State of New York
Office of the Inspector General

A Critical Examination of State Agency Investigations into Allegations of Abuse of Jonathan Carey

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State Inspector General
Pursuant to Executive Law § 53, the New York State Inspector General is charged with investigating corruption, fraud, criminal activity, conflicts of interest, or abuse in agencies within its jurisdiction. The Inspector General is further directed to recommend appropriate action to be taken against individuals who have engaged in misconduct and remedial measures to be instituted by agencies to prevent or eliminate future wrongdoing. The Inspector General’s jurisdiction extends to executive branch agencies, departments, divisions, officers, boards and commissions, public authorities (other than multi-state or multinational authorities), and public benefit corporations, the heads of which are appointed by the governor and which do not have their own inspector general by statute, as well as persons doing business with any such agency.

This report is issued in accordance with Executive Law § 53(4), which provides for public written reports of the Inspector General’s investigations.
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I. Executive Summary

INTRODUCTION

This report presents the findings of a comprehensive examination by the New York State Inspector General of whether state agencies responded appropriately and sufficiently to allegations that Jonathan Carey, an 11-year-old child diagnosed with autism and mental retardation, was abused in 2004 while a resident at the Anderson School in Staatsburg, New York. The Inspector General’s Office commenced its investigation of Jonathan’s care at the Anderson School in March 2007. The investigation was initiated in response to requests from Governor Eliot Spitzer and State Senate Majority Leader Joseph L. Bruno, as well as Jonathan’s parents, Michael and Lisa Carey. Jonathan died under the care of workers at a state-run facility in February 2007. Both workers responsible were prosecuted by the Albany County District Attorney and later convicted.

This report primarily focuses on the investigations of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) in response to the allegations of child abuse at the Anderson School. The actions of the State Police and the Dutchess County District Attorney, the State Education Department, and the Governor’s Office in response to these allegations were also reviewed. All responded to complaints by Jonathan’s parents that their son had been abused and neglected at the Anderson School, a not-for-profit institution offering services to individuals with developmental disabilities.
The alleged abuse began in September 2004, one year and eight months after Jonathan entered the Anderson School. Although Jonathan had made some progress at the school, he continued to display aggression toward others, and he often would throw himself to the floor or run away from the staff members who were supervising him. Jonathan had begun to remove his clothes at inappropriate times, and he frequently soiled himself. In an attempt to manage some of Jonathan’s maladaptive behaviors, the Anderson School implemented a “planned ignore” treatment plan that instructed staff to ignore bad behaviors and reinforce good behaviors. Despite the implementation of the treatment plan intended to address these behaviors, Jonathan’s maladaptive behaviors escalated. Sometimes this resulted in staff members “ignoring” Jonathan for most of a day. Ultimately, Jonathan was confined to his room for extended periods while he was acting out. Access to regular meals became contingent on his displaying cooperative behaviors. As a result, Jonathan frequently was not provided regular meals because of his behaviors. During this period, a nurse at the Anderson School documented, “It is becoming more frequent that [Jonathan] will not [get dressed to eat] and longer periods of time are occurring without nourishment.” Although provisions were eventually formalized for Jonathan to receive substitute food items when he was not provided his regular meals, it was impossible to determine Jonathan’s overall food intake or what food was offered because documentation was poor or missing altogether. Further, the Anderson School did not have this meal plan reviewed by a dietician until 25 days after the plan was implemented.

While in his room, Jonathan was not permitted to have toys, books, or other items he enjoyed. Several weeks after the initial treatment plan was implemented, his window
was covered with frosted paper to prevent him from looking out, and eventually staff members were instructed to limit Jonathan’s communication with his parents.

On October 22, 2004, Jonathan’s parents removed him from the Anderson School and the next day, brought him to a hospital emergency room for an examination. The Careys alleged that Jonathan had been neglected, and that he was malnourished as a result of the school’s practice of limiting his access to meals. They also alleged that Jonathan’s treatment plan was modified without their consent, that he had been forced to remain in his bare room for extended periods, and that he was left to lie naked on a urine-soaked bed. Anderson School records indicate that Jonathan sustained multiple bruises during this period, and Jonathan’s parents suggested that these were the result of physical abuse. The Careys further alleged that the school had allowed Jonathan to eat dairy products, in violation of his prescribed diet, and that he had missed multiple days of school. As required by law, the emergency room nurse reported the child abuse allegations to the State Central Register of Child Abuse and Maltreatment.

The Inspector General’s review covered Jonathan’s care at the Anderson School, which began in January 2003 and ended in late October 2004, and the investigative and review activities that followed from late October 2004 through 2006. To address the Careys’ allegations, the Inspector General devoted significant resources to this investigation. Beginning in March 2007, attorneys, auditors, and investigators were dedicated to this project for approximately a one-year period. Over 75 interviews were conducted with pertinent staff, executives, and other relevant witnesses and over 25,000 pages of documents were received and analyzed by the Inspector General’s Office. The Inspector General’s office also devoted over 10 hours of in-person interview time with
Michael and Lisa Carey. Along with the specific allegations, which provided the initial basis for this review, more than 30 investigations of alleged child abuse conducted by CQC were evaluated to examine the adequacy of CQC’s interpretation and application of Social Services Law § 412.

STATE AGENCY INVESTIGATIONS

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), which certifies the Anderson School, conducted a survey assessing the school’s regulatory compliance, while its regional office, the Taconic Developmental Disabilities Services Office (Taconic regional office), conducted an investigation into the abuse allegation. The survey identified regulatory non-compliance related to staff training and implementation of treatment plans. The Taconic regional office identified additional violations at the school, and determined that Jonathan Carey was a victim of neglect and maltreatment, both forms of abuse according to OMRDD regulations. The Anderson School was required to correct deficiencies found in both reports. No action was taken against any staff members as a result of Jonathan’s care.

As required by law, the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), an independent oversight body, investigated the child abuse allegation that was referred to it by the State Central Register for Child Abuse and Maltreatment. Using the standards set forth in the state Social Services Law, CQC found that Jonathan’s treatment did not constitute abuse or neglect. However, under the umbrella of a “care and treatment review,” CQC criticized the Anderson School for its treatment of Jonathan.
In June 2005, the Dutchess County District Attorney’s office reviewed the case for potential criminal charges. A New York State Police investigator assigned to a local child abuse task force investigated the matter under the supervision of the assistant district attorney assigned to the case. The district attorney did not pursue a criminal prosecution and closed the case in April 2006.

In October 2005, the New York State Education Department’s Office of Professional Discipline opened an investigation regarding a nurse at the school who was involved in Jonathan’s care. In March 2006, the Education Department closed its investigation, citing a lack of cooperation from the Careys. The Careys disputed this claim and at the behest of the Inspector General, the Office of Professional Discipline subsequently re-opened the case. It is still pending as of the issuance of this report.

Although some of the investigations proceeded simultaneously, each agency acted independently in gathering evidence, conducting interviews, and reaching conclusions.

COMPLAINT TO THE INSPECTOR GENERAL

The Careys were dissatisfied with the thoroughness and findings of the various investigations, and claimed that the agencies were engaged in a deliberate and perhaps collaborative attempt to minimize the child abuse incident at the Anderson School. The Careys further alleged that an incorrect application of the state’s definition of child abuse by CQC has resulted in the agency’s failure to prevent ongoing abuse and neglect at facilities for the disabled throughout the state.
The Careys filed a complaint with the New York State Inspector General, which initiated its own examination of the state agencies over which the Inspector General has jurisdiction. In order to assess whether each investigating agency fulfilled its responsibilities, the Inspector General identified the following questions for this review:

1. Were the investigating agencies’ reviews thorough, in light of their mandates?

2. Did the investigating agencies follow their own internal policies and procedures during the conduct of the investigations?

3. Did the investigating agencies meet their obligations to inform the Careys of their findings and to disclose information regarding the investigation as required by law or agency policy?

4. Did the investigating agencies effectively communicate their findings to the Anderson School and take appropriate measures to protect all children residing at the Anderson School?

5. Were there efforts by any of the investigating agencies to conceal or suppress information to cover up child abuse in the Jonathan Carey investigations?

6. Did the investigating agencies, together or separately, attempt to influence the district attorney or the police to prevent them from investigating or prosecuting the case?

In response to the Careys’ complaint that CQC, as a general policy, applies the child abuse statutes improperly, this report also examined CQC’s interpretation of Social Services Law § 412 through interviews with executive staff, review of procedure manuals, and a review of a sample of child abuse investigations.

This report describes the incidents leading to the Careys’ allegation of abuse at the Anderson School. Although the Inspector General did not make findings regarding Jonathan’s standard of care, to understand the context of the state investigations into this matter, the Inspector General consulted experts regarding treatment of children with
developmental disabilities. The experts were critical of Jonathan’s care at the Anderson School, but this report will not revisit the initial clinical judgments or make a finding of child abuse. Those determinations are appropriately left to the agencies with relevant expertise that are charged with that responsibility. This report also will not address the circumstances surrounding Jonathan’s death, as the Albany County District Attorney had begun its prosecution at the time this investigation was initiated.

The Inspector General’s mandate is to receive and investigate complaints concerning allegations of corruption, fraud, criminal activity, conflicts of interest, or abuse in any agencies under its jurisdiction. Accordingly, this investigation is limited to the actions of the oversight agencies in response to the Careys’ complaints. Although the actions of the Dutchess County District Attorney and the State Education Department are discussed briefly herein, the Inspector General makes no findings regarding these agencies, as they are not subject to the Inspector General’s jurisdiction.

**FINDINGS OF THE INSPECTOR GENERAL**

This investigation found deficiencies related to each investigation or review discussed in this report, with the most significant deficiencies related to CQC’s child abuse investigation and purported care and treatment review. However, the Inspector General did not find any evidence indicating that any agencies uncovered evidence of child abuse at the Anderson School that they deliberately tried to minimize, either separately or in collaboration. Nor did this investigation identify any evidence that the Dutchess County District Attorney had been pressured by any state agency or employee to discontinue its investigation or to decline to prosecute the case.
The Taconic Regional Office’s Investigation

As noted above, the Taconic regional office of OMRDD conducted an investigation into the allegations of abuse of Jonathan Carey at the Anderson School. Although this report notes a few criticisms, the Inspector General found that the Taconic regional office’s investigation was comprehensive and competently executed. The Taconic investigation involved over two dozen interviews and multiple site visits, and the resulting report addressed every allegation raised by the Careys.

The Taconic regional office’s report found that the Anderson School’s practice of isolating Jonathan and withholding meals constituted “mistreatment” and “neglect,” both forms of abuse under OMRDD regulations. It also confirmed that Jonathan’s parents were not involved in, and possibly actively excluded from, the development of Jonathan’s plan of care; Jonathan did miss several days of school; the school intended to suspend the Careys’ contact with their son for a period without first discussing this with them; a staff member’s allegation of abuse involving Jonathan was not properly reported; and, at times, staff did not adhere to his prescribed diet. The Taconic regional office’s report did not substantiate allegations that Jonathan was allowed to lie in urine for extended periods or that his bruises were the result of physical abuse. With regard to the bruises, the report concluded that they were likely the result of Jonathan’s own aggressive behaviors or staff interventions to curb those behaviors. On December 20, 2004, the Taconic regional office reported its findings to the Anderson School and recommended immediate action by the school to correct the identified deficiencies.

The Inspector General’s review found only minor deficiencies in the Taconic regional office’s investigation. Initially, the Taconic regional office directed the
Anderson School to investigate on its own, even though school management officials were named in the allegations and the school’s Executive Director had informed the Taconic regional office Director that he perceived a conflict of interest. Additionally, Taconic investigators failed to interview two school employees who could have provided relevant information.

Based on a review of the same evidence available to the Taconic regional office, the Inspector General questions one finding of the office’s report that Jonathan was not left or forced to lie naked, or in urine, for any extended period of time.

In addition, there were a few minor omissions in the Taconic regional office’s letter to the Anderson School after the completion of its investigation.

Finally, the Taconic regional office’s letter of its findings to the Careys was only a brief summary of its investigation, which omitted several important findings. While the Taconic regional office has the discretion to disclose what information it deems relevant and appropriate in a letter of findings to the parents, a complete disclosure would have been more prudent.

Despite these minor deficiencies, the Inspector General found that the Taconic regional office conducted a thorough and appropriate investigation.

**The OMRDD Central Office’s Survey**

Although its regional office was conducting an investigation into the primary complaint of abuse of Jonathan Carey, OMRDD Central Office’s Division of Quality Assurance conducted a survey that reviewed Jonathan’s care as part of a broader examination of systemic issues and regulatory compliance at the Anderson School. The
regulatory violations identified in the survey were set forth in a November 2004 Statement of Deficiencies and sent to the Anderson School. OMRDD officials explained that the Statement of Deficiencies typically would cite only one instance of a violation identified by surveyors as an illustrative example, even though the surveyors may have identified multiple instances of the same violation.

The Inspector General found that OMRDD Central Office’s survey of the Anderson School was adequate and its follow-up assistance was extensive. From late 2004 and continuing into early 2007, OMRDD Central Office staff maintained a regular presence at the Anderson School, providing technical assistance to improve behavioral intervention, consumer rights, incident management, dietary services, and coordination of services. OMRDD Central Office staff conducted at least 17 separate site visits to the school between November 2004 and January 2007, a 27-month span. The evidence does not indicate that OMRDD “purposefully minimized” its findings or attempted to “cover up” any findings of child abuse involving Jonathan Carey, as alleged.

In its survey, OMRDD correctly identified serious problems at the Anderson School, with particular focus on its use of techniques like planned ignoring in its behavior plans, developing a behavior plan that prohibited family visits and limited telephone contact to Jonathan from his parents, as well as the improper withholding of meals for behavior modification, the lack of staff training, and the failure to provide the family the opportunity to participate in treatment plans or to object to treatment. However, the Inspector General found some oversights in its review methodology. The Inspector General also identified regulatory violations related to Jonathan’s care that were not addressed.
In conducting its survey, OMRDD failed to obtain information collected by the Taconic regional office or to learn of its findings. As a result, the Statement of Deficiencies was incomplete and, in places, inconsistent with the findings of the Taconic regional office’s investigation. OMRDD officials, including the Commissioner at the time, conceded that this lack of coordination was a problem.

OMRDD Central Office also did not interview Jonathan’s parents and did not seek to examine an Anderson School logbook in the Careys’ possession that they claimed held evidence of abuse against Jonathan.

While OMRDD cited several regulatory violations by the Anderson School regarding Jonathan’s care, it obtained evidence of other violations, some very serious in nature, that were not included in the Statement of Deficiencies. Notably, OMRDD failed to mention potential violations of regulations prohibiting seclusion, unauthorized timeout, or neglect, all of which are forms of abuse under OMRDD regulations.

OMRDD Central Office accepted a Plan of Corrective Action from the Anderson School in response to the Statement of Deficiencies, even though the school’s Plan of Corrective Action contained erroneous or dubious information that should have been rejected.

OMRDD also provided inaccurate and misleading information regarding their investigative efforts to the Governor’s Office when asked to respond to the Careys’ complaint to Governor George Pataki.

Finally, the Inspector General learned that there are inconsistent regulatory safeguards for OMRDD consumers receiving services in some private settings when
compared to consumers in state-operated programs. Draft OMRDD regulations dating back to at least 1994 provide additional clarification and guidance on the practice of behavior modification, including the issues of restraint, seclusion, restrictive behavior modification techniques, and time-out. All of these policies would have guided the Anderson School’s treatment of Jonathan. Although the draft regulations were never promulgated, OMRDD issued them as policies applicable to state-operated facilities. However, private providers like the Anderson School are not required to abide by them. This results in consumers receiving different protections and guidance solely due to whether they are placed in state-operated or voluntary programs.

CQC’s Investigations

The Inspector General found that CQC conducted a cursory investigation of the child abuse complaint that did not address all of the allegations presented to it. In addition, the agency issued findings under the umbrella of a separate care and treatment review, even though no such review was conducted. When criticized for the shortcomings of its investigation of the Careys’ allegations, CQC repeatedly overstated the extent of its investigative activities to several parties, including the Careys, the New York State Senate, the office of Governor Pataki, and the Inspector General. Also, deficiencies in documentation of investigative activities revealed a lack of supervision within the agency.

As required by Social Services Law, CQC investigated the allegations regarding Jonathan Carey’s abuse which was referred to it by the State Central Register of Child Abuse and Maltreatment. In contrast to the comprehensive review of the Taconic regional office of OMRDD, CQC made only one site visit to the Anderson School and
conducted only four interviews. Three of these interviews were with the targets of the child abuse investigation. Only one non-target witness was interviewed, and the notes from this interview were difficult for the CQC investigator to interpret and explain to the Inspector General. In violation of CQC policy, the investigator failed to document her activities of her one site visit to the school or her initial telephone discussion with Michael Carey. The investigator also failed to review all relevant documents, including a logbook in the possession of Michael and Lisa Carey that they claimed contained evidence of abuse against Jonathan. CQC was made aware of the logbook on multiple occasions.

The investigation focused solely on whether Jonathan’s meals were withheld inappropriately, on the related behavior plans, and on whether, as a result, Jonathan was physically injured or placed at risk of physical injury. None of the Careys’ other allegations regarding bruising, missed school, isolation, limited communication with their son, the stark conditions in his bedroom, or unsanitary practices were investigated by CQC. CQC did not obtain investigative results from the Taconic regional office, nor did it obtain the results of the OMRDD Central Office’s survey, documents that CQC is legally entitled to and routinely requests in its investigations. These documents could have assisted CQC in determining whether all of the Careys’ complaints had been identified, addressed, and corrected.

Likewise, CQC did not adequately attempt to determine whether Jonathan experienced serious emotional injury, or was at risk of serious emotional injury, as set forth in the Social Services Law definitions of “abuse” and “neglect.” Although CQC identified some concerns that it planned on addressing “under separate cover,” it
determined that Jonathan’s treatment did not constitute abuse or neglect as those terms are defined in the Social Services Law.¹

Two months after the conclusion of the child abuse investigation, CQC opened a care and treatment review, and the investigator issued findings of that review on the same day. Letters of findings were sent to the Anderson School and subsequently to the Careys. CQC informed the Careys that “in an attempt to manage [Jonathan’s] periodic refusal to put on clothes and come to the table and eat, staff did withhold his regular meal and offer a basic nutritional substitute as part of his behavior plan.”

CQC also criticized the Anderson School for:

- Poorly developed and implemented behavior plans
- Failure to provide staff direction on what to do if Jonathan refused to dress and come to meals
- Insufficient documentation by staff
- Failure to include the Careys in Jonathan’s treatment team meetings or obtain their approval for aspects of his behavior plan

The investigator informed the Inspector General that, although she did not conduct a care and treatment review, she presented problems discovered during her child abuse investigation as if they were discovered during a care and treatment review. She stated that she did this so that the findings would be publicly available, since all records related to child abuse investigations are confidential. An actual care and treatment review would have been a full examination of Jonathan’s care, including examination of relevant records for the previous six months. The child abuse investigation, and therefore

¹ This finding is not necessarily in conflict with the finding of the Taconic regional office of OMRDD that Jonathan had been a victim of maltreatment and neglect pursuant to OMRDD regulations. The standards set forth in the Social Services Law are more stringent than those in the OMRDD regulations.
the purported care and treatment findings, focused primarily on the withholding of meals and related behavior plans.

When questioned or criticized regarding its actions, CQC executives repeatedly insisted that the agency had conducted two comprehensive reviews of Jonathan’s care, even contradicting the investigator who acknowledged that she did not do a care and treatment review. CQC made misleading claims about the care and treatment review to the Careys, the state Senate, and to the Inspector General. In addition, CQC provided other misleading or inaccurate information to the Governor’s Office in a written response to a complaint by the Careys.

In examining CQC’s application of the Social Services Law definitions of abuse and neglect, the Inspector General examined all 32 child abuse investigations opened in January 2007. Based on this review and interviews with CQC officials, the Inspector General found that CQC rarely substantiates cases based on actual serious emotional injury and virtually never substantiates cases based on risk of serious emotional injury, two components of child abuse investigations that CQC is charged with evaluating in reaching its determinations. In the Jonathan Carey case, CQC did not thoroughly investigate whether Jonathan sustained, or was placed at a risk of, serious emotional injury by the treatment he received at the Anderson School.

Another complaint in the Inspector General’s sample of child abuse cases from January 2007 arguably could have been substantiated based on the risk of serious emotional injury standard, but it appears that CQC did not adequately explore this possibility. Yet another case reviewed suggested that CQC incorrectly unfounded a case involving a risk of physical injury.
Statements from CQC executives and case examples suggest that CQC is overly conservative in recommending that cases be substantiated. Further, a comparison of CQC indication rates with the institutional abuse data of the New York State Office of Children and Family Services reveal that the latter has an indication rate more than three times higher, on average, than that of CQC.

Although this investigation found deficiencies with CQC’s application of the definitions of child abuse and neglect in the Social Services Law, the Inspector General acknowledges that the definitions themselves may make it difficult for CQC to find abuse in some instances. Specifically, current institutional child abuse laws center around serious injury or the risk of such that must be satisfied to indicate (substantiate) a case of child abuse, regardless of the degree and/or nature of the inappropriate conduct of the employee. Current CQC officials noted the limitations of the Social Services Law. Additionally, a former CQC official interviewed stated that given the vulnerability of this population, unacceptable staff behavior should not be tolerated regardless of the seriousness of the injury to the child. Therefore, he suggested that the standard be re-examined to focus solely on the actions or behaviors of the employee, rather than the extent of injury or impact to the child.

Finally, CQC policies for designating a child as “institutionally neglected” appear to be at odds with the plain language of the enacting law and its sponsors’ legislative intent. This has led to findings of institutional neglect where there were none, and findings of “unfounded” that may have been better classified as institutional neglect.
Office of Governor Pataki

Following OMRDD and CQC’s reviews, the Careys complained in a letter to Governor George Pataki that the two agencies minimized and covered up their findings of child abuse. The Governor’s Office then tasked the agencies involved with providing a joint written response to the complaints delineated in the Careys’ letter. Subsequently, a meeting was held, which was attended by representatives of Governor Pataki, the aforementioned agencies, and the Careys. A second meeting was held between the Careys and the two agency heads.

Dissatisfied with the Governor’s response, the Careys complained to the Inspector General of collusion between the Governor’s Office and the investigative bodies. Given the governor’s role as chief executive of the State of New York, it is within his discretion to request agencies to respond to complaints in this manner. Neither the joint response nor the meetings were inappropriate, and there was no evidence that Governor Pataki’s office attempted to minimize any findings of child abuse involving Jonathan Carey at the Anderson School or to cover up the agencies’ investigative failures. Rather, the Inspector General found evidence to suggest that Governor Pataki’s office attempted to address the Careys’ complaints efficiently and to foster open discussion about their concerns.

Dutchess County District Attorney and the New York State Police

The Dutchess County District Attorney’s office in conjunction with an investigator from the State Police reviewed the abuse allegations regarding Jonathan Carey and, after an investigation, declined to prosecute. In their complaint to the Inspector General, the Careys alleged that the district attorney had agreed to prosecute the case, but subsequently closed the investigation as a result of political pressure from the
investigating agencies or the Governor. The Inspector General found no evidence that the State Police or the assistant district attorney was pressured to discontinue the investigation or prosecution of the case.

**RECOMMENDATIONS**

The Inspector General has provided copies of this report to the relevant state agencies. In addition, copies have been provided to the Albany, Schenectady, and Dutchess County district attorneys’ offices for information and review.

**Taconic Developmental Disabilities Services Office**

1. The Inspector General recommends that the Taconic regional office of OMRDD, or any regional office, take primary responsibility for an investigation regarding a child’s care at a facility within its jurisdiction whenever the facility discloses a conflict of interest or an appearance of such a conflict that would interfere with an internal investigation.

2. The Inspector General recommends that the Taconic regional office take steps to ensure full cooperation of employees in state-certified facilities with OMRDD investigations, as required by law. These steps could include notification of the facility’s Executive Director or Board of Directors of an employee’s failure to comply with this obligation, as well as a referral of the matter to OMRDD Central Office to review the provider’s certification to operate in New York.
Office of Mental Retardation and Developmental Disabilities

1. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to fully incorporate all regulatory violations into a Statements of Deficiencies.

2. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to examine all available information, including pertinent documents and witness interviews.

3. In instances when a survey related to a separate investigation by one of OMRDD’s regional offices is conducted, the Inspector General recommends that OMRDD Central Office coordinate such efforts and obtain the investigative findings of the regional office.

4. In light of Jonathan’s Law which provides families with greater access to certain investigatory records, the Inspector General encourages OMRDD to re-evaluate the language used in its Statements of Deficiencies to determine whether the document should indicate when many instances occurred, even if only one instance of a violation is being cited.

5. The Inspector General reminds OMRDD Central Office of its ethical and legal responsibility to provide thoroughly accurate information to the Governor’s Office. OMRDD should take measures to ensure compliance with the fulfillment of such responsibility.

6. The Inspector General recommends that OMRDD review the conduct of those responsible for providing a response to Governor Pataki’s office that did not accurately reflect OMRDD’s actions in this matter.
7. There is no justification for a child placed in a private, state-certified facility to be afforded less protection from abuse than a child in a state-run facility. The Inspector General encourages OMRDD to re-examine draft regulations on behavior management (14 NYCRR § 633.16) to ensure consistent safety and oversight protections for all consumers statewide.

8. The Inspector General recommends that OMRDD explicitly recommend agencies under its jurisdiction to review an employee’s conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

**Commission on Quality of Care and Advocacy for Persons with Disabilities**

1. This investigation revealed that CQC officials made inaccurate and misleading statements to Governor Pataki’s office, the Inspector General, the State Senate, and the Careys. The Inspector General recommends that the Governor’s Office review the conduct of CQC, and its leadership, with respect to the findings of this report.

2. The Inspector General recommends that CQC review the conduct of staff members assigned to investigate and oversee the Jonathan Carey investigation, and take appropriate action, given the significant and numerous deficiencies cited in this report.

3. The Inspector General recommends that CQC review its investigative policies and procedures to ensure that cases are investigated thoroughly, actions are documented appropriately, relevant evidence is obtained, and case files are completed.
4. The Inspector General recommends that CQC ensure that its child abuse investigations are not simply repackaged when it is necessary to also conduct a broader and separate care and treatment review to evaluate the overall quality of care for individuals with disabilities.

5. The Inspector General recommends that CQC utilize all aspects of the Social Services statute, including the risk of physical and emotional injury, when assessing allegations of child abuse for the State Central Register for Child Abuse and Maltreatment.

6. The Inspector General recommends that CQC, as an independent oversight agency, obtain and review the investigative findings of the investigatory bodies that it oversees when CQC is also investigating the same matter to ensure that full and appropriate inquiries were conducted.

7. The Inspector General reminds CQC of its ethical and legal responsibility to provide thoroughly accurate information to the Governor’s Office. CQC should take measures to ensure compliance with the fulfillment of such responsibility.

8. The Inspector General recommends that CQC re-evaluate its policies regarding Social Services Law § 412(10), “Institutionally neglected child in residential care,” to ensure that the law is applied in accordance with its plain language and its legislative intent to identify systemic problems at regulated institutions and ensure that the appropriate agency is aware of and addresses the problem.

9. The Inspector General recommends that CQC explicitly recommend agencies under its jurisdiction to review an employee’s conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.
**Legislative Recommendation**

The Inspector General recommends that the New York State Legislature review current Social Services statutes that are used to uncover abuse or neglect of a child in an institutional setting, including Social Services Law §412, to determine if they are adequate.
II. Introduction

Jonathan Carey, born September 12, 1993, was diagnosed with mental retardation at the age of two and autism at the age of six, according to his parents, Michael and Lisa Carey. Jonathan exhibited repetitive behaviors typical of some autistic children, such as repeatedly flipping through the pages of a book without looking at the pictures and multiple cycles of crouching down, touching the ground, and standing back up. At times, Jonathan exhibited negative behaviors such as pinching, grabbing, hair pulling, hitting, temper tantrums, and throwing himself to the ground. By the age of nine, Jonathan spoke only a few words and phrases.

Beginning with his initial diagnosis at the age of two, Jonathan received services for the disabled near his home in Bethlehem, New York. As he grew older, Jonathan became increasingly difficult for his parents to manage at home, especially since they had been unsuccessful in teaching him to use the toilet. Lisa Carey reported that Jonathan wore diapers or “pull-ups” on a full-time basis and did not seem to understand the purpose of the toilet. Michael Carey stated that he and his wife had heard that the Anderson School was successful in toileting and “one of the big reasons why [they] put Jonathan in the Anderson School” was to toilet train him.

Jonathan arrived at the Anderson School in January 2003. He made progress in learning to use the toilet, but continued to exhibit some undesirable behaviors such as aggression toward other children, throwing himself on the floor (“flopping”), and running away from staff (“bolting”). On December 31, 2003, a plan to address his negative behaviors, including Jonathan’s incontinence, was implemented at the Anderson School. The staff members who cared for Jonathan were instructed to ignore negative behaviors
and give positive reinforcement for more desirable behaviors. However, Jonathan’s noncompliant behaviors, such as flopping, aggression, stripping, and urinating on the floor, increased during the summer of 2004.

According to records reviewed by the Inspector General, in response to Jonathan’s worsening behavior, on September 23, 2004, a new plan was implemented at the school that intensified the “ignoring.” Staff members were instructed to place Jonathan in an empty room or in his own room, without his toys, books, or games, when he displayed negative behaviors. The modified plan did not have the desired effect, and Jonathan’s negative behaviors continued and increased. However, the plan was not abandoned. Over the course of four weeks, the plan escalated into a program of meal modification and increased isolation in his room. Jonathan was placed in his room for extended periods and was not permitted to attend school or to attend meals at the residence dining table if he did not comply with verbal instructions to dress. Jonathan also was not permitted to eat regular meals in his room. After approximately two weeks of missing some of his regular meals and at least one full day with virtually no food at all, a plan was written to provide Jonathan with substitute foods of soy milk, juice, soy yogurt, or ice pops in his room. Several days later, Jonathan’s window was covered with a frosted coating so that he could not look out. Staff had been instructed to change his sheets only once in the morning if they were wet with urine and to leave the bed unmade if Jonathan wet the bed again. Jonathan’s parents claimed that on two separate weekend visits before his withdrawal from the school, they found him hungry and bruised, lying naked on a urine-soaked mattress. The school’s proposed plans to implement a program
limiting Jonathan’s contact with his parents prompted them to remove him from the school on October 22, 2004.

**ALLEGATIONS**

On the same day, Michael and Lisa Carey alleged to their Medicaid Service Coordinator that their 11-year-old child, Jonathan, who had developmental disabilities, had been abused at the Anderson School. The Anderson School is a not-for-profit institution that is certified by New York State to care for individuals with developmental disabilities. The Careys’ complaint resulted in investigations by several state agencies with jurisdiction over the matter. OMRDD, which certifies the Anderson School, conducted a program review and its Taconic regional office completed an investigation, each of which resulted in a report. In addition, CQC, an independent oversight body, also investigated the matter and issued two reports. The State Education Department’s Office of Professional Discipline opened an investigation regarding licensed professionals at the school that were involved in the matter. Several months later, the Dutchess County District Attorney’s office, with the assistance of the State Police, reviewed the case for potential criminal charges.

