 177,000 children and adults with developmental

[4] See Penal Code § 368.

disabilities. (DDS, n.d.). DDS operates five large developmental centers[5] and two relatively smaller facilities[6]. According to DDS, but disputed by advocates and others, the developmental centers provide services to individuals whose needs cannot readily be met by community-based services and who require programs, intensive training, care, treatment, and supervision in a structured health facility setting on a 24-hour basis. (DDS, 2003). The developmental centers house over 3200 residents in the seven facilities; this represents nearly two percent (2 %) of the population DDS serves. (DDS, n.d.).

Each developmental center has a law enforcement division, known as the Office of Protective Services (OPS), which employs peace officers and special investigators. Law enforcement staff at the developmental centers report to middle management level police personnel at each facility who, in turn, report to the centralized law enforcement branch of OPS at DDS.

Peace Officers

Under the supervision of more senior officers in the OPS, peace officers (campus police) perform a range of duties typically expected of uniformed police officers. These duties include patrolling the campus; enforcing and maintaining law and order; and ensuring the security and safety of developmental center residents, staff, and property. These officers are typically the first responders to incidents and emergency calls, including complaints or allegations of abuse or neglect. They are expected to secure the scene and obtain preliminary information. Their duties do not include conducting investigations into possible abuse or neglect.

Special Investigators

The Special Investigator (SI) and Senior Special Investigator (SSI) are responsible for conducting investigations into possible violations of state law and regulations and developmental center and DDS rules and policies. This includes investigating possible client abuse and neglect and staff misconduct. They preserve evidence;

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[5] The five developmental centers are licensed and certified acute care hospitals and serve individuals with developmental disabilities in distinct parts licensed and certified as Nursing Facility (NF) and Intermediate Care Facility/Mentally Retarded (ICF/MR) services.
[6] The two community facilities are licensed as ICF/MR facilities.

locate and interview complainants, witnesses, suspects, and professional experts; gather and evaluate pertinent information; and coordinate with other developmental center staff to ensure a thorough review of all reported incidents. The SI and SSI prepare written investigative reports following an investigation. Reports by the SSI may include recommendations for administrative action or criminal prosecution.

Clients' Rights Advocate

The Clients' Rights Advocate (CRA) at the developmental center is the advocate for residents, ensuring residents' rights are guaranteed, protected, and asserted. CRAs at the developmental centers are independent of DDS. They work under the direction and supervision of the local Area Board and, ultimately, the State Council on Developmental Disabilities.[7] CRAs investigate suspected violations of the rights of clients guaranteed under state law. The CRA may initiate action on behalf of a resident when the resident is unable to register a complaint on his or her own behalf. Complaints include incidents involving alleged or suspected abuse and neglect and physical injury. Developmental Center policies require that the CRA be notified of possible neglect or abuse or injuries consistent with or suggestive of abuse or neglect.

C. Elder Abuse and Dependent Adult Civil Protection Act

Recognizing that elders and dependent adults may be subjected to abuse and neglect, in 1982, the California Legislature enacted the Elder Abuse and Dependent Adult Civil Protection Act (Abuse Reporting Act) to protect vulnerable persons[8] from abuse and neglect. Welf. & Inst. Code § 15600 et seq. The Abuse Reporting Act requires certain individuals (mandated reporters) to report known or

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[7] Under contract with DDS, the State Council on Developmental Disabilities, through the Area Boards, provides advocacy services to developmental center residents.

[8] Vulnerable persons include: elders (any person 65 years of age or older) and dependent adults (any person, between the ages of 18 and 64 years, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age). Welf. & Inst. Code §§ 15610.23 and 15610.27.

suspected abuse or neglect of dependent adults and elders. Mandated reporters[9] include physicians, licensed nurses and non-licensed nursing care staff, therapists, and managers and administrators at the developmental center.

The obligation of mandated reporters to make a report arises when they, in their professional capacity or within the scope of their employment, know or reasonably suspect abuse or neglect.[10] Reportable incidents include physical abuse (including sexual assault), abandonment, abduction, isolation, financial abuse, and neglect.

The required abuse or neglect report must be made by telephone immediately or as soon as practicably possible to specific designated agencies based upon where the abuse likely occurred. If the abuse occurred in a state developmental center, the report must be made to designated investigators of DDS or to the local law enforcement agency. A written report must follow within two working days.

The following generally summarizes the only exceptions to these reporting requirements:

1. If two or more mandated reporters are present and jointly have knowledge or a reasonable suspicion of abuse, by mutual agreement, only one report need be submitted.

2. Physicians, surgeons, registered nurses and psychotherapists are excused from reporting incidents **told to them** by the dependent adult

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[9] A mandated reporter is any person who has assumed full or intermittent responsibility for care or custody of en elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency. Welf. & Inst. Code § 15630(a).

[10] A mandated reporter who… has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, and neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse… or neglect, or reasonably suspects that abuse, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicable possible, and by written report sent within two working days…. Welf. & Inst. Code § 15630(b).

if (1) they are not aware of any independent evidence corroborating the statement; (2) the dependent adult has a mental illness or dementia or is subject to a court- ordered conservatorship because of mental illness or dementia; and (3) the physician, surgeon, registered nurse, or psychotherapist reasonably believes the abuse did not occur. [Emphasis added].

3. In long-term care facilities, when (1) a physical, mental, or medical injury occurred as a result of care provided; (2) the mandated reporter was aware that there is a proper plan of care; (3) the mandated reporter was aware that the plan of care was properly provided or executed; and (4) the mandated reporter reasonably believes that the injury was not the result of abuse.

Many facilities have internal policies for reporting abuse, but these do not satisfy the mandated reporter's individual duties. The Abuse Reporting Act designates specific penalties for mandated reporters who fail to report known or suspected abuse.

IV. GENITAL LACERATION CASE SUMMARIES

Over the course of five years, five men living at Developmental Center[11] sustained serious and unexplained lacerations to their penis or scrotum.[12] The injuries ranged in size from 1.5 to 8.0 centimeters and required between three and 20 sutures to close.[13] All of the victims have significant developmental disabilities and cognitive limitations. The records indicate that four of the five are nonverbal. Most require assistance with toileting and/or bathing. Two wear adult briefs (diapers). While they live in three different residences, all but one of the victims were residents of the same program.

The causes of these injuries remain unknown. The following is a brief account of the circumstances surrounding each injury:

A. Neal D.

Neal D. was 33 years old in January 1999. He was living on Program C, Residence 2 at Developmental Center. Neal has profound mental retardation (IQ 9), impulse control disorder and possibly Fragile X syndrome. He is nonverbal but communicates using some sounds. Neal is independent with dressing and toileting but needs some assistance with buttoning, snapping, and tying. Neal has behavioral challenges, such as assaulting peers (hitting, kicking, and pushing) and reckless or impulsive behavior causing self-injury; he throws himself onto furniture or the floor or into walls. Neal exhibits other self-injurious behaviors typically seen in this population including head-banging, slapping his face, and biting his hands. According to DDS records at the time of his injury, Neal did not have a history of sexually inappropriate behaviors and was not sexually active.

At 9:00 a.m. on January 24, 1999, when Neal returned from using the bathroom, staff noticed blood on his hands. Staff moved Neal to a place of privacy and looked for the source of the bleeding. A 1.5 cm laceration was noted on the upper shaft of the penis near the crown (or glans). The record fails to describe the exact location

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[11] To protect the confidentiality of the victims described in this report, the facility is referred to as Developmental Center.

[12] Two additional injuries are not included in this report. The earliest laceration incident, occurring in January 1998 and resulting in three sutures, was likely the result of a witnessed resident-to-resident assault. PAI also did not include in this report a scrotal laceration, occurring in October 2002, resulting in five sutures. PAI could have, but elected not to pursue its federal and state authority to access to the records of this victim, despite the refusal of the victim's legal guardian to grant PAI access. See 42 U.S.C. § 15043(a)(2)(I)(iii); Welf. & Inst. Code § 4903(a)(4). This victim was in the same program as most of the other victims.

[13] In two cases, there was a second laceration of smaller size not included in these figures.

(anterior or posterior) and appearance of the injury (horizontal or vertical, clean cut or tear). Slight swelling was noted at the shaft of penis for several days following. The physician on duty was called. He applied three sutures to close the laceration.

Although the cause of this injury was unknown and the nature of the injury suspicious, it was not reported to campus police or the SI. No abuse report was completed. No sexual assault examination was documented. No investigation was conducted. No photographs were taken of the injury. No witnesses were identified or interviewed. No physical evidence was obtained (clothing, swabs, and fingernail scrapings). The records failed to indicate any search of the surroundings to determine the presence of any safety hazards or blood droplets. The CRA was not notified.