Although the Careys named several individuals as instrumental in the alleged mistreatment of Jonathan, none of the investigating agencies identified any individual as being liable in the matter. CQC, which was responsible in this case for determining whether any employee committed child abuse or neglect under the state’s definition in Social Services Law § 412, did not find any individual responsible. However, CQC issued a separate report criticizing systemic deficiencies related to Jonathan’s care and treatment at the school. In addition, OMRDD and its Taconic regional office issued two
separate reports. Taconic’s was in direct response to the allegations; OMRDD’s was the result of a more general “survey” of the school. Both were critical of the school’s treatment of Jonathan and identified deficiencies at the school related to the development and implementation of treatment plans. The State Education Department closed its investigation, citing a lack of cooperation from the Careys. The Careys disputed this claim, and the Education Department reopened the case following inquiries from the Inspector General. The Dutchess County District Attorney, who worked with the State Police, did not bring criminal charges in the case.

The Careys were dissatisfied with the thoroughness and findings of the various investigations, and subsequent events, and alleged to the Inspector General the following claims:

1. The findings of the OMRDD investigation were “watered down” and “purposefully minimized the scope of what really happened to our son.”
2. The CQC investigation was superficial and included only one site visit to the Anderson School.
3. CQC recommended to the State Central Register of Child Abuse and Maltreatment that the case be unfounded (or unsubstantiated) despite the Taconic regional office’s finding of abuse.
4. Neither OMRDD nor CQC ever conducted a face-to-face interview with the Careys.
5. Although aware of the existence of a logbook, which contained what the Careys described as strong evidence of the abuse of Jonathan, CQC never obtained and reviewed it until years later, and then only after the Careys persistently demanded that CQC do so.
6. Neither CQC nor OMRDD recommended the matter to a law enforcement entity for prosecution as required by Mental Hygiene Law and despite findings of abuse by the Taconic regional office.
7. Both OMRDD and CQC sought to “cover-up” findings that Jonathan was abused.
8. Records pertinent to their son’s case were withheld from the Careys.
9. OMRDD “refused to release the investigative records to the State Education Department” so that the State Education Department could commence its investigation.

10. “The state got involved in the criminal investigation and influenced the DA, by insuring them that they were working with the Anderson School to bring about proper corrective action, which was untrue.”

11. The Dutchess County District Attorney and the New York State Police “believed … laws … were broken and agreed to immediately investigate,” yet soon after, “began not returning [Michael Carey’s] calls” and tried to “get us to drop the criminal [charges]” and only pursue a civil lawsuit.

12. Governor Pataki’s Office was not responsive to their complaints and mishandled their complaints by directing CQC and OMRDD to meet jointly with them to discuss their allegations.

13. No one was ever held accountable for the abuse of their son.

14. CQC has misinterpreted the definitions of child abuse and neglect in Social Services Law and this misinterpretation results in a failure to identify and prevent child abuse throughout the system.

The Careys filed their first complaint with the New York State Inspector General in November 2006. In a preliminary assessment, the Inspector General’s Office concluded that their concerns were being addressed by the Governor’s Office and top management in the relevant state agencies. In March 2007, under a new Governor and new Inspector General, this office re-opened its investigation.

In response to these allegations, the Inspector General identified the following questions for this review:

1. Were the investigating agencies’ reviews thorough, in light of each agency’s mandate?

2. Did the investigating agencies follow their own internal policies and procedures during the conduct of the investigations?

3. Did the investigating agencies meet their obligations to inform the Careys of their findings and to disclose information regarding the investigation as required by law or agency policy?
4. Did the investigating agencies effectively communicate their findings to the Anderson School and take appropriate measures to protect all children residing at the Anderson School?

5. Were there efforts by any of the investigating agencies to conceal or suppress information to cover up child abuse in the Jonathan Carey investigation?

6. Did the investigating agencies, together or separately, attempt to influence the district attorney or the police to prevent them from investigating or prosecuting the case?

7. Does CQC interpret and apply the definitions of child abuse and neglect in Social Services Law § 412 in a way that conforms to legislative intent?

SCOPE AND METHODOLOGY

The time frame of the Inspector General’s review consisted primarily of Jonathan’s care at the Anderson School, which began in January 2003 and ended in late October 2004, and the investigative and review activities that followed from late October 2004 through 2006. The circumstances surrounding Jonathan Carey’s tragic death in February 2007 were not covered by this review, as the death occurred over two years after Jonathan was removed from the Anderson School. During the course of this investigation, the matter of Jonathan’s death was handled in the criminal courts.

To address the Careys’ allegations, the Inspector General devoted significant resources. Beginning in March 2007, attorneys, auditors and investigators were dedicated to this project for a one-year period. Over 75 interviews were conducted with pertinent staff, executives, and other witnesses. Investigators from the Inspector General’s Office also spent over 10 hours in personal interviews with Michael and Lisa Carey.

Over 25,000 pages of documents related to the Careys’ allegations were received and analyzed by the Inspector General’s Office. These documents included policies,
memos, internal and external correspondence, e-mail, medical and clinical records, and all investigative materials from CQC, OMRDD, Taconic regional office, the State Police, the Office of Children and Family Services’ State Central Register, the State Education Department, and the Anderson School. Also, records from the Governor’s Office, Jonathan’s personal physicians, hospital visits, psychiatric assessments and evaluations, and the Bethlehem Central School District were examined. Additionally, New York State Senate hearing minutes and various reference materials were reviewed throughout the investigation.

Along with the specific allegations that provided the initial basis for this review, more than 30 CQC investigations of alleged child abuse were evaluated by the Inspector General’s Office to examine the adequacy of CQC’s interpretation and application of Social Services Law § 412. As the investigation proceeded, issues arose that caused the Inspector General’s Office to question the efficacy of the Social Services Law provisions that are intended to protect children from abuse or neglect.

Although this report details the incidents leading to the Careys’ allegations of abuse, the Inspector General will not make findings in this report regarding the standard of care provided to Jonathan at the Anderson School and will not assess whether any of the agencies involved should have made a finding of abuse in the case. Those determinations are appropriately left to the agencies with relevant expertise that are charged with that responsibility.

However, the Inspector General consulted two experts regarding the treatment of children with developmental disabilities, Dr. Kevin Sutherland and Dr. Maureen Conroy, to understand the context of the state investigations. Sutherland is an associate professor
in the Department of Special Education and Disability Policy in the School of Education at Virginia Commonwealth University and has served as a principal investigator or co-investigator on several federally-funded projects. He also serves as an expert to a federally court-appointed monitor involving the State of California. Sutherland’s expertise is in effective practices and interventions for students with emotional/behavioral disorders. Conroy is a professor in the same department at Virginia Commonwealth University. She has extensive experience and publications in working with individuals with autism and has served as a principal investigator on a number of federally-funded research projects involving individuals with autism.

Although this investigation’s analysis is limited to the actions of the oversight agencies in responding to the Careys’ complaint, understanding what occurred to Jonathan at the Anderson School was essential. Accordingly, this agency made an exhaustive effort to establish and report on the underlying facts and events that occurred at the Anderson School to be able to establish the adequacy of the ensuing investigations.

Much of the information related to Jonathan’s medical and clinical care, as well as the investigations into allegations of child abuse, are protected by a variety of strict confidentiality laws. The Inspector General obtained consent from Michael and Lisa Carey to obtain and disclose information related to Jonathan’s medical and clinical records and treatment in the interest of ensuring that this report would be thorough and complete. The Inspector General also obtained explicit authorization from the Office of Children and Family Services, pursuant to Social Services Law § 422-a, to disclose certain information from the State Central Register. To comply with law, the Inspector
General has redacted the names of subjects named in unfounded child abuse allegations throughout this report.²

² Social Services Law § 422(5)(b).
III. Background

NEW YORK STATE SERVICES FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

A child with developmental disabilities is entitled to special services from state and local government. Local school districts are required to provide special education services to qualifying students within their jurisdictions. Jonathan was served by the Bethlehem Central School District and his services were coordinated in consultation with the district’s Committee for Special Education. As required, the committee developed and regularly reviewed an Individualized Education Program for Jonathan. The Individualized Education Program detailed his learning needs, goals for the coming year, and the services that the school district would provide to help him meet those goals. At the Careys’ request, Jonathan’s transfer to the Anderson School was approved by the Bethlehem Central School District’s Committee for Special Education.

OMRDD is responsible for administering the state’s programs for citizens with developmental disabilities and for overseeing and certifying private providers of services to those individuals within the state. Approximately 140,000 individuals with developmental disabilities within the state receive services, but the majority of services are not provided directly by the state. Private, or “voluntary,” providers certified by OMRDD administer nearly 80% of services for individuals with developmental disabilities in New York. The Anderson School is one such voluntary provider.

Individuals or families of individuals with developmental disabilities gain access to services through OMRDD’s regional developmental disabilities services offices.
Some individuals with disabilities and their families receive case management from a Medicaid Service Coordinator, who is a single point of contact and helps to identify and manage services available to the family or the individual. Jonathan’s Medicaid Service Coordinator worked at the Capital District Developmental Disabilities Services Office, which served the region of the Careys’ Bethlehem, New York home.

NEW YORK STATE AGENCIES RESPONDING TO ALLEGATIONS OF JONATHAN CAREY’S ABUSE

Office of Children and Family Services’ State Central Register of Child Abuse and Maltreatment

The New York State Office of Children and Family Services operates and maintains the State Central Register of Child Abuse and Maltreatment. According to law, the purpose of the State Central Register and New York’s child protective system is “to encourage more complete reporting of suspected child abuse and maltreatment and to establish in each county of the state a child protective service capable of investigating such reports swiftly and competently and capable of providing protection for the child or children from further abuse or maltreatment and rehabilitative services for the child or children and parents involved.” In essence, the State Central Register is a central location to report and refer cases of suspected child abuse to the appropriate investigative agency, as well as a repository for names of individuals found to have abused or maltreated a child.

The register is in continuous operation and receives telephone calls from mandated reporters and the general public (including anonymous sources) alleging child

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3 Social Services Law § 422.
abuse or maltreatment within New York State. Upon receipt of a call, a trained specialist at the State Central Register determines whether the information provided is sufficient to warrant the opening of a child abuse investigation. If the information contained in the report “could reasonably constitute a report of child abuse or maltreatment” or “if true would constitute child abuse or maltreatment” the complaint is accepted and relayed to the appropriate agency for investigation. The State Central Register accepts more than 140,000 complaints of suspected child abuse or maltreatment annually from mandated reporters and private citizens. The vast majority of complaints of abuse involve children in family settings. Less than one percent of reports per year deal with allegations of abuse or maltreatment in institutional settings. Allegations of child abuse may be investigated by one of many agencies within the state, depending on whether the abuse is alleged to have occurred in a family or institutional setting, and depending on the type of institutional setting.

If the Office of Children and Family Services determines, based on its own investigation or the recommendation of another investigating agency or the determination of a local child protective service office, that the complaint is substantiated, or “indicated,” then the individual named in the complaint will be retained as substantiated on the State Central Register. 4 If the complaint is unfounded, then the record of the complaint is sealed.

In the case of Jonathan Carey’s alleged abuse at the Anderson School, the register received allegations of abuse or neglect from at least two sources. One source told the

4 The Office of Children and Family Services may substantiate a complaint of abuse without a determination from a court. However, an individual who has been placed on the State Central Register may contest this finding in an administrative hearing.
Inspector General that her complaint was not accepted by the State Central Register. The complaint by the other source was accepted and, in accordance with Mental Hygiene Law and Social Services Law, it was referred to CQC for investigation. No allegation of abuse or neglect was substantiated as a result of Jonathan’s treatment at the Anderson School.

**Commission on Quality of Care and Advocacy for Persons with Disabilities**

According to its Web site, CQC “serves people with mental, physical and sensory disabilities by promoting public policies that meet the needs and advance the rights of all persons with disabilities and by providing independent oversight of the quality and cost-effectiveness of services provided by mental hygiene programs in New York State” (emphasis original). CQC has broad authority to make recommendations regarding care and treatment of individuals with developmental disabilities and/or mental illness in New York. The CQC Web site also states, “The Commission fulfills its mission by ensuring its accessibility and responsiveness to persons with disabilities, their families and advocates, by establishing a reputation for conducting credible and objective investigations.”

CQC consists of a full-time chairperson and two unsalaried members, each appointed by the Governor and confirmed by the Senate to serve for staggered five-year terms. In 1998, Gary O’Brien was named chairperson of the CQC by then Governor George Pataki. His current term expires in 2009.

As part of its oversight responsibilities, CQC is mandated by law to investigate complaints received by the State Central Register of child abuse or neglect occurring in
certain OMRDD-certified facilities, including the Anderson School.\footnote{Mental Hygiene Law § 45.07.} The State Central Register refers approximately 300 cases annually to CQC for investigation. CQC staff members are on call 24-hours a day, 7-days a week to receive notifications from the State Central Register about an allegation. Investigations are commenced within 24 hours of the reporting of the allegation and initially seek to determine that the child is safe and require action to protect the child’s safety, if necessary. Within 60 days, CQC is required to make a recommendation to the Office of Children and Family Services to either “indicate” (substantiate) or “unfound” (unsubstantiate) a case. Upon completion of the investigation, CQC transmits its recommendation to the Office of Children and Family Services, which makes its own determination whether the report is substantiated or unfounded. CQC recommends indicating in approximately five percent of the child abuse cases it investigates. Thus, CQC determined that in approximately 95 percent of the cases it investigated, there was insufficient credible evidence that the suspected individual abused or neglected the child as defined in Social Service Law.

CQC may open additional investigations when, in the course of the initial investigation, other deficiencies or problems with care are discovered. CQC’s broad mandate enables it to conduct investigations of systemic problems and to make recommendations for improving services for individuals with developmental disabilities, in addition to investigating specific complaints. CQC can require a facility to establish a corrective action plan, including retraining of employees, in response to the findings of a child abuse investigation. CQC neither has the authority to discipline an employee nor
can they require the facility to do so, but nothing prevents it from making such a recommendation.

The Careys’ complaint regarding the Anderson School was referred to CQC for investigation. CQC recommended that the child abuse allegations be unfounded, but it issued a separate letter to the school criticizing Jonathan’s care and treatment. The Anderson School responded to CQC with a plan to correct deficiencies. On April 28, 2005, CQC sent the Careys a letter summarizing its findings.

Office of Mental Retardation and Developmental Disabilities

OMRDD is the agency responsible for providing and regulating services for individuals with mental retardation and developmental disabilities in New York State. As noted above, the majority of services for individuals with mental retardation and developmental disabilities in New York are provided by private organizations, or voluntary providers, such as the Anderson School, which are certified by OMRDD. The Division of Quality Assurance within OMRDD ensures that certified providers, including the Anderson School, comply with state regulations. The actions taken by OMRDD in response to regulatory noncompliance are largely dependent on the types of deficiencies found, with those that could potentially negatively affect the health and safety of consumers being the most significant, requiring prompt remedial action by the agency.

In response to the allegation of mistreatment of Jonathan Carey by the Anderson School, OMRDD Central Office launched a survey. The survey, a review of regulatory compliance, included Jonathan Carey’s treatment in its scope. On November 24, 2004, OMRDD Central Office issued a Statement of Deficiencies, a document identifying
instances in which the Anderson School was not in compliance with regulations. As required, the Anderson School responded with a Plan of Corrective Action to remedy the problems identified. The Careys received a copy of the Statement of Deficiencies and the Plan of Corrective Action after making a request in accordance with the state’s Freedom of Information Law.

OMRDD’s Taconic Developmental Disabilities Services Office (Taconic regional office) conducted an investigation, and issued a report finding “mistreatment” and “neglect” pursuant to OMRDD regulations. Although services to Jonathan and his family were coordinated through the Capital District regional office, the Taconic regional office conducted the investigation because the Anderson School was within Taconic’s jurisdiction. The Taconic regional office completed its investigatory report on December 1, 2004, and communicated a summary of its findings to the Anderson School in a letter dated December 20, 2004. In a letter dated the same day, the Taconic regional office provided the Careys with a summary of its findings.

**State Education Department**

The Anderson School’s educational programs, but not its residential and treatment programs, are licensed by the State Education Department. The Education Department’s division of Vocational and Educational Services for Individuals with Disabilities reviewed the allegations but determined that the alleged abuses occurred in the residential program at the Anderson School, and were therefore outside of its jurisdiction.

However, the Education Department, which oversees the preparation, licensure, and practice of certain professions, opened an investigation of a registered nurse at the
Anderson School. Nurses are licensed by the Education Department, and their licenses can be suspended or revoked upon a finding of professional misconduct. The Office of Professional Discipline closed its investigation of the nurse prior to its completion, citing a lack of cooperation by the Careys. The Careys told the Inspector General that they were willing to cooperate and wanted the investigation to continue. At the behest of the Inspector General, the Office of Professional Discipline subsequently re-opened the case, which is still pending as of the issuance of this report.

The Inspector General does not have jurisdiction over the State Education Department and therefore will not make findings in this report regarding its investigation into the matter.

**Dutchess County District Attorney and the New York State Police**

The Assistant District Attorney/Chief of the Special Victims Unit at the Dutchess County District Attorney’s office reviewed the abuse allegations regarding Jonathan Carey and, after an investigation, declined to prosecute. She was assisted in her investigation by a State Police investigator assigned to a multi-disciplinary team composed of state and county agencies that is charged with investigating serious offenses against children.

In their complaint to the Inspector General, the Careys alleged that the district attorney had agreed to prosecute the case, but subsequently closed the investigation as a result of political pressure from the investigating agencies or the governor.

The Inspector General does not have jurisdiction over any of the state’s district attorneys. Accordingly, the Inspector General makes no findings regarding the
appropriateness of the Dutchess County District Attorney’s decision not to prosecute this case, except in relation to the accusation that an individual or state agency under the Inspector General’s jurisdiction interfered with the district attorney’s investigation or prosecution. The Inspector General found no evidence that the State Police or the district attorney was pressured to discontinue the investigation or prosecution of the case.

**Office of Governor George Pataki**

The Careys requested a meeting with Governor George Pataki to discuss their allegations against the Anderson School and their complaints regarding the investigating agencies. A representative of the Governor attended a meeting, organized by the Governor’s Office, with the Careys and representatives of OMRDD and CQC. The Careys alleged to the Inspector General that the Governor’s Office was not responsive to their complaints, and that it was inappropriate to invite OMRDD and CQC to attend the meeting.
THE ANDERSON SCHOOL

In January 2003, the Bethlehem Central School District’s Committee for Special Education (CSE), in conjunction with Jonathan’s parents, determined that the Anderson School was an appropriate placement for Jonathan. According to its Web site, the Anderson School (part of the Anderson Center for Autism) was founded in 1924 in Staatsburg, New York. It is a private, not-for-profit organization, managed by an executive director under the guidance of a board of trustees. The school provides educational, residential, health, clinical, and other programs for children and adults with developmental disabilities. Within the field, Anderson School is what is commonly referred to as a “voluntary agency,” a private agency that is certified by the state to provide services. The Anderson School’s Web site notes:

Anderson Center for Autism, a not for profit organization, offers the highest quality year round day and residential programs to children and adults who have been diagnosed on the autism spectrum. Our progressive curriculum features educational, cultural and recreational opportunities specifically designed to challenge each individual to the limits of his or her own abilities.

At Anderson Center for Autism, we’re committed to offering children and adults with autism a progressive, nurturing environment where opportunities for Lifelong Learning are not only possible, but something we experience everyday.

The Anderson School children’s programs include several types of residential care facilities, an educational program and after-school programs. The programs combine to offer educational, social, vocational, and life-skill opportunities in a campus setting.
Diagram of the Anderson School campus in Staatsburg, New York, from Web site (left) and front entrance sign (right).

As a voluntary agency, the Anderson School is certified by OMRDD, which issues an operating certificate for the residential components of the Anderson School, among other programs. The State Education Department licenses the private school component.  

It should be noted, in April 2004, CQC identified concerns regarding the care of children at the Anderson School and alerted OMRDD. Both agencies independently visited the Anderson School in attempt to correct some of these concerns. In May 2004, OMRDD conducted a survey of the Anderson School. A Statement of Deficiencies was issued which cited the Anderson School for a number of shortcomings, including serious and systemic deficiencies in the areas of investigations, incident review processes,

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6 8 NYCRR Part 200.
medication administration, storage, and handling, and some physical plant conditions. The May 2004 Statement of Deficiencies also cited the agency for failing to immediately initiate an investigation for serious reportable incidents and allegations of abuse and for allowing residence managers to investigate incidents in their own residences. “This practice presents an obvious conflict of and potential loss in objectivity,” according to the report.

It should also be noted that the OMRDD Division of Quality Assurance facilitates monthly “Early Alert” meetings to ensure strong internal communication between stakeholders regarding voluntary programs with significant or systemic issues. The Anderson School was placed on “Early Alert” status, according to OMRDD Early Alert meeting minutes, virtually every month from June 2004 through February 2007.

**APPLICABLE LAWS AND REGULATIONS**

The Anderson School is governed by Mental Hygiene Law and by OMRDD regulations. The Mental Hygiene Law requires, among other things, that OMRDD is responsible for delivering comprehensively planned care, treatment, and rehabilitation to those with developmental disabilities; ensuring that consistent, high quality services are provided and consumers’ personal and civil rights are protected; notifying law enforcement if it appears that a crime may have been committed, reporting and investigating untoward incidents, and conducting inspections of facilities.\(^7\)

\(^7\) Mental Hygiene Law §§ 13, 16.
Additionally, the Mental Hygiene Law and Social Services Law require the prompt reporting of any allegations of abuse or mistreatment of a person receiving services to CQC and the State Central Register.8

New York State laws establish the statutory authority for the commissioner of OMRDD to adopt rules and regulations applicable to all programs that provide services for individuals with mental retardation and developmental disabilities.9 As pertinent to this investigation, four sections of OMRDD regulations applied to the Anderson School in 2004. One deals with the operation of a private school, Part 81 of the New York Code of Rules and Regulations (14 NYCRR Part 81), while the other three contain generic regulations that apply to all OMRDD service providers. The three generic regulations are: 14 NYCRR Part 624, which addresses reportable incidents and abuse at facilities; 14 NYCRR Part 633, which addresses quality of care issues and protection of individuals; and 14 NYCRR Part 635, which deals with physical plant criteria and certain services.

Part 81 describes requirements that apply to residential schools providing a program of 24-hour professional care and treatment for individuals with developmental disabilities.10 It includes, among others, regulations which speak to: certification; organization and administration, including a review of untoward incidents (including assaults, accidents) and “extra risk procedures” (including behavior modification and restraints or seclusion); an individual written plan of care and treatment; staffing qualifications; and recordkeeping.

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8 Mental Hygiene Law § 45, Social Services Law § 413.
9 Mental Hygiene Law §13.
10 14 NYCRR Part 81.
Part 624 sets forth the minimum requirements for the management of incidents and abuse allegations, as required by OMRDD. To enhance the quality of care, protect consumers from harm, mental and physical abuse, this part requires the reporting, investigating, reviewing, correcting and/or monitoring of certain events. It describes and delineates what situations or events must be reported and to whom. Incidents are documented on an OMR Form 147 (I) or OMR Form 147 (A); entitled, Reportable or Serious Reportable Incidents and Allegation of Abuse Reporting Form, respectively. 11 Allegations of abuse against children must be reported to the State Central Register and CQC immediately.

Part 633’s intent is to specify minimum requirements for ensuring the protection of persons with developmental disabilities12. Each facility is tasked with adequately addressing quality of care, individual rights, safety, and fiscal accountability as they pertain to individuals receiving services. Part 633 also addresses employee hiring, training and conduct; supervisory requirements; follow-up to allegations of abuse; informed consent for medical treatment; and the opportunity to object to a plan of care and treatment. According to OMRDD General Counsel Patricia Martinelli Parts 624 and 633 are controlling over any other regulations in this area.

11 According to OMRDD’s Provider Resource Manual:
**Reportable Incident**: Significant events/situations endangering a person's well-being; **Serious Reportable Incident**: Significant event/situation endangering a person's well-being so severe or sensitive that the situation must also be immediately reported to the DDSO in the area of jurisdiction where the incident occurred; **Abuse**: The maltreatment or mishandling of a person receiving services which would endanger the physical or emotional well-being of the person through the action or inaction on the part of anyone, whether or not the person is or appears to be injured or harmed.

12 14 NYCRR 633.
Among the protections offered in this part are those related to individual rights, which are not to be arbitrarily denied by the facility. These rights include: a safe and sanitary environment; freedom from physical or psychological abuse; a written individualized plan of service; a balanced and nutritious diet; the opportunity to request an alternative residential setting; the right to express grievances and issues; and the opportunity to receive visitors at reasonable times, among others. Any limitations of the aforementioned rights are required to be “on an individual basis, for a specific period of time and for clinical purposes only.” The rights listed in this section may only be denied on a temporary basis for a valid treatment purpose.13

Section 633.9 addresses follow-up activities subsequent to a reported allegation of abuse. It demands that: situations be immediately evaluated; investigations launched if deemed appropriate; removal, reassignment, relocation or suspension of the alleged abuser; and an immediate report to law enforcement “when it appears that a crime may have been committed against a person receiving services.”14

Although Part 635 is one of the three universal regulations for all sites, it is not relevant to this investigation. As noted above, Part 635 which addresses the physical plant and other services is not related to the complaints made by the Careys.

**APPLICABLE POLICIES AND PROCEDURES**

The Anderson School has created policies and standard operating procedures that reflect the duties imposed upon it by the abovementioned regulations. Pertinent to this investigation are several policies of importance. For example, the Anderson School’s

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13 14 NYCRR 633.4(a)(4).
14 14 NYCRR 633.9.
policy on behavior plans applies to individuals exhibiting maladaptive behaviors and provides a very specific protocol for staff to follow toward the goal of eliminating these behaviors.\textsuperscript{15} Not all students have behavior plans. For example, it does not appear that Jonathan had a behavior plan for his first 12 months at the facility.

The Anderson School’s policy entitled Individual Rights/Objection to Services Process ensures that individuals and their parents can object to any plan of service.\textsuperscript{16} The Anderson School’s policy for management of endangering behaviors by students requires that students who exhibit these behaviors are not excluded from educational programming unless absolutely necessary and with concurrent notification of the school district.\textsuperscript{17} In most cases, parents are to be notified of the behavior plan at the individual’s educational plan meeting and all plans are to be mailed to the parents.

Other provisions related to this case include Anderson School’s policy on an student’s education plan, which seeks to ensure that the plan is compliant with applicable regulations.\textsuperscript{18} The school’s policy regarding nutrition standards necessitates that foods served meet the federal recommended daily allowances.\textsuperscript{19} Anderson School’s visitation policy for individuals and their parents allows the opportunity for individuals to receive visitors in person or to communicate by telephone, at reasonable times within the limits of their individual behavior plans.\textsuperscript{20}

\textsuperscript{15} Policy #F-1.
\textsuperscript{16} Policy #C-2, 11/18/02.
\textsuperscript{17} Policy #D-1, 3/1/00.
\textsuperscript{18} Policy #D-2, 6/1/00.
\textsuperscript{19} Policy #E-4, 5/21/02.
\textsuperscript{20} Policy #C-4, 3/1/00.
To ensure the safety of the resident and others, the Anderson School may employ physical interventions such as escorting or holding the child. Anderson School’s policy regarding physical interventions requires timely necessary medical follow-up.\textsuperscript{21} Staff members who were not involved in the intervention are directed to examine the individual, implement first-aid if necessary, and notify the nurse and residence manager. There are approximately 10 registered nurses on staff, who are responsible for the medical care of the children in the residences, including management of their doctors’ appointments (medical, dental, and vision) and any medical conditions.

Whenever a student sustains an injury, as a result of an intervention or otherwise, nursing staff completes an Anderson School Student Injury/Illness Report to describe the incident (setting, participants), nature of the illness or injury, and follow-up. The form includes a physical diagram of a body to illustrate any markings, bruises, scratches, injuries, etc. Other forms, like the Behavioral Report Form (which describes an incident, the setting, physical managements and follow-up actions) and an OMR Form 147 (which documents reportable incidents) are completed if the injury meets the criteria. In addition, the school’s incident management policy is consistent with state regulations.\textsuperscript{22}

Jonathan’s was given a physical examination and a battery of clinical assessments to determine his physical, medical, educational and occupational needs upon placement at the Anderson School. His parents received an admission packet containing consent forms for medical, psychiatric, and dental services. They also received a copy of his

\textsuperscript{21} Policy #F-2, 3/1/00.
\textsuperscript{22} Policy #G-2, 3/1/2000- Incident Reporting Management and Procedure #IR-01, 7/14/04 – Incident Reporting and Management.
rights as a consumer as articulated in state regulations, and the grievance procedure for objection to services.

INDIVIDUAL RIGHTS

As an individual receiving residential and/or educational services from Anderson School, you (or your parent, guardian(s), correspondent(s) or advocate on your behalf) are guaranteed the following rights:

1. The respect and dignity which is extended to every person regardless of race, religion, national origin, creed, age, gender, ethnic background, developmental disability or other handicap.
2. A safe and sanitary environment.
3. Freedom from physical or psychological abuse.
4. Freedom from corporal punishment.
5. Freedom from unnecessary use of mechanical restraining devices.
6. Freedom from unnecessary or excessive medication.
7. Protection from commercial or other exploitation.
8. Confidentiality with regard to all information contained in your individual record and access to such information, subject to the provisions of Article 33 of the Mental Hygiene Law and Commissioner's regulations. Confidential HR-related information will also be maintained per Article 27-F of the Public Health Law, 10 NYCRR Part 63 and the provisions of section 653.19 of this part.
9. A written individualized education program or individualized plan of service which has as its goal the maximumization of your individual abilities to cope with your environment, factors social competency, includes meaningful recreation and community programs and contact with non-disabled persons as well as the opportunity to live as independently as possible.
   a. The opportunity to participate in the development and modification of an individualized education program or individualized service plan, unless constrained by your ability to do so.
   b. The opportunity to object to any provision within an individualized education program or individualized service plan and the

16. The receipt of information on or prior to admission regarding the supplies and services that Anderson School will provide with timely notification of any additional changes or charges.
17. The use of your personal money and property with assistance from staff as needed, as well as routine information of balances and overall financial status.
18. A balanced and nutritious diet served at appropriate times and in as normal a manner as possible, and which is not altered or totally denied for behavior management or disciplinary purposes.
19. The opportunity to be involved in the selection of individually owned, well-maintained clothing which appeals to you, fits properly and is appropriate for your age as well as the season and activity.
20. Adequate individually owned basic grooming and personal hygiene supplies.
21. Privacy in sleeping, bathing and toileting to the extent possible.
22. A reasonable amount of safe, individual and accessible storage space for clothing and other personal belongings.
23. The opportunity to request a change of room or residence, and involvement in the decisions regarding such changes.
24. The opportunity, either personally or through parent(s), guardian(s) or correspondent to express grievances, concerns and suggestions to Anderson School executive and administrative personnel, the Commissioner of MHHHS or the Commissioner of Quality Care for the Mentally Disabled without fear of reprisal.
25. The opportunity to receive visitors at reasonable times in privacy, provided such visits do not infringe upon the rights of others as well as the opportunity to communicate freely with persons within or outside Anderson School.
26. The opportunity to make or have made on your behalf an informed decision regarding cardiopulmonary resuscitation, in accordance with the provisions of Article 29-B of the Public Health Law, and any other regulation.
27. The opportunity to create a health care proxy in accordance with 14 NYCRR 633.05.