In the progress notes, the physician speculated that the injury was probably caused by the penis becoming caught in the zipper. Staff members were advised to, "prompt [Neal] to remember to pull up his underwear and pants more slowly before zipping when they see him go toward the bathroom."

In the days immediately following the injury, Neal was more agitated than in previous weeks. He was "disruptive," "throwing furniture," and "yelling all night." He did not sleep for the four consecutive nights. Over one seven-day period, Neal sustained four injuries to his brow and forehead, probably caused by head-banging. Ultimately, he was placed in five-point restraints in a padded chair. Neal had not been restrained in the previous two years. The team considered that his change in behavior may have been related to a change in medication.

B. Roger G.

Roger G. was 50 years old when he was injured. He was living on Residence 3 of Program C. Mr. G. has profound mental retardation (IQ 6) and is legally blind. He is nonverbal and communicates with "physical actions, vocalizations, and facial expressions." Although he can ambulate, Roger has an unsteady gait and uses a wheelchair when he leaves the residence. He wears a protective helmet with a face guard to prevent injury in case he falls. He is able to dress himself but requires assistance toileting. He engages in self-injurious behaviors, banging his forearms on objects. According to DDS records, Roger exhibits sexually inappropriate behavior including disrobing and masturbating in public. According to staff reports, "[Roger] has a habit of pulling his pants off and flinging them when they

were [sic] wet…. [Roger] masturbates a lot, usually putting both of his hands down his pants."

On the evening of October 25, 2000, while sitting in a common area of the residence, Roger suddenly stripped off his pants, which had an elastic waist, and underwear. He had defecated in the chair. He was taken to the bathroom and given a shower. Because of his unsteady gait, staff used a shower chair. Roger was cooperative and quiet. Following the shower, as Roger finished toileting, staff noted blood on the toilet seat. Upon further inspection, staff saw a "deep laceration" of the scrotum with exposure of the right testicle. The records offer varying descriptions of the injury. The initial incident report describes the injury as L-shaped, approximately 4 cm by 1.5 cm. Later records from the local emergency department indicate the laceration was U-shaped, approximately 8 cm. No photographs were taken at the time the injury was discovered. No diagrams of the injury were made. No abuse report was made. It was not reported to the campus police or the SI. No physical evidence was secured, including his pants and underwear. The environment was checked (chair in group room, shower chair, shower area, and toilet seat) and no hazards were found. The CRA was not notified.

The physician on duty was called. After looking at the injury and determining that Roger would not be cooperative with the necessary surgical intervention, the physician ordered that he be transferred to the local medical center for "debridement and closure" of the laceration.

At the hospital, Roger was combative. He was placed in restraints and given medication to consciously sedate him. The wound was irrigated and 20 sutures were applied. Although the records from the emergency department note that the cause of the injury was unknown, no investigation was initiated. No abuse report was completed. Law enforcement was not contacted. No photographs were taken of the injury. No witnesses were identified or interviewed. No physical evidence was obtained. The physician noted that Mr. G. had not sustained a similar injury previously, as might be expected with repetitive self-injurious behavior.

Developmental Center staff speculated that the injury was caused by the scrotum being "snagged by the zipper." At a team meeting held two days later, it was decided that Roger should be, "provided with non-zipper pants to prevent any injury," even though he was wearing pants with an elastic waist at the time of the

incident and did not appear to be using the zipper when he suddenly removed his pants after being incontinent.

Five days later, the SI was notified about "an injury of unknown origin." At that point, he initiated a thorough investigation, including interviewing eight witnesses and inspecting the scene. The pants and underwear had already been washed.[14] The chair in which Roger had been seated had been cleaned of all feces and blood.[15] The shower chair, shower area, and toilet seat were inspected and found to be "intacted," with no obvious defect that could have caused this serious injury.

Ultimately, the SI was unable to conclude what caused the injury. He wrote:

> However, due to the actual occurrence of the incident (10/25/2000) and the reporting of the incident (10/30/2000) the investigation was unable to provide evidence to substantiate [that the injury was cause by the zipper]. Based upon the evidence and information gathered it is inconclusive as to how the injury to [Mr. G.'s] scrotum occurred.

C. Lenny M.

Lenny M. was 47 years old and living in Program D, Residence 10 when his injury was discovered. Lenny has profound mental retardation (IQ 9), attention deficit disorder (hyperactive-impulsive type), epilepsy, arthritis, abnormal involuntary movements of the hands and face, and anxiety. He is nonverbal and, although able to communicate through gestures and vocalizations, Lenny cannot indicate a source of pain, distress, or illness. Lenny is unsteady on his feet and uses a wheelchair with a lap belt when ambulating for long distances. He wears a protective helmet both during waking hours and at bedtime and protective knee and elbow pads. Lenny requires assistance with hygiene and self-care and wears disposable briefs. He does not have a history of masturbation or removing his disposable brief independently. Lenny has a history of self-injurious behavior, sitting on the floor and tripping peers, or throwing himself out of his wheelchair onto the floor.

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[14] Witnesses did not recall seeing any blood on the zipper pants that Roger removed.
[15] There are inconsistent statements about whether there was blood on the chair in which Roger was seated when he removed his pants.

On the evening of June 4, 2002, Lenny was brought to the shower room with several other clients. He was strapped[16] in his wheelchair fully clothed (including underwear) and wearing a disposable brief. Staff eventually acknowledged leaving the residents unsupervised in the shower room for an undetermined period of time.[17] While removing Lenny's adult brief, staff noted a small amount of blood on the diaper. A body check showed a laceration around nearly the entire circumference of the shaft of his penis. The laceration was a "straight fresh cut" that continued to bleed slightly. Further examination revealed a second laceration (approximately 1 cm in length), parallel to the first, near the glans of the penis. The physician on duty was called. Under local anesthesia, the physician applied 14 sutures to the larger laceration and 1 suture to the second. He did not document conducting a sexual assault examination.

Staff speculated that the injury was due to an unwitnessed and unreported fall from his wheelchair. According to the incident report:

> [I]t is possible that his penis was caught in the wheelchair. The wheelchair has 2 foot rests with a locking lever that when unlocked allows the foot rest to swing out to the side…. The wheelchair may have been left with the foot rest in the open position when staff assisted him out of the chair. There is a possibility that [Lenny] sat on the floor on his knees (as he often does) and his penis was caught in the bracket area of the chair….

In the alternative, staff considered that the injury was self-induced, following administration of a suppository shortly preceding the shower. According to the incident report:

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[16] Lenny is secured to the wheelchair with two belts: one across the waist secured to the chair; a second secured from the bottom of the wheelchair up between the legs and attaching to the waist belt.

[17] Reports of how long the residents were left unsupervised in the shower area are inconsistent. At the time of the initial investigation, the staff member in the shower area reported leaving for two to three minutes while he returned another client to the group room. A follow-up investigation found that the residents may have been left unsupervised for up to one hour while the assigned staff member took a lunch break. This was refuted by the senior staff on duty who assured investigators that she assigned another staff to cover the shower area during the lunch break. But, she was unable to recall to whom she assigned that task. Further investigation failed to reveal who was assigned to supervise the residents during the lunch break.

> [Lenny] had been given a suppository prior to the injury occurring. There were no injuries noted at the time the suppository was given. A diaper was applied following the suppository and he was wearing underwear under his pants. He may have been experiencing some discomfort related to receiving a suppository therefore he may have attempted to pull down his pants, underwear, [and] diaper (which usually requires staff assistance to complete this task) or his pants/clothing may have slid down from moving out of chair [sic] onto the floor causing his penis to be partially exposed.

Lenny was dressed in adult briefs, underwear and pants and was seated in his wheelchair with his lap belt on when he was disrobed by staff.

The following morning, the incident was reported to the Developmental Center SI as an injury of unknown origin and an investigation commenced. Photographs were taken of the sutured injury. Witnesses were interviewed, but the treating physician was not. The surrounding area was examined, including Lenny's wheelchair and the shower room. The SI explored whether the injury could have been caused by a catheter used to obtain a urine sample or during an inpatient hospital admission in the preceding weeks. The investigator inspected Lenny's fingernails, clothing and bedroom. The cause of the injury was not found. The CRA was never notified.

D. Sean A.

Sean A.[18] was resident of Program C, Residence 3 on June 22, 2002. Sean wears adult briefs and requires some assistance with changing his clothes, including his briefs. The record suggests that Sean is nonverbal.

At approximately 2:45 p.m., while assisting Sean with changing his clothes, staff observed blood on Sean's adult brief. Staff checked the area further and noticed bleeding from the penis. The physician on duty was contacted. He noted two lacerations on the underside of the penis near the glans measuring 1.5 cm and 0.3 cm respectively. A diagram of the injury by the physician shows the lacerations

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[18] Sean's legal guardian refused to grant PAI access to confidential records. PAI could have, but elected not to pursue its federal and state authority to access to the records regardless of the guardian's refusal. See 42 U.S.C. § 15043(a)(2)(I)(iii); Welf. & Inst. Code § 4903(a)(4).

were approximately parallel and ran perpendicular to the penile shaft. A total of six sutures were applied.

Although the cause was unknown and the nature of the injury suspicious, it was not reported to campus police or the SI. No investigation was conducted. No sexual assault examination was documented. No abuse report was completed. The CRA was not notified. Therefore, the only information PAI has about Sean and this incident comes from the initial incident report and general information provided by DDS.

Ultimately staff members were unable to determine the cause of the lacerations. As Sean was on constant one-to-one staff supervision at the time of the injury, consideration was given to increasing the number of staff necessary "to safely change [Sean's] diaper as well as specify how often penis and area should be checked."

E. Alan B.

In November 2003, Alan B. was a 41 year old resident of Residence 2, Program C. Alan has tuberous sclerosis with cognitive regression (IQ 50) and an impulse control disorder with unprovoked aggression to others. The records also indicate that Mr. B. is, at times, paranoid with verbal hallucinations, believing that peers are talking about him or planning to assault him. He has a history of seizures and wears a helmet during waking hours to prevent a head injury when seizing.

Alan is verbal and able to verbalize his needs with a vocabulary of more than 900 words. According to staff, Alan tells staff if, "anything happen[s] to him," including when he is in pain and, "what is hurting." Alan is independent with grooming, toileting and dressing. Alan requires close direct supervision for behavioral issues, including hitting, biting, kicking, striking others, and destroying property. He is aggressive with his peers but does not defend himself when he is the victim of aggression by others. He disrobes and exposes himself in public when he is angry. He is known for making false accusations, including blaming peers not present.

At approximately 5:00 p.m. on November 16, 2003, while on a nature walk, Alan said he needed to urinate. Rather than waiting until they reached the nearest restroom, Alan exposed his genitals. At that time staff noticed a 2 cm laceration on

the lateral aspect of the right scrotum and bruising (“discoloration”) on the tip of the penis and the right upper inner thigh. Upon questioning, Alan said, “These kids did it.” When asked who, Alan responded, “[Ken] [a peer]. [Ken] kicked me.”

Alan was returned to his residence and the physician on duty was contacted. While awaiting the physician’s arrival, staff again asked Alan what happened. He responded, “by talking about something totally unrelated to the situation.” Finally, Alan again said, “[Ken] kicked me,” and then repeatedly said, “[Ken].” Ken also lives on Residence 2 and had participated in some group activities with Alan earlier that day.

The physician applied 5 sutures under local anesthesia. Campus police were notified and they took several photographs of the injury.

Staff initiated an inquiry. When questioned, Ken denied kicking Alan. Staff familiar with Ken felt his reaction to their questioning indicated a truthful answer. One staff member reported that, “[Alan B.] would always say that [Ken] did it.” Staff on duty that shift and the previous shifts did not recall any incident or altercation between Alan and Ken and no altercation between the two residents was recorded in Alan’s clinical records. Following discovery of the injury, staff separated Alan and Ken for 24 hours and provided direct supervision to both.

Two days later, investigators were informed of the incident by the Quality Assurance department. The underwear Alan was wearing was secured in the OPS evidence locker but their report says nothing about inspection of the garment. Staff members were interviewed but not the treating physician. No staff reported seeing any altercation or incident between Alan and Ken. Investigators were unable to determine the cause of the injury but found insufficient evidence to charge Ken with misdemeanor battery. The CRA was never informed about this incident.

Summary of Injuries

Victim	Date/Time	Program	Residence	Injury	Sutures
Neal D.	1/24/99 9:00 a.m.	C	2	1.5 cm laceration near glans of penis	3 sutures
Roger G.	10/25/00 8:30 p.m.	C	3	8 cm U shaped laceration of the scrotum with exposure of the right testicle	20 sutures
Lenny M.	6/4/02 8:15 p.m.	D	10	#1 laceration around circumference of penis #2 1 cm near glans of penis	14 sutures 1 suture
Sean A.	6/22/02 2:45 p.m.	C	3	#1 1.5 cm laceration of penis near glans #2 0.30 cm laceration of penis near glans	6 sutures
Alan B.	11/16/03 5:10 p.m.	C	2	2 inch laceration to the right scrotum	5 sutures

V. PAI'S INVESTIGATION OF THE FIVE GENITAL LACERATIONS

PAI conducted an investigation into each of the cases summarized above. PAI's investigation of the genital laceration incidents included:

Reviewing each incident report documenting the genital laceration incident for all five victims;
Reviewing the clinical records for four of the victims for a three to four month period surrounding the incident;[19]
Examining select incident reports, special incident briefs and SI reports for four of the victims for a three to four year period surrounding the laceration incidents,[20]
Analyzing staffing records for the residence and program staff for six to 14 days surrounding discovery of each injury;
Examining the medical records from the local hospital treating Roger G.'s injury;
Verifying the reporting of each incident to DDS, the SI or SSI, the CRA, DHS, community law enforcement, and the local county District Attorney;
Reviewing DHS citations issued to Developmental Center pertaining to the injuries sustained by Lenny M. and Alan B.;
Querying DHS about all citations and statements of deficiency issued to Developmental Center from January 1998 through January 2003 pertaining to violations of patients rights and patient care plans, including specific inquiries regarding the injuries sustained by Neal D., Roger G., and Sean A.;
Consulting with experts in self-injurious behavior, elder and dependent adult abuse, and emergency medicine;
Reviewing the investigation conducted by the DDS' OPS for three of the victims, including a staff profile;[21]

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[19] The legal representative for one of the victims declined to grant PAI access to the individual's confidential records. PAI could have, but elected not to pursue its federal and state authority to access to the records despite the guardian's refusal. See 42 U.S.C. § 15043(a)(2)(I)(iii); Welf. & Inst. Code § 4903(a)(4).

[20] DDS refused to provide certain incident reports, even redacted of client identifiers, on the ground that PAI lacked proper authorization for access.

[21] The legal representative for one of the victims declined to grant PAI access to the individual's confidential records. PAI could have, but elected not to pursue its federal and state authority to access to the records regardless of the guardian's refusal. See 42 U.S.C. § 15043(a)(2)(I)(iii); Welf. & Inst. Code § 4903(a)(4). The last incident occurred after OPS concluded these secondary investigations.

Examining DDS and Developmental Center current policies, procedures, administrative directives, and memorandums and those effective at the time of each incident, pertaining to abuse, special incident reporting, and SI investigations;
Reviewing redacted incident reports from Developmental Center pertaining to all genital lacerations from November 1997 through August 2003;
Reviewing select redacted incident reports from all other developmental centers pertaining to genital lacerations and/or genital injuries from January 1998 through mid June 2003;[22]
Reviewing current policies, procedures, administrative directives and facility bulletins for all other developmental centers regarding abuse, incident reporting and SI investigations;
Touring the Developmental Center; Interviewing the Developmental Center CRA;
Reviewing publicly available material about DDS and Developmental Center;
Reviewing job duty statements and California State Personnel Board specifications for developmental center Peace Officer, SI, SSI, and the job description for CRA;
Reviewing California law about dependent adult abuse reporting; Analyzing California regulations pertaining to special incident reporting by vendors and long-term health care facilities;
Conducting searches of publicly available information from the Medical Board of California about the physicians attending each of the five laceration injuries;
Reviewing select medical protocols and guidelines developed by the United States Department of Justice and the California State Office of Emergency Services pertaining to examination of and response to child abuse victims, training of sexual assault nurse examiners, and documenting elder and dependent adult abuse and neglect examinations;
Searching a historic PAI case file pertaining to an Agnews Developmental Center resident who sustained a suspicious genital laceration;
Reviewing data from a 2003 survey of Developmental Center conducted by

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[22] DDS refused to provide certain incident reports, even redacted of client identifiers, on the basis that PAI lacked proper authorization for access.

DHS for the Centers for Medicare and Medicaid Services; and
Periodically contacting the county District Attorney, including learning the outcome of their investigation into the incidents.