The Anderson School list of “Individual Rights” provided to Michael and Lisa Carey upon Jonathan’s acceptance into the program.

An Individualized Educational Plan (IEP) for the student is established by the Anderson School in conjunction with each resident’s school district to address his needs - communication, social interaction, organization and independent life skills - and guide his daily activities. Quarterly IEP meetings are held, attended by numerous Anderson School representatives and sometimes the family, and reports of the student’s progress in each related service (speech, music, physical and occupational therapy) are generated.
Once admitted, children are assigned to residences, based on age and level of functioning. The residential component of the Anderson School is supervised by a Director of Children’s Residential Services, who oversees daily operations and coordinators of the residences. Birch Cottage, where Jonathan resided, was supervised by a residence manager who oversaw the residential care staff and residents and acted as the primary liaison with parents, nursing staff, and the school. The cottage utilized the services of approximately 22 Anderson School employees, direct care aides and others, to meet the daily needs of the children.

The residence component seeks to strengthen skills such as personal care, communication, social interaction, recreation and community integration. Residents participate in community activities such as visits to parks and festivals. They also join in cottage activities, such as arts and crafts and games.

Students attend classes at the Anderson School’s private school, which is located on the grounds. Teachers’ assistants escort students to and from the residence and support teachers in their lessons and activities. Elementary-age classes address school readiness behaviors (sitting, listening to a speaker, taking turns, etc.), academic functioning and social skills development. Behavior specialists and speech and occupational therapists provide assistance in implementing and developing these skills.

In response to maladaptive and defiant behaviors by residents, the Anderson School may employ a Behavior Support Plan, which attempts to address and manage
these behaviors; to foster more positive, appropriate, and pro-social behavior; and to ensure the safety of the residents and their peers. The development of a Behavior Support Plan commences with the identification by staff of maladaptive behaviors to be targeted and the recording of the frequency and intensity of the behaviors, which are documented in a Behavioral Report Form.

A clinician identifies a pattern of behavior from the review of these Behavioral Report Forms, and with team input, decides if a behavior plan is required or a current plan needs to be modified. A Functional Behavior Assessment is then conducted to identify contributing factors and formulate a hypothesis about the conditions under which the behavior occurs and the consequences that maintain it.

After evaluating the behavior, a treatment team creates a plan. Team members could include a behavioral specialist, a case manager, and the directors of clinical services, education, children’s residential services, and health services. This team meets to review assessments and to determine if the individual’s behavior plan needs to be modified. Behavior support management techniques can range from verbal persuasion to physical interventions. Policies dictate that the techniques employ the least restrictive alternatives possible to ensure the safety of all parties. The facility’s clinician also is responsible for providing in-service training to all staff involved so that the plan will be consistently implemented. The overall implementation of the behavior plan is the responsibility of the Director of Clinical Services.

On an as-needed basis, supplemental forms are used to capture important clinical information such as a child’s urinary output, caloric intake, and refusal to dress, which was done in Jonathan’s case. Anderson School Weekly Body Check Forms document a
resident’s physical condition, including the description of any marks, bruises, bites and a body diagram to mark locations of injuries. Medical reviews, such as the ones conducted monthly in Jonathan’s case, may include input from the facility psychiatrist, clinician, nurse, and sometimes the teacher and/or residence manager. Medical staff keep track of issues in on-going medical progress notes, which include outside medical appointments (dental and vision), weekly medication reviews, on-site clinic visits, an annual physical exam, contacts with family members, and noted behavioral issues. Additionally, any contacts with a family member or external agency to discuss clinical issues are documented on a Clinical Team Contact Form.

Records related to medical and psychological consults, including Professional Service Sheet Referral Reports, document the specifics of the consultation and the recommendation for treatment. Also, psychiatric assessment/plan forms are used to reflect psychiatric referrals, medications, observations, and strategies.
IV. Jonathan Carey’s Residency at the Anderson School

In order to fully assess the state agencies’ responses to the allegations of abuse, it is necessary to understand what happened to Jonathan Carey while at the Anderson School.

PRE-ENROLLMENT

Jonathan Carey was born September 12, 1993, at the Albany Medical Center in Albany, New York. According to Jonathan’s parents, Michael and Lisa Carey, at 15 to 16 months of age, he began to display a consistent pattern of hyperactivity and occasional aggression. At 19 months, he was diagnosed as mentally retarded. At age six, he also was diagnosed as autistic. The Careys consulted with doctors and tried numerous medications to combat his behaviors. A host of clinicians, including those at the Anderson School, diagnosed Jonathan as mentally retarded and having pervasive developmental disorder, an umbrella category of neurological disorders including autism. Children with pervasive developmental disorder display deficits in social interaction, difficulty with verbal and nonverbal communication, and repetitive, compulsive behaviors.

According to his family, Jonathan was largely non-verbal, except for a few words such as “daddy,” and “nanny” (a horse). His repetitive behaviors included flipping book pages without looking at the pictures and multiple cycles of crouching, touching the ground and standing up. Jonathan craved comforting routines and behaviors, such as watching videos or playing with toy cars. He was fond of horses.
He could also become physically aggressive. He would pinch, grab or have a temper tantrum. Jonathan would also throw himself down, which his Anderson School caregivers called “flopping.” After dropping to the floor, he would refuse to get up and become aggressive to those who tried to move him.

By 20 months, Jonathan was seeing four therapists twice weekly in the Carey home for speech, special education, and physical and occupational therapy through an early intervention program.

Jonathan attended pre-schools with special education programs and, in 1998, entered a day program at the Wildwood School in Guilderland. While there, he was assigned a one-to-one aide to assist in the classroom. Staff rotated out frequently due to the intensity of the work, according to his Medicaid Service Coordinator, who was assigned to the family in 2000 through OMRDD’s Capital District regional office. By 2002, the Wildwood School discussed plans for physical intervention and the use of a “safe room” because Jonathan was exhibiting “hurting behaviors” such as “biting, pinching, [and] hair pulling.”

Like some other parents of autistic children, Lisa Carey had read about a possible link between autism and casein, a protein found in dairy products. Throughout this time, Jonathan was placed on a casein-free diet. Proponents say that many autistic children have trouble digesting milk protein and may have higher levels of protein by-products in their blood, which may affect their behavior. Lisa Carey’s pediatrician approved the diet, although he reported that there was no medical data to suggest that Jonathan was casein-intolerant.
Jonathan’s parents reported that as Jonathan grew older and larger, managing him at home became increasingly difficult. Jonathan wore diapers or “pull-ups” on a full-time basis and did not seem to understand the purpose of the toilet. Their efforts to toilet train Jonathan failed and they were concerned about caring for him as he continued to grow. Although it was difficult for the Careys to place their son two hours from their home, Lisa Carey explained, “Before too long, he was going to be really difficult to change physically, and it was getting hard at age nine to change his diapers and things.”

It was also hard to keep residential habilitation for various reasons, including the fact that Jonathan “was very difficult to care for,” the Careys’ Medicaid Service Coordinator stated. She added:

It was really hard. For Lisa especially. I remember one time her calling me hysterical, ‘He’s all over the place. I don’t know what to do. I’ve had it.’ You know, her nerves were fried.

In December 2002, Lisa Carey reported that “Jon has become very aggressive,” that “at this point the behaviors are unmanageable,” according to meeting records from the Bethlehem Central School District’s CSE. She also asked that her son move to a residential program at the Anderson School “immediately.”

The Careys had heard that the Anderson School was successful in toilet training. They toured the school in the fall of 2002. They learned that the school’s toilet-training method was to cease the use of diapers or pull-ups and place the students in underwear, with frequent trips to the bathroom.
RESIDENCY AT THE ANDERSON SCHOOL

In January 2003, at age nine, Jonathan was admitted to the Anderson School. His initial psychiatric evaluation encouraged family contact. Additionally, his medications were reassessed. An education interview review sheet noted that, at his parents’ request, Jonathan was to follow a dairy-free and casein-free diet.

Like other staffers, the former Anderson School Behavior Specialist who was assigned to Jonathan described him as a sociable child. She told the Inspector General that when she first met Jonathan:

He came up behind me and tapped me on the shoulder and I turned around and here’s this, you know, the cutest kid. It was these glasses that were all cockeyed and buck teeth and he was just so incredibly friendly. But he was non-verbal. And he was very, very…I don’t know that I should use the word bright, but he was a sharp little guy and he was a very social little guy. And that’s all he wanted was, you know, people’s attention. And his only way, a lot of times, of getting it was, you know, by touching people because he couldn’t talk.... That little boy was, you know, one of my favorites.

Jonathan lived in a residence called the Birch Cottage with approximately nine other children in single and double rooms. He attended classes in a separate building. His Individualized Education Plan (IEP) called for music, occupational, physical, and other therapies as well as schooling. Goals were set for each of these activities. These included such goals as, “Correctly respond to the verbal prompt of ‘Stop,’ ” “engage in a play activity with an adult for 2 minutes” and “eating using a fork or spoon [with] intermittent physical cues through an entire meal,” among others. The IEP also contained a medical report which included notes on Jonathan’s height, weight, and diagnosis. Jonathan maintained communication with his family through almost-daily telephone calls, and he participated in family outings and weekend home visits.
Initially, reports indicated that Jonathan’s placement was “extremely positive” and “an appropriate placement.” However, the reports also noted that Jonathan still exhibited maladaptive behaviors such as “flobbing,” “bolting” (running or wandering away from staff) and “aggressiveness” (hitting or biting staff and students).

On a “good day,” as described in Jonathan’s records, Jonathan would eat lunch in the cafeteria with other children, follow instructions well, play with his toy cars, but would nonetheless display maladaptive behaviors such as occasional bolting and flopping, as well as wetting himself several times. He’d watch a Barney video and talk to his parents on the phone. Behavior swings were common, and good days were often followed by “bad days,” on which Jonathan would flop repeatedly, bolt for the door, take off his clothes, bite staff and attack other children.

A Birch Cottage bedroom similar to Jonathan’s room in 2004.
Shortly after his admission, Jonathan was assigned a one-to-one aide due to his challenging behaviors and his need for assistance with many daily activities.

According to a March 11, 2003 report, Jonathan’s maladaptive behaviors were considered non-significant when compared to other emotionally disturbed children at Anderson, although his aggression and bolting were still identified as particular problems.

Six months after his admittance, in June 2003, Jonathan was observed with scratches on his face. The matter was investigated by the Anderson School, which determined that Jonathan most likely was scratched during an altercation with his roommate in the early morning hours in their shared bedroom. The school found that the staffers responsible for supervision that evening were negligent in performing their duties. As a result of the incident, the Careys advocated for Jonathan to be assigned to a single bedroom. According to the Careys, the school did not immediately act on this request. Existing records do not reveal when he moved to a private room.

On July 30, 2003, the Anderson School presented Jonathan’s parents with a notification form allowing them the option to be notified within one hour, within 24 hours, or not at all in the case of various injuries, illnesses, or physical interventions involving the child. Lisa Carey signed the form, requesting to be contacted within 24 hours if Jonathan sustained minor injuries or was subjected to physical intervention. She asked to be notified within one hour if he had significant injuries or seizures.
By December 2003, Jonathan’s bolting, flopping, and biting of staff and students was interfering with his ability to participate in the classroom, the residence, and out in the community. On December 31, 2003, the first Behavior Support Plan was implemented for Jonathan. It called for positive reinforcement of appropriate behaviors and a planned ignoring of inappropriate behaviors. Positive reinforcement could include
a snack such as cereal or verbal praise. The former Director of Clinical Services, who supervised the implementation of Jonathan’s behavior plan at the time, wrote that “planned ignoring” is defined as a “non-exclusionary time out where social reinforcers [attention by others, verbal interaction] are removed…contingent upon the occurrence of an inappropriate behavior.”

Despite the fact that Jonathan’s daily behavior was disruptive, gains were still found in certain areas. Anderson School and his school district’s CSE records noted that Jonathan showed improvement throughout 2003 and into early 2004, and it appeared as though his residential placement was meeting many of his needs.

Michael and Lisa Carey agreed that during this period Jonathan showed signs of improvement in toilet training at the Anderson School. The Careys indicated that Jonathan was successfully using the toilet about 50 percent of the time and they were pleased with this progress.

However, by the summer of 2004, Jonathan’s behavioral problems and non-compliance escalated. Anderson School staff could not determine why. An April-to-June 2004 quarterly progress report noted that Jonathan was disrobing more frequently. Jonathan’s removal of shirts, pants, shoes and socks presented a significant challenge to staff, as they did not want Jonathan to perform daily activities in various states of undress, especially in front of other students. Staff interviewed by the Inspector General cited “health” and “safety” concerns regarding Jonathan’s state of undress, especially during mealtimes, particularly since he was urinating and defecating, sometimes in public areas. Jonathan’s personal communication logbook, a journal of activities and behaviors that accompanies each resident throughout the day and is used to enhance
communications between the residential and school staff, noted the increased incidence of Jonathan’s aggressive behaviors. Many of the behaviors required the staff to physically hold, restrain, or escort Jonathan in an effort to prevent him from harming himself or others.

Jonathan’s behaviors of flopping, attacking staff and students, removing clothes, and throwing things increased even more in September 2004. According to the Residence Manager, who oversees residence care staff, “He started spiraling out of control and they were frantically trying to come up with appropriate behavior plans and changing meds.”

On September 11, 2004, the Careys visited Jonathan to celebrate his 11th birthday, which fell on the following day. His log entry states:

Jonathan had a good morning he was playing with cars, and also…walking. Their parents came at 11:30 a.m. When he saw them he was very happy. They came for …Festival. He had fun time there. He ate breakfast and lunch well…Jonathan had a great afternoon. He enjoyed all the parents visiting, the festival, his birthday party, etc. He seemed very happy and peaceful.

Two days later, on September 13, he had a very rough day, staff wrote. “Not very many toileting issues but he ‘flopped’ for about 85% of the day. He was very aggressive toward students and female staff in the classroom…He had to be restrained after attacking some students & staff.”

The Careys, too, observed Jonathan’s increased maladaptive behaviors. “I could hardly even manage him,” Michael Carey told the Inspector General’s office, describing a late September home visit. Lisa Carey added, “Yeah, it was like a nightmare all
weekend, his behavior was so bad, so it wasn't just the school… This carried right over to home -- the change -- there is no doubt in our mind.”

Entries in Jonathan’s personal communication logbook around this time revealed the confusion that staff had over his casein-free diet. One employee wrote that Jonathan received milk for lunch and reminded staff to follow his casein-free diet. Another staffer responded that Jonathan was drinking lactose-free milk. However, Jonathan should have been given soy milk, not lactose-free milk, which contains casein.

On September 23, 2004, Anderson School staff launched a new Behavior Support Plan. This plan reiterated the use of planned ignore and directed staff to ignore all of Jonathan’s bad behaviors, while attempting to redirect his focus to the task or activity at hand. It also authorized staff to remove Jonathan from the classroom to a vacant room when he disturbed other children in school. If he displayed maladaptive behaviors in the residence, staff members were instructed to escort Jonathan to his bedroom. When Jonathan was in his bedroom, the plan directed staff to remove all of his “reinforcers,” such as toys, books, and cars.

Four days later, on September 27, 2004, nine clinical staffers at the Anderson School held a Team Problem Solving Meeting to discuss Jonathan’s extreme difficulties. At the meeting, staffers noted that Jonathan’s behaviors were preventing him from doing any work at school, where he was “targeting other students in the classroom” and were causing problems in the residence and during home visits. The staff attributed some of Jonathan’s negative behaviors to attention-seeking and defiance. That afternoon, for example, Jonathan required a two-person escort from the school to the residence, where
he stripped off all his clothes and repeatedly lunged for an exit door handle to set off the alarm, according to a logbook entry.

In response, staff developed another Behavior Support Plan. The September 27 plan, implemented immediately, added more restrictions. For the first time, Jonathan’s Behavior Support Plan included restrictions on Jonathan’s access to regular meals. The plan required Jonathan to be dressed and seated in a dining table chair before he could eat his regular meal. Staff would give one verbal prompt that it was time to eat and place his meal on the dining room table in front of him. At school, Jonathan’s classroom desk would be used for meals when he acted appropriately. If he failed to comply, Jonathan would be removed to an adjacent room to eat. Nursing staff directed that his food intake at all meals be documented. However, the new plan did not specify how staff members should react if Jonathan refused to come to the table or dress to eat. It did not state what alternative foods, if any, should be provided.

There is no evidence that the Careys were aware of this new Behavior Support Plan. Despite instructions to record Jonathan’s food intake, documentation of meals during this period was inconsistent or missing altogether. Therefore, the Inspector General could not determine what Jonathan did or did not eat during this time or what food he was provided.

However, some documents indicated that Jonathan “refused to eat.” The notation that Jonathan “refused to eat” was interpreted by staff in two ways. One was that he physically shunned the food placed before him; the other was that Jonathan refused to comply with the directive to put his clothes on and, therefore, was not permitted to eat a regular meal with other children in the school or the residence.
Experts retained by the Inspector General’s Office were questioned on the lack of documentation by the Anderson School. In describing what should have occurred, they wrote, “Documenting an individual’s food intake should have been highly organized, systematic, and occur across multiple sources (e.g., amount of food consumed, weight) in order to reliably assess and evaluate the potential of any negative side effects.”

At this point, Jonathan began to spend long durations of time in his bedroom or a vacant room at the school, according to his logbook. On September 29, 2004, for example, the logbook noted that he “spent from 11 am until the end of the day in quiet room.” On October 5, 2004, a staff member noted that Jonathan “refused to work, eat, play all day all due to the fact that he would not put on any of his clothes.” Records show that Jonathan “refused to eat” or dress frequently throughout this period.

Jonathan’s behavior continued to deteriorate. According to a Behavioral Report Form dated October 8, 2004, Anderson School staff described Jonathan’s behavior as occurring with “an intensity that this staff has never seen and with no regard for his own safety.” The note stated that Jonathan “cried,” “flopped on the floor,” “urinated in his clothing,” “refused to change [his clothing] for long periods of time,” attempted to run out the back door constantly, threw his belongings and displayed extreme aggressiveness towards others. The entry captured how difficult the day was. “It was a very distressing day for this staff member who has worked with Jonathan since he first arrived at Anderson,” the employee wrote. While Jonathan routinely had to be restrained, on this day staff had to restrain him four times. Clinical records and interviews indicated that Jonathan had practically nothing to eat all day.
On the morning of October 9, the Director of Clinical Services arrived to find Jonathan in his bedroom. According to medical records and interviews, Jonathan was naked and covered with bruises. The Residence Manager and a nurse were already in the bedroom assessing Jonathan’s condition. The Director of Clinical Services wrote in her statement that “Planned Ignoring procedures outlined in his [Behavior Support Plan] were not being followed,” apparently because staff were present in Jonathan’s room with him.

Records and interviews with staff at the Anderson School revealed that Jonathan sustained bruising throughout this crisis period. The bruising that was observed on October 9 was documented in an Anderson School Student Injury/Illness Report, as displayed below. The nurse who filled out the form also noted that Jonathan’s lips were becoming dry and instructed staff to offer him juice and ice pops.

Staff at the Anderson School decided that something had to be done to address Jonathan’s behaviors and to ensure that he received nourishment. The Executive Director held a meeting that day with the Director of Clinical Services, the Residence Manager, and a registered nurse.

A medical note, written by a nurse on October 9, 2004, noted, “It is becoming more frequent that he will not [get dressed to eat] and longer periods of time are occurring without nourishment.” This nurse reported to the Inspector General’s Office: “When I saw him on Saturday [October 9] and found out he had not eaten in a day; that seemed to be beyond a behavior plan.” She contacted the Director of Clinical Services and told her that the behavior plan was not working and needed to be changed.
The October 9, 2004, Anderson School Student Injury/Illness Report, completed by a nurse, documenting Jonathan’s bruising. (Note – “SIB” stands for Self Injurious Behavior)

Also on October 9, Anderson School officials made two telephone calls to Michael Carey to advise him of the new situation. Medical notes and interviews of Anderson School staff reflected that Michael Carey was informed about the seriousness
of Jonathan’s condition and that Michael Carey acknowledged that Jonathan’s bruising was a result of physical interventions. Contemporaneous Anderson School Medical Progress Notes read, “[Michael Carey] understands that bruises are self-caused & that staff is doing their best to protect Jon from the acts which caused this bruising.”

Anderson School administrators stated that they recommended to Michael Carey that Jonathan be seen at a hospital because of his behaviors and bruising. They claimed that Michael Carey denied their request to send Jonathan to the hospital. Michael Carey disputes this claim. Contemporaneous Medical Progress Notes read, “[Hospital] Admission was discussed but the feeling was this would not be needed at this time.”

Medical notes also indicated that Mr. Carey was made aware that Jonathan was going to be given substitute foods in his room, as he had not eaten the previous day. The nurse wrote that Michael Carey was pleased that there was a plan “to continue nourishment while Jon remains in his room and understands that full meals cannot be brought to room which might encourage this behavior.” The Executive Director also recalled telling Michael Carey about the food issue and that he had been told by staff that Jonathan was eating nutritional substitute foods. According to the Executive Director, Michael Carey purportedly responded, “What would you do if you feed him the standard meal that everyone else is having in the house? You would be rewarding bad behavior.”

Michael and Lisa Carey contend that October 9, 2004, was the first time they were informed in any detail about the extent of the crisis situation involving their son, and that they previously were not informed of the changes to Jonathan’s meal or behavior plan, his removal of clothing, or the source of the bruising. The Careys claimed that they received a call on this date from the Executive Director who said that Jonathan “was
really losing it, going bananas basically, and that they did not know what to do.” Lisa Carey told the Inspector General, “They were not telling us the fullness of what was going on and how bad things had gotten down there until October 9th.” According to Michael Carey, Anderson School administrators told him that they would have Jonathan examined by a doctor on October 9, 2004, and determine if a hospital visit was necessary.

Consistent with Michael Carey’s account, the medical note written on that date indicated the Anderson School nurse examined Jonathan and found him to be physically fine, although she noted that he was “somewhat thinner.” The nurse contacted a doctor from a local medical clinic, who reported that no hospitalization was needed from a physical standpoint unless the bruises were being caused by an unknown problem or if Jonathan was dehydrated, both of which the nurse determined were not the case.

The note mentioned that Jonathan would be seen by a physician and would also get a psychiatric evaluation. It also was documented that Michael Carey planned to visit his son the next day.

Once Anderson School executives formalized a plan to offer substitute foods to Jonathan in his bedroom, the nurse filled out a Medication Change/Medical Treatment Notification form which outlined when and what alternative foods would be offered. The form stated, “While awake: if meal refused offer soy milk or juice or ice pops or yogurt every hour. If refused, offer again in one half hour.” The note directed staff to document Jonathan’s food intake. The nurse explained that she wanted to ensure that Jonathan was getting nourishment, especially since he had virtually nothing to eat on October 8.

The plan didn’t specify the quantities of food to be offered or how staff should document the information. One staff recalled jotting down Jonathan’s food intake on a
Two staffers who worked directly with Jonathan told the Inspector General’s Office that they never documented any of Jonathan’s food intake during this time. Records revealed that staff logged Jonathan’s food intake inconsistently, as illustrated below on an unlabeled document noting food consumed or refused by Jonathan between October 9 and 16.

A page from the unlabeled document delineating some of Jonathan Carey’s food intake, food “refusals,” and bedding changes in October 2004.

During this period, in addition to the substitute food items that were offered, Jonathan also ate some regular meals, according to this document. For example, the
document indicated that Jonathan ate “2 bagels with mar., 2 sausages, 1 hash brown, 1 bowl of Golden Grahams with soymilk, 8 ounces soy,” on October 11, 2004. Other notations indicated that Jonathan ate very little or refused to eat the substitutes.

In addition, the Inspector General’s office learned that Jonathan also consumed other food, known as “edible reinforcers,” which were not documented by staff throughout this period. Regarding the amount of undocumented “edible reinforcement” that Jonathan would typically consume, one direct care staffer stated:

We would have it [Corn Pops] usually in baggies, in sandwich baggies, full, and like, usually for the days that I did get him to go to the School the bag would be gone. You know, because it’s constant giving him one at a time.

Additionally, this staffer reported to the Inspector General that Jonathan, in a deviation from the Behavior Support Plan instructions, was allowed to eat some regular meals at the table when other residents were not present, even though he was not fully dressed.

A logbook entry from October 9, 2004, reads: “JC has spent his entire day in room w/no clothing on. He is refusing to use toilet.” That day, a portable toilet was placed in his bedroom to assist with toileting during the planned ignores.

The Anderson School staff gave two basic explanations why they did not bring full meals to Jonathan’s room. The Director of Children’s Residential Services reported that “full meals were not offered in Jonathan’s room due to safety and hygiene issues.” She further added, “We didn’t want to take the chance that he would be throwing his food, smearing his food, doing whatever with it and then not have a good environment.”
The second explanation was that allowing Jonathan to eat his regular meal in his bedroom would reinforce his behavior of staying naked in his bedroom when the goal was for him to come out and eat with the other residents. “If meals were brought to him in that state [naked], he would never get dressed,” a nurse stated. The second explanation appears more plausible because they were allowing him to eat meal substitutes, such as soy yogurt, in his bedroom.

On October 10, 2004, Michael Carey visited his son. He stated that he found Jonathan covered with bruises, lying on his bed atop a sheet that was “soaked” in his own urine. He added that there was a staff member posted “like a guard” outside his son’s room with the door ajar a few inches. He indicated that he helped clean and dress his son and they went to a McDonald’s restaurant, where his son ate an extremely large meal. “I don’t think I ever saw him eat that much. He just wanted to eat and eat and eat, still not registering to me just, just you know, and I didn’t know what to make of the whole thing.”

An October 11 Behavioral Report Form revealed that Jonathan’s behavior was fluctuating. It noted that “the dynamics and intensity…was much different than on Friday [October 8]. He was laughing a lot and trying to get staff’s attention more.” Jonathan’s logbook stated that Jonathan ate breakfast and lunch and seemed very happy during the first shift. Later that day, however, reports showed that Jonathan flopped on the floor, urinated in his pants, threw his shoes and was aggressive.

In response, the Anderson School obtained an emergency psychiatric medication review and Jonathan’s medication was boosted to address his behaviors. Lisa Carey was
notified and she consented to the medication increase the next day, according to clinical
contact records.

On October 12, 2004, Jonathan’s logbook and behavioral reports showed that
Jonathan was “relatively cheerful” but was without his pants while in his room. Jonathan
refused all prompts to get dressed for snacks, dinner, or walks. Staff noted new bruises
on Jonathan’s back and under his chin. The nurse and pediatrician examined him. The
pediatrician wrote that Jonathan had been in behavioral crisis, with some improvement
after Michael Carey’s visit two days earlier. He was eating and drinking better,
according to progress notes. The pediatrician also documented that Jonathan had
multiple bruises due to self-injurious behavior and recommended that Jonathan be
weighed weekly and that Jonathan’s intake and output be recorded.

On October 13, 2004, Jonathan refused to use the toilet or leave his bedroom
almost the entire day, even needing to be carried out for a fire drill in the morning hours,
according to his personal communication logbook and the Birch Residence log, which is
maintained in the residence and is used to document daily and significant events there.

In response, a Treatment Team Problem Solving Meeting was held that day with
12 Anderson School administrators and clinical staff. It was noted that Jonathan had
many marks on his body from “escorting him immediately after flopping, attempting to
run out of the house and throwing himself into the railings on the front porch at the
residence.”

Concerns were raised about Jonathan’s intense behaviors and discussions ensued
regarding appropriate services, including questioning whether the Anderson School was
the suitable placement for Jonathan. Jonathan’s Behavior Specialist told the Inspector General that she was:

Very concerned overall with what was going on….It got to the point where it just wasn’t working and we didn’t have the tools to provide for him. And I think what happened was it just, it went too far. And there was just no going back.

According to the minutes from the October 13 meeting, “At this time, Jonathan’s behaviors are surpassing our ability to ‘bring him back’ to his usual self. In the past he has responded to favorite staff and his [sic] is not doing that right now and reinforcers are not motivating for him.” It was suggested by Anderson School Treatment Team members that Jonathan may be receiving some positive reinforcement in his bedroom or from looking out the window. The minutes noted that, “Jonathan needs a plan of Planned Ignore. At Anderson School, the facilities are not set-up for this type of plan.”

Following this October 13 meeting, Jonathan’s Behavior Support Plan was again altered and immediately implemented. This new plan called for Anderson School staff to:

- Add “frosted adhesive” paper to Jonathan’s bedroom windows to “eliminate the reinforcer of looking out the window.”
- “Truly ignore” Jonathan in his room.
- “Change Jonathan’s sheets once in the a.m. when he gets up (if bed is wet). If wets again take sheets off and don’t put clean ones on until he leaves for school. If he doesn’t go to school leave bed unmade (until bedtime).”
- Remove all books, “horse pillows,” or anything else that “he would find reinforcing in his room when he is non compliant.”
- Require that Jonathan “not go to school” and “remain in residence” if he does not follow verbal prompts to get dressed.
The Anderson School Executive Director told the Inspector General that the October 13 document was neither a protocol nor a Behavior Support Plan but rather a reflection of some general thoughts and concepts on Jonathan’s treatment. However, other staff referred to the document as a “protocol” and as a “behavior plan.” An attached Post-it note written by Jonathan’s Residence Manager states, “This was written by me…to serve as plan until [another staff member] formally write [sic] it up.” The Residence Manager stated to the Inspector General that the document was indeed a protocol and was handwritten because it needed to be implemented immediately.

After the October 13 changes, staff members who worked with Jonathan provided inconsistent reports about the conditions that Jonathan was subjected to in his room. Several indicated that they did not see Jonathan lying in urine and that he would be changed into new clothes if he did urinate. However, the Residential Coordinator reported that she had observed Jonathan lying on his bed, in urine, without a sheet. A direct care staff member also stated he observed Jonathan on one occasion lying on his bed after Jonathan had urinated on it. Another staff member stated, “I know that there was a point that came, a point in time where I came, where the bed was not to be made if he urinated on it.”
The October 13, 2004, handwritten protocol that staff members were directed to follow for Jonathan Carey, which reads, “Do not deviate from this plan.” Staff members’ names have been redacted.

Throughout this period, Anderson School staffers were instructed to remain outside Jonathan’s door and “ignore.” However, there is no evidence that Jonathan’s door was ever fully closed or locked. “I was told to hold the door, leaving a space, but not let Jonathan out,” a direct care staff member stated. The Residence Manager noted, “[Jonathan] became aggressive and fought to get out. It was very hard to hold door closed to about 3 inches. He tried squeezing out several times.” The Director of Clinical Services reported that staff members were to block the door if Jonathan was agitated or...
naked to prevent him from leaving the room. This, the Director of Children’s Residential Services told investigators, was for privacy issues and the rights of other residents.

Not all staff members were comfortable with this plan. One described the approach with Jonathan as “putting him in a dark hole, giving him nothing.” Other staff reported that Jonathan was occasionally let out of his room when he was not fully dressed, and that he sporadically ate meals at the dining room table when other residents were at school, and was let out to shower.

The handwritten October 13 behavioral protocol also directed staff to keep Jonathan at the residence and not to attend school if he would not respond to their verbal prompts to dress to come to the table. Consistent with this protocol, several staff members informed investigators that Jonathan missed many days of school because of his behaviors, although the exact number is not known. The Director of Clinical Services stated that Jonathan was not allowed to be in the classroom if he would not get dressed or allow staff to assist him in dressing.