A. PAI Experts

PAI referred the series of genital lacerations to the following three experts:

Diana Koin, M.D.: Dr. Koin is the Director of the Elder and Dependent Adult Abuse Education Program at the California Medical Training Center at the University of California, Davis; a project teaching health care professionals and law enforcement about all forms of interpersonal violence including dependent adult abuse. Dr. Koin was the first physician in the United States to publish a medical paper describing elder abuse. She chaired the committee, funded by the California Office of Emergency Services (OES)[23] that developed the Forensic Medical Report: Elder and Dependent Adult Abuse and Neglect Examination and accompanying instructions, a form medical personnel use to document their examination of abuse or neglect victims. Dr. Koin participates on interdisciplinary teams for elder and dependent adult abuse in two large northern California counties. Recently, Dr. Koin co-authored guidelines for health care professionals to identify and respond to elder abuse in health care settings, still in draft form at the time of this report's release. She is a physician practicing in the field of geriatric medicine and is the Medical Director of The Sequoias, a skilled nursing facility. She is also an Associate Clinical Professor of Medicine at the University of California, San Francisco. After reviewing the records, Dr. Koin was interviewed on September 7, 2004.

Johannes Rojahn, Ph.D.: Dr. Rojahn is a national expert in behavioral issues and self-injury among adults with severe or profound mental retardation residing in institutions. He has dedicated his entire career to working with people with developmental disabilities and mental retardation, focusing specifically on self-injurious behavior and other behavioral issues. He is Professor of Psychology at George Mason University and Director of the George Mason University Center of Cognitive Development. He is President-Elect of the Mental Retardation and

[23] OES funded development of guidelines for conducting sexual assault examinations, including a standard form for documenting the examination.

Developmental Disabilities division of the American Psychological Association and editor of several publications on mental retardation and developmental disabilities. Dr. Rojahn has published extensively regarding the prevalence, assessment, and treatment of self-injurious behavior, including research into the causes of self-injurious behavior and behavioral and pharmacological treatment. After reviewing the records, Dr. Rojahn was interviewed on October 14, 2004.

Gail Hubbell, M.D.: Dr. Hubbell is an emergency medicine physician, certified by the American Board of Emergency Medicine. She has been an expert medical reviewer in over 70 cases for the Medical Board of California and in several medical malpractice cases. She has worked in emergency medicine for over 20 years and is currently practicing in a Bay Area hospital emergency department. Dr. Hubbell's expert opinion centered on the community standard of care of a physician/primary responder to injuries such as these. After reviewing the records, Dr. Hubbell was interviewed on August 18, 2004.

The experts were provided with records of the injuries, including the incident reports, copies of the photographs where they existed, and portions of the clinical record. Each expert stated that the severity and location of each injury made them highly suspicious of abuse, particularly without an adequate explanation of how the injury occurred. Based upon the location of the injuries, the experts concluded that each of the victims should have received a sexual assault examination. The experts did not believe that the injuries were likely self-inflicted, nor caused by self-injurious behavior or masturbation. At least one expert found that the injuries are not typical for the population of institutionalized men with developmental disabilities or for these men individually. All of the injuries should have been reported as suspected abuse or neglect pursuant to the Abuse Reporting Act and promptly investigated. Lastly, the experts remarked on the pattern of injuries of this severity. As the incidents occurred over time, their suspiciousness mounted, making each one progressively more suspect and reinforcing the need to investigate them as possible abuse or neglect.

1. Suspiciousness of Injuries

Each of the experts concluded that these five injuries were highly suspect. Their opinions were based upon the location and severity of the injuries and the lack of a known cause. According to Dr. Rojahn, "the severity of the injuries should raise some concerns, particularly as far as immediate reporting to internal investigators."

After reviewing records describing Roger G.'s injury, Dr. Koin reasoned:

> In one quick motion, [Mr. G.] stripped off his zippered pants and underwear, throwing them across the room. Staff noticed the action and immediately intervened. Then they took him in the shower chair. And there was no injury noted at that time, other than that he soiled himself. After being cleaned up, he came back and there was a gapping wound. Yes, [this injury] is suspicious because of its size, 8 centimeters, and the fact that his testicles were eviscerated. That's a really significant injury. Yes, I do think it's suspicious.

In their experience, Dr. Koin and Dr. Hubbell felt severity of disability also contributed to the suspicious nature of the injuries. Dr. Hubbell said:

> A person that needs help dressing and toileting, removing their pants, with this extent of a disability, suddenly has a laceration on the penis – I'd be alarmed. This patient is unable to give you any bit of information. Therefore obligating [the physician] to do a more extensive workup instead of a small workup.

All of the experts became more suspicious as the injuries accumulated over time, although extended over five years. Dr. Hubbell concluded, "Taken together, the cases are fairly horrifying."

2. Inadequate Description of Cause

In each case, staff discovered the injuries while bathing or following toileting. None of the injuries was witnessed; therefore, staff members were left to speculate about the cause.

PAI's experts were critical of apparent acceptance of rather implausible explanations for how the injuries occurred. Talking about Roger G., Dr. Hubbell said:

> He has an eight centimeter laceration, which is big – four inches – huge. Staff suspected [his scrotum was] snagged by the zipper. That seems completely impossible. Not counting the fact that he needs assistance with toileting. He barely can walk. It's hard to imagine that he could have given

> himself such a massive laceration by a zipper. This was completely inappropriate.

Talking about Sean A., Dr. Hubbell stated:

> This is an incredibly suspect injury – a one and a half by point three centimeter laceration on the penis. He can offer no words of explanation, nothing. How can a person wearing a diaper receive a laceration to the glans of the penis? It's inconceivable. It should have had a police report. It should have had a dependent adult abuse form. It probably should have had a sexual assault workup.

After reviewing Lenny M.'s injury, Dr. Hubbell found:

> It's impossible that this injury could have happened by any way except abuse. Impossible. How does one get a laceration completely around the circumference of the penis? [Developmental Center staff members] speculate it was due to him sitting on the floor, the pants and clothes slide on their own. He was wearing a diaper, underpants, and pants. Again, impossible. It would have been impossible, even if he wasn't wearing all of that. A complete circumferential laceration just doesn't happen unless someone does it intentionally to someone else.

Dr. Koin affirmed Dr. Hubbell's opinion about Lenny M.'s injury, stating:

> This injury, in particular, I would have considered suspicious because it was around the entire diameter of the penis. An accidental injury would typically be on only one side of the penis. It would not be circumferential. This injury does not match a description of falling out of a wheelchair.

After reviewing the records describing Alan B.'s injury, Dr. Koin felt that a kick was not the likely cause. In her experience, a kick usually causes a skin tear, not a laceration of this size. Alan also had a bruise on the inner thigh. According to Dr. Koin, it is unlikely that a kick would bruise this area. She explained, "A bruise on the inner thigh would be somewhat unlikely because the inner thighs are usually protected areas of the body when a person is kicked."

In at least two of the cases, staff attributed the injuries as possibly being caused by the penis or scrotum becoming caught in the zipper of the resident's pants. Dr. Koin and Dr. Hubbell were doubtful that these injuries could have been caused by the genitals becoming caught on the pant's zipper. The location and description were not typical for that sort of injury.

Typically a zipper laceration is small in size and superficial – "a puncture lesion, a little break in the skin," as described by Dr. Koin. According to the experts, these injuries were much longer and deeper than a typical zipper catch.

Zipper injuries are typically vertical wounds, following the opening of the zipper. Several of these injuries were lateral, across the penile shaft. Dr. Koin explained:

> It is clear from the diagrams, that the injuries to [Lenny M.] and [Sean A.] were lateral wounds. [Sean's injury] just wouldn't fit with a zipper injury. You had this almost one inch injury laterally. It just wouldn't work that way. A zipper injury would be vertical – up and down the penile shaft.

Dr. Koin and Dr. Hubbell expressed doubt that these victims were accessing their genitals through the zipper opening, particularly in light of the fact that several of the injuries were found when the victims were wearing clothes, with underpants and, in some cases, a diaper. Based on her experience working with people living in long term care facilities, Dr. Koin felt it very likely that these residents wear elasticized pants and access their genitals through the waistband, not through the zipper opening.

Dr. Koin was critical of staff's failure to adequately document the appearance of many of the injuries that could support or refute the alleged cause. For example, Neal D.'s injury was attributed to a zipper catch. But there is no description of the location and direction of the injury, and no photographs or diagrams to support this presumption.

3. Self-Injurious Behavior Unlikely

Based on his extensive research and work in the area of self-injurious behavior and its causes, Dr. Rojahn was asked if these injuries were consistent with self-injurious behavior among men with developmental disabilities in an institutionalized setting. He responded saying:

> Self-injuries to male genitals, such as lacerations to the penis and scrotum, are not typical results of self-injury. The most common forms of self-injurious behavior among individuals with profound mental retardation are head banging, self-biting, self-hitting, and skin picking; behaviors that do not typically cause harm in the genital area. Genital self-mutilation has not been reported in any of the [self- injurious behavior] prevalence studies I have reviewed.

Self-injurious behavior in individuals with developmental disabilities is typically a recurring phenomenon. According to Dr. Rojahn, "If someone is known as somebody who engages in self-injury, that means that the person is doing it repeatedly. A person is typically known for a particular idiosyncratic type of injury or behavior." Yet, the clinical records of the five Developmental Center victims did not show a repeated occurrence of genital lacerations or similar injuries. As summarized by Dr. Rojahn, "Hence, the reported incidents, which do not suggest repeated occurrence of the same type of injuries in the same individuals, do not fit the pattern of self-injurious behavior."

From his review of the records, Dr. Rojahn also excluded client-to-client sexual activity as a likely cause. He explained, "I have not heard about or have not seen, in my experience, that [genital lacerations from client to client sexual activity] is a known or common circumstance of such a severe injury."

Dr. Rojahn acknowledged that lacerations can occur from self-stimulation and masturbation. And in these cases, at least one of the victims was known to masturbate. But, according to Dr. Rojahn, injuries from self-stimulation or masturbation would not be an isolated event but a repetitive pattern. None of the victims had a clearly documented history of open forceful masturbation or a pattern of similar injuries. Dr. Rojahn also emphasized the duty of the facility to protect individuals with known forceful self-stimulation from self-injury. He said, "There should certainly be injury prevention measures; additional supervision of clients; ensuring they are not wearing zipper pants."

Dr. Koin stated that, in her opinion, it was unlikely these injuries were due to masturbation. Although she does not have extensive experience with men with developmental disabilities residing in long term care institutions, she based her opinion on her experience with populations of men residing in Veteran's Administration longer term care settings who are disinhibited and "have a lot of

masturbatory activity" following head injuries or neurological diseases. According to Dr. Koin, "I never saw injuries like this. These injuries are unlike any injuries I've encountered in taking care of male populations of people with severe disabilities who have been known to be actively masturbating."

4. Pattern of Injuries

According to PAI's experts, the pattern of injuries, occurring at one facility and clustered in one program, is noteworthy. According to Dr. Hubbell, "Injuries to the penis and the scrotum are really uncommon; even more uncommon if the victim is diapered or requires assistance removing pants or using the bathroom."

According to Dr. Koin:

> The thing that is striking to me about these cases is there is a pattern. It is very notable that the injuries are very similar, albeit they've been occurring over approximately a five year period. The injuries are pretty much the same size. They seem to be incise wounds, rather than tears. Several of the injuries were lateral, which would be inconsistent with a vertical zipper.
>
> When you have an isolated injury, you tend to look for the etiology from likely kinds of historical pieces. But when you have multiple injuries that are very consistent, that are affecting the same part of the body, then you have a pattern. And that raises your suspicion greatly. I just find it unbelievable that this progressed and was not dealt with.
>
> [Identifying a suspicious pattern] is exactly what we teach [at the California Medical Training Center] in elder and dependent adult abuse cases. It is the multiple injuries that are certainly noteworthy. As the number of these injuries mount, the injuries become more and more peculiar. They are less and less consistent with an accidental source.

Dr. Rojahn cautions that individuals with profound mental retardation residing in institutions are at an increased risk of unintentional injuries. But, based on his 30 years of research and experience, he stated:

> The severity of injuries [in these cases] should raise concern, particularly in instances where the cause of the injury was undetermined. While self-

> injurious behavior leading to tissue damage is possible, the prevalence of such unusual [self-injurious behavior] resulting in tissue damage in the genital area occurring at a single facility would be highly unusual.

5. Reporting as Suspected Abuse

As physicians practicing in California, both Dr. Koin and Dr. Hubbell were asked, in their professional opinion, if these injuries should have been reported pursuant to the Abuse Reporting Act. In each case, they answered affirmatively. According to Dr. Koin, one of California's leading medical experts in elder and dependent adult abuse, "Reporting is dependent on suspicions, not investigations. If you have a suspicious situation, a mandated reporter must report it. Any suspicious injury has to be reported."

Even Dr. Rojahn, who is unfamiliar with California's reporting requirements, felt these injuries should have been reported to investigators. He explained, "Injuries as severe, as potentially suspicious, and with undetermined causation should trigger a rigorous internal review with a report being filed to an internal investigator on the same day as the incident is noticed."

PAI's experts were critical of the Developmental Center staff who either failed to recognize these injuries as suspicious or to meet their mandated reporting requirements. According to Dr. Koin:

What kind of training does the Developmental Center staff have? Is it mandatory for staff? Does it include sexual assault? Abuse? I know these injuries go over several years where some of this has changed, but it seems to me that people did not fulfill their reporting requirements and they were probably educated to do so. If nothing else were to come of this, I would hope that the self-reporting system in the developmental centers will be changed. In each case, [Developmental Center staff] managed to destroy all the evidence from a forensics point of view.

6. Sexual Assault Examination

All three experts felt that each victim should have received a sexual assault examination. Sexual assault examinations are forensic examinations designed to gather evidence of a sexual assault for potential prosecution. These examinations involve careful assessment and inspection of the body, including examining the

rectum and oral cavity, looking for bite marks and bruising, collecting swabs, and running laboratory tests for the presence of motile sperm and venereal disease.

In California, the California Medical Training Center has developed statewide standards and trains qualified medical professionals in sexual assault response, including training Sexual Assault Response Teams (SART). OES funded the development of guidelines for conducting sexual assault examinations, including a standard form for documenting the examination.

Because it involves collection of evidence, Dr. Koin recommends that only clinicians who have been trained conduct sexual assault examinations, with the exception of physicians. She said, “Most physicians can competently perform sexual assault exams and they often times do. But the best SART exams are by forensic nurse examiners who have had the SART training."

The experts recommended sexual assault examinations in these cases because they involved injuries to the genitals. According to Dr. Koin:

> Because these lesions involved the genitalia, it may indicate that there has been a sexual assault. Every one of these should have gone out as a SART exam. SARTs are performed on male victims. Aside from obvious anatomical differences [between men and women], there is no difference in the evidence collection.

Dr. Rojahn concurred, saying:

> I would strongly recommend a sexual assault exam or something akin to that, where the physician has a procedure to follow that would explore further possible damage. Forensic sexual assault examinations should be considered, especially when the individual is nonverbal and there is profound mental retardation, if there is no known cause and no history of self-injury or masturbation (open forceful masturbation). The injuries here that were reported that caused laceration of the genital areas, particularly to the extent we’re talking about here, should trigger a sexual assault examination.

As a practicing emergency room physician, Dr. Hubbell offered the following sequence of treatment for these five victims:

> After examining the patient and getting a history, first thing you do is treat the injury. Second, I would at least do some cultures for venereal disease. Third, I would probably offer treatment for venereal disease. Fourth, I would call the police and we would decide about where to do the sexual assault exam. If you send a person for a SART, they do one in virtually every circumstance. I can't imagine anyone refusing to do it.
>
> Every emergency room has a sexual assault kit that we use to collect evidence. It is extremely straight forward and very specific about what evidence is collected. Most [emergency department] physicians are pretty experienced in doing sexual assault exams.

Dr. Koin offered another reason to send these victims for SART examination – the prompt notification and involvement of law enforcement. SARTs require law enforcement authorization. Dr. Koin explained:

> The police are definitely involved by the time there is an official SART examination underway. [SARTs] are officially ordered by the police. The evidence is collected per the guidelines [the California Medical Training Center] developed. The universal central report form is being used throughout the state so that the same information is being gathered for each of these examinations.

B. DDS and Developmental Center Policies, Procedures and Administrative Directives

PAI reviewed all DDS and Developmental Center policies, procedures and administrative directives pertaining to detection and investigation of possible abuse and neglect that were in effect at the time of each laceration incident and are currently in effect. Developmental Center policies advise staff to be alert for possible abuse or neglect. The policy pertaining to alleged neglect or abuse requires that, "Particular attention shall be given to repeated unexplained injuries, unusual injuries, unobserved injuries… and the anatomical distribution and extent of any injuries."

In cases of suspected or alleged abuse or neglect, physicians are to immediately complete a thorough physical examination. Clients with injuries suggestive of sexual assault are to be referred to the Sexual Assault Center of the neighboring

medical center. From the documents reviewed, it appears that none of the victims in these cases received a sexual assault examination or were sent off campus for a SART examination.