At an October 14, 2004, Bethlehem Central School District Committee on Special Education (CSE) meeting, it was suggested that the Anderson School have Jonathan taken to an emergency room for a physiological exam and “baseline information.” Weeks later, the CSE sent a letter to the Anderson School criticizing it for not having Jonathan examined by a doctor as early as October 9 and for failing to communicate to the CSE and the Careys the radical changes in Jonathan’s condition and his behavior plan. Records show that the Anderson School pediatrician had examined Jonathan on October 12.
During the October 14 CSE meeting, Anderson School staff expressed concern about Jonathan’s deterioration, according to the school’s Executive Director. The Anderson School Individualized Education Plan (IEP) coordinator claimed that he advised the CSE that “Jonathan had reached a point of being in crisis.” The school’s Executive Director indicated to CSE participants that a new program, including a medication regimen, would need to be consistently implemented by all parties, including Jonathan’s family, to treat him.

Anderson School officials and staff had concerns that the Careys were not providing consistency for Jonathan and had refused to consent to medication recommendations by the psychiatrist. Staff also complained that Jonathan’s program wasn’t followed during parental visits. For example, although Jonathan was supposed to be toilet training, one document noted, “Recently, parents came to pick him up and immediately put a pull-up (diaper) on him.”

At the October 14 meeting, CSE members told the Anderson School that the committee wanted a copy of any behavior plan before it was implemented, according to the Anderson School IEP Coordinator. A follow-up meeting was scheduled for October 21 to discuss the final plan.

After the October 14 CSE meeting, the Anderson School took Jonathan to a local medical clinic. A medical note reflected that Jonathan was found to be fine except for an excoriation over his left ear, which was to be treated with an antibiotic. Lab results from blood work taken during the examination came back as normal. The medical examination report made no comment about the presence of extensive bruising that had been observed by both Michael Carey and Anderson School staff.
Anderson School Weekly Body Check Forms dated October 14 and 15 noted the existence of “old” bruise marks. On October 14, the Anderson School implemented a new form entitled “Jonathan Carey Refusal to Dress Tracking.” It listed the times that Jonathan refused to put on clothes or remain clothed, from October 14 to 22.

October 15 was another difficult day for Jonathan, according to his logbook, clinical records, and e-mail correspondence. Although he ate a full breakfast, his behavioral issues increased later in the day, requiring physical escorts. He refused to eat lunch, dinner, or any substitutes and he would not dress. The log stated that he “spent the rest of the day in the quiet room.” A second shift entry on October 15 noted, “He spent all day curled up on his bed.”

On Saturday, October 16, 2004, Michael and Lisa Carey visited Jonathan. According to the Careys, Jonathan was gaunt, naked, and bruised atop urine-soaked sheets on his bed, monitored by an aide who sat outside his door, which was slightly ajar. Lisa Carey stated, “Jonathan was laying there totally naked on his bed, and he looked up and he looked very dazed, very shell-shocked look, and he did finally recognize that it was us.” Lisa Carey added that Jonathan was in a “round pool of urine and he was laying directly in it.”

“We noticed Jonathan’s face starting to sink in…we started noticing ribs showing more and his arms thinner,” Michael Carey stated. He also recalled seeing the windows covered with paper. Lisa Carey confirmed her husband’s description and added, “When we walked in, I noticed right away all of his pictures were removed, all of his toys, all of his books, the entire room had been stripped bare…and all of his bedding was stacked up on an open shelf; none of it was on his bed except the fitted sheet once again.” Lisa
Carey added that this was “on a totally different scale” from what she thought a planned ignore entailed, which was the mere disregarding of an attention-seeking behavior in the hope that it would pass.

The Careys told the Inspector General’s office that they dressed Jonathan and brought him to a McDonald’s restaurant for lunch. According to Lisa Carey, they discussed their options as to what to do with Jonathan, given what they had observed. An Anderson School e-mail noted that Lisa Carey reported to the school that Jonathan ate “2 hamburgers, fries, soda, ½ a donut, Fritos, and 2 meatballs from Dad’s sandwich.”

According to this e-mail and the October 16 entry in Jonathan’s logbook, Jonathan refused to get dressed for breakfast before his parents arrived and refused to sit at the dinner table after he returned from their outing.

Staff had discussed, in problem solving meetings, their concerns that the Careys interfered with programming during visits and that their nightly phone calls could “trigger” some of Jonathan’s behaviors.

The next day, October 17, 2004, Jonathan stayed in his bedroom all day, except for a brief moment when he came out, took two bites of a peanut butter and jelly sandwich and flopped to the floor, Anderson School records state. He refused all other regular meals. That same day, Anderson School administrators discussed having a dietician consult on Jonathan’s meal program. An e-mail from the Anderson School Director of Children’s Residential Services to Jonathan’s Residence Manager on October 17 stated:

Have we been weighing Jon regularly to monitor any weight loss? If not, I think we should, maybe every other day or so as long as this cycle
continues. Does he take a multivitamin at all? That might help nutritionally. [Name] is our consulting dietician; has she been brought in on this at all? If not, now is the time, and Mrs. Carey needs to know that we will be asking [the dietician] to do a nutritional assessment of Jon’s status this Thursday [October 21, 2004] when she is here....She would be the expert on what to offer Jon in addition to the soy milk as well as have recommendations on any multivitamins.... [The dietician] needs to be advised of this situation and involved in it to help all members of the team ensure Jon remains healthy. P.S. [Staff Name]: What is your assessment of his weight loss/appearance?

The Careys spent October 17 mulling their options for Jonathan. “I just remember my husband and I at length discussing what to do next, having a lot of conversation about going into the school the following day and who to confront and what to do,” Lisa Carey said.

On October 18, 2004, Michael and Lisa Carey visited the Anderson School to confront Jonathan’s treatment team about their concerns and to take Jonathan to a dentist appointment. They spoke with several treatment team members, but claimed they were told they would not be allowed to attend an upcoming team meeting to discuss Jonathan’s crisis. Their interactions were documented on an Anderson School Clinical Team Contact log, which indicated that Lisa Carey voiced concerns about Jonathan only eating soy milk and yogurt: “[Lisa Carey] stated that she wants him to eat solid food regardless of what he is wearing and where he is. She also indicated that she was concerned about family visitation being restricted in the new plan.”

Lisa Carey reported that she had heard that the Anderson School was considering restricting their visitation rights for a period of time. “There is no way we would ever consent to not be able to visit Jonathan,” she stated to the Inspector General.

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When the Careys took Jonathan to the dentist, they claimed that they discovered Jonathan’s personal communication logbook in his clothing bag. The next day, they provided the logbook to their attorney.

Following team meetings on October 19 and October 20, the school launched yet another Behavior Support Plan for Jonathan, dated October 20, 2004. It was not finalized, according to Anderson School staff, but it had been forwarded to the Bethlehem School District and Jonathan’s parents in preparation for the October 21 CSE meeting. It contained many techniques already in place such as planned ignore, removal of all reinforcers inside Jonathan’s bedroom, and mealtime protocols including the offer of nutritional supplements when he “refused” meals. The plan further directed staff to hold the doorknob to Jonathan’s room when he was in the room to prevent him from pulling or shaking the door handle.

The proposed plan also added a new factor: the suspension of home visits or visits from the family for four weeks to allow for “intense programming” with Jonathan. Communication between Jonathan and his parents would be limited to telephone calls from Jonathan to his parents twice a week.

Although Anderson School administrators claimed the October 20 Behavior Support Plan had not been finalized, many of the instructions delineated in the plan were already being implemented by Anderson School staff. For example, the Careys reported to the Inspector General that they made multiple telephone calls to the Anderson School and were told by staff who answered the phone that they had been instructed not to speak to them when they called the facility. One staffer informed investigators that the Residence Manager had instructed her not to answer the phone. The Anderson School
Executive Director stated that around this time they had established a single point-of-contact, the Director of Children’s Residential Services, and that staff had been instructed that communication with the Careys should go through her.

An October 22, 2004, e-mail from the Residence Manager to the Director of Children’s Residential Services confirmed that the staff were “trained on the plan at 5:30 [October 21]” dealing with communication restrictions regarding the Careys. The same e-mail quoted Michael Carey as saying that, “Anderson School better think about what they are doing because [the Careys] haven’t agreed to the plan and they won’t go along with the phone call issue.”

On October 21, the Anderson School consulted a dietician for the first time since the September 27 change in Jonathan’s meal protocol. The experts retained by the Inspector General’s Office wrote that “when a meal contingency program is implemented, a nutritional consultant should have been a part of the planning prior to implementation of the intervention and should have been a member of the team monitoring and evaluating the intervention” (emphasis original). In Jonathan’s case, however, it was not until 25 days after his meal protocol was modified that the Anderson School first conferred with a dietician.

The dietician found Jonathan’s lab work to be within normal limits, although she noted that he was borderline underweight at 68 pounds and 56 inches tall. She implemented a formal meal plan that included substitute food items and a new nutritional supplement – Polycose added to four ounces of juice – to meet nutritional needs. She recommended an 1800-calorie diet, consisting of at least 600 calories per meal.
As for Jonathan, he had a good evening on October 21. He dressed completely for dinner, sat at the table and ate “two helpings of fried chicken, corn on the cob and potatoe [sic], he had salad and Jell-O as well.” He also engaged in constructive activities. This progress was communicated to Michael Carey by the Residence Manager that evening. The Residence Manager noted in an internal e-mail that she was making an exception to the new directive of restricted communication with the Careys.

Overall, however, Jonathan’s Behavior Specialist told the Inspector General’s office that she believed that Jonathan, near the end of his stay at Anderson School, “looked sad” and “like he had given up.” She said:

He was thin and he just was not, you know, that same boy. He wasn’t that happy-go-lucky, bouncing-off-the-wall boy, you know, who he was when he first came in….That boy was long gone….To say that he was abused at Anderson, I don’t know that I’d say that. Because it’s a matter of …the staff did not have the wherewithal or the tools to be able to work with him toward the end.

When the Careys learned that their visitation rights were to be suspended, they objected. Lisa Carey told the Inspector General, they decided, “We’re going to send a school bus down…[on] Friday [October 22], picking him up, and he’s never going back there again. Our decision was firm at that point.”

On October 22, prior to Jonathan’s departure from the school, Michael Carey called Jonathan’s OMRDD Medicaid Service Coordinator. According to the coordinator, he informed her of the alleged abuse, including, “food being withheld, only providing him with milk or yogurt as a substitute to his meals, spending time in his bedroom naked and soiled” and their decision to withdraw Jonathan from the school. As required by
OMRDD regulations, OMRDD called the State Central Register to report the alleged abuse of Jonathan Carey. However, the State Central Register did not accept the complaint. On the same day, the Medicaid Service Coordinator called and informed the Anderson School’s Director of Children’s Residential Services of the Careys’ allegations that Jonathan, during his residence at the school, “was consistently naked, not fed and not permitted to speak with his parents.” Additionally, the Medicaid Service Coordinator reported the allegations to her supervisors.

Upon learning of the allegations, an Anderson School nurse conducted a physical examination of Jonathan and completed a Student Injury/Illness Report in which she documented “small scratches on both sides of nose,” but no other injuries. After the examination, Jonathan departed for home. As required, the school’s Director of Children’s Residential Services completed an Allegation of Abuse Reporting Form and brought the allegations to the attention of the school’s Incident Review Manager. Anderson School administrators made a required report of the allegations to its designated OMRDD regional office, in this case the Taconic regional office.

On Friday, October 22, 2004, Michael and Lisa Carey withdrew Jonathan from the Anderson School, citing abuse and neglect. “The bus came home, brought Jonathan home, he was dressed in a one-piece outfit zipped up the back, and high-top sneakers…and we began caring for him at home and he never went back,” Lisa Carey recalled.

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23 The State Central Register has the discretion to accept or reject allegations of abuse based on whether the facts presented to them could reasonably constitute a report of child abuse or maltreatment (Social Services Law § 422 [2][a]).
The next day, October 23, the Careys brought Jonathan to a hospital emergency room to assess his condition related to what they contend was significant bruising and withholding of food. Emergency room records indicated that he was examined for symptoms of: “1. Sexual abuse, 2. Dehydration, 3. Malnutrition.” Jonathan’s bruises were healing, Lisa Carey stated, but he still had an “excoriation across his toes.” Lisa also told the nurse that, “We didn’t necessarily think [the abuse] was sexual, we felt that it was more emotional and physical in the sense that they were withholding his meals and he had become emaciated due to that.” Lisa Carey claimed that the emergency room nurse asked her for contact names at Anderson School, rather than the names of the parties which she believed to be involved in the abuse. The Careys’ allegations were reported to the State Central Register, which initiated a child abuse investigation. The State Central Register Intake Report read:

Narrative – 11 yr old Jonathan is autistic and acts out by taking off his clothes. The staff at the Anderson School withhold food from Jonathan whenever he comes to the dinner table without clothes. This situation has gone on everyday for the past month and he would go without two out of his three meals a day.

Miscellaneous Information – The parents brought Jonathan to the hospital today for a physical examination because they feared he was being molested at the residence. Jonathan currently has small bruises on his back and he has increasingly become violent. He has only started stripping naked in the last few months. The parents were told by staff that Jonathan received the bruises during a restraint. The staff also told the parents originally that Jonathan was refusing his meals before they found out the School was deliberately withholding meals as a part of the treatment plan. When the parents complained, the staff started giving Jonathan soymilk and yogurt as a replacement.

24 Records show that Jonathan was removing his clothes or refusing to dress as early as May 2003, 17 months before the above intake report.
CQC investigator’s notes reflected that the examining nurse described Jonathan as appearing “thin but not malnourished.” She also told CQC that the Careys had complaints about “possible malnutrition, abuse, and neglect.” She added that Michael and Lisa Carey had informed her that Jonathan’s “demeanor has changed significantly.”

Numerous records reviewed by the Inspector General’s Office revealed that Jonathan was admitted to the Anderson School weighing 61 pounds at a height of 53 inches. During his placement there, Jonathan grew three inches to 56 inches. Records from the emergency room visit immediately following his removal from the Anderson School listed Jonathan’s weight as 70 pounds. Thus, Jonathan grew three inches and gained approximately nine pounds while at the Anderson School. According to weight charts provided by the Center for Disease Control and Prevention, Jonathan’s weight was categorized as “a healthy weight” throughout the crisis period in September and October 2004.

On October 25, 2004, at a Bethlehem School District CSE meeting, the Careys read a 16-page handwritten statement outlining their numerous complaints against the Anderson School and requesting investigations. According to the statement, the Careys alleged the following (in summary):

1. Jonathan was not provided with a casein-free diet.
2. “Food was repeatedly withheld from Jonathan daily, over a period of weeks, if he did not comply with staff directives to get dressed.”
3. Food was used as part of Jonathan’s behavior plan and as “discipline” and the Careys did not “agree with,” or “consent” to, this technique.
4. Jonathan lay “on his bed naked all day” and “was not allowed out of his room unless he would comply with the directive to get dressed.”
5. These conditions were reportedly witnessed by the Careys on three occasions (October 10, 16 and 18, 2004) when they found Jonathan
lying naked, uncovered, on his bed. On two of those occasions, October 10 and 16, the mattress was soaked with urine. The Careys believed that Jonathan had been left to lay naked for periods of 36 hours or more.

6. Jonathan’s “body was covered with extensive bruises” and the Careys were told it was due to Jonathan “trying to get out the front or back door of the cottage repeatedly.”

7. Jonathan missed between “one and two weeks of school.”

8. The Careys did not agree with, or consent to, “the school’s decision, to suspend our right as Jonathan’s family to visit him” or to “restrict our phone contact with our son, and the staff working directly with him each day, so severely.”

9. A “point-of-contact” person was implemented by the Anderson School, thereby filtering the Careys’ communication with their son.

The Careys’ lawyer sent a letter dated November 1 with a copy of the statement to the Taconic regional office. CQC also received a copy of the letter and the statement.

SUBSEQUENT RESIDENTIAL PLACEMENTS

While Jonathan’s experiences after the October 25 meeting are not the focus of this investigation, they merit mention. Records show the following:

Jonathan lived with his parents and younger brother for several months, entering the Kevin G. Langan School in Albany as a day student in early 2005. In October, his aide-to-student ratio was increased from one aide to two. Several attempts to find residential placement failed. After one interview with Jonathan, St. Colman’s in Latham stated that it could not address his aggressive behaviors and that his presence there was unsafe for children and staff.

Subsequently, Jonathan was treated by a psychiatrist during sessions spanning the period August 18, 2005 to October 23, 2006. During his treatment, the psychiatrist authored a June 22, 2006 letter to then-OMRDD Commissioner Thomas Maul in which
the psychiatrist wrote (in part), “It has been my clinical impression that Jonathan has been suffering from post-traumatic stress disorder (PTSD) as a result of child abuse. I cannot presume to know what exactly took place at the Anderson School, and Jonathan will never have the verbal abilities to tell us what happened.”

The Inspector General’s Office interviewed this psychiatrist regarding his “clinical impression” that Jonathan was suffering from PTSD. The psychiatrist reported that the behaviors and aggression displayed by Jonathan were unusual, and it was his “clinical hunch” that Jonathan may have been suffering from PTSD as a result of the treatment at the Anderson School. He said this was based on the parents’ verbal report of events, as well as the behaviors he observed and heard about from Jonathan’s parents. When asked whether he ever actually diagnosed Jonathan with PTSD, the psychiatrist replied “no.” He indicated that he “could never confirm or discount that diagnosis” of PTSD in Jonathan, mostly because Jonathan was non-verbal and because no one really knew what happened at the Anderson School. He said that he never officially diagnosed Jonathan with anything other than autism. The psychiatrist further told the Inspector General that he recognized that the language in the letter to Maul may have been too strong, stating “I would never say that under oath that he had PTSD. I can’t back that up.” He said he should have used “more cautious phrasing” and that “nobody can diagnose this child with PTSD with certainty.”

In 2005, the Careys sued the Anderson School in state Supreme Court in Albany claiming Jonathan’s rights had been violated. The lawsuit is pending.

By October 2005, Jonathan was living at the OMRDD-operated O.D. Heck Developmental Center in Niskayuna. There, he spent much of his school day in a quiet
room with three aides, wearing a one-piece jumper that was difficult for him to remove himself. By June 2006, the Careys had placed Jonathan in a residential program at Tradewinds Educational Center in Utica. There, he was subdued “at least 141 times” in less than a month, “typically for aggressive behaviors.”

On July 20, 2006, Lisa Carey sought to remove Jonathan from Tradewinds. In a handwritten letter to the OMRDD Capital District regional office she cited “severe escalation of maladaptive behaviors…excessive use of physical restraining…excessive use of placing Jonathan in a time out room…significant bruising,” lack of notification of bruising, weight loss, and loss of academic learning.

Jonathan returned to O.D. Heck, and shortly thereafter he turned 13 on September 12, 2006. Five months later, on February 15, 2007, Jonathan was on a field trip when he was smothered to death in a van during an improper restraint by a health aide. Two workers were prosecuted by the Albany County District Attorney and convicted in the case.

In May 2007, New York State enacted “Jonathan’s Law,” which gives parents and guardians of individuals with disabilities greater access to records related to their care. A copy of the statute is provided in the Appendix to this report.
V. State Agency Investigations of Allegations of Jonathan Carey’s Abuse

Three state entities responded at the time to the Careys’ allegations that Jonathan had been abused at the Anderson School: the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC); the Office of Mental Retardation and Developmental Disabilities (OMRDD) Central Office; and OMRDD’s regional Taconic Developmental Disabilities Services Office (Taconic regional office), the office serving the area where the Anderson School is located. As described below, the three entities received information about the allegations through various means and commenced investigations or reviews that had somewhat different focuses. Later, the allegations were examined by the Dutchess County District Attorney’s office working with the State Police, the Governor’s Office, and the State Education Department.

In accordance with state regulations, non-state agencies such as the Anderson School are responsible for conducting their own investigations of abuse allegations. In this case, with administrative staff at the Anderson School implicated in the allegations, the school’s Executive Director requested that the Taconic regional office conduct the investigation. However, consistent with normal procedure, John Mizerak, the Taconic regional office’s Director, instructed the Anderson School to conduct its own investigation, of which the Taconic regional office would provide “oversight.”

As directed by Mizerak, the Anderson School commenced its own investigation. The school’s Incident Review Manager was assigned primary responsibility. In the week following October 22, the Incident Review Manager took a number of investigative steps, including interviewing some staff and examining records.
As required by state law, the State Central Register reported the abuse allegations to CQC. On the same date, October 23, 2004, CQC initiated an investigation of the allegations. The State Central Register report transmitted to CQC identified the name of the facility, the Anderson School; the name of the child, Jonathan Carey; and the name of the person who reported the allegations. It also listed the names of the suspected targets of the investigation, three Anderson School employees. The Inspector General’s Office cannot identify the subjects of the State Central Register case due to confidentiality laws.

After the State Central Register transmitted the allegation of abuse involving Jonathan Carey to CQC on October 23, 2004, CQC first called the emergency room nurse. The nurse told a CQC investigator that Jonathan appeared “thin but not malnourished.” Additionally, she noted that Jonathan’s family complained of his “possible malnutrition, abuse, & neglect.” She added that the parents reported that Jonathan’s “demeanor had changed significantly.” A hospital physician examined Jonathan and noted some small bruises on his back. The child was then discharged from the emergency room with follow-up instructions.

A CQC investigator also contacted the Anderson School to inform it of the allegation and obtain additional background information. The Anderson School administrator who was on call was unaware of the allegation, but informed the CQC investigator that he would have the child examined and separated from the named subjects when Jonathan returned. A CQC document, entitled “Checklist for State Central Register Intake/Follow-up,” which lists the completion of initial activities by CQC, indicated that the police were not informed of the allegation at this time.
On October 25, 2004, the Careys attended a meeting of the Bethlehem Central School District’s Committee for Special Education (CSE). During the meeting, Lisa Carey read a 16-page written statement outlining their numerous complaints, as noted above. On October 26, 2004, CQC advised OMRDD Central Office that it had received the Careys’ allegations through the State Central Register and that it had opened an investigation. As noted, OMRDD had been previously apprised of the allegations on October 22, 2004, when Michael Carey contacted the OMRDD Medicaid Service Coordinator.

On November 2, 2004, an attorney representing the Careys faxed a letter dated November 1, 2004, to the Taconic regional office, requesting an investigation of the Careys’ allegations by the Taconic regional office. A copy of the letter was sent to CQC. Enclosed with the letter was a copy of the statement presented by the Careys at the October 25 CSE meeting. In addition, the letter cited two occasions, October 10 and 16, 2004, on which Michael Carey arrived at the Anderson School to pick up Jonathan and discovered that he was naked in his room, lying in urine, atop his bed. According to the letter, the Careys claimed that although they had received prior reports from the Anderson School of some behavioral problems involving Jonathan, they had not received notification about any modification to Jonathan’s Behavior Support Plan, and thus, had not consented to such plans.

The attorney’s letter further stated that the Careys had discovered Jonathan in a condition they described as “gaunt and dazed,” and they claimed that although Jonathan had gained several inches in height between June and October 2004, he had lost one pound during that same period. “The Carey’s [sic] discovered that not only had the
Anderson School staff been instructed to let Jonathan remain in his room naked, but Jonathan had been deprived of food for at least one week, and on more than [one] occasion during that period of time.” Additionally, the letter said that Jonathan was supposed to be on a casein-free diet, but Lisa Carey learned from one of the direct care staff that Jonathan was provided lactose-free, fat-free milk, which was not casein-free milk. The Careys also alleged that Jonathan had a great number of bruises on his back and legs and that he had been left to lie naked for a period of thirty-six hours or more.

On that same date, November 2, 2004, after receiving the letter, Taconic regional office Director Mizerak decided, contrary to his earlier determination, that the Taconic regional office, and not the Anderson School, would assume responsibility for the investigation. Advised of Mizerak’s decision, the Anderson School provided the Taconic regional office the investigative materials it had gathered to that point.

In response to the Careys’ allegations, OMRDD Central Office decided it would examine broader, systemic issues at the Anderson School and the Anderson School’s regulatory compliance through what is termed a survey. OMRDD’s survey commenced on November 3, 2004.

Thus, as of November 3, 2004, 12 days after the Careys withdrew Jonathan from the Anderson School, three state entities had begun active investigations or reviews of issues related directly or indirectly to Jonathan’s stay at the school.
INVESTIGATION BY THE TACONIC REGIONAL OFFICE OF OMRDD

The Inspector General found that the Taconic Developmental Disabilities Services Office (Taconic regional office) of OMRDD conducted a thorough investigation of the allegations with which it was presented. Of all the agencies investigating this matter, the Taconic regional office performed the most interviews and site visits and produced the most comprehensive report regarding Jonathan’s care. Using definitions set forth in agency regulations, the Taconic regional office found “evidence to support that Mistreatment…and Neglect…occurred with Jonathan” at the Anderson School.

The Taconic regional office fully documented Jonathan’s care and addressed violations with the Anderson School to ensure that the problems leading to its findings that mistreatment and neglect which occurred with Jonathan were corrected. The Taconic regional office used the investigation as an opportunity to fully document the circumstances surrounding Jonathan’s care and to require the Anderson School to reform and update its policies and practices to ensure better care for its service recipients. This report notes a few areas in which the Taconic regional office could have improved its oversight of the Anderson School, to ensure that the school was accurately informed about the extent of the investigation and appropriately acknowledged problems so that they would not recur.

Background

The Taconic regional office provides services for individuals with developmental disabilities in Columbia, Dutchess, Greene, Putnam and Ulster counties. The Taconic regional office has direct administrative responsibility for OMRDD-operated facilities in
the region, and also works closely with private voluntary agencies, including the Anderson School, providing them with technical assistance, training, and oversight.

OMRDD regulations require that allegations of abuse or other serious incidents be immediately investigated.\textsuperscript{25} For allegations pertaining to OMRDD-operated facilities, each regional developmental disabilities services office is responsible for coordinating investigative activities. Allegations occurring in voluntary agencies like the Anderson School are typically investigated by the agencies themselves, after the agency has notified the OMRDD regional office of the allegation. Voluntary agencies are required by regulation to immediately notify their designated regional office of allegations of abuse in their facilities.\textsuperscript{26}

As noted, the Anderson School first learned of the Careys’ allegations when it was contacted by Jonathan’s OMRDD Medicaid Service Coordinator on October 22, 2004. As required, the Anderson School notified the Taconic regional office of the allegations. Following this notification, the Anderson School Executive Director contacted the Taconic regional office and requested that the Taconic regional office, rather than the school, assume responsibility for the investigation, citing a conflict of interest in that the allegations implicated the school’s administrative staff. However, Taconic regional office Director Mizerak instructed the Anderson School to conduct its own investigation, with “oversight” by the regional office. In explaining his decision, Mizerak told the Inspector General that voluntary agencies such as the Anderson School

\textsuperscript{25} 14 NYCRR Part 624.
\textsuperscript{26} 14 NYCRR Part 624.5 (b)(3).
are responsible for conducting their own investigations, and that the Taconic regional office lacks the staff to support them in all instances.

As directed by Mizerak, the Anderson School commenced its own investigation. The Anderson School’s internal investigation continued until November 2, 2004, when the Taconic regional office received a letter from the Careys’ attorney detailing the complaint and Taconic assumed responsibility for the investigation. The Anderson School then forwarded to the Taconic regional office the documentation of its investigation to date.

**Investigative Activities of the Taconic Regional Office**

The Inspector General determined that the Taconic regional office conducted a comprehensive investigation, addressing all of the allegations made by the Careys concerning their son’s treatment at the Anderson School. The investigation clearly was a high priority within the Taconic regional office administration. Director Mizerak described it as one of the most extensive investigations that had been done by the Taconic regional office and cited the amount of paper created and the number of people interviewed as evidence of that.

In criticizing the thoroughness of the investigation, the Inspector General notes the failure to interview two witnesses with information pertinent to the case. However, investigators did obtain a written statement from one witness who declined to be interviewed. In addition, the Inspector General questions Director Mizerak’s initial decision to instruct the Anderson School to investigate the allegation after the Executive Director had presented evidence of a conflict of interest. The Inspector General found
that the evidence generally supported the findings of Taconic regional office Investigator Mark Searle’s report, with the exception of the report’s failure to find that Jonathan was allowed to lie in his bed naked while it was wet with urine for any extended period. The following section also includes some minor criticisms regarding the office’s communications with the Anderson School and the Careys following the investigation.

**Description of Investigative Activities**

Taconic regional office investigators analyzed records to determine the number of meals Jonathan missed during the time he was in crisis. As discussed below, this is a step that neither CQC nor OMRDD Central Office took. In further contrast to CQC and OMRDD Central Office, the Taconic regional office examined Jonathan’s personal communication logbook, which the Careys made available and which they said contained information relevant to their allegations. The Careys claimed to have discovered the logbook in Jonathan’s clothing bag during a trip to the dentist.

After assuming responsibility for the investigation from the Anderson School, the Taconic regional office investigators made seven site visits to the Anderson School from November 5, 2004, to November 16, 2004, to examine records and interview staff. In addition to the logbook, the investigators reviewed relevant documents pertaining to Jonathan’s care and treatment including Student Injury/Illness Reports; Individualized Education Program goals and progress reports; the Birch residence log; Behavior Support Plans; Team Problem Solving Meeting minutes; Clinical Team Contact Forms; Weekly Body Check Forms; Professional Service Sheet Referral Reports; tracking and data sheets regarding Jonathan’s food intake and program participation; clinical and medical records; miscellaneous Anderson School e-mail and internal memos; and pertinent Anderson
School policies and procedures. Investigators analyzed available records to determine the number of meals Jonathan missed during the time he was in crisis.

Investigators interviewed and obtained statements from 25 Anderson School employees, including 15 staff members who had direct interaction with Jonathan on an almost daily basis, either in the residence or the classroom. Investigators also interviewed the school’s Executive Director, the Director of Children’s Residential Services, Jonathan’s Behavioral Specialist, the Birch Residence Manager, the Committee on Special Education Coordinator, the Staff Development Specialist, Jonathan’s case manager, the residential coordinator and Jonathan’s OMRDD Medicaid Service Coordinator. Additionally, Taconic regional office investigators conducted a telephone interview with the Careys.

**Inspector General’s Findings Regarding Investigative Activities**

*Initial deferment of investigation to Anderson School*

While the Taconic regional office’s initial decision to have the Anderson School conduct the investigation probably had no substantive impact on the final outcome, it would have been best practice for the Taconic regional office to accept primary responsibility for investigating the Careys’ allegation from the outset. Although the Inspector General acknowledges that OMRDD regional offices may not have the resources to investigate every allegation at a private facility, the agency should closely examine potential conflicts of interest at the facility that is the subject of the complaint, rather than deferring automatically to its policy requiring voluntary agencies to conduct their own investigations. Where the facility’s administrator has openly acknowledged a
conflict of interest, whatever the source, OMRDD has a responsibility to preserve the credibility of the investigatory process and avoid the appearance of bias.

*Failure to interview two pertinent witnesses*

   The Inspector General’s Office determined that the Taconic regional office investigators failed to interview two Anderson School employees who could have provided valuable information.