Per Developmental Center policy, possible neglect or abuse or injuries "consistent with or suggestive of abuse or neglect" must be reported immediately by telephone to the Developmental Center Investigator or Developmental Center police in his/her absence. This is inconsistent with the Abuse Reporting Act which requires reporting to "designated investigators of… the State Department of Developmental Services," not developmental center police. Welf. & Inst. Code § 15630(b)(1)(B). Only three of the injuries were reported to the SI or SSI; none were reported by the staff initially observing or treating the injury. None was reported within the time frame required by the policy. Developmental Center policy also requires reporting to the CRA no later than the end of the next business day. According to the CRA, none of the five injuries described above was reported.

DDS requires that serious incidents be reported within one working day to the Residential Services (or Developmental Centers) Division of DDS. At the time of these injuries, incidents reportable to DDS included suspected client abuse and lacerations requiring five or more sutures or staples. Reporting of these injuries to DDS lagged days. In two cases, the injuries were never reported to DDS.

Effective August 2001, amendments to Welfare and Institutions Code § 4427.5 requires developmental centers to immediately report to local law enforcement agencies, "all resident deaths and serious injuries of unknown origin." DDS defined serious injuries to include lacerations requiring five or more sutures. Yet, a memorandum of understanding between the Developmental Center and the local law enforcement is inconsistent with this policy as it only requires reporting of injuries resulting in 10 or more sutures. Four of the five injuries involved more than five sutures. Two required more than 10 sutures. Only one of the incidents was reported to local law enforcement.

According to DDS policy, suspected client abuse and lacerations requiring five or more sutures must also to be reported to DHS in a "timely manner." California regulations require developmental centers to report to DHS any unusual occurrence

that threatens the safety or health of residents within 24 hours of the occurrence.[24] Three of the five were reported to DHS but not within the time frame required. Two were not reported.

On October 22, 2004, DDS issued a new policy memorandum addressing the reporting and notification of incidents/unusual occurrences. This policy broadens the definition of events reportable to developmental center OPS, DDS, and DHS to include lacerations requiring any sutures or staples, injuries of unknown origin, and any injury to the genitals. DDS is applauded for this expansion in the standard for reportable events as it clearly captures suspicious incidents such as these injuries. But, in these cases, each of the injuries fell within the existing definition of a reportable event at the time of the incident. Staff failed to comply with the policies.

[24] See Cal. Code of Regs. tit. 22, § 76551.

Reporting of Five Laceration Incidents[25]

Victim	Date & Time Injury Discovered	Developmental Center Management[26]	CRA	SSI	Developmental Center Executive Director	DDS Developmental Centers Division	DHS
As required by policy	As required by policy	Within one working day	Next business day	Within 24 hours	Immediately, no later than on working day	End of following business day	Timely
Neal D.	1-24-99 0900	1-24-99 1403 *Same day*	Not reported	Not reported	1-29-99 *5 days later*	Not reported	Not reported
Roger G.	10-25-00 2030	10-25-00 2205 *Same day*	Not reported	10-30-00 1630 *5 days later*	10-30-00 *5 days later*	10-31-00 1056 *6 days later*	10-31-00 by letter *6 days later*
Lenny M.	6-4-02 2015	6-5-02 0800	Not reported	6-5-02 0825	6-5-02	6-12-02	6-7-02

[25] This information is gathered from the incident report, the medical records, or information provided by DDS upon PAI's inquiry.
[26] Dates and times listed are when the Program Director was notified.

		next day		*next day*	*next day*	*7 days later*	*3 days later*
Sean A.	6-22-02 1445	6-22-02 1600 *same day*	Not reported	Not reported	6-26-02 *4 days later*	Not reported	Not reported
Alan B.	11-16-03 1710	11-16-03 1830 *Same day*	Not reported	11-18-03 0900 *2 days later*	11-17-03 1130 *Next day*	11-18-03 *2 days later*	11-19-03 *3 days later*

C. Protocol or Guidelines for Identifying Dependent Adult Abuse

According to PAI's experts and a search of the medical literature, there are no published protocols or guidelines for identifying indications of suspected abuse or neglect of dependent adults with developmental disabilities. There are publications that address the victimization of an equally vulnerable population and one with like characteristics, which similarly predispose them to victimization – children. Despite many differences between dependent adults with cognitive impairments and children, there are relevant similarities pertaining to their vulnerability to abuse and neglect. Both groups require and are provided adult supervision to ensure their safety and welfare. In both cases, the victim may have difficulty reporting abuse and may not even recognize that he/she has been abused. They rely upon the skills and judgment of others, including care providers and mandated reporters, to assist in identifying and reporting injuries suspect of abuse or neglect.

The United States Department of Justice (DOJ) issued Law Enforcement Response to Child Abuse: Portable guides to investigating child abuse (1997). In this publication, the DOJ lists unique characteristics that make children "perfect victims" and crimes involving child abuse difficult to investigate. They include:

> The victims are usually unable to protect themselves because of their level of physical and mental development;
> Crimes of abuse are not usually isolated incidents, instead they take place over time, often with increasing severity;
> In most sexual abuse cases, there is no conclusive medical evidence that sexual abuse occurred; and
> In most sexual abuse cases, the abuse occurs in a private place with no witnesses.

State of California OES has published a medical protocol for examining children who may be victims of abuse or neglect (OES n.d.). Physicians are instructed to recognize medical evidence of possible abuse or neglect from the appearance of the injury, the victim's history, and laboratory and radiology tests. The comprehensive physical examination should include "special scrutiny" of "important abuse areas" such as genitals and anus.

In most cases of child abuse, diagnosis rests with the lack of adequate explanatory history. Clinicians should extensively probe the history of explanatory events with the victim and caregivers. The OES Protocol instructs physicians to be alert for times:

> when an individual's history of how the injury occurred does not match the examination findings;
> when there is no explanation for how the injury occurred; when the history provided is not consistent; or
> when the explanation fails to explain the nature, severity, or pattern of the injury.

The victim and caregiver should be interviewed separately wherever possible. "If a practitioner recognizes one of the medical findings suggestive of abuse… and fails to find a reasonable explanation, suspicion is reasonable, regardless of the social circumstances and reporting should occur." (OES, n.d.).

The OES protocol directs physicians about how to collect evidence (fingernail scrapings, clothes, swabs) to ensure its integrity. For bruising and other injuries, physicians are advised to photograph the injury. Photographs should include a ruler for size reference. At least one or two photographs should be taken without the ruler to orient the injury and demonstrate that important evidence is not covered.

Finally, physicians are encouraged to report suspected abuse and neglect and refer these cases for consultation with abuse experts. With dependent adults, as with children, the health care professionals treating the individual may be the only link abused and vulnerable victims have to safety.

D. Developmental Center Employee Review

As part of its investigation, PAI reviewed Developmental Center schedules and attendance information for residence and program direct care staff members who worked in proximity with Lenny M., Neal D., Roger G., Sean A., and Alan B. The records covered the time period ranging from six to 14 days surrounding each incident. PAI could not find any direct care staff members who were common to all incidents.

Late in PAI's investigation, it was determined that residents from the two programs involved in these cases may have attended a day program in the same building. PAI was unable to determine whether the five victims were attending the day program in the days immediately preceding discovery of the injury. Therefore, PAI did not review the staffing records of day program staff.

Developmental Center is an open campus. While keys may be required to enter many buildings, staff members generally have keys which access areas available to residents, regardless of the residence or program to which staff are assigned. Lost or misplaced keys are replaced for a nominal fee.

E. DDS' Office of Protective Services' Secondary Investigation

In June 2003, PAI notified DDS of six genital lacerations[27] occurring at Developmental Center. PAI also notified the county Deputy District Attorney for the Elder Abuse and Domestic Violence Division. PAI expressed concern that the lacerations may reflect a pattern of abuse. PAI requested that DDS and the District Attorney review the incidents and take the necessary steps to protect clients at Developmental Center from harm.

In response to PAI's concerns, OPS initiated an investigation in consultation with the District Attorney's office. During the course of their four-month investigation, PAI was asked to refrain from proceeding with its investigation; PAI complied with this request. In March 2004, PAI obtained copies of the DDS' OPS investigation reports submitted to the District Attorney's office for Lenny M., Neal D., and Roger G.[28]

These investigations found some deficiencies but did not find any evidence of sexual or physical abuse. The investigations did not comment about possible neglect. Administrative findings included:

1. Where staff failed to report the incidents to investigators, OPS found staff did not follow Developmental Center policy on alleged abuse or neglect.