   The Director of Clinical Services, who is responsible for supervision of implementation of behavior programs at the school, declined to be interviewed and only provided a written statement. When asked to be interviewed, she reportedly said that “she had other things of greater importance to do and very limited time rather than to speak with the investigators concerning Jonathan Carey.” Although OMRDD investigators are authorized by regulation to interview any staff or other person in the course of investigating incidents and allegations of abuse, they did not do so in this instance.

   Likewise, in what appears to be an oversight, investigators did not interview or attempt to interview the registered nurse who had observed and treated Jonathan. This nurse had direct evidence regarding Jonathan’s physical condition, noted he was going “longer periods of time…without nourishment,” and identified the substitute food items to be offered to Jonathan.
Taconic Regional Office’s Findings

Using criteria set forth in regulation, the Taconic regional office determined that Jonathan had suffered mistreatment and neglect at the Anderson School, both forms of abuse under OMRDD regulations. It also determined that Jonathan’s rights as a resident of an OMRDD-regulated facility were violated, rights that are also set forth in regulations. Investigators were thorough in examining each of the allegations regarding Jonathan’s care and making a finding regarding each, including inappropriate modification of Jonathan’s meals, the source of Jonathan’s bruises, exclusion of Jonathan’s parents from planning his treatment, failure to adhere to Jonathan’s prescribed casein-free diet, and inappropriate segregation of Jonathan from activities, including school. The Inspector General criticizes only one finding in the report – the failure to confirm the allegation that Jonathan was permitted to lie in urine on his bed for any extended period.

Description of Findings

The Taconic regional office’s findings, dated December 1, 2004, addressed each of the allegations made by the Careys. The 10-page report provided a detailed account of the investigation, noting all the witnesses interviewed and itemizing the documents examined. The results of an interview with the Careys were included. The report served as a basis for two letters sent out on December 20, 2004: a detailed letter of findings to the Anderson School and a brief, less detailed summary letter to the Careys.

Apart from finding regulatory violations of mistreatment and neglect, the investigation also concluded that school staff’s treatment of Jonathan entailed rights
violations. It found that Jonathan’s treatment plan included restrictive elements without appropriate consent. In addition, school staff members were not properly trained to execute the treatment plan. And, a balanced and nutritious diet was not provided to Jonathan in an appropriate manner and was altered for behavior management purposes, among others.

As described in the report, the Taconic regional office’s investigation further substantiated that the following occurred with respect to Jonathan’s care at the Anderson School:

- While food was not withheld or denied, strict contingencies were placed on Jonathan’s access to routine meals. The Taconic office’s review of Jonathan’s personal logbook revealed that Jonathan “missed no more than five consecutive regular meals” and that for the period of September 23 – October 22, 2004, “Jonathan did not take his regular meal 39.29% of the time; he missed 33 of 84 offered meals.”

- Jonathan’s Behavior Support Plan was structured in such a way that he did not participate in many routine activities, including school, meals, and recreation. Jonathan missed approximately two weeks of school.

- Lactose-free milk as opposed to a soy milk substitute was given to Jonathan on occasion at school, but not at the residence, and staff training regarding Jonathan’s dietary needs was inadequate. However, the investigation did not find that Jonathan’s behavior was adversely affected by his having occasionally received dairy products.

- Evidence suggests that, on a routine basis, the Careys were not involved in, and possibly actively excluded from, the development of Jonathan’s plan of care.

- The school intended to suspend the Careys’ contact with their son for a period without first discussing this with them. The school directed staff to have no contact with the Careys and established a single contact person for communications, also without discussing it with the Careys.

- The school failed to adequately follow up on a school employee’s comment about the propriety of withholding meals from Jonathan in
an entry on an October 4, 2004, Behavioral Report Form. The direct care staffer who completed this report wrote, “I feel that it’s abusive to refuse food for this reason,” referring to directives to staff to withhold regular meals from Jonathan when he did not get fully dressed to dine with the other residents. Regulations require that allegations of abuse must be immediately reported to OMRDD and within 48 hours to CQC.

- The Taconic office’s investigation disconfirmed allegations that Jonathan was allowed or forced to lie on his bed naked for any extended period of time or that the bruises on Jonathan’s body were the result of physical abuse.

**Inspector General’s Findings Regarding Investigative Report**

Of the two findings that the Taconic regional office disconfirmed, the Inspector General determined that the finding that Jonathan was not left to lie naked on his bed was in conflict with the evidence. Regarding the other allegation that Jonathan’s bruises were a result of physical abuse, the Inspector General found no evidence to contradict the report’s conclusions that Jonathan’s bruises were the result of “the physical interventions employed and the defiant non-compliant behaviors he manifest.”

*Finding that Jonathan was not left to lie naked on a bed wet with urine*

The December 1, 2004, report of the Taconic regional office’s investigation stated that, “there is no evidence to support the allegation that Jonathan was allowed or forced

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27 This staff person ultimately deviated from the Behavior Support Plan and allowed Jonathan to eat at the table, even though he was not fully clothed. When interviewed by Inspector General’s Office, this direct care staff member stated that he was subsequently reprimanded for having made this accommodation because he was not “part of the team.” He went on to explain his conduct to the Inspector General: “There was no negative behavior [by Jonathan] and he was sitting there like, I want food… I felt I should give him the food at that point. That’s why I deviated independently from this new plan because I was going with my gut… I have never encountered another behavior as intense as [Jonathan’s behaviors]…this is like a special situation…I wanted to know if I could hold back the breakfast and I was told yes, I can and I should. I went against the plan, so I was talked to about it…that was me not being a part of the team…so I remember it more because I was reprimanded [by a supervisor].” He added that after he wrote the Behavioral Report, Jonathan’s Behavioral Support Plan changed, allowing staff to offer him substitutes for his regular meal.
to lay [sic] on his bed naked for any extended period of time.” The report continued to say that there were “no reports of Jonathan lying on a urine-soaked bed for an extended period of time, although an increase in the frequency of urination was noted.”

The Inspector General’s Office found sufficient evidence to support a finding that multiple staff members and Jonathan’s own parents observed Jonathan lying naked in his own urine on several occasions, although for unknown durations.

Michael Carey reported to the Taconic regional office that he had witnessed Jonathan lying naked in his room on October 10, 16, and 18, 2004, when he arrived at the Anderson School to visit his son, and, on two of those occasions, the bed was wet with urine.

Michael Carey’s claims are supported by the testimony of two Anderson School employees who were interviewed during the Taconic regional office’s investigation. The residential coordinator reported that she had observed Jonathan lying on his urine-soaked bed with no sheet. Another direct care staff member stated he observed Jonathan lying on his bed once after Jonathan had urinated on it, and he was told by other staff they had already changed the bed and to keep sheets off the bed for hygiene reasons.

In addition to the direct witness accounts to his condition, documents obtained during the Inspector General’s investigation also indicate that Jonathan’s sheets were not changed regularly. A handwritten document entitled “New Protocol,” dated October 13, 2004, advised staff to “Change Jonathan’s sheets once in the a.m. when he gets up (if bed is wet). If he wets again – take sheets off and don’t put clean ones on until he leaves for School. If he doesn’t go to School – leave bed unmade (until bedtime). If Jonathan comes home from School and wets the bed – strip the bed until bedtime.”
When questioned about the Taconic regional office’s conclusions regarding these allegations, Investigator Searle stated that he did not have enough information to believe it was a routine practice for Jonathan to be left to lie naked on a urine-soaked bed for hours. While Searle agreed that Michael Carey could have found Jonathan as he alleged, he contended that Carey’s observations alone could not substantiate that Jonathan remained in this condition for any extended period of time. Although, what constitutes a “routine practice” and an “extended period of time” is open to interpretation, Taconic regional office had evidence that the Anderson School improperly allowed Jonathan to lie naked on his bed for some period, and on some occasions after urinating on the sheets or the bed, even though regulations require Anderson School to provide every student with a “safe and sanitary environment.”

**Taconic Regional Office’s Letter of Findings and Recommendations to the Anderson School**

Director Mizerak of the Taconic regional office notified the Anderson School of the findings of the investigation by letter dated December 20, 2004.\(^\text{28}\) The letter emphasized the most important findings of the investigation – that the allegation of abuse as defined in regulations was substantiated, and that the Anderson School must take action regarding deficiencies in its drafting and implementation of behavior plans. The Inspector General notes that three findings of the investigation were not communicated to the Anderson School. Two of the omitted findings were those that were unsubstantiated. One could assume that because they were not mentioned, that the Anderson School

\(^{28}\) The letter denotes copies of the correspondence were also sent to OMRDD Division of Quality Assurance and the Anderson School Board of Directors.
inferred that the investigation had not substantiated the allegation. The third finding, that Jonathan missed eight days of school, will be discussed below.

**Description of Letter to the Anderson School**

The three-page letter focused on those findings of the investigation that constituted substantiation of particular allegations, identifying also the specific OMRDD regulations that had been violated. Notably, the report informed the school that the investigation substantiated mistreatment and neglect of Jonathan.

In the letter, Mizerak directed the Anderson School to take “immediate action to ensure that no other student is subjected to comparable abuse, neglect and/or mistreatment.” The letter recommended that the Anderson School review all Behavior Support Plans “to ensure that no other student is involved in a program with restrictive interventions without due consent” and, if identified, the Behavior Support Plan must be “terminated immediately.” Also, the Taconic regional office recommended that the Anderson School review, and revise as appropriate, its policies and practices regarding “behavioral programs that include the planned use of restrictive techniques so as to be in full compliance with applicable regulations.”

More specifically, the Taconic regional office recommended that the Behavior Support Plans “provide clear instructions for staff as well as providing time-limited intervention for students.” It added, “Food/meals [should] not be offered or restricted in a manner that is altered for behavior management purposes,” and physical interventions should “not be used as planned intervention in any treatment plan unless there is prior authorization.” It also recommended that the Anderson School ensure that parents are
involved “fully in the program planning process prior to the implementation of any
treatment program” and that parents are to be “considered active members of the
treatment team by all Anderson School staff.” Additionally, the Taconic regional office
advised that the Anderson School should “consider reviewing with the Director of
Clinical Services and Birch House Residence Manager that their roles include being
responsive to the needs of parents/families/guardians/advocates.” A “comprehensive
training for all staff relative to student programs,” which “must address BSPs [Behavior
Support Plans] and nutritional/diet issues,” was also recommended. The Taconic
regional office also suggested the Anderson School consider designating “an operations
manager who is knowledgeable and skilled in the area of professional clinical services
and direct student operations.”

Inspector General’s Findings Regarding Letter to the Anderson School

Despite confirming that Jonathan missed approximately two weeks of school
during his crisis period, the Taconic regional office did not discuss this finding in its
letter to the Anderson School. State Compulsory Education laws require that all minors,
six to sixteen years of age, attend full time instruction “if in proper mental and physical
condition.”29 State Education Department regulations provide that students may be
removed from their educational programs for periods of time under certain conditions and
guidelines. However, regulations also note that alternate instruction must be provided for
the student in the event of a removal from educational programming due to conduct that
endangers the safety, morals, health, and welfare of others to ensure continuity of

29 Education Law §§ 3205 & 3208.
educational programming. Although Jonathan’s behavior may have prevented him from attending classes with other children, the implementation of a behavior plan that left Jonathan alone in his room for most of the day with no stimulation is not in keeping with the Anderson School’s obligation to provide Jonathan with an education or with Jonathan’s right to participate to the extent possible in ordinary activities, as set forth in regulations.

No recommendation for discipline against Anderson School employees

Given the Taconic regional office’s finding of mistreatment and neglect, and the fact that Director Mizerak stated that the Director of Clinical Services was responsible, the Inspector General’s Office questions the lack of a more precise, compelling recommendation for accountability to include possible disciplinary action against this person. The closest the Taconic regional office came to recommending that anyone be held accountable, was in the December 20, 2004, letter to the Anderson School which recommended that the school’s management “consider reviewing” with the Director of Clinical Services and the Residence Manager “that their roles include being responsive to the needs of parents / families / guardians / advocates.”

When asked if he thought any personnel action was in order based on its findings, Mizerak informed the Inspector General that he did not make any recommendations for disciplinary action in this case. He added that private community providers, such as the Anderson School, do not have to follow the Taconic regional office’s recommendations. Mizerak said the following:
What were the employees doing that was against the regulations of that agency as they had written them? It was the agency’s policy, and according to what I read, the staff were doing and being accepted by the supervisors as being ok and appropriate. They [the staff] didn’t know any better…. So who was the recommended bad guy in this? It was the clinical director. The clinical director was not there. Now, did I recommend in writing that the clinical director be fired? No. But I think there was enough discussion…I’m sure there was discussion saying, what’s going on here? I never had any discussion with [the Executive Director] to say you know, your clinical director is way off base on this, what the hell are you doing?

The Board of Directors of that particular agency who had fiduciary responsibility for that agency are the ones that should have looked at that damn report and said [to the Executive Director], what the hell are you doing? And if they wanted to discipline [the Executive Director] or if they wanted to do anything else after that....[The Executive Director] has some responsibility in either changing the facility and the board has responsibility…Its a private-based agency and that board is responsible.

According to OMRDD Central Office and Taconic regional office officials, neither office has the authority to sanction or discipline any employee of a private agency, such as the Anderson School. Yet, OMRDD is a state certifying agency, and there is nothing that prohibits OMRDD, or one of its regional offices from making such a recommendation.

Taconic regional office’s records reveal that during the investigation period, the Taconic regional office investigator questioned the Executive Director regarding any personnel actions (suspensions, terminations or removal from student contact pending re-training) resulting from the Carey investigation and Taconic regional office’s referral of their findings to the Anderson School Board of Trustees. According to the investigator, the Executive Director responded that a number of systemic issues had been identified as a result of investigations by OMRDD, CQC, State Education, and the Taconic regional
When the Inspector General’s Office asked Taconic regional office Director Mizerak to comment on the Executive Director’s response, Mizerak stated, “It’s bewildering to me…regardless of what any outside entity is saying to me, I control that entity internally and am responsible for the internal operations.” Mizerak added that just because a state agency did not make a recommendation for disciplinary action, “It should not have made a difference…it does not relieve [them]. For a state agency to say something to a board of directors makes no difference on the responsibility of that board to look at that particular thing….It should be the incident itself that is the judge and jury of that.”

The Inspector General notes that the Clinical Director responsible for Jonathan’s clinical treatment at the Anderson School is no longer employed by the agency and has since relocated.

**Anderson School’s Response to Taconic Regional Office’s Recommendations**

On December 29, 2004, the Anderson School’s Executive Director responded to the Taconic regional office’s letter of investigative findings and recommendations with a point-by-point response to each area identified in the letter, addressing each conclusion and recommendation. At this point, the Anderson School had already received a separate report of regulatory violations from OMRDD Central Office and had responded with a Plan of Corrective Action. Accordingly, some of the responses to the Taconic regional office referred to corrective actions that had already been submitted to the OMRDD
Central Office. Although the Anderson School addressed each of the Taconic regional office’s criticisms with a plan to correct the deficiency, it also included a discussion defending the school’s treatment of Jonathan Carey and disagreeing with several of the investigation’s findings.

**Description of Anderson School’s Response**

In his response to the Taconic regional office’s investigation, the Anderson School’s Executive Director disagreed with several of Taconic regional office’s conclusions. First, regarding the Careys’ parental involvement in the treatment planning for Jonathan, he advised that the “Careys had maintained frequent and ongoing contact with many team members and Jonathan throughout the period Jonathan was in crisis.” He referred to discussions that he had with Michael Carey on October 9 and 10, as well as on October 14, 2004, as detailed earlier.

With regard to the Taconic regional office’s conclusion that Jonathan’s diet was altered for behavior management purposes, the Executive Director responded that Jonathan’s meals could not be served in a typical manner because of the “unsafe and/or unsanitary conditions caused by his behavior.” In addition, the Executive Director stated that on October 9, 2004, Michael Carey acknowledged to him that he was “fully aware of this practice and Jonathan’s status regarding meals,” and “Mr. Carey indicated his view that offering standard meals in his room would be ‘reinforcing poor behaviors.’” As previously mentioned, Mr. Carey disputes this account.

As for the Taconic regional office’s assertion that Jonathan’s Behavior Support Plan placed unrealistic expectations on Jonathan relative to his compliance with
directions to dress, the Executive Director replied, “The expectations regarding participation in dressing and mealtime routines contained in the BSP [Behavior Support Plan] were based on Jonathan’s identified progress in these areas during the prior year.” Anderson School maintained that when Jonathan began to demonstrate instability, they “requested a meeting of the family and CSE [Committee for Special Education],” which took place on October 14, 2004. “Additional collaboration and discussion between Anderson School, the family and the CSE was scheduled to continue until a revised program plan for Jonathan could be jointly agreed upon.” However, the Executive Director added, this did not occur due to Jonathan’s “abrupt discharge” from the Anderson School by the Careys.

The Executive Director also disputed the Taconic regional office’s finding that Jonathan’s Behavior Support Plan did not incorporate positive reinforcement to encourage desirable behaviors. He cited the September 27, 2004, Behavior Support Plan, which stated that, “Jonathan will be reinforced on a continuous reinforcement schedule (CRS) where he should receive an enormous amount of attention for using functional communication properly and for the absence of maladaptive behaviors,” and the October 20, 2004 proposed Behavior Support Plan which read, “Jonathan is on a [continuous reinforcement schedule] where he should be given edible reinforcement every twenty seconds coupled with a tremendous amount of exuberant praise.”

The Anderson School rebutted the Taconic regional office’s conclusion that the Anderson School intended to suspend the Careys’ contact with Jonathan and designate a single contact person, without their consent, by stating that, “Anderson School never suspended contact between Jonathan and his family.” The Executive Director
acknowledged there was a “proposed” Behavior Support Plan that would have limited telephone contact and home visits for a period of 30 days in order to stabilize Jonathan’s behavior. However, he claimed “this component of the [Behavior Support Plan] was never implemented because it was never fully discussed and/or agreed upon with the family.” He further commented, “The family was in frequent and extended contact with most team members which served to thwart [the Anderson School staff’s] ability to concentrate on Jonathan.” He added that the idea of identifying one main contact for the family was to “consolidate and streamline information sharing” and that it is “typical for an agency to appoint a lead professional to maintain communications.”

With regard to the conclusions relating to Jonathan’s casein-free diet, obtaining parental consent for Behavior Support Plans containing rights restrictions and the use of planned ignoring, staff training in executing Behavior Support Plans, the Executive Director referred to the Anderson School’s December 21, 2004, Plan of Corrective Action issued to OMRDD Central Office in response to its survey. This plan outlined new standard operating procedures and training initiatives that addressed each issue and the issue of reporting allegations of abuse.

In response to Taconic regional office’s finding of regulatory violations of mistreatment and neglect, the Executive Director replied that, “At no time did [the Anderson School] mistreat [or] neglect Jonathan Carey. Staff of the agency diligently contacted family members throughout this period and attempted to develop alternative plans to effectively provide for Jonathan’s needs.”

Furthermore, the Executive Director claimed that in early 2004 Anderson School “set a course for reforming its clinical department as has been the case in all other areas.”
“This plus the aforementioned responses to any of the findings taken in context refute the allegation of willful and benign mistreatment and neglect.”

With regard to the Taconic regional office’s nine recommendations, the Executive Director restated that “at no time did it [the Anderson School] mistreat, abuse, [or] neglect Jonathan Carey.” For each recommendation, he referenced the December 21, 2004, Plan of Corrective Action he submitted to OMRDD and the development of new standard operating procedures.

Inspector General’s Findings Regarding Anderson School’s Response

Written statements from the Taconic regional office’s investigation and testimony of Anderson School staff obtained by the Inspector General contradicted the Anderson School’s Executive Director’s claim that Behavior Support Plan elements restricting Jonathan’s communications with his family were not implemented. Some staff reported to investigators that they had been instructed not to speak to the Careys and to direct their telephone calls to the Director of Children’s Residential Services and the Careys reported that the person they typically called when attempting to contact Jonathan had “hung up” on them.

Likewise, in contrast to the Executive Director’s assertion that the Careys had not objected to Jonathan’s behavior plan, staff members reported to the Taconic regional office, and later to the Inspector General, that they were well aware that the Careys would have objected to treatment components.
Taconic Regional Office's Letter to the Careys

In a separate December 20, 2004, correspondence, Taconic regional office Director Mizerak notified Michael and Lisa Carey that his office’s investigation had been completed. The single-page letter advised the Careys that “many of your complaints” about Jonathan’s treatment at the Anderson School had been substantiated, and noted that the investigation’s findings and recommendations had been communicated to the school “so as to ensure that similar events do not recur.” The Careys were dissatisfied with the brevity of this letter and its failure to address all of their allegations regarding Jonathan’s care. However, Mizerak followed agency policy in communicating a brief summary of the Taconic regional office’s findings to the Careys, highlighting what he viewed as the most important points.

Description of Letter to the Careys

Director Mizerak’s letter to the Careys included only four of the investigation’s findings, failed to mention several key conclusions and did not sufficiently indicate the scope of Taconic regional office’s investigation. The letter informed the Careys that the investigation had found OMRDD regulation violations by school staff and cited the following in general terms:

- “evidence that [the Careys] were not actively involved in the development of Jonathan’s plan of care”
- “restrictive interventions were employed with [Jonathan] that did not have [the Careys’] consent”
- “staff training was inadequate such that programs and treatments were not carried out in a consistent manner as prescribed”
- “Jonathan’s meals were not provided as prescribed and were modified for behavioral management purposes.”
But there were omissions in the letter as it did not address some of the Careys’ complaints. Notably, Lisa Carey’s handwritten statement claimed: “Jonathan’s casein free diet has not been adhered to,” Jonathan was found “laying naked, uncovered, on his bed, in his urine,” Jonathan missed between “one and two weeks of School” and Jonathan’s “body was covered with extensive bruises.”

In contrast, the Taconic regional office’s letter to the Anderson School provided at least limited comments on these allegations. The Taconic regional office’s findings revealed that these allegations were, in fact, investigated. The Taconic investigator substantiated that there were occasions when Anderson School failed to provide Jonathan with a casein-free diet. A statement by a direct care staff to Taconic regional office investigators read, “A maximum of 4 to 5 times [Jonathan] may have received the lactose free milk” and on a separate written statement by the same staff member he wrote “the amount of times that I was able to get [Jonathan’s] milk was probably less than 6 to 8 and that I generally got the lactose free milk.” With regard to Jonathan’s attendance at school, Taconic regional office investigators found evidence that Jonathan missed eight days of school over a two-week period. Additionally, the findings “disconfirmed” the other two allegations and reported, “No reports of Jonathan lying naked on a urine-soaked bed for an extended period of time,” and “There is no evidence to suggest that he was subjected to physical abuse.” Despite the determinations, the Careys were not notified of these outcomes.

When asked by the Inspector General about the lack of details provided to the Careys, Taconic regional office Director Mizerak explained to the Inspector General that
it is not his office’s policy to provide the family with the same documentation that is
given to a voluntary agency, such as the Anderson School. He explained:

I gave a summary statement to the parents which I thought adequately
addressed the concerns of that particular parent in terms of his speaking to
me and making an allegation that, at that point, it was verified – your
allegation in certain areas were correct….The detail that they needed to
know was different. If you’re running an agency I need to know what the
heck you found that is very specific to my policies and procedures. To the
parents and the questions that that parent asked me, I answered.

Inspector General’s Findings Regarding Letter to the Careys

While the Taconic regional office has the discretion to disclose what information
it deems relevant and appropriate in a letter of findings to the parents, a complete
disclosure would have been more prudent. Although not in effect at the time, in May
2007, the state Legislature enacted Jonathan’s Law, which provides parents the right to
obtain complete information regarding records related to incidents and allegations
involving individuals residing in mental hygiene facilities.

Conclusion

Although the Inspector General’s Office disagreed with some findings and
identified some opportunities for improvement, overall, the Inspector General found that
the Taconic regional office performed satisfactorily in that it conducted a thorough and
detailed investigation into the Jonathan Carey allegations. It was, by far, the most
comprehensive review of the matter that was examined by the Inspector General’s Office
in this matter. The Taconic regional office took appropriate and far-reaching
investigative steps that other primary investigating entities failed to perform.
Investigators interviewed 25 individuals in investigating this case and analyzed records to
determine the number of meals Jonathan missed during the time he was in crisis, a step that neither CQC nor OMRDD Central Office took.
SURVEY BY THE OMRDD CENTRAL OFFICE

As discussed in this report’s introduction, the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) is responsible for certification and oversight of privately-owned facilities that provide services for individuals with developmental disabilities. In response to the allegations of abuse of Jonathan Carey, OMRDD Central Office conducted a survey in which it examined regulatory compliance at the Anderson School. Although the survey was initiated in response to the specific allegation, it was intended to be broader than the Taconic regional office’s investigation, which was discussed in the previous section. The Central Office’s survey team reviewed the care of other children, as well as Jonathan’s care, as part of its examination. The focus of the survey, according to OMRDD officials, was to assess school-wide regulatory compliance concerning issues raised by the Careys’ complaint. Violations noted in the survey were communicated to the Anderson School in a Statement of Deficiencies. As required by OMRDD policy, the Anderson School responded to the Statement of Deficiencies with a plan to correct each violation.

In its survey, OMRDD correctly identified serious problems at the Anderson School, with particular focus on its use of techniques like planned ignoring in its behavior plans and the lack of training among the staff. However, the Inspector General notes some oversights in its review methodology. In addition, the Inspector General identified regulatory violations involving Jonathan’s care that were not addressed in the Statement of Deficiencies. OMRDD Central Office accepted a Plan of Corrective Action from the Anderson School that made statements contradicting the findings of the survey.
Policies and Procedures Related to OMRDD Surveys

According to a manual provided by OMRDD to service providers to acquaint them with the survey process, OMRDD’s Division of Quality Assurance conducts surveys to “determine if programs and services are operating in compliance with New York State regulations and OMRDD policy.” The manual describes the general activities involved in a survey:

Surveys include some observation centered on at least one mealtime routine, if applicable. Interviews are conducted with consumers, and/or families and advocates. Consumers, families and advocates may choose whether they want to participate in the survey process. Record reviews are completed for a sample of consumers. Most surveys include reviews of the principle areas of service delivery and program operation, for example: environmental/physical plant; medication administration; infection control; personal allowance; rights; informed consent; incident reporting; program planning.

A survey is conducted annually of each facility. However, as occurred in this case, the Division of Quality Assurance may make additional visits at its discretion, and may do so upon learning of a complaint against a facility.

If the survey discovers significant violations, OMRDD will issue a Statement of Deficiencies, and the facility must respond with a Plan of Corrective Action. OMRDD may require an immediate corrective action for a dangerous situation. The provider must respond within specified time periods, depending on the nature of the finding. A survey may be conducted at any time, and is unannounced, when possible.

Survey Activities of the OMRDD Central Office

OMRDD Central Office’s three visits to the Anderson School and the interviews it conducted were generally sufficient for the purposes of the survey. However,
additional information was available regarding Jonathan Carey that could have aided the
surveyors in identifying additional regulatory violations.

OMRDD’s survey consisted of site visits on three separate dates in which
investigators reviewed case files and interviewed employees and supervisors at the
Anderson School. During the first visit, on November 3, 2004, surveyors primarily
reviewed the care of Jonathan Carey. OMRDD surveyors interviewed several Anderson
School administrators and staff and reviewed numerous records. OMRDD Central Office
sent a second survey team to the Anderson School on November 9 and 10, 2004. The
focus of this visit, according to OMRDD Central Office officials, was to assess systemic
weaknesses and deficiencies in behavior plans and residents’ treatment, rather than
focusing only on Jonathan Carey. Thus, surveyors reviewed other Anderson School
residents’ behavior plans and records to determine if the problems identified in
Jonathan’s case reflected broader issues and problems at the Anderson School.

**Inspector General’s Findings Regarding Survey Activities**

Although surveyors did spend one full day at the Anderson School dedicated to
reviewing Jonathan’s care, and included him in the sample of residents whose behavior
plans were reviewed, the Inspector General notes additional steps that could have been
taken to identify regulatory violations related to his treatment. Most significantly,
coordinating with the Taconic regional office’s investigation would have taken little
effort but would have provided the surveyors with a wealth of information regarding
Jonathan’s care and regulatory violations that had been identified during the Taconic
regional office’s investigation of the abuse allegations.
**Failure to coordinate with Taconic regional office**

Although the Taconic regional office conducted a thorough investigation of the allegations and noted a number of regulatory violations, the OMRDD Central Office failed to obtain Taconic regional office’s findings or speak to investigators prior to issuing its Statement of Deficiencies. As a result, the Statement of Deficiencies issued by the OMRDD Central Office was incomplete, and at times was inconsistent with findings of the Taconic regional office’s investigation. In addition, the OMRDD Central Office was able to interview one witness, the Director of Clinical Services, who would not make herself available to the Taconic regional office. The Taconic regional office’s investigation could have benefitted from OMRDD Central Office’s sharing of information obtained from this witness.

On November 16, 2004, OMRDD Regional Director Tom Articola wrote an e-mail indicating that the Statement of Deficiencies would include findings from the OMRDD Central Office’s two site survey visits, as well as information obtained during Taconic regional office’s investigation. However, the Statement of Deficiencies was mailed to the Anderson School on November 24, a week before the Taconic regional office completed its final report. On November 16, 2004, Investigator Searle, who led the Taconic regional office investigation, sent an e-mail to Articola, identifying himself as the investigator assigned to the Carey case and requesting that they discuss the matter. Searle told the Inspector General’s Office that no one at OMRDD Central Office responded to his November 16, 2004, e-mail. According to Articola, who drafted the Statement of Deficiencies, he never saw the report from the Taconic regional office and he could not recall speaking with anyone there regarding its investigation. Furthermore,
his supervisor at the time, then-Area Director Judy Trent, also acknowledged that she did not recall reading the Taconic regional office’s investigation report.

The Inspector General’s Office asked senior officials at OMRDD about the lack of coordination and apparent breakdown in communication between OMRDD and the Taconic regional office. Former Executive Deputy Commissioner Helene DeSanto agreed that, ideally, OMRDD Central Office and the Taconic regional office should have better coordinated their efforts, but she could not explain why they did not. When asked if she thought the surveyors should have had the results of the Taconic regional office investigation prior to issuing the Statement of Deficiencies, DeSanto replied, “Yes, that’s the best practice.”

Trent acknowledged that the Statement of Deficiencies might have been a more dramatic document if OMRDD had obtained information from the incident investigation. “Maybe, on our part, we could have done more, too,” she said, with regards to coordinating responses. Trent added, “In this instance…we might have profitably joined forces.” She conceded that, “It is a fair comment that maybe there should have been better coordination.”

Former OMRDD Commissioner Maul also confirmed that coordinating the two processes could have strengthened OMRDD Central Office’s November 2004 Statement of Deficiencies. He expressed surprise that OMRDD Central Office did not obtain the Taconic regional office’s findings. Maul stated, “That shouldn’t be. My response is, obviously, that dialogue [between OMRDD and Taconic] should have existed.” He continued, “If you don’t know the specifics of Jonathan, or at least as known at the time, it is very difficult to make an overall judgment. The purposes are very, very related.”
Failure to interview the family or obtain all pertinent information

According to OMRDD documents, a survey generally entails a review of pertinent documents and interviews of consumers/residents or their parents. Documentation suggested that OMRDD did not communicate with Michael and Lisa Carey at any point during their survey, nor did they obtain a logbook from the Careys that they claimed proved the abuse of their son. The logbook would have given the surveyors a more complete picture of Jonathan’s daily treatment, and might have led to additional regulatory findings, some of which are discussed below.

According to an October 30, 2006, e-mail from former OMRDD General Counsel Paul Kietzman, it appeared OMRDD first reviewed the logbook in the fall of 2006, nearly two years after the Statement of Deficiencies was issued. Given that Jonathan’s alleged abuse was the impetus for the survey, and that interviews with parents are typically a part of the survey process, it would have been appropriate for surveyors to speak to Jonathan’s parents and obtain any evidence they could provide.

Findings of OMRDD Central Office’s Survey

The Inspector General reviewed internal memos and correspondence of the OMRDD survey team, which recorded their observations and preliminary conclusions. Several e-mails and the minutes of one meeting reflect a wide range of concerns regarding Jonathan’s care. Most of these findings were later included in the resulting Statement of Deficiencies.

Several violations that were omitted from the Statement of Deficiencies had been noted by surveyors in internal communications. One finding included in internal memos
that is absent from the Statement of Deficiencies concerns the Anderson School’s extreme use of planned ignoring constituted seclusion or the unauthorized use of time-out. In addition, surveyors suggested in internal documents that Jonathan may have been neglected and/or abused, but there was no finding of either in the Statement of Deficiencies.

**Internal Documentation of Preliminary Findings**

Following the first site visit, one of the surveyors in an internal e-mail wrote that the survey team “virtually confirmed the allegation and began to uncover a number of other systemic problems,” indicating inadequate protections for resident children. The e-mail noted problems with reporting injuries and abuse, understanding what constitutes abuse, and the lack of clear policies and procedures regarding restrictive techniques and family consent and involvement. The surveyor also reported that the team spoke with the Anderson School’s Director of Clinical Services about the Anderson School’s use of planned ignore. The Director of Clinical Services told surveyors that planned ignore was used “quite readily and without time limits” and that planned ignore “is not only used with children, but is very successful with ‘dogs and adults.’ ” The surveyor’s findings noted that “planned ignoring may occur by placing kids in empty classrooms/bedroom from which they have no escape (staff hold the door closed)… they don’t seem to grasp the abuse aspect of this practice.”

A week later, the surveyors reported their findings related to this visit in another e-mail to OMRDD executives. The e-mail stated, “The Carey’s complaint is essentially substantiated. Under the guise of ‘planned ignoring’ staff would isolate [Jonathan Carey] in his bedroom, prevent him from leaving, and not allow him to eat for extended periods
of time. Even the nurse confirmed there were no assurances his diet was being followed and monitored as prescribed.” Specifically, the surveyors found:

- The Anderson School uses a planned ignore approach to behavior management, but the approach has no time limits and prevents Jonathan from leaving his room. The surveyor reported that this practice, “taken in the extreme in which it was used with [Jonathan Carey], constitutes seclusion, unauthorized time out or even neglect” (emphasis original).

- The Anderson School does not seek or require “written informed consent to implement behavioral approaches that involve untoward risks/rights restrictions” (emphasis original).

- Anderson School staff failed to follow Jonathan Carey’s prescribed diet. When questioned, even the nurse at the facility was unable to define a casein-free diet.

- “Some nursing notes (10/9/04) revealed that, due to his maladaptive behaviors, [Jonathan] was going for longer periods of time...without nourishment.”

- Anderson School’s Director of Clinical Services told surveyors that if an individual fails to act appropriately at meal time and for an extended time thereafter, there are no specified timeframes in which staff must offer individuals any food.

The surveyors stated that their greatest concern was “the failure – at all levels of the organization – to recognize when this behavioral intervention [planned ignoring] becomes abuse.”

OMRDD Central Office officials discussed the problems at the Anderson School during an Early Alert meeting, a monthly meeting held at OMRDD Central Office to address problem programs, in November 2004. The minutes from the meeting reflect concerns regarding the Anderson School: “[The] overall consensus seems to be a philosophical problem from top down at [the Anderson School] relating to a poor understanding of: risk management, what determines abuse (physical/psychological),
clinical director role, psychiatrist - over medication dangers.” The minutes cited Jonathan Carey as an example, noting an “11 year old child with autism withheld food as a behavior management; leaving him in his room for 36 hours (unsubstantiated); lack of clothing; no food.”

OMRDD’s former Deputy Commissioner for Quality Assurance, Dr. Jan Abelseth, reported that the initial survey team substantiated the majority of the Careys’ allegations. She recalled that the planned ignoring was one of the problems with Jonathan’s behavior plan and further told the Inspector General’s Office that Jonathan’s plan was “not planned ignore, that’s neglect.” She added, “You use planned ignoring all the time….Think about as a parent, you ignore behaviors because you don’t want to reinforce it by giving it attention. But the planned ignoring, when you are actually refusing to give people basic services, is when it becomes abuse.” Trent stated to the Inspector General’s Office, “I think the techniques that Anderson School [used] clearly met the definition of abuse. What they were doing was abusive; whether they intended it to be, or not, is beside the point…you can’t do that stuff.” She referred to the behavior management procedures used with Jonathan Carey as “appalling.” When informed by the Inspector General that a proposed behavior plan did not get approval from the family and that the techniques did not seem to be properly vetted, former OMRDD Commissioner Maul indicated that, “Some [behavioral] programs should not be offered up for approval anyhow….You seem to be talking about a situation that totally removes all dignity and all rights from an individual.”

E-mail correspondence from the November 9-10, 2004, survey team indicates that the team identified, among other problems, systemic flaws in behavior plans, inadequate
staff training, and a lack of coordination at the Anderson School. It was noted in the e-mail that the surveyor “did not find any gross negligence or failure at the school, however, there does appear to be some significant flaws that if left unchecked could lead to serious problems for individual students.”

**Description of Statement of Deficiencies**

The Statement of Deficiencies identified a number of violations of rights set forth in 14 NYCRR § 633.4. All individuals in facilities certified by OMRDD are entitled to these rights, as outlined earlier in this report, with any limitations being “on an individual basis, for a specific period of time, and for clinical purposes only.” According to the regulation, “The rights… are intended to establish the living and/or program environment that protects individuals and contributes to providing an environment in keeping with the community at large, to the extent possible, given the degree of the disabilities of those individuals.” The following violations were identified by OMRDD:

- The Anderson School presented completed treatment plans to parents/guardians for review, not providing them with the opportunity to participate in the development of the plans and with little or no opportunity to object to plans (§ 633.4(a)(4)(viii)(a)).

- The Anderson School violated the right to “services, including assistance and guidance, from staff who are trained to administer services adequately, skillfully, safely, and humanely, with full respect for the individual’s dignity and integrity” (§ 633.4(a)(4)(ix)). The lack of clarity and guidance in treatment plans, and specifically the failure to specify a time limit for forcing Jonathan to remain in his room were criticized in this finding.

- The Anderson School violated the right to “a balanced and nutritious diet, served at appropriate times and in as normal a manner as possible, and which is not altered or totally denied for behavior management or disciplinary purposes” (§ 633.4(a)(4)(xvii)). According to the Statement of Deficiencies, the behavior plan for Jonathan made his access to meals at...
the table contingent on appropriate behavior and dress on October 16, 2004. The document notes that there was no provision for an alternative meal or supplements.

- The Anderson School violated the right to have “the opportunity to receive visitors at reasonable times; to have privacy when visited, provided such visits avoid infringement on the rights of others, and to communicate freely with anyone within or outside the facility” (§ 633.4(a)(4)(xxiv)) in developing a behavior plan that prohibited family visits and limited telephone contact to Jonathan from his parents. This plan was not approved by Jonathan’s parents.

In addition, regulations require that schools for individuals with developmental disabilities appoint a special review committee, including members of the clinical staff at the school, to “review and evaluate untoward incidents and extra risk procedures…Extra risk procedures may include…behavior modification…and restraint or seclusion.” According to the Statement of Deficiencies, Anderson School violated this provision and the “use of ‘planned ignore’ behavior plans without specific guidelines…poses potential danger to consumers.” A violation of this provision related to another resident at the facility is mentioned, but Jonathan is not mentioned specifically.

The remaining two violations discuss the failure of the Anderson School to provide sufficient training, or documentation of training, regarding “behavior plan implementation, provision of special diets, incident reporting and other clinical services.”

**The Inspector General's Findings Regarding OMRDD Central Office’s Survey**

OMRDD promptly responded to the Careys’ allegations and required the Anderson School to correct regulatory violations it found in its survey. Nonetheless, the

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30 14 NYCRR § 81.5(b)(5).
Inspector General’s Office found some deficiencies in the response of OMRDD Central Office. The Inspector General does not dispute any of the findings of the Statement of Deficiencies, although the description of one violation is inaccurate and some omissions are noted in the following sections.

**Appropriate Findings of the Statement of Deficiencies**

Although a Statement of Deficiencies is intended to communicate violations and require correction from a regulated facility and is not typically provided to residents or their guardians, the Careys obtained a copy of OMRDD Central Office’s Statement of Deficiencies through a request under the state’s Freedom of Information Law.

As described above, the November 24, 2004, Statement of Deficiencies at the Anderson School noted seven regulatory violations. In each case, a brief explanation of the violation is provided. For some noted violations, an example is given. For other violations, no example is given. For instance, the Statement of Deficiencies discusses the Anderson School’s failure to include parents in the development of behavior plans. No specific instances of this violation are mentioned. Accordingly, the Anderson School’s failure to include the Careys in the development of Jonathan’s behavior plans is not mentioned. Jonathan is specifically mentioned as an example of a violation in only three of the seven instances, once regarding the insufficient specificity of Jonathan’s behavior plan, once regarding his “access to meals at the table contingent on appropriate behavior,” and once regarding the development of a plan that limited Jonathan’s communication with his family. For one of the violations, another child is mentioned as an example. The other violations relate to Jonathan’s care, but do not mention any specific children.
Former Regional Director Articola stated that surveyors do not have to cite each and every instance of the violation; only one must be cited as an example of a violation. He said citing every example of a violation could lead to multiple pages of documentation of the same violation. Former Executive Deputy Commissioner DeSanto also explained to the Inspector General that the surveyor is not expected to cite all the dates, rather citing one example as an illustration. Former Area Director Trent similarly maintained that the purpose of the survey is not to identify every instance of noncompliance, but to identify one example, illustrating there could be more, and to ensure the agency takes systemic corrective action.

As set forth below, OMRDD Central Office’s Statement of Deficiencies sufficiently criticized the Anderson School for several violations that were outlined by the Careys in their allegation of abuse.

*Lack of parental consent for behavior plans*

The first item of the Statement of Deficiencies criticizes the Anderson School for failing to include parents or guardians in developing treatment plans, instead presenting completed treatment plans to them for approval. OMRDD noted the appropriate regulatory violation, and required the Anderson School to correct this deficiency. The Inspector General notes, however, that the Statement of Deficiencies could have gone farther in describing this violation. It fails to mention that during the period of crisis prior to Jonathan’s removal from the school, his behavior plan was modified without even informing the Careys of the modifications after the fact.
Dietary restrictions

Staff at the Anderson School admitted that Jonathan was fed dairy products on some occasions, even though his parents had requested a casein-free diet. Evidence indicates that this was due to a lack of understanding at the school regarding Jonathan’s dietary requirements. Although Jonathan is not mentioned, the Statement of Deficiencies sufficiently notes violations of training requirements regarding dietary needs, and criticizes the staff dietician for not taking a more active part in supervising meals at the school.

Withholding of regular meals for behavior management purposes

The Statement of Deficiencies was accurate in criticizing the Anderson School for violating Jonathan’s right to a balanced and nutritious diet served at appropriate times and in as normal a manner as possible, and which is not altered or totally denied for behavior management purposes, except under the conditions stated in the regulations. Although the Statement of Deficiencies provided only a single example of the withholding of Jonathan’s regular meal, this, as explained earlier, is not inconsistent with the surveyors’ purposes.

Careys denied communication with Jonathan

The Statement of Deficiencies appropriately criticizes the Anderson School for developing and implementing a behavior plan that limited Jonathan’s contact with his family in violation of Jonathan’s rights and without approval from his parents.
**Bruising**

Although the Careys noted that Jonathan had multiple bruises, which also were documented by the Anderson School, the surveyors did not note any violations related to Jonathan’s bruising. The Inspector General did not find any evidence to contradict this. Jonathan frequently threw himself to the floor or ran away from caretakers, and he had to be restrained at times. Anderson School cited these as possible reasons for his bruising, and investigators from the Taconic regional office concurred.

The Anderson School had presented the Careys with a form to allow them to ask to be notified of injuries to Jonathan, and Lisa Carey had requested to be notified within 24 hours of minor injuries such as bruising. The Anderson School violated this agreement, but did not violate any laws or OMRDD regulations in not making the notifications to the parents. Institutions such as the Anderson School are required to report certain types of injuries to OMRDD, but bruising that only requires first-aid is not a reportable injury.31

In the absence of a regulatory violation related to Jonathan’s bruising, there would be no reason to mention the bruising in the context of a Statement of Deficiencies.

**No law enforcement notification**

The Mental Hygiene Law requires providers of services in the abovementioned facilities to notify the district attorney or other appropriate law enforcement officials and the commissioner as soon as possible, but at least within three working days “if it appears that a crime may have been committed” against a person receiving services.32

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31 14 NCYRR § 624.4(b)(1).
32 Mental Hygiene Law § 16.13.
OMRDD identified violations in relation to Jonathan Carey’s treatment, it is not clear that Jonathan’s treatment constituted a crime. Even a regulatory finding of abuse by OMRDD does not necessarily imply that a crime has been committed. A criminal statute, such as endangering the welfare of a child, requires a higher standard of proof and a different level of risk to the child than the OMRDD regulations. The prosecutor at the Dutchess County District Attorney’s Office, after weighing the evidence, declined to prosecute the case. She stated, “My standard is beyond a reasonable doubt and I have an obligation to not bring cases if I don’t think I can prove that standard beyond a reasonable doubt….I see nothing here that would have constituted any abusive behavior that I would have been able to do anything about.”

Inadequate Findings or Omissions from the Statement of Deficiencies

Then-OMRDD Regional Director Articola indicated in interviews with the Inspector General that any violation of regulations should have been cited in the Statement of Deficiencies. Although several significant regulatory violations were cited by OMRDD in the November 2004 Statement of Deficiencies, there was evidence of other violations, some of which were serious in nature, that were not specifically addressed. Many of the violations that were missing from the Statement of Deficiencies had been identified by OMRDD survey team members identified during their November 3, 2004 visit to the Anderson School. The section below notes regulatory violations by the Anderson School that were not noted in the Statement of Deficiencies.
Seclusion / unauthorized time-out / abuse / neglect

The school’s use of planned ignore is cited in two places in the Statement of Deficiencies, in relation to a lack of guidance and clarity to staff in plan implementation as well as a lack of review by a special committee to examine high-risk therapies. However, to the extent that the planned ignore treatment involved extended periods in which Jonathan was confined to his room, and the conditions therein, the treatment constituted additional violations, including seclusion, unauthorized time-out, or neglect, all of which are forms of abuse.

OMRDD regulations defining abuse specifically prohibit seclusion, “The placement of a person in a secured room or area from which he or she cannot leave at will.”33 Although regulations permit a temporary time-out, its use must be implemented by “appropriately trained staff” according to a “written plan” and with “appropriate permissions.” Use of time-out for disciplinary purposes is prohibited.34 Neglect is a form of abuse defined as, “A condition of deprivation in which persons receiving services receive insufficient, inconsistent or inappropriate services, treatment, or care to meet their needs; or failure to provide an appropriate and/or safe environment for persons receiving services. Failure to provide appropriate services, treatment, or care by gross error in judgment, inattention, or ignoring may also be considered a form of neglect”35 (emphasis added).

33 14 NYCRR § 624.4(c)(4).
34 14 NYCRR § 624.20(ap); 14 NCRR § 624.4(c)(7).
35 14 NYCRR § 624.4(c)(10).
Although staff interviewed by the Inspector General’s Office differed as to whether Jonathan’s treatment constituted seclusion, time-out, or neglect, many agreed that it was at least one of the above. Former OMRDD Executive Deputy Commissioner DeSanto said that the Anderson School violated regulations regarding time-out because there was no approved time-out room and written time-out plan utilized by staff. Former Deputy Commissioner Abelseth told Inspector General’s Office investigators that the term, time-out or seclusion “is pretty irrelevant…if you want to call it bad time-out [or] bad seclusion, it was neglect….It was planned ignoring gone wrong….This was his own bedroom, they weren’t letting him out of his bedroom.” Former Area Director Trent said: “I would call that seclusion if they’re not letting him out…. [Planned ignoring] is not about sticking someone in a room….It’s prohibited and considered abuse in our system.” Trent added, “I would have classified it as seclusion and therefore abuse.” An OMRDD surveyor who had visited the Anderson School on November 3, 2004, reported that “this practice, taken in the extreme in which it was used with [Jonathan], constitutes seclusion, unauthorized time out or even neglect” (emphasis original).

When asked why the Statement of Deficiencies did not cite the Anderson School for using seclusion, unauthorized time-out, neglect, or mistreatment, Abelseth explained to the Inspector General that the behavior plan was not written as such. According to Abelseth, this means that Jonathan’s behavior plan, which was focused on implementing a planned ignore, did not appear to intend to implement seclusion or time-out, per se. Abelseth added, “Through a lot of incompetence at all levels, staff was doing what they thought was right.” She continued, “It was a poor behavior plan to begin with, Jonathan Carey was very difficult, very difficult…staff were at their wits’ end, there was no
monitoring or supervision by clinical or administrative staff probably…so [direct care staff] were doing their best.” Abelseth’s explanation implies that OMRDD need not cite a violation that was not intentional, in contrast to Articola’s statement that any violation should be noted.

Abelseth also said that OMRDD Central Office deferred the determination of abuse to the Taconic regional office, which was conducting the primary investigation. Abelseth said that neglect was the outcome, and OMRDD’s responsibility was to cite the deficiencies with the processes, not the result, and subsequently obtain a Plan of Corrective Action. She stated the purpose of the survey is to identify how the agency failed to meet regulatory requirements, and she was confident that OMRDD cited all the deficiencies appropriately and accurately. She said, “It’s not a punishment list.”

While it could be debated whether the use of Jonathan’s bedroom in the manner it was used (i.e., no time limits, removal of all stimuli, covering his windows, refusing to let him out) at the Anderson School constituted seclusion, unauthorized time-out, or neglect, all are characterized as abuse under OMRDD regulations. OMRDD did not cite any of these violations in its Statement of Deficiencies.

Depriving Jonathan of access to school

OMRDD did not address the Careys’ allegation of Jonathan missing several days of school. The Taconic regional office’s investigation substantiated that Jonathan missed school for a period of approximately two weeks. Had the survey cited the violation of Jonathan’s right to “meaningful and productive activities within the person’s capacity,” it might have noted Jonathan’s missed school as an example. As discussed earlier, State
Compulsory Education laws require that all minors, six to sixteen years of age, attend full time instruction “if in proper mental and physical condition.” State Education regulations state that students may be removed from their educational programs for periods of time under certain conditions and guidelines, but require that alternate instruction be provided for the student in the event of a removal from educational programming.

Expert opinion obtained by this office determined that, “There would appear to be no clinically appropriate reason for Jonathan Carey to miss multiple days of school, unless he was ill, to remain in his room…it would be necessary for him to be in school receiving services.” They suggested that if the Anderson School was concerned that Jonathan would remove his clothes at school, “Staff could have dressed Jonathan in clothing that would be difficult to remove.”

Permitting Jonathan to lie in urine

As noted in the previous section regarding the investigation by the Taconic regional office, the Inspector General found evidence that Jonathan was permitted to lie on a soiled bed for at least some period of time. Staff members were instructed to provide Jonathan with clean linens only a limited number of times during the day. Leaving Jonathan in this state could have been cited as a violation of his right to a “safe and sanitary environment.”

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36 Education Law §§ 3205, 3208.
37 14 NYCRR § 633.4(a)(4)(i).
Investigation of complaint by an involved party

OMRDD regulations specifically prohibit an individual involved in a complaint of abuse from participating in the investigation of that complaint. During OMRDD’s November 3, 2004, site visit to the Anderson School, an OMRDD surveyor found that this regulation had been violated. OMRDD did not mention this violation in its November 24 Statement of Deficiencies. OMRDD noted in a subsequent letter to the Anderson School, dated December 10, 2004, that the school had improved its procedures regarding investigations. However, like the November 24, 2004, Statement of Deficiencies, the December 10, 2004, letter did not mention Jonathan Carey or the Anderson School’s violation of protocols in this instance.

Unreported allegation of abuse

A violation identified in the Taconic regional office’s letter of findings to the Anderson School, but not in OMRDD’s Statement of Deficiencies, was a finding of “Inadequate follow-up on staff comment about alleged abuse (633.9 violation) – Behavior Management Report 10/4/04.” An Anderson School staff member wrote in a Behavioral Report Form on October 4, 2004, that he considered it to be abusive to deny Jonathan food because he would not put on his shirt. Regulations require that allegations of abuse be “recorded, reviewed, investigated, and reported to designated parties.” Anderson School supervisory staff did not generate a required report and make the proper notifications regarding the incident. This finding was not included in OMRDD’s November 2004 Statement of Deficiencies, although internal e-mails following the

38 14 NYCRR § 624.5(c)(1).
39 14 NYCRR § 624.4(a).
surveyors’ first site visit on November 3, 2004, noted problems with reporting abuse allegations.

Inaccurate example regarding meal modification

The Statement of Deficiencies criticized the Anderson School for depriving Jonathan of his regular meals on October 16, 2004, noting that “he was denied access to meals at the table contingent upon appropriate behavior and dress” and “there were no provisions for [him] to receive any meal or supplements if he did not get dressed.” The language in the one example given implies that Jonathan received no food on this date, which is inaccurate. Although Jonathan did miss meals on October 16, the Inspector General’s Office found that Jonathan was provided with substitute foods in the morning and ate a large meal with his parents in the afternoon. As noted above, OMRDD officials explained to the Inspector General that it is typical for a Statement of Deficiencies to give only one example of a violation. However, the statement should be accurate in the examples that it does reference.

Acceptance of a Plan of Corrective Action Containing Factual Errors

OMRDD required the Anderson School to prepare a Plan of Corrective Action that would remedy all violations identified in the Statement of Deficiencies. Although OMRDD required the Anderson School to revise its Plan of Corrective Action, it later accepted the document even though the school made statements contradicting OMRDD’s findings and provided dubious explanations for Jonathan’s treatment.

On December 21, 2004, the Anderson School submitted its Plan of Corrective Action, which responded to each of the violations cited in the Statement of Deficiencies
and included supporting documentation of improvements, revised policies and procedures, and evidence of enhanced services. The plan attempted to address the problems identified with behavioral programming development and implementation, consumer rights, dietary services, and staff training. The response by the Anderson School modified the process for the development of behavior plans to allow for participation and objection by family members/guardians and a review committee at the school, among other corrective actions. The plan was not initially accepted by OMRDD because the school “did not identify a specific staff person who would be responsible to ensure corrective action was taken” for each problem, and several corrective actions lacked “specificity” in terms of implementation (emphasis original). After the Anderson School clarified its response in January 2005, OMRDD accepted the Plan of Corrective Action.

In the plan, the Anderson School made claims regarding provision of meals to Jonathan that are not supported by the facts. The plan stated:

During the time in question...JC [Jonathan Carey] was consistently offered nutritionally equivalent meal substitutes in his room if he was exhibiting these behaviors at mealtimes. Nutritionally equivalent substitutes were offered to JC in his room regardless of his state of dress and/or behavior, unless his behaviors would have placed him at risk of harm.... Additionally, the consulting dietician conducted and documented an updated assessment on JC’s nutritional status during this time period to ensure that his nutritional status remained stable despite his refusals of meals and/or substitutes.

Evidence in records refutes these claims. Nursing notes revealed that Jonathan was going for longer periods of time without nourishment. Additionally, the November 30, 2004, e-mail from the Taconic regional office investigator to the OMRDD Central Office staff reported that, in the initial stages of Jonathan’s behavior plan, “If the boy did
not dress, there was no meal supplement or replacement. Such events were noted as ‘refusals,’ the boy refused to eat.” Taconic regional office’s investigation report also documented the number of regular meals missed by Jonathan (33 out of 84 meals, or 39.3 percent, between September 23, 2004 and October 22, 2004) and could not determine what foods Jonathan was offered during periods of time due to poor documentation.

Also of question was the Anderson School’s claim that the meals were “nutritionally equivalent meal substitutes” and that a “dietician conducted and documented an updated assessment on [Jonathan’s] nutritional status during this time period to ensure that his nutritional status remained stable despite his refusals of meals and/or substitutes.” In contrast to these claims, no dietician or nutritionist was consulted until 25 days after the September 27 behavior plan was modified and just one day before Jonathan’s parents withdrew him from the Anderson School. Even then, the nutritional supplement (polycose) recommended by the nutritionist was not obtained for Jonathan until days after his parents had removed him from the Anderson School. Prior to this consult, the meal alternatives were not consistent in amount, frequency, and type due to vague and ambiguous instructions.

In its Plan of Corrective Action, the Anderson School gave an unsupported justification for its failure to provide Jonathan with his regular meal. According to the Anderson School, “In order to preserve his safety and the rights of others, [Jonathan] was consistently offered nutritionally equivalent meal substitutes in his room if he was exhibiting these behaviors [refusing to dress, soiling himself] at mealtimes.” In fact, OMRDD found in its Statement of Deficiencies that Jonathan’s meals were withheld as part of a program of behavior modification. The Residence Manager stated, “I don’t
think they wanted him to have the regular meal in his room because it was basically where Jonathan would not come out of his room, everybody really wanted him to come back, and come out of his room…it got to the point where he seemed content to stay in the room.” An Anderson School nurse commented, “It would not have been in his best interest to bring his regular meal into his room because...the behavior wouldn’t have ended. I think [the Behavior Specialist’s] goal was just to get him back to the norm of getting dressed and coming to the table.” The Director of Children’s Residential Services added, “Well, we didn’t want to really encourage him to eat his regular meal in his room because it would be reinforcing for him. And then he would never want to reintegrate into it.” The Anderson School’s “safety and rights of others” justification for Jonathan’s meal deprivation went unchallenged by OMRDD.

In addition, the Anderson School’s response directly contradicted OMRDD’s finding that the school had implemented a behavior plan that prevented Jonathan from speaking to his parents. The Anderson School claimed that it was only a draft plan and had not yet been implemented. However, statements from Anderson School staff members clearly indicated that communication was being limited to one specific staff person and that other staff members were instructed not to have any communication with the parents. Additionally, the Careys reported that staff at the Anderson School “had already politely hung up on us before this week, they had already terminated our call.” Lisa Carey reported that the staff person she normally called to speak with Jonathan told her that she had been instructed not to speak with the Careys.

The Inspector General’s Office asked former Regional Director Articola about the Anderson School’s responses and evidence that suggested that some of the responses
were inaccurate. Regarding the evidence contradicting the Anderson School’s response that Jonathan was “consistently offered nutritionally equivalent meal substitutes in his room,” Articola stated, “I think you are right and I don’t know what we did about it…. This contradicts the findings, so it raises the question of acceptability.” He thought it might have been accepted because they looked at what the agency planned to do regarding the violation, going forward. He reiterated that there were differences between the focus of the survey and the investigation and that OMRDD Central Office is more concerned with preventing similar issues from occurring again.

The Inspector General’s Office questioned former Deputy Commissioner Abelseth about the accuracy of the Anderson School’s response with regard to Jonathan’s meal plan. After reviewing the response, Abelseth stated that although the first part of the response was not accurate, and more akin to a denial, the Anderson School then provided corrective actions to address the problem, including the development of a task force and new standard operating procedure. She emphasized that OMRDD’s acceptance of the Plan of Corrective Action does not signify that OMRDD agrees with Anderson School’s denial. “I can definitely see your point,” Abelseth said, responding to the Inspector General’s questions about the Anderson School’s response containing misinformation. She claimed that OMRDD did not get into the rhetoric as long as the corrective actions were acceptable. “We were pursuing getting correction at that time.”

Therefore, while OMRDD appeared to respond aggressively and appropriately to ensure systemic corrective actions were taking place, it also accepted a response from the Anderson School that was, in a number of cases, contradicted and unsupported by the evidence in the Jonathan Carey incident.
Inaccurate Information Provided to the Governor’s Office

On June 2, 2006, after learning that the Dutchess County District Attorney would not prosecute the case, the Careys wrote a letter of complaint to Governor George Pataki. In addition to arranging a meeting with the Careys, which is discussed further in a subsequent section of this report, the Governor’s Office requested that OMRDD and CQC prepare a combined joint response to the Careys’ complaints. The joint response was coordinated by OMRDD Associate Commissioner Michelle Gatens and was transmitted to the Governor’s Office on August 14, 2006. The information regarding OMRDD was provided to Gatens by OMRDD’s Regional Director for Quality Assurance Ron Rzepnicki. The joint response was reviewed by Executive Deputy Commissioner DeSanto prior to its transmission to the Governor’s Office.

The Inspector General found that OMRDD provided misleading or incorrect information to the Governor’s Office in this joint response. The Inspector General cautions OMRDD and all state agencies that information communicated to the governor should be factually accurate and verified prior to transmission.

For example, the Careys’ complaint to the Governor included an allegation that OMRDD did not address the following:

We personally found Jonathan on a visit lying naked on his bed, the bed almost completely soaked with urine, no sheet to cover him (in October) urine on the floor, Jonathan’s only window blocked with special paper to let light in, but he could not look out or anyone in. All of Jonathan’s toys and books were removed from his room. Jonathan’s pictures were also all removed from his walls.

The joint response provided to the Governor’s Office responded to this complaint with the following:
At the time of OMRDD’s investigation, Jonathan had already left Anderson School, so these allegations cannot be directly verified or refuted.

There was no documentary evidence to support the allegation and no evidence that the parents ever reported this to OMR[DD], CQCAPD, or CPS.

The Inspector General finds that these assertions are inaccurate or misleading.

The first bullet implies that Jonathan’s continued presence at the school was essential to addressing a complaint about his treatment. Not only is this poor investigatory practice, but the Inspector General obtained documentary evidence and statements from employees that indicate that Jonathan was allowed to remain on a urine-soaked mattress, that Jonathan’s window was covered with frosted paper, and that Jonathan’s toys, books, and pictures were removed from his room.

As previously addressed in the Taconic regional office analysis section of this report, the Inspector General’s Office identified numerous documents and Anderson School employees’ statements that lend support to this particular allegation.

Furthermore, as previously stated, the October 13, 2004 handwritten “New Protocol” for Jonathan, which was signed by staff working with Jonathan, read, “Sometime tomorrow we will [be] having frosted adhesive put up on window to eliminate the reinforcer of looking out the window. He should have No books, horse pillows, or anything he would find reinforcing in his room when he is non compliant.” In addition, it read, “If he wets again – take sheets off and don’t put clean ones on” (emphasis original).

In the second bullet, OMRDD wrongly reports that it did not learn of these allegations. The letter from the Careys’ attorney which contained Lisa Carey’s handwritten statement regarding Jonathan’s treatment at the Anderson School included
this allegation. The letter was transmitted to OMRDD on more than one occasion. On
November 2, 2004, the letter was transmitted to the Taconic regional office by the
Careys’ attorney. Also on this date, a facsimile was sent from Taconic regional office to
OMRDD Central Office.