2. Where staff reported the incidents to investigators, OPS found staff complied with Developmental Center and DDS policies regarding alleged

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[27] As described above, two genital lacerations (occurring in January 1998 and October 2002) are not included in this report. These victims also resided in Program C. The seventh injury to Alan B. occurred in November 2003, after PAI notified DDS about the series of suspicious injuries.
[28] PAI could have, but elected not to pursue its federal and state authority to access OPS' investigation into the injuries to Sean A. despite the guardian's refusal to grant PAI access.

or suspected abuse but failed to timely report the incidents to investigators.

3. Staff failed to comply with Developmental Center policies regarding client supervision and timely abuse reporting.

4. The original investigations were inadequate because key staff members were not interviewed, including the treating physician, and staffing records were not reviewed.

In a report prepared by Developmental Center Quality Assurance (QA) as part of OPS' investigation, QA faulted the physicians for failing to include more information about the nature of the lacerations and recommended that forensic training or a forensic consultant could provide "more tools" in understanding these types of incidents. OPS did not include this finding and recommendation in its final investigation reports. In two cases, OPS relied upon scant physician's notes and notations by other medical personnel to conclude there was no evidence of abuse.

As part of its investigation, OPS interviewed witnesses and compiled a staff profile of approximately 68 employees who worked on or about the date that each of the incidents was discovered.[29] It appears from the records that OPS did not include in the staff profile any vocational or other day program staff, the one possible commonality for all of the victims. This profile is also not accurate. PAI's review of the employment records provided by DDS found 12 individuals who were working on the day other genital lacerations were discovered but were not noted in OPS' profile as working on those days.

OPS failed to include in their staff profile a psychiatric technician working the day of Lenny's injury who was likely the last person to change Lenny's diaper before the injury was discovered. The profile also did not include two senior psychiatric technicians who worked on the day that Lenny M.'s lacerations were discovered and were interviewed by the SI and/or OPS.

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[29] The profile includes two incidents which PAI did not report to DDS. These incidents are excluded from PAI's analysis.

VI. FINDINGS

A. The five genital laceration injuries are suspect of abuse or neglect.

According to PAI's experts, the five lacerations described in this report are highly suspect of abuse. Laceration injuries to the genitals are unusual, particularly injuries so severe as to require suturing. Lacerations to the penis or scrotum are not reflective of self-injurious behavior or other behavioral issues typically seen in men with developmental disabilities residing in institutions or by these men individually. No one saw how the injuries occurred. Almost all of the victims were nonverbal and could not offer a reliable explanation for how they became hurt. Finally, according to PAI's experts, the pattern of injuries, five over five years clustering in one facility, in two programs, is remarkable and consistent with suspected abuse.

In at least one case, DDS acknowledges that injuries of this nature are suspicious. In their report regarding Neal D.'s injury, OPS stated:

> [Developmental Center Alleged Neglect or Abuse Policy] does not specifically state that injuries of unknown origin and/or injuries to a client's genitalia must be reported to the [Developmental Center] Police and/or the [Developmental Center] Special Investigations Unit; however, an injury of unknown origin to a client's genitalia is highly questionable and warrants further investigation. In [Neal D.'s] case no investigation was conducted.

There is no clear evidence that these injuries were caused by intentional physical or sexual abuse. Initial Developmental Center investigations and OPS' secondary investigations also did not find evidence of sexual or physical abuse. But, without the prompt involvement of trained investigators and preservation of evidence, corroboration of abuse is impossible. OPS acknowledges that the initial investigations were inadequate and were not conducted in all cases where indicated. This raises the question, how can one conclude there was no evidence of abuse when little, if any, evidence was gathered.

B. Each of these injuries should have been reported as suspected abuse or neglect pursuant to the Abuse Reporting Act.

It is the opinion of PAI's experts, after reviewing available records, that these injuries should have been reported under the Abuse Reporting Act. California law requires individuals who are responsible for the care and custody of a dependent

adult (mandated reporters) to report incidents or injuries that they reasonably suspect or that reasonably appear to be caused by abuse or neglect. All of the direct care and clinical management staff at the developmental centers are mandated reporters.

None of the genital laceration injuries were reported as required by the Abuse Reporting Act. In the case of Roger G., the failure to report extends to the emergency department staff that repaired the laceration. Two of the five incidents were not reported at all. Three incidents were reported to Developmental Center investigators but not within the time frame required; reporting lapsed from twelve hours to five days.

In Dr. Koin's opinion:

> People failed to fulfill their reporting requirements. Reporting is dependent on suspicions, not investigations. And here you have a suspicious situation. The fact that staff did not consider these injuries suspicious is, in itself, concerning. I just find it unbelievable that this progressed and wasn't dealt with.

C. Each of the genital laceration victims should have received a sexual assault examination to collect further evidence of sexual abuse.

Based upon the documentary and photographic evidence available, all three of PAI's experts recommended that the victims receive an independent sexual assault examination by trained clinicians. According to Dr. Koin:

> A sexual assault examination or evaluation for injuries to the rectum is certainly something that should be a part of any incident of genital damage or laceration. I would strongly recommend it. By sending victims for a SART examination, clinicians involve independent investigators, generally community law enforcement. [With SARTs] you have law enforcement and the victims right there. [Law enforcement] gathers evidence in a timely manner. If nothing else were to come of this, I would hope that the self-reporting system in the developmental centers would change.

It appears from the records that none of the victims in these cases received a sexual assault examination. None of the physicians treating the Developmental Center

victims made a notation about conducting a sexual assault examination or any examination of the rectum or the surrounding areas for other injuries consistent with a sexual assault. None were sent off campus to receive a SART examination.

Roger G. was sent to a local hospital to have the laceration sutured while he was sedated. Hospital staff made several notations about the unknown source of the injury, suggesting some suspicions. Yet, no sexual assault examination was conducted by emergency department staff.

D. Developmental Center investigations, where conducted, failed to sufficiently explore abuse as a possible cause.

In the face of significant injuries to a vulnerable area, investigators did not sufficiently rule out abuse as a possible cause. Photographs were not taken. Not all witnesses, nor all key witnesses, were interviewed. Physical evidence was not collected. Victims did not receive thorough medical workups to look for other indications of abuse. Medical staff were not queried about whether the injuries were consistent with the alleged cause, particular those injuries attributed to, but inconsistent with, zipper catches. Several of the injuries were lateral which is inconsistent with a vertical zipper opening. As the incidents accumulated over time, investigators did not review the incidents in total, looking for commonalities or patterns, including reviewing staffing records. None of the original investigations found staff had failed to comply with facility incident reporting procedures or state abuse reporting laws, a misdemeanor offense.

Granted, investigations were hampered by delays in reporting and the subsequent destruction of physical evidence. These delays thwarted a thorough investigation. Staff failed to secure important physical evidence, including garments and equipment suspected to have caused the injuries. In the investigation into Roger G.'s injury, the SI wrote:

> Staff suspected that a possible cause could have been due to the scrotum being snagged by the zipper. However, due to the actual occurrence of the incident (10/25/2000) and the reporting of the incident (10/30/2000) the investigation was unable to provide evidence to substantiate this belief.… I was unable to retrieve the pants and underwear [Roger] was wearing at the time the injury was noted due to [sic] being soiled and sent off the residence for cleaning.

Investigators did endeavor to eliminate other possible causes, including environmental hazards. They inspected furniture and other materials for sharp edges or physical evidence, including blood and tissue. In the case of Lenny M., the SI explored whether the injury could have been caused by a catheter worn by the victim in the preceding weeks. Investigators interviewed many witnesses. In the case of Alan B., investigators thoroughly explored contact between Alan and Ken, the alleged perpetrator, in the hours preceding discovery of the injury to establish whether there was an opportunity that the two were alone together, unobserved by staff.

E. Developmental Center staff failed to follow state law and Developmental Center and DDS policies pertaining to reporting of suspected abuse or neglect.

Developmental Center staff failed to comply with DDS and Developmental Center policies and the Abuse Reporting Act by not reporting these incidents as suspected abuse or neglect (or serious injuries) in a timely fashion. Two of the incidents were not reported to investigators at all. The remaining three were not reported within the time line required by the Abuse Reporting Act. None were reported directly to the SI or SSI by the staff initially observing or treating the injury.

The incidents were not reported to Developmental Center executive staff, DDS headquarters, and outside investigators as required by DDS and Developmental Center policies. None of the incidents were reported to the CRA. Only one of the injuries was reported to community law enforcement. At the time of this report, DDS has been unable to verify the date and time that report was made. Two were not reported to DHS.

According to OPS' investigation into Roger G.'s injury:

> [DDS Incident Reporting Policy Memorandum] states serious injuries (including injuries requiring five (5) or more sutures) will be reported in a timely manner to all external agencies such as the Department of Health Services (DHS) Licensing and Certification (L&C) and the DDS Residential Services Division (now known as the Developmental Centers Division). Staff did not comply with the time frames outlined in the policy for reporting [Roger's] injury.

F. Developmental Center policies are inconsistent with the Abuse Reporting Act and DDS policies

The Abuse Reporting Act requires that mandated reporters report alleged or suspected abuse or neglect directly to developmental center investigators. Developmental Center's Alleged Neglect or Abuse Policy directs mandated reporters to contact campus police in the absence of the SI or SSI. This is not consistent with state law. Examination of the duty statements for these two positions underscores why staff are directed to report the suspected abuse to developmental center investigators. Campus police are not trained or expected to conduct abuse or neglect investigations. The Abuse Reporting Act intends to promptly and directly alert properly trained investigators. Notification to campus police fails to meet the requirements and intent of this law.

In October 2004, DDS issued a new policy memorandum addressing the reporting and notification of incidents/unusual occurrences to investigators, DDS, and DHS. This policy broadens the definition of reportable events to include lacerations requiring any sutures or staples, injuries of unknown origin, and any injury to the genitals. The policy is silent regarding reporting to community law enforcement. California law requires developmental centers to immediately report all deaths and serious injuries of unknown origin to local law enforcement. Welf. & Inst. Code § 4427.5.

The Developmental Center's memorandum of understanding with local law enforcement is inconsistent with DDS policy, which required reporting of injuries requiring five or more sutures. The Developmental Center's memorandum of understanding with local law enforcement (the California Highway Patrol) states that Developmental Center shall report all injuries requiring 10 or more sutures, instead of five. This inconsistency permits a gap allowing serious injuries to go unreported to independent investigators.

VII. RECOMMENDATIONS

A. DDS must evaluate and modify its abuse and neglect training and reporting system to ensure that injuries like these do not escape the attention of staff.

When a developmental resident presents with a suspicious injury and there is no adequate explanation for the cause, investigators must be promptly notified and abuse or neglect must be considered as a possible cause. That did not happen in these cases. DDS must review its policies and training of staff to ensure that injuries characteristic of abuse or neglect are promptly reported and investigated.

Medical personnel performing physical exams and licensed care staff must be knowledgeable about the epidemiology and clinical presentation of common accidental injuries and injuries that are suspect of abuse or neglect. Staff members must be provided with current information regarding what experts believe represent suspicious injuries and regularly reminded of their mandated reporting obligation.

When staff members fail to comply with their reporting duties, they must be promptly counseled. In these cases, this included the direct care staff who first observed each laceration, the physicians who sutured the victims, and management staff who reviewed each incident report before sending it forward. Each of these incidents presented a training opportunity to prevent the investigatory lapses that followed.

B. DDS must ensure that medical and direct care staff, in the case of suspicious injuries of unknown origin, perform thorough physical examinations, carefully make a record of the injury and the examination, and secure possible evidence.

Adequate protection of possible victims of abuse and neglect is hampered by the lack of consistent and comprehensive medical examinations. Medical personnel must be able to perform a detailed and careful physical examination and document clearly in writing the findings of that examination. This includes detailed descriptions of the injury, diagrams, and photographs. Staff must be trained about the importance of scene preservation and evidence collection. In the case of serious genital injuries of unknown cause, this includes referring victims for SART examinations.

Staff must query how the injury occurred. Clinicians, specifically physicians, must be trained to recognize when the individual's history does not match the clinical findings. When the history does not match the alleged cause, or in the absence of a known cause, clinicians must conduct further assessments to identify other indications of abuse. As summarized by Dr. Hubbell, "This patient is unable to give you any bit of information. Therefore obligating [the physician] to do a more extensive workup instead of a small workup."

C. DDS must ensure that investigations into unusual and unexplained injuries suggestive of abuse consider that abuse or neglect may be a contributing factor or direct cause.

According to PAI's investigation, these injuries were suggestive of possible abuse or neglect. While benign explanations were thoroughly pursued, including environmental hazards such as external catheters and the footrest of a wheelchair, investigators did not appear to pursue abuse or neglect as a possible cause. In cases of injuries of unknown origin that are suggestive of abuse or neglect, DDS must ensure that investigators equally investigate abuse or neglect as a possible cause. This includes interviewing medical personnel about whether the injuries were consistent with the alleged cause, examining staffing records, interviewing all possible witnesses, reviewing client records for self-injurious behavior patterns, consulting with abuse and neglect experts in the community, and promptly gathering potential physical evidence, including that obtained through sexual assault examinations.

D. DDS and Developmental Center policies must be internally consistent and consistent with the Abuse Reporting Act.

DDS and Developmental Center must review and revise their policies pertaining to abuse and neglect reporting and investigation to ensure they comply with State law. Specifically, staff must be required to report alleged, suspected, reported, or observed abuse or neglect directly to the SIs (as required by the Abuse Reporting Act) and not developmental center police. DDS and Developmental Center must ensure that policies reflect the current standards in the community.

DDS must also ensure that all DDS and developmental center policies are consistent with DDS' new incident/unusual occurrence reporting and notification policy. In this new policy, DDS has justly expanded reportable events to include

any laceration requiring sutures, all injuries of unknown origin, and any injury to the genitals. DDS and the developmental centers must revise all existing policies and memoranda to ensure that they are consistent regarding reportable events and reporting time frames. Specifically, Developmental Center should revise its memorandum of understanding with the California Highway Patrol to include serious injuries as defined by DDS. PAI also encourages DDS to modify this new policy memorandum to include notification of community law enforcement and to specifically list alleged or suspected abuse or neglect as examples of alleged or suspected violations of consumer rights.

E. DDS and Developmental Center must ensure that staff members comply with all applicable policies.

In these cases, staff consistently failed to comply with DDS and Developmental Center policies. Policies in place at the time of each incident required staff to report these injuries; the injuries fell clearly within the definition of reportable events. This failure resulted in delays in the timely investigation of injuries characteristic of abuse or neglect. DDS and Developmental Center must ensure that all staff understand and comply with all existing policies. Where staff members fail to comply, investigations must include examining the reasons for noncompliance, including lapses in individual staff performance and gaps or inadequacies in training programs. Corrective measures must be implemented to remedy identified deficits, including prompt staff performance remediation.

F. DDS and Developmental Center should use the incident reporting system to detect trends, including infrequently occurring unusual injuries suggestive of abuse or neglect.

DDS has a system for identifying and reporting unusual incidents. This includes a semi-annual review of incidents and data trend analysis. DDS must ensure that the incident reporting system is utilized to review injuries over time to identify a possible pattern or common elements. Repetitive suspicious injuries of a similar type may indicate intentional abuse or hazards in the environment that pose a repetitive risk of serious harm.

Prompt identification of common elements to similar incidents will enhance investigations and possibly identify preventative measures. In these cases, Developmental Center and DDS did not identify this pattern of cases until notified

by PAI. Therefore, investigation of common elements was not pursued. DDS and Developmental Center are urged to evaluate the incident reporting system to ensure that unusual and serious injuries like these are identified and that performance improvement measures are implemented to prevent future harm.

VIII. CONCLUSION

Abuse and neglect of dependent adults is a crime. Dependent adults rely on everyone around them to be alert for possible signs of abuse or neglect. Staff should not accept a bizarre explanation for a highly suspicious injury without also considering possible abuse. It is the duty of all of caregivers for people with severe cognitive impairments to honor this responsibility to provide for their care, safety, and protection.

At the end of the day (or of this report) we do not know what happened here. We do not know if any or all these injuries were the result of abuse or neglect or if they were nothing more than a random set of accidental, albeit unexplained, injuries. But there could have been something else. And that possibility should have been fully investigated, at the time, and carefully documented. Because that did not happen here, however, we will never know which, if any, of these injuries were the result of abuse or neglect.

References

29 U.S.C. § 794e et seq.

42 U.S.C. § 10801 et seq.

42 U.S.C. § 15001 et seq.

42 U.S.C. § 15043(a)(2)(I)(iii).

Cal. Code of Regs. tit. 22, § 76551.

Cal. Penal Code § 368.

Cal. Welf. & Inst. Code § 4427.5.

Cal. Welf. & Inst. Code § 4900 et seq.

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Cal. Welf. & Inst. Code § 15610.23.

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