The Inspector General’s Office questioned former OMRDD Commissioner Maul
regarding the misleading information provided to the Governor’s Office. He told the
Inspector General’s Office he did not recall ever reviewing the document. He said that his
special assistant likely reviewed the document and briefed him on its contents.

Release of Records

OMRDD Central Office does not notify parents of the result of its surveys, even if
a survey finds systemic deficiencies that impact a particular child. The Statement of
Deficiencies is provided only to the surveyed facility with a request for a responding Plan
of Corrective Action. The Careys made a written request pursuant to the Freedom of
Information Law to obtain a copy of the November 24 Statement of Deficiencies and the
Anderson School’s Plan of Corrective Action. According to the Careys, they received
the documents from an OMRDD attorney in the summer of 2005, approximately six
months after the Plan of Corrective Action was accepted. Michael and Lisa Carey claim
that they requested this material multiple times prior to this date, but OMRDD never sent
them the items as promised. While OMRDD could have been more responsive to the
Careys’ request, it appears that they complied with their obligations under the Freedom of
Information Law to release the records. Effective May 5, 2007, “Jonathan’s Law” was
passed, entitling parents and guardians greater access to records of investigations of
abuse and mistreatment at facilities regulated by OMRDD.
The Careys also alleged that OMRDD interfered with an investigation by the State Education Department by refusing to release records. According to the State Education Department, their investigation was closed because they believed the Careys had declined to cooperate. The State Education Department informed the Inspector General that they initially had difficulty obtaining records from OMRDD, but State Education Department records revealed that OMRDD eventually agreed to allow State Education investigators to review its entire file. Thus, the Inspector General’s Office found no evidence that the State Education Department closed its investigation because of OMRDD’s failure to produce records. As noted above, the Inspector General communicated to the State Education Department that the Careys wished the investigation to go forward, and the case was reopened.

**Additional Monitoring of the Anderson School**

OMRDD Central Office appropriately continued to monitor the Anderson School following its initial survey in November 24, 2004. These activities, as described below, indicate that OMRDD identified the serious problems associated with the Anderson School’s treatment of Jonathan, and sought to pursue additional reforms through subsequent monitoring.

From late 2004 and continuing into early 2007, OMRDD Central Office staff maintained a regular presence at the Anderson School, providing technical assistance to improve behavioral intervention, consumer rights, incident management, dietary services, and coordination of services. OMRDD Central Office staff conducted at least 17 separate site visits to the school between November 2004 and January 2007, a 27-month span.
While reports indicated that the Anderson School made improvements in many of these areas, ongoing issues continued to be found and documented.

Only two weeks after it issued its Statement of Deficiencies regarding Jonathan Carey, OMRDD made another visit to the Anderson School. On December 6-7, 2004, OMRDD Deputy Commissioner for Quality Assurance Abelseth, Chief Psychologist Jill Pettinger, and other OMRDD staff members conducted this monitoring site visit at the Anderson School. After the visit, Abelseth notified the Anderson School, in a letter dated December 10, 2004, of various deficiencies relating to behavior plans, use of planned ignore, and incident management. Although the letter noted incident management and investigation procedures had improved since OMRDD’s last visit, other areas of concern remained. With regard to one of the school’s residential programs, OMRDD noted that one behavior plan sampled was “poorly written,” while another behavior plan lacked “adequate data collection methodologies as only target behavior data was collected.”

Similar deficiencies were found by OMRDD with the agency’s educational program. Problems with data collection were noted in the sample of behavior plans, which included Jonathan Carey’s plan:

The data collection methods at the…School were deficient as they only involved collecting data on the target behaviors and did not provide a data collection or tracking system to monitor progress with use of the identified replacement behaviors.

The December 10, 2004, letter also stated that there were “no monthly psychology notes related to monitoring the progress of the consumers related to the goals/objectives identified in their Behavior Support Plans” and “no indication as to when the plans get
reviewed by the team to determine their effectiveness and when and if changes are in order.”

The December 10 letter further addressed the Anderson School’s use of planned ignore, citing Jonathan Carey as an example. “As written in the behavior plan for [Jonathan], planned ignoring could occur for a very lengthy period of time if the consumer did not meet the criteria for reentering the residence environment. Also, there were no time limits identified as to how long this time-out could occur and/or how many repeat interventions were appropriate.”

OMRDD issued another Statement of Deficiencies in July 2005 related to quality of behavior plans and incident management systems. In July 2006, yet another Statement of Deficiencies was issued for continued problems with program monitoring and implementation, dietary processes, and Individualized Education Program coordination between the residential and educational programs at the Anderson School. In each instance, Anderson School responded with a plan of correction action. As recently as January 2007, OMRDD issued a Statement of Deficiencies to the Anderson School for continued problems in the area of behavior plan implementation and monitoring, and lack of an appropriate number of occupational and/or physical therapies for residents.

**Differing Regulatory Standards for Consumers in State-Operated and Private Settings**

Under New York State law, OMRDD has broad discretion in managing state-operated programs, but must satisfy more stringent procedural requirements when issuing regulations applicable to private facilities. While OMRDD need only issue a policy to bind state facilities under its jurisdiction, in order to impose standards upon private
facilities like the Anderson School, OMRDD must promulgate regulations. Under the State Administrative Procedure Act, the promulgation of regulations requires the satisfaction of several procedural steps which include the publication of the proposed regulation, the opportunity for public comment, and a potential public hearing. The rule making process is facilitated by the Governor’s Office of Regulatory Reform (GORR), which provides oversight of the regulatory process, including conducting cost-benefit and impact analyses of proposed rules and analyzing with agencies whether certain rules should be eliminated.

The Inspector General’s investigation revealed that since at least 1994, OMRDD has had draft regulations on behavior management for modifying or controlling maladaptive or inappropriate behaviors. Relevant to this investigation, the draft regulations provide additional clarification and guidance on the practice of behavior modification, including the issues of restraint, seclusion, restrictive behavior modification techniques, and time-out. Additionally, the proposed section requires that all interventions “shall emphasize positive approaches in modifying behavior, focus on teaching new behaviors, and provide persons with the skills needed to enhance their everyday functions and quality of life.” Also, the draft regulations go beyond existing regulations in clearly prohibiting the use of food as a behavior management tool. The draft regulations specify that: (1) “No behavior management plan may deprive a person of a balanced and nutritious diet, served in appropriate times throughout the day;” and (2) “No behavior management plan may incorporate the use of food in which the form of the food served is different to that served other people in the facility (e.g., pureed when others get sliced meat/vegetables).”
These draft regulations are policy in OMRDD state-operated facilities, but since they have not been promulgated as regulations, they are not binding on voluntary programs such as the Anderson School. As OMRDD General Counsel Martinelli explained, “They are not obligated to comply with it because it is not a reg[ulation], and it is viewed more a[s] guidance from the state.”

This results in consumers receiving different protections solely due to whether they are placed in state-operated or voluntary programs. Because OMRDD’s ability to supervise voluntary programs is limited to enacted regulations, voluntary programs, generally, have less direction and guidance on implementing behavior management plans, when compared to state-operated programs. This discrepancy has substantial effects as there are approximately 140,000 individuals receiving services through state-operated or voluntary programs in New York State. Approximately 112,000 (80%) of these individuals receive services from voluntary agencies. The vast majority of individuals receiving services from voluntary providers in certain settings are not protected by the same standards and guidance as those in state-operated facilities.

Notably, some of the restrictive techniques employed by the Anderson School to modify Jonathan Carey’s maladaptive behaviors, such as his mealtime protocol and substitute food items, may have been prohibited under the draft regulations which apply in state facilities. Other practices, those that infringed on the rights of a consumer, would have been subject to additional scrutiny and review prior to implementation and would require continual oversight and careful vigilance when in use.

In 2001, a draft of this regulation was filed with the GORR. Martinelli reported to the Inspector General’s Office that the “1994 regs were formally proposed in the State
registry, and then it seems there was a lot of controversy, especially as it relates to certain restrictive behavior modification techniques, and the regulations were never adopted. Some thought the regulations to be insufficiently restrictive because they did not outlaw certain restrictive behavior modification techniques and others found them too restrictive.” A former OMRDD official familiar with this draft regulation recalled that some of the voluntary agencies had raised objections relative to their implementation, including insufficient staffing levels and financial concerns.

Subsequently, after two years of discussion between OMRDD and GORR staff, which included concerns voiced by outside parties, OMRDD agreed to withdraw the proposed regulation from GORR in the fall of 2003.

Former OMRDD executives were in favor of officially implementing behavior modification regulations. Former Deputy Commissioner Abelseth stated that the draft regulations parallel those already in effect for certain facilities and steps should be taken to enact them system-wide. Former Area Director Trent stated, “Clearly there are safeguards in [the draft regulations] that need to be in place for every provider of service.” Trent stated, “I would recommend that they get promulgated. Anything you can do to get that promulgated would be a safeguard and a protection to the people in our system.”

When asked if he thought the regulations should be enacted, former Regional Director Articola replied, “Yes, absolutely….Because without them we don’t have clear cut guidelines and we don’t have any standards in which to apply to the whole issue of behavioral programming throughout our community. They have to be there….I mean we [have] regulations on incident review, we [have] regulations for medication, but we don’t
have regulations for behavioral management? One of the keystones of OMRDD is behavioral management. It’s ludicrous.”

According to Martinelli, “OMRDD needs to re-focus its efforts on getting regulations promulgated in this area and this will be a priority in 2008.” OMRDD Director of Regulatory Affairs Barbara Brundage reported that OMRDD has formed a committee to discuss the proposed behavior modification regulations and that the agency is looking to promulgate the regulations that the committee suggests. Brundage said that OMRDD would likely “welcome” any recommendation to adopt behavior management regulations. The Inspector General’s Office encourages OMRDD to re-examine this issue to ensure consistent safety and oversight protections for all consumers statewide.

Conclusion

In conclusion, although OMRDD’s response to the incident was prompt and its technical assistance to the Anderson School following the incident was extensive, the Inspector General identified some areas of weakness in the survey conducted on November 3, 9, and 10. In particular, the Statement of Deficiencies resulting from the survey failed to note several regulatory violations, and incorrect statements made by the Anderson School in its Plan of Corrective Action were accepted by OMRDD. Also, the authors of the Statement of Deficiencies failed to coordinate with the Taconic regional office investigator, despite their stated intention to do so. Although OMRDD inappropriately provided misleading and inaccurate information to the Governor Pataki’s Office in defense of its review, the Inspector General’s investigation did not find that the OMRDD Central Office “purposefully minimized” its findings or attempted to “cover up” any findings of child abuse as alleged by the Careys.
The New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) is charged with oversight of the state’s mental hygiene programs for individuals with disabilities, regardless of whether those programs are run by the state or by private providers certified by the state. CQC has broad authority to make recommendations regarding care and treatment of individuals with disabilities in New York. As part of its oversight responsibilities, CQC is mandated by law to investigate complaints of child abuse or neglect occurring in OMRDD certified facilities, including the Anderson School. A child abuse investigation may generate additional investigations when, in the course of the initial investigation, other deficiencies and concerns related to quality of care are discovered. CQC’s broad mandate enables it to conduct investigations of systemic problems and to make recommendations for improving services to individuals with disabilities, in addition to investigating specific complaints.

The Inspector General found that CQC’s investigation of the Anderson School’s treatment of Jonathan Carey was insufficient. CQC’s investigator conducted a limited investigation and failed to adequately document her activities and to address all of the allegations concerning Jonathan’s care. CQC officials later overstated the extent of the agency’s investigatory activities in interviews with the Inspector General, in a hearing before the New York State Senate on the use of restraints, and in a written response provided to the Governor’s Office. In addition, CQC told the Inspector General that it

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40 Mental Hygiene Law § 45.07.
rarely “indicates” (substantiates) cases for serious emotional injury and almost never substantiates cases based on risk of serious emotional injury when conducting its child abuse investigations, despite the language of the law they are mandated to follow.

CQC’s Child Abuse Investigation & Findings

On October 23, 2004, the following report was transmitted to CQC from the State Central Register for investigation:

Narrative – 11 yr old Jonathan is autistic and acts out by taking off his clothes. The staff at the Anderson School withhold food from Jonathan whenever he comes to the dinner table without clothes. This situation has gone on everyday for the past month and he would go without two out of his three meals a day.

Miscellaneous Information – The parents brought Jonathan to the hospital today for a physical examination because they feared he was being molested at the residence. Jonathan currently has small bruises on his back and he has increasingly become violent. He has only started stripping naked in the last few months. The parents were told by staff that Jonathan received the bruises during a restraint. The staff also told the parents originally that Jonathan was refusing his meals before they found out the School was deliberately withholding meals as a part of the treatment plan. When the parents complained, the staff started giving Jonathan soymilk and yogurt as a replacement.

Laws Governing Child Abuse Investigations

CQC conducted a child abuse investigation which was referred to it by the State Central Register in response to the specific complaint regarding Jonathan Carey’s treatment at the Anderson School. In accordance with law, the purpose of the investigation was solely to determine if there was “some credible evidence” that the
target(s) of the complaint engaged in child abuse or neglect as those terms are defined in Social Services Law.\textsuperscript{41}

By law, CQC has 60 days to complete a child abuse investigation and make a recommendation to the State Central Register of whether to indicate (substantiate) or unfound (unsubstantiate) the allegation of abuse.

Two sections of the Social Services Law defining abuse and neglect are relevant to CQC’s child abuse investigations. Social Service Law § 412(8) defines an “abused child in residential care” as one who has experienced “death, serious or protracted disfigurement, serious or protracted impairment of physical health, serious or protracted loss or impairment of the function of any organ, or a serious emotional injury.” The responsible party may have inflicted the injury by any means other than accidental, or may have allowed the infliction of such an injury, or may have simply created a “substantial risk” of one of the types of injuries listed in the law. Commission of a sex offense against a child, or failure to comply with certain regulations resulting in a reasonably foreseeable serious injury to the child, can also lead to a finding of abuse.

The second relevant section, Social Service Law § 412(9), defines “neglected child in residential care.” A neglected child has experienced physical injury (rather than one of the more serious types of injuries described in the abuse section), other than minor injury, or the substantial risk of such injury, inflicted by other than accidental means. Failure to comply with certain regulations involving care, services or supervision of a child and such failure to comply results in physical injury, excluding minor injury, or serious emotional injury to such child where such result was reasonably foreseeable may

\textsuperscript{41} Social Services Law §§ 412(8), (9).
result in a finding of neglect. Also, failure to meet a personal duty that results in physical injury, excluding minor injury, or serious emotional injury or the risk thereof to the child may result in a finding of neglect.

CQC officials explained to the Inspector General’s Office that it has interpreted these two subdivisions of Social Services Law to mean that two factors must be met for CQC to substantiate a case: (1) an individual must breach a duty arising in law, regulation or facility policy that was owed to a child; and (2) that breach must result in a serious physical injury or a substantial risk of the same. Regarding the breach of an owed duty, CQC General Counsel Robert Boehlert stated that examples of this included: falling asleep while on duty, ignoring a child, or hitting a child during the course of supervising that child. As to the result of “physical injury,” or risk thereof, Boehlert stated that § 412(8), which defines abuse, contains “Draconian terms” which speak of “very, very significant, serious injuries,” while § 412(9), which defines neglect, “lowers the bar a little bit.”

As described above, the abuse and neglect sections applicable to CQC’s child abuse investigations also provide for indication of a complaint based on “a serious emotional injury” or “a substantial risk of…serious emotional injury.” However, CQC officials reported their belief that the emotional injury standard is difficult to meet and is

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42 Although Social Services Law § 412 does not provide a definition of “serious emotional injury,” a relevant and related section of the Family Court Act defining abuse and neglect in the familial setting does supply a definition of “Impairment of emotional health”/“impairment of mental or emotional condition” which is useful in clarifying the meaning of the term in the Social Services Law, particularly in regard to the allegations concerning Jonathan Carey. Under the Family Court Act, impairment of emotional and mental health “includes a state of substantially diminished psychological or intellectual functioning in relation to, but not limited to, such factors as failure to thrive, control of aggressive or self-destructive impulses, ability to think and reason, or acting out or misbehavior, including incorrigibility, ungovernability or habitual truancy; provided, however, that such impairment must be clearly attributable to the unwillingness or inability of the respondent to exercise a minimum degree of care toward the child.”
rarely used by CQC to substantiate a report. CQC’s application of abuse and neglect sections, in general, is discussed further below.

Although CQC will not substantiate a case unless there is both a breach of an owed duty by a custodian and serious injury or risk thereof to a child, CQC’s recommendation against indicating a case does not mean that there was no injury to the child or misconduct on the part of the caretaker. Rather, both factors must be met to substantiate the report for the purposes of the State Central Register of Child Abuse and Maltreatment.

If CQC determines that a child abuse allegation is unfounded, it may nonetheless determine that the child has been a victim of “institutional neglect” pursuant to Social Services Law § 412(10). A victim of institutional neglect is a child whose “health, safety or welfare is harmed or placed in imminent danger of harm” as a result of a failure within the institution. Institutional neglect may be caused by, but is not limited to, a problem related to “the provision of supervision, food, clothing, shelter, education, medical, dental, optometric or surgical care.” Such a finding is not reflected in the State Central Register, but a determination of institutional neglect, as with other unfounded reports, results in a notification to OMRDD or the Office of Mental Health, and CQC may choose to take further action, as it may with any founded or unfounded allegation of child abuse.

**Investigatory Activities**

CQC assigned Team Leader Doreen Bowser to conduct a child abuse investigation of the matter. In this instance, Bowser was the sole investigator assigned to this matter. Bowser conducted a site visit to the Anderson School on November 10,
2004. This was the only site visit conducted by CQC on this entire matter. During that lone visit, she interviewed four staff members: the three subjects of the child abuse allegation and a nurse. Additionally, the Director of Clinical Services provided Bowser with a prepared typed statement, although she was not interviewed. No other staff members were interviewed on this matter.

CQC reviewed a variety of documents during its investigation. These documents included numerous clinical and communication records from the Anderson School; medical records; injury reports; special education records; and correspondence between OMRDD, the Careys, and their attorney.

Report of Findings

CQC recommended that the allegation of child abuse or neglect be “unfounded,” or unsubstantiated. According to CQC’s December 2, 2004 Unfounded Case Summary, CQC’s rationale for its recommendation was as follows:

There is credible evidence that between September 27, 2004 and October 22, 2004, direct care staff occasionally withheld regularly scheduled meals from Jonathan in an attempt to manage his behavior (i.e., refusing to eat and/or refusing to get dressed to come to meals). When Jonathan did not get his regularly scheduled meal, he was offered alternate food items in his room. This was part of Jonathan’s behavior plan.

By their own accounts, all three subject staff members were aware of Jonathan’s behavior and what was being done to address it. However, as there is no credible evidence to suggest that the child was withheld all food or withheld food as a punishment, there is no breach of duty.

Jonathan was not harmed nor does it appear that he was at substantial risk of harm. On October 9, 2004, after Jonathan had refused to eat for an entire day, the Residence Manager appropriately contacted nursing staff who assessed Jonathan and noted no concerns. Subsequent examinations by a pediatrician and a nutritionist also revealed no concerns. Finally, the ER nurse…stated that the child appeared thin but not malnourished.
The second paragraph of the case summary finds that there was no breach of duty, one of the criteria needed for indication, according to CQC, for finding abuse. The final paragraph finds that Jonathan was not injured; injury is the second criterion for finding abuse.

On the basis of these findings, on December 20, 2004, CQC recommended to the State Central Register that the allegation of child abuse be unfounded. CQC’s recommendation was accepted by the register, which sent a letter to the Anderson School on December 21, 2004, officially notifying the school that the case was unfounded.

CQC also directly notified the Anderson School of its recommendation that the case be unfounded by letter dated December 20, 2004. In this, CQC noted that during the child abuse investigation, CQC “found several concerns which we plan on addressing with the [school] under separate cover.”

**The Inspector General’s Analysis of CQC’s Child Abuse Investigation**

In comparison with the investigation by the Taconic regional office and the survey by the OMRDD Central Office, the investigation by CQC of Jonathan’s treatment at the Anderson School was the most cursory. CQC Investigator Bowser conducted only one site visit, during which she interviewed only four witnesses, three of whom were the subjects of the complaint. In addition, she failed to investigate or issue findings related to the majority of the abuse allegations regarding Jonathan, focusing solely on the provision of meals. Finally, Bowser did not fully document her investigative activities and managerial oversight of the entire investigation was lacking.
Sufficiency of Investigation

*Failure to interview all pertinent witnesses*

CQC Investigator Bowser interviewed only four individuals during the course of her child abuse investigation. She interviewed the three subjects of the child abuse complaint, along with a nurse at the school. She did not interview any other administrators or any of the numerous members of the direct care staff who personally implemented Jonathan’s Behavior Support Plan, provided Jonathan with meals and substitute foods throughout this period, and witnessed the conditions in his bedroom.

One important witness who was not interviewed by Bowser was the Director of Clinical Services, who was ultimately responsible for behavioral programming at the school. Jonathan’s behavior plan called for treatment techniques that constituted the crux of the allegations of abuse. Bowser said she did not interview the Director of Clinical Services because this individual was not available at the time of her single visit to the Anderson School. Instead, she relied on a written statement which had been previously prepared by the Director of Clinical Services for the Taconic regional office’s investigation.

Investigator Bowser also never met or observed Jonathan Carey, even though CQC’s policies state, “As determined necessary by the work plan, we [CQC] will attempt to obtain written statements from the victim, witnesses and subject.” Although Jonathan was largely non-verbal, personally observing him and assessing his weight, as well as his overall physical and mental condition, might have proved valuable in this investigation.
CQC Director of Quality Assurance and Investigation Bureau Mark Keegan, Bowser’s supervisor, explained that the investigator did not meet Jonathan because he had already left the school. “There wasn’t a whole lot that we could do to try and make sure that his services and programming and life in general at Anderson School were better, because he was already gone….He was gone. We can’t make his life any better,” stated Keegan. He added, “In the ordinary course of events in a typical child abuse case, we, of course, will meet the child. We, of course, will try and interview the child, but again this is a different situation because the child was gone.” Bowser acknowledged that CQC has interviewed children at their homes, but she “didn’t feel that it was warranted [in this case].”

In contrast to CQC’s four total interviews, the Taconic investigator conducted at least 25 interviews with all levels of management and staff at the Anderson School in its investigation of the Careys’ complaints.

*Failure to obtain all pertinent documents*

On March 5, 2007, the New York Senate Committee on Mental Health and Developmental Disabilities held a public hearing to discuss “the use of restraints on our most vulnerable population in the care of OMRDD run or licensed facilities.” The testimony noted the recent tragic death of Jonathan Carey had raised concerns about the quality of care children with disabilities were receiving. In a hearing before the State Senate regarding CQC’s investigative process, CQC Chairman Gary O’Brien stated that CQC will “go about doing a thorough investigation, looking at record reviews and interviewing folks, looking at medical records or any record we can find.” However, O’Brien’s description of CQC’s investigative standards is not reflected in the agency’s
investigation of Jonathan Carey’s alleged abuse. In fact, CQC was aware of documentary evidence that was available, but CQC Investigator Bowser never sought or reviewed this evidence during her investigations.

CQC administrators did not obtain the investigative and survey documents although they acknowledged that it has the authority to request and obtain investigative information and findings from other entities as part of its routine activities. For example, CQC never requested a copy of the Taconic regional office’s investigative file, Taconic regional office had statements from approximately two dozen witnesses that were never seen by CQC. Although, like CQC, the Taconic regional office was conducting an investigation to determine whether it could substantiate allegations of abuse against Jonathan, in Keegan’s words, obtaining Taconic’s documents was “not necessary…we know what they found. It didn’t pertain at all to the child abuse case.” Bowser hypothesized that the statements would not have changed the outcome of the child abuse case because she already had obtained medical evidence that Jonathan was not physically harmed. Likewise, CQC never obtained investigative documents from OMRDD Central Office’s review.

In another example, CQC failed to review a logbook that the Careys’ claim to have found in Jonathan’s clothes bag. CQC was made aware of the logbook and the Careys’ claim that the logbook contained evidence of Jonathan’s abuse, but CQC never took steps to obtain the logbook during its investigation. Bowser’s handwritten progress notes indicate that she discussed the logbook in detail with the Taconic investigator on November 17, 2004. Her notes state, “[the log]book has good handle on the # of meals missed [by Jonathan].” As CQC’s findings in the child abuse investigation related
primarily to the provision of meals to Jonathan, the logbook should have been obtained and reviewed. Despite Bowser’s notes, during interviews with the Inspector General’s Office, CQC administrators reported that having the logbook would not have changed any of its findings and that it would not have added anything to the investigation.

CQC did not view the logbook until approximately two years later, in October 2006, well after its investigations had been completed. Keegan told the Inspector General’s Office that the only reason the logbook was examined at all was because the Governor’s Office requested that it be reviewed. When informed that Michael and Lisa Carey thought the logbook was critical because it contained evidence about their son’s mistreatment, Keegan disagreed, stating, “It was not - but they may have thought it was very important, but in terms of the child abuse investigation, it [the logbook] made no difference whatsoever.”

CQC staff even questioned the authenticity of the logbook possessed by the Careys. Keegan reported to the Inspector General’s Office that CQC eventually reviewed “something that’s purported to be a copy of the logbook…the Careys could have made it up, we have no idea.” However, the Inspector General’s Office easily verified the authenticity of the logbook by showing a certified copy of it to Anderson School staff during this investigation.

_Critical investigative activities not documented by CQC_

CQC child abuse investigation policies specify that, “All site visits require written documentation of the work accomplished.” In violation of CQC’s policies, Investigator Bowser failed to adequately document critical investigative activities, including specific
details about her sole site visit to the Anderson School and important witness interviews. Regarding interviews, the policy states, “All documentation of interviews must contain the following information: the name of the individual interviewed, the date and type of interview (in person or over the phone), the purpose of the interview, and the pertinent information obtained.” Bowser did not prepare required documentation of her telephone interview with Michael Carey. In addition, documentation of her interview of the nurse at the Anderson School was incomplete.

Bowser’s progress notes for the child abuse investigation contained two entries, dated October 29, 2004 and November 10, 2004, respectively, in which she wrote that a “memo to file” was completed to document the details of investigative activities on each date. However, Bowser did not prepare either memo. The first entry, dated October 29, 2004, reflected the investigator’s initial contact with Michael Carey to discuss the allegations in the child abuse case. In an interview with the Inspector General’s Office, Bowser admitted that she did not complete memos to the file about the conversation and site visit, but “fully intended” to write them. As a result of these lapses, CQC’s file has no information about the details of these significant activities.

In addition, the documentation of one of Bowser’s four interviews at the Anderson School was incomplete and difficult to interpret, as seen below. Bowser documented an interview with the Anderson School nurse on November 10, 2004, in handwritten notes on a piece of paper, which listed the nurse’s first name only. During an interview with the Inspector General’s Office, Bowser had difficulty reading and interpreting what her own interview notes meant. She indicated that typically her
interview notes would have been explained in more detail in the “memo to file” regarding
the site visit, but this was never completed.

CQC investigator’s November 10, 2004, interview note from the Anderson School nurse.
The investigator was unable to fully explain what her notes meant during her interview
with the Inspector General’s Office.

**Appropriateness of CQC’s Findings Regarding the Child Abuse Allegation**

CQC’s finding that Jonathan did not suffer physical injury or the risk thereof is
supported by the statements of medical professionals who examined Jonathan. However,
the Inspector General notes a number of deficiencies in CQC’s report of findings. The
The report does not address whether Jonathan’s treatment at the Anderson School caused him serious emotional injury or put him at risk of such injury. Neither does the report address any of the other allegations that were included in the original complaint received by CQC from the State Central Register regarding Jonathan’s care other than the withholding of meals. CQC’s determination that there was no “breach of duty” by the Anderson School is based on a determination that Jonathan’s food was not entirely withheld or withheld as punishment, and does not address any other potential errors or improprieties related to Jonathan’s treatment. Finally, the report inaccurately asserts that Jonathan was consistently provided substitute foods when his regular meals were denied or “refused.”

**Allegations of abuse not addressed in report**

The Careys made a number of allegations of abuse that were not addressed by CQC’s child abuse investigation. CQC’s case summary exclusively addressed the withholding of meals and related behavior plans. The initial allegation that the State Central Register transmitted to CQC, as well as the description of the Careys’ complaints by the hospital nurse to CQC, were much broader than simply the charge of withholding of food or meals. The nurse noted bruising to his back, and said that Jonathan had become increasingly violent. Although not an allegation made by the Careys, the nurse also transmitted an allegation of potential sexual abuse. These items were mentioned in the miscellaneous section of the child abuse report, just below the primary allegation. In CQC’s initial conversation with the hospital nurse who reported the allegation, the nurse again depicted problems beyond the withholding of meals. CQC’s progress notes reflect that the nurse reported that, in addition to “possible malnutrition,” Jonathan’s family complained of abuse and neglect. The notes also indicated that the parents reported that
Jonathan’s “demeanor has changed significantly,” a factor that could have represented the possible manifestation of some emotional injury.

*Incomplete or inaccurate findings regarding provision of meals*

The Inspector General’s Office found that CQC overstated its determination that the Anderson School provided substitute food items to Jonathan when he did not eat his regular meal. This finding was not supported by the evidence.

According to CQC’s Facility Investigation Summary Report, which was transmitted to the State Central Register, “when Jonathan did not get his regular meal, he was offered alternate food items in his room.” Similarly, CQC’s April 28, 2005 letter to Michael and Lisa Carey concluded, “In an attempt to manage Jonathan’s periodic refusal to put on clothes to come to the table and eat, staff did withhold his regular meal and offer a basic nutritional substitute as part of his behavior plan.” These letters and reports suggest that CQC was able to verify that substitutes were offered each and every time when Jonathan was not afforded his regular meal.

However, the evidence obtained by the Inspector General from the Anderson School and from CQC does not support this conclusion. Although the Anderson School began withholding meals from Jonathan on September 27, 2004, his behavior plan included no instructions for staff on what substitute foods, if any, to offer Jonathan if he did not eat his regular meal between September 27 and October 9, 2004. Furthermore, staff did not consistently document his food intake, and the nurse did not identify specific substitute food items for Jonathan until October 9, 2004, almost two full weeks later.
Even then, the October 9, 2004 protocol did not specify the amounts of substitutes to be given and in what combinations.

Although Anderson School administrators interviewed at the time by CQC, and later by the Inspector General, claimed that substitute foods were consistently provided in Jonathan’s case, there is insufficient documentary evidence to support this finding. Documentation of what, when, and in what amounts substitute food items were offered during this period was meager or missing altogether. Thus, there was insufficient evidence to conclude that Jonathan was consistently “offered alternate food items” when he did not get his regular meals throughout this period and that this was a component of his behavior plan. In its letter of findings CQC staff admitted that it had no way to determine what Jonathan actually ate during this period because Anderson School’s documentation was so poor.

Also, CQC’s case report is incomplete in that it does not address other allegations of abuse that were presented to it by the State Central Register. Although the Careys apparently never alleged that Jonathan had been molested, this accusation was nonetheless transmitted to CQC as part of the allegation to the State Central Register. The Inspector General’s Office found no evidence that CQC investigated the allegation of molestation at all. Likewise, CQC did not address the Careys’ broader concerns about abuse and neglect at the Anderson School, such as Jonathan’s bruises and his behavior changes. CQC staff acknowledged that the child abuse investigation focused solely on the issues of withholding of meals and behavioral plan implementation and development.

CQC staff offered the Inspector General’s Office two explanations for not examining all of the complaints levied in the child abuse case. First, CQC staff reported
that the additional complaints of abuse, neglect and molestation were contained in the
“Miscellaneous Information” section of the report from the State Central Register rather
than the actual narrative of the allegation. The second explanation provided was that
other investigative bodies were looking into all of the other allegations, relieving CQC of
its responsibility of investigating these aspects of the child abuse allegation and report.

The claim that CQC must only limit its investigation to complaints documented in
one section of the child abuse intake report, while ignoring information and allegations
contained in the miscellaneous or other sections of the report is specious. In fact, Mental
Hygiene Law requires that CQC commence “an appropriate investigation” of a report of
abuse or neglect of a child in residential care that includes, “A determination of the
nature, extent, and cause of any condition enumerated in such report.” It is improper
for an investigative agency such as CQC to ignore allegations because they do not appear
in the first section of the report.

The second explanation, that other investigative bodies were looking into all of
the other allegations, also falls short. CQC is charged by law with investigating
allegations of abuse or maltreatment at residential institutions like the Anderson School.
It must make a recommendation of its findings to the State Central Register. It cannot
chose one portion of an abuse allegation and refer other allegations that may constitute
abuse to another agency. Even if it were permitted, there is no evidence that CQC made
such a referral and as mentioned above, CQC took no steps to obtain materials reviewed
by other agencies.

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43 Mental Hygiene Law § 45.07(c)(2)(e).
No attempt to determine whether Jonathan suffered serious emotional injury or was put at risk of serious emotional injury

CQC’s finding that Jonathan did not suffer abuse at the Anderson School was, in part, supported by a lack of evidence of physical abuse. Although a finding of abuse can be based on a finding of serious emotional injury or risk of serious emotional injury to the child, CQC failed to sufficiently explore this possibility and ignored statements regarding Jonathan’s changed demeanor and increasingly violent behavior.

Despite CQC progress notes showing that the Careys told the emergency room nurse that Jonathan’s “demeanor has changed significantly” and that “he has increasingly become violent,” General Counsel Boehlert declared when interviewed by the Inspector General, “I don’t think there was any suggestion at the time from the parents that emotional impact was an issue; it was not a finding that we made. We had no evidence to suggest that there was emotional impact.” CQC Director of Quality Assurance and Investigations Mark Keegan expressed the same denial, stating, “There was never, to my knowledge, any complaint, any concern, any evidence of anything given to us that Jonathan was at risk of emotional harm. There’s nothing that we saw from his record that would indicate that he was in any way emotionally harmed. There was not even a concern, a consideration.” CQC Investigator Bowser said, “In looking at the stuff from [the hospital] and in talking with the parents, it was never implied that…Jonathan has…suffered greatly as a result of all of this.”

In contrast to these assertions, Michael and Lisa Carey reported to the Inspector General that Jonathan’s behavior had changed and that he had become more violent. Also, interviews with the Careys revealed that Jonathan displayed unusually obsessive
and aggressive behavior related to meals when he was removed from the Anderson School by his parents. Lisa Carey recounted it:

One thing I remember at the end of October is when we brought Jonathan home, we saw something with him we had never seen before where I would give him his meal and he would eat it seriously and give me back his plate and want more and I would give him seconds, and I was giving him a healthy second portion, and then he would give it back to me and want more. I had never seen him obsess on food this way, where he just felt like he couldn’t stop, and I would say ‘Jonathan, you have had enough, honey.’ I was afraid he might eat until he threw up, and he would just start to cry, very upset that I was saying no more, because I didn’t want him to eat until he threw up and I had never seen him do that before.

Lisa Carey added, “He came home having untriggered rages….He would just have them even sitting at the kitchen table in the middle of a meal….We had never seen this before so we didn’t know what to make of it.” She described, Jonathan was “crying at the end of the meal” when he returned home, but he stopped this behavior after “four or five weeks” when he “seemed to realize that he would be consistently fed again.” She postulated, “I honestly believe that behavior was spawned out of his fear of not knowing when his next meal might be.”

CQC did not explore the changes in Jonathan’s behavior that the Carey’s observed after Jonathan was removed from the Anderson School or even interview Lisa Carey. In addition, CQC failed to interview Jonathan’s Behavior Specialist at the Anderson School or any direct care staff member who may have provided insight into Jonathan’s deterioration and behavioral changes during his final months at the Anderson School.

CQC Chairman O’Brien acknowledged the potential negative emotional impact of what occurred with Jonathan. “I think anything done to any one of us has an impact on
us, whether good or for the bad,” he told the Inspector General’s Office. When asked about the specific techniques used on Jonathan, O’Brien stated, “I don’t know if it was part of their plan, I mean I don’t know the regulations, it was in violation -- I just don’t know them. Certainly it doesn’t sound very good.”

CQC has a Medical Review Board that can assist it in assessing the quality of care and treatment for individuals with disabilities. Members of the Board include a diverse group of physicians, surgeons, psychologists, pathologists, forensic pathologists, internists, pharmacologists and mental health professionals, among others. Despite having this resource available, Jonathan’s case was not referred to it for clinical evaluation, according to Chairman O’Brien and Investigator Bowser.

**CQC’s Care and Treatment Investigation & Findings**

Although CQC did not find that Jonathan Carey was a victim of abuse or neglect as defined in Social Services Law, it later issued a letter of criticism to the Anderson School under the umbrella of a care and treatment review of Jonathan’s care at the school. The letter primarily focused on the poor implementation of the meal modification portion of Jonathan’s treatment plan, but also criticized the school, as OMRDD had, for failing to include the parents in the development of Jonathan’s behavior plan.

**Purpose of a Care and Treatment Review**

According to CQC policy, a care and treatment review is initiated if “it is possible that the consumer will benefit from Commission intervention and if the situation described by the requestor is serious enough to warrant Commission review to insure that services are adequate, or if the Commission is likely to gain information that may have
systemic significance.” In a hearing before the New York State Senate on March 5, 2007, CQC Chairman O’Brien provided the following information about CQC’s care and treatment reviews:

Pursuant to Mental Hygiene Law, any one can contact the Commission to register a concern about their care and treatment, or that of a loved one. As a first step, we try to resolve the issue by offering the requestor advice, or by contacting the facility on the requestor’s behalf. When necessary, we initiate a review of the individual’s care and treatment, which usually entails site visits, record reviews, interviews, etc. During the course of our review we keep the requestor, usually a family member, regularly informed of the status of our investigation and, at its conclusion, we inform them of our findings both by telephone and letter. Last year [2006] we conducted nearly 250 such reviews.

The primary purpose of both death investigations and care and treatment reviews is to offer facilities recommendations on actions they should take to improve the quality of the care they offer individuals. In both of these types of investigations, we issue a written report of findings to the facility. When recommendations are offered, we request that the facility respond in writing within 30 days.

Chairman O’Brien added, “In the process of investigating a child abuse allegation we may see broader problematic issues that do not fit into the Social Services Law’s definitions of abuse or maltreatment. In such cases, we initiate separate care and treatment reviews which result in reports of findings, recommendations and requirements for submission and implementation of corrective action plans that are subject to further monitoring by the Commission.”

Investigative Activities Related to the Care and Treatment Review

According to CQC Investigator Bowser, although she could not substantiate the child abuse allegations of Jonathan Carey, her investigation revealed problems at the Anderson School that merited correction. Approximately two months after the conclusion of the child abuse investigation, on February 14, 2005, CQC Investigator
Bowser opened a “care and treatment” review regarding Jonathan Carey. On this same date, she sent the Anderson School a letter describing her findings. Although reportedly the result of a separate investigation, the findings of the care and treatment investigation were based solely on the information she collected for the initial child abuse investigation. Bowser testified to the Inspector General’s Office that she took no additional investigatory steps for the care and treatment review.

**Findings of the Care and Treatment Review**

CQC’s care and treatment letter to the Anderson School noted some of the same violations that were found by OMRDD Central Office in its survey of behavior plans at the school. Like OMRDD, CQC criticized the Anderson School for failure to include the parents in treatment plan development, and for providing insufficient detail in Jonathan’s behavior plan. The primary concerns listed in Bowser’s letter to the Anderson School were as follows:

- The Anderson School did not include Jonathan’s family in the “treatment team meetings or in the development of his behavior plans. It is also unclear what information from these meetings was shared with the family and when.”

- The Anderson School’s behavior plans and memos “did not provide staff with direction on how to respond if Jonathan refused to get dressed to come to meals.”

- There was no way to determine if the Anderson School’s September 27, 2004 memo (directing staff to document Jonathan’s food intake) was communicated to staff, as it was not part of Jonathan’s clinical record nor were staff signatures on it.

- Anderson School staff failed to track Jonathan’s food intake as required by nursing staff in the September 27, 2004 treatment team meeting until October 9, 2004.
Anderson School did not have consistent forms for documenting the food intake, so staff had to write this information freehand. “It is unclear what staff were required to document….It was unclear whether Jonathan was refusing to eat or refusing get dressed and come to the table to eat.”

**Correspondence with the Anderson School**

The Anderson School responded to CQC’s care and treatment investigation findings on March 1, 2005, stating that “our responses in no way should be construed as an admission of fact or agreement on the details of this matter.” Despite not acknowledging wrongdoing, the Anderson School outlined an extensive corrective action plan. Specifically, the Anderson School revised its standard operating procedures regarding developing and implementing Behavior Support Plans to include parental involvement in the treatment process, consent from the family and an internal review committee for plans that restrict resident rights or privileges, improved training for staff on behavior plans, development of a Behavior Support Plan tracking document, random sampling of residents’ Behavior Support Plans by the school’s Risk Management Committee to ensure compliance and oversight; and upgraded dietary services.

CQC replied to the Anderson School’s response on March 28, 2005. CQC’s letter stated, “While your response did not comment on our findings specific to this child, it did indicate that you have subsequently updated your Standard Operating Procedure (SOP) for the development and implementation of Behavior Support Plans.” CQC indicated that the Anderson School’s response addressed its concerns, so CQC concluded its review. CQC promised continued monitoring of the Anderson School’s effectiveness in the development and implementation of behavior plans.
CQC sent a letter signed by Bowser to Michael Carey on April 28, 2005, explaining its findings and the Anderson School’s corrective actions. The letter cited many of the findings related to the development and implementation of Behavior Support Plans contained in the aforesaid February 14, 2005 letter to the Anderson School. Specifically, the letter said that Jonathan’s Behavior Support Plan was not “updated to provide staff with specific direction on how to address Jonathan’s refusals and what staff were required to document. As a result, it is not clear why Jonathan did not always eat his regular meal (refused meal or refused to get dressed for meal), what staff did to address these refusals, and what Jonathan actually ate.” CQC concluded that the “Commission [CQC] found no clear evidence that staff were withholding food from Jonathan as punishment. In an attempt to manage Jonathan’s periodic refusal to put on clothes to come to the table and eat, staff did withhold his regular meal and offer a basic nutritional substitute as part of his behavior plan.” Additionally, the letter mentioned that the Anderson School had failed to include the family in the development and implementation of Jonathan’s plans.

**Complaint by the Careys**

Michael Carey responded to CQC on May 12, 2005, protesting that many of his complaints were not addressed by CQC and those that were investigated, were not done thoroughly. “We as Jonathan’s parents appreciate the work that was done by Doreen [Bowser], but we feel very strongly that all of our complaints were not followed up with, nor was the most important one, of Jonathan’s food being withheld from him for more than a month’s time for behavioral management, investigated thoroughly,” wrote Michael Carey. He reiterated his complaints that the Anderson School did not comply with
Jonathan’s casein-free diet, that Jonathan missed “8 full days of school,” that meals were used as behavior management, that Jonathan had “extensive bruises all over his body,” that he was allowed to lie naked in his room, that he was prevented from leaving his bedroom, and that the Anderson School attempted to suspend the Careys’ visitation rights and restrict their communication with Jonathan through a “point-of-contact” person at the School. He requested that CQC explain what was done on the investigation and provide clarification on the scope of its review so “we [the Careys] could possibly understand it better…. If these questions are outside of the investigation, please let us know. If not, we would like to know that this has been fully reviewed.” Mr. Carey also asked that CQC further investigate his concerns.

CQC acknowledged this complaint in a June 2, 2005 letter to Michael Carey signed by Director Keegan. Keegan informed Michael Carey that he would be reviewing the investigation conducted by Bowser. CQC General Counsel Boehlert explained to the Inspector General’s Office that CQC decided to re-examine the case because Michael Carey “was unhappy and he wrote to us and he asked us to review it again.” In the days following this letter, Keegan and Michael Carey spoke on the telephone and communicated via facsimile in an effort to clarify CQC’s role in the investigation.

On June 9, 2005, Keegan wrote a letter attempting to explain CQC’s role, the investigation, and the findings. Director Keegan reiterated in this letter that CQC conducted “two separate investigations” into the Careys’ complaints. The first, a child abuse investigation on behalf of the State Central Register, was unfounded “based in part on the results of Jonathan’s October 23 medical examination at [a local hospital], which revealed that [Jonathan] had no medical problems.” CQC reiterated that the criteria used
to indicate a child abuse case under Social Services Law are “quite severe.” However, as a result of concerns raised during the child abuse investigation, Keegan continued, CQC “opened a second investigation [the care and treatment investigation] which was designed to look at clinical issues regarding Jonathan’s care.” Keegan restated many of the findings that were identified in CQC’s April 2005 care and treatment investigation letter to Michael Carey.

The letter also informed Michael and Lisa Carey that the Anderson School revamped its procedures and policies regarding Behavior Support Plans and that CQC had recommended that the school take “systemic action” to ensure that future problems, like those encountered by Jonathan, were prevented. CQC further advised the Careys that it had met with OMRDD and Taconic regional office staff in December 2004 to discuss the problems at the facility, including incident management procedures (i.e., Jonathan’s bruising), and that OMRDD would “take the lead” to monitor the Anderson School as it implements change.

**Inspector General’s Analysis of CQC’s Care & Treatment Review**

Although CQC’s care and treatment letter notified the Anderson School of certain deficiencies related to Jonathan’s care, the Inspector General found that CQC never actually conducted a discrete care and treatment review as purported. Rather, it based its findings solely on the evidence collected during its cursory child abuse investigation. Investigator Bowser did not document any investigative activities in relation to the care and treatment review, and did not follow CQC policies regarding the breadth and scope of such a review. CQC officials later overstated the extent of the agency’s care and
treatment review to the Careys, the Inspector General, the New York State Senate, and Governor Pataki’s office.

**Sufficiency of Investigation**

The Inspector General found that CQC’s care and treatment review was not only insufficient, it was nonexistent. Despite assertions under oath by CQC senior officials to the contrary, Investigator Bowser admitted that she did not conduct a care and treatment review, but rather communicated certain findings of her child abuse investigation under the guise of a care and treatment review. CQC policies indicate that a care and treatment review should include a thorough examination of the child’s care, including interviews with relevant witnesses and a review of documents related to the child’s care going back six months. Because she merely repackaged findings of a care and treatment investigation that focused solely on Jonathan’s meals and related behavior plans, the findings of the purported care and treatment review were necessarily limited to these topics as well.

As noted above, Bowser’s care and treatment investigation did not involve any investigative activities other than those she had already completed for the child abuse investigation. Despite her admission under oath that she did not conduct a care and treatment investigation, CQC officials nonetheless insisted that she did. They contended that the reviews were performed simultaneously, with the investigator looking at the evidence with two different purposes in mind.

Bowser maintained that there was just one investigation, and that she opened the care and treatment review merely to issue a letter to the Anderson School, pointing out
some of its deficiencies. In her interview with the Inspector General’s Office she testified that the care and treatment investigation “was the exact same thing” as the child abuse investigation.

Bowser acknowledged that she could have written her findings into the child abuse letter of findings, but she said she wanted to make her findings accessible to the public. According to CQC staff, child abuse files are not subject to Freedom of Information Law (FOIL) and are sealed once they are completed. Bowser reported, “I could have written in to the closing child abuse letter our concerns, but you can’t FOIL those [requests] and I thought it was important enough that somebody -- that this is a serious matter. It needs to be FOIL’ed.”

According to her own testimony, Bowser issued findings of a care and treatment review that she never actually conducted. She simply transposed findings from her child abuse investigation under the umbrella of a care and treatment review. Had Bowser conducted a comprehensive examination of Jonathan Carey’s care while investigating the allegation of child abuse, it may have been legitimate to rely on the evidence she collected during the child abuse investigation to make care and treatment findings. However, as discussed above, Bowser limited her review of the child abuse allegation to the single accusation regarding Jonathan’s meals and related behavior plans, and didn’t fully explore other aspects of his care and treatment that were detailed by the Careys. As noted above, CQC’s care and treatment policies and testimony from several CQC executives suggest that the care and treatment review should have been a comprehensive examination of Jonathan’s care.
Documentation of investigatory activities

Below are forms from the file of Jonathan Carey’s care and treatment review that are intended to document investigative activities. (The date February 18, 2005, appears to be an error. It should read February 14, 2005.) While a separate investigation should have resulted in a complete and distinct case file, the care and treatment file progress notes and docket sheet were blank, as shown below.

![Progress Notes Form]

![Docket Sheet Form]

Actual CQC case file documents for Jonathan’s care and treatment review.

Even if Bowser relied on documents and interviews related to the child abuse investigation, the documents she relied on to make her care and treatment findings should have been recorded in the care and treatment file. Bowser told the Inspector General’s
Office that progress notes and a document inventory related to the care and treatment investigation were not completed because she did not do a care and treatment investigation.

*Interview of witnesses*

CQC’s General Counsel Boehlert told investigators from the Inspector General’s Office, “Our investigators would interview anyone who they thought may have information relevant to care and treatment.” However, since CQC’s investigator only interviewed four individuals at the Anderson School for her child abuse investigation, she relied only on those interviews in making her care and treatment findings. In doing so, she missed issues related to Jonathan’s care and treatment that were identified by Taconic regional office Investigator Searle. Many witnesses interviewed by Searle voiced concerns about the way Jonathan was treated at the Anderson School. Some acknowledged that they were uncomfortable about the way Jonathan was kept in his room and the practice of holding the door, that his regular meals were withheld if he would not get dressed, and that he was observed lying in his own urine, among other concerns.

*Obtaining documents*

CQC policies on care and treatment investigations require, “If possible, all information recorded for at least the past six months should be reviewed to ensure that an accurate and thorough review is completed” (emphasis original). Bowser did not obtain all information recorded for the last six months regarding Jonathan for her child abuse investigation, and therefore did not have it for her care and treatment review.
As noted above, Bowser also failed to obtain records from OMRDD and Taconic regional office before issuing her child abuse findings. She admitted that obtaining Taconic regional office’s investigative material and findings would have provided insight for a care and treatment review, but she had no need to obtain them since she did not conduct one. She stated, “It’s all the same. There was nothing different. There was nothing different for the care and treatment [case].” Bowser acknowledged during the interview that she would have done more had she completed a care and treatment review.

**Appropriateness of CQC’s Care and Treatment Findings**

Evidence suggests that the care and treatment review— as ultimately conceded by Chairman O’Brien – did not address many of the Carey’s complaints. In the care and treatment review, CQC had the opportunity to address any issues related to Jonathan’s care, even those that would not qualify as abuse or maltreatment under the laws governing the State Central Register. However, the findings of this investigation were limited to the withholding of food and behavior plan deficiencies, the same narrow focus of the child abuse investigation.

*Complaints related to care and treatment that were not addressed*

As in the child abuse investigation, CQC’s findings regarding Jonathan’s care and treatment primarily addressed the provision of meals to Jonathan and ignored other complaints. Investigator Bowser confirmed that Michael Carey made numerous complaints about the Anderson School during a telephone call on October 29, 2004. In addition, CQC received a copy of a letter from Michael and Lisa Carey’s attorney that included their 16-page handwritten statement detailing a myriad of allegations regarding
Jonathan’s care, not just the single allegation of withholding meals. CQC received another copy of the letter by fax from OMRDD Central Office around the same time. Other allegations included failure to provide a casein-free diet, extensive bruising that went unreported, missing one-to-two weeks of school, the conditions Jonathan was placed in while in his bedroom, planning to suspend parental contact, and filtering their communication with Jonathan and staff who cared for him through a “point of contact.”

When asked why CQC focused solely on the issues of withholding of meals and the related behavior plan development and implementation, Keegan replied, “Because...that’s what we chose to do. We get to pick and choose what we’re going to look at in terms of internal investigations, and that’s what we chose -- that was identified to us. That was something that we identified as a problem.” Keegan also offered another justification; “The Careys never made a complaint to us....They made a complaint to OMRDD. OMRDD was already investigating it. They chose to make their complaints to OMRDD, not to CQC.” As noted earlier, the Careys also sent their complaint to CQC, placing CQC on notice of their concerns.

Claim of coordination with OMRDD

As an alternative explanation for not conducting an extensive care and treatment review, CQC officials indicated that they were aware that other entities were conducting the investigation, so any duplication of efforts would have been wasteful. “And we’re also aware that OMRDD had received those concerns and was doing an investigation into those concerns, and it would be -- it would be duplication and a waste of our very, very limited resources to go in and do exactly what OMRDD was already doing,” said Director Keegan. This sentiment was also expressed by Bowser, who admitted that she
did not do a full care and treatment review in this case. She explained that if the Careys had contacted CQC, as opposed to the Taconic regional office, and CQC was conducting a typical care and treatment investigation, then she would likely have interviewed more people and explored more issues. She contended that she told Mr. Carey on October 29, 2004 that she was going to focus on the child abuse allegation and that Taconic regional office was addressing the other issues. She reportedly told him that if he was unhappy with Taconic regional office’s investigation, he could then complain to CQC. Bowser said that she told Mr. Carey that “since the [Taconic regional office] is going in...and looking at his concerns and doing an investigation, that we wouldn’t be duplicating that. You know, I have to do this piece...for the SCR [State Central Register], which is what I’d be concentrating on and that if he wasn’t satisfied with the outcome of the [Taconic regional office] investigation, he could always give us a call.”

The Inspector General recognizes that CQC has discretion to choose the focus of its care and treatment investigations. In its responsibility as an oversight agency, it may logically and appropriately choose not to devote resources where OMRDD has sufficiently done so. However, evidence in this case does not indicate that a thoughtful application of CQC’s discretion was the cause of its abbreviated care and treatment review. Rather, the findings of the care and treatment review were based on an abbreviated child abuse investigation, which necessarily limited the scope of the care and treatment review.

In interviews with the Inspector General’s Office, CQC officials overstated the agency’s role in coordinating with OMRDD and the Taconic regional office and ensuring that aspects of the investigation were addressed by both. CQC claimed it communicated
with OMRDD and the Taconic regional office to coordinate investigative responsibilities and roles in responding to the Careys’ complaints. According to Boehlert, “We knew in the course of the child abuse investigation, Mr. Carey had also complained to OMRDD. We spoke with OMRDD and we agreed that we would follow-up with the behavioral treatment plan issues that we’ve identified during the course of the child abuse investigations and OMRDD was going to see to some of the other complaints that Carey [sic] brought forth.” Keegan added, “We [CQC] were looking at the behavioral programming. OMRDD was looking at the broader issues,” and he pointed to a meeting that was held in December 2004 in which they claimed these things were discussed.

However, no official at the Taconic regional office or at OMRDD Central Office recalled any discussions with CQC to parse out investigative responsibilities in this case. In contrast, several administrators from OMRDD commented that CQC’s assertion did not make sense, that it was not something CQC had done previously, and that they could not even understand how an agency would be able to break out parts of an investigation. Former Commissioner Thomas Maul told the Inspector General that he did not recall any discussions with CQC about these purported distinct roles. He added:

You would still have to do the proper fact finding....I would consider that [breaking up investigative responsibilities between OMRDD and CQC] highly unusual. Personally, I do not think that was the case and secondly, to my knowledge it never existed on another [investigation]. CQC’s role is as an independent, investigative body, so how could you delineate it that way? They have to come up with complete findings. It doesn’t make any sense….[CQC] would have to look at the entire thing….I would go even further. It would be inappropriate for [CQC] to even offer that power [separating out an investigation] because you couldn’t possibly come to a factual conclusion.

Other OMRDD executives reported to the Inspector General’s Office that they had no recollection of any discussions with CQC to divide investigatory responsibilities.
CQC’s progress notes indicate that Investigator Bowser communicated with Taconic regional office’s Investigator Searle on November 8, 2004, and again on November 17, 2004, but the notes contain no indication of splitting investigative assignments between Taconic regional office and CQC. Further, both OMRDD and Taconic regional office also reviewed the allegation of withholding of meals and behavior plan development and implementation, thereby duplicating CQC’s investigative work.

Even if CQC was under the belief that other agencies were handling different parts of the investigation, CQC inexplicably failed to obtain Taconic regional office’s and OMRDD’s final reports; investigative documents and materials; and all letters of findings, if only to ensure that each and every complaint made by the Careys had been thoroughly examined by these entities, which is part of CQC’s oversight responsibilities. When ask by the Inspector General why she did not get all of the relevant materials, Bowser said, candidly, “I don’t know, because I do, typically, do that.”

Expert opinion of Jonathan’s care and treatment

Although the Inspector General did not make findings regarding the quality and appropriateness of Jonathan’s care and treatment, the office engaged experts specializing in autism-spectrum disorders to provide context for this investigation. Unlike CQC, the experts performed a full review of Jonathan’s care and treatment, based on the documentation and evidence provided, and their findings are summarized briefly in this section.

The experts noted, “The care and treatment that Jonathan Carey received…was not based on research or recommended practices that were available in 2003 – 2004 and
was provided by individuals that lacked the competence and skills to implement the treatment strategies in a correct and acceptable manner.” A number of concerns were cited by the experts including the use of highly restrictive interventions, the failure to “collect ongoing, systematic data on the effectiveness of these strategies and their potential side effects,” and the lack of parental notification and consent. As for the meal contingency program, the experts determined, “The contingent use of food or withholding of food for a child engaging in noncompliance and other problem behaviors overall is considered clinically inappropriate….Withholding regular meals for an individual who is nonverbal…is particularly unethical according to recommended practices in the field of developmental disabilities.”

They further added:

Moreover, individuals with training and certification in applied behavior analytic methods…certainly should have been aware of best practice as well as ensured that direct care staff implemented best practices with integrity; clearly this did not occur….When Jonathan’s behavior escalated, they continued to implement practices that would be considered punishment….These strategies prevented Jonathan from obtaining adequate nourishment and opportunities to socially interact and learn from attending school and in our professional opinion violated Jonathan’s basic rights. As a result, Jonathan appeared to suffer physical and emotional harm, which is demonstrated by the bruises on his body and the anxiety he displayed through the increase of behaviors, such as bolting, aggression, and incontinence.

Inaccurate Information Provided by CQC Officials

As established above, CQC conducted a limited child abuse investigation and issued findings of a care and treatment review that was never conducted. The Inspector General found that, following the completion of the investigation, CQC officials
repeatedly attempted to exaggerate the extent of their efforts in investigating Jonathan Carey’s treatment at the Anderson School.

Claim of Two Investigations

As noted above, Bowser, who was assigned to investigate the allegations regarding Jonathan Carey, testified clearly and repeatedly to the Inspector General that she did not conduct a full care and treatment review, but rather she issued findings related to her child abuse investigation under the guise of a care and treatment review so that the document could be made public. The investigative file related to the care and treatment review supported her assertion that she took no additional investigative steps. Nonetheless, CQC executives insisted in interviews under oath with the Inspector General that a care and treatment investigation was conducted, and they overstated the extent of the agency’s activities in a letter to the Careys, in a hearing before the New York State Senate, and in a communication to the Governor’s Office.

In a hearing before the State Senate Committee on Mental Health on March 5, 2007, CQC Chairman O’Brien said that, in addition to the child abuse investigation, CQC “worked with the Careys. We [CQC] opened up a care and treatment review….We investigated his care and treatment because we saw significant problems with the way that Jonathan was being treated at the Anderson School.”

Similarly, Director Keegan and General Counsel Boehlert also made after-the-fact claims that CQC conducted two separate investigations. Keegan wrote, in a June 9, 2005 letter to the Careys, that “the Commission [CQC] conducted two separate investigations….As a result of concerns which surfaced during our initial investigation,
we opened a second investigation which was designed to look at clinical issues regarding Jonathan’s care.” After an inquiry from the Governor’s Office, in August 2006 Boehlert coordinated a response to the Governor’s Office stating, “CQCAPD conducted two separate investigations; a child abuse investigation pursuant to a complaint filed with the State Central Register (SCR) based on the parent’s report that the school had denied meals to the child, and a care and treatment review which followed up on issues identified by CQCAPD in the course of the SCR investigation.”

CQC executives claimed to the Inspector General that its care and treatment review was “thorough.” However, the Inspector General finds this claim, that it conducted a separate “thorough” care and treatment investigation, incredible. As documented above, CQC conducted no additional interviews or site visits as part of the care and treatment investigation. Furthermore, no additional records were obtained by CQC during this so-called second investigation.

In fact, CQC conducted only one superficial investigation, the child abuse investigation, during which it identified some systemic weaknesses that were later transmitted in a separate letter. Investigator Bowser admitted that CQC’s claim that two separate and independent investigations were done was not accurate, stating, “No, I didn’t go down and do a separate…site visit and a separate care and treatment case looking at…a separate…a separate situation or whatever, so no. I didn’t.”

CQC management claimed that Bowser was mistaken in her testimony in the Inspector General’s investigation. Director Keegan, Bowser’s supervisor, said that he was surprised that Bowser said she did not do a second investigation because she did do one. He claimed that the two investigations were done simultaneously but with different
focuses. “We did it at the same time, but they’re two separate activities. It was more
than what was required to do the child abuse investigation,” he said. He added that the
second investigation had its own case file (albeit, the progress notes and docket sheet are
blank as depicted earlier) and case number and generated a separate findings letter.
However, he acknowledged that the second investigation consisted of the very same
information, interviews, and site visit as CQC’s child abuse investigation.

As for the scope of the purported second investigation, or care and treatment
review, Chairman O’Brien initially characterized it to the Inspector General’s Office as
“very thorough,” “broader” than a child abuse investigation and “expansive.” Yet when
pressed by the Inspector General on the fact that no additional activities were conducted,
Chairman O’Brien replied that it was actually a “focused, specific review.” “We
narrowed what we were doing, that’s all I know.”

Other Misleading or Inconsistent Information Provided by CQC to the
Governor’s Office

In addition to the misleading information about the extent of CQC’s care and
treatment investigation, CQC provided further inaccurate information related to its
investigation of the Carey matter in a document transmitted to Governor Pataki’s Office.
The information was requested by the Governor’s Office in response to the Careys’
complaint about the investigations of their son’s case. The information was transmitted
to the Governor’s Office by OMRDD Associate Commissioner Gatens, who was
responsible for coordinating the responses of OMRDD and CQC to the Careys’
complaint. CQC General Counsel Boehlert provided the information related to his
agency to Gatens. The Inspector General cautions CQC and all state agencies that
information communicated to the governor should be factually accurate and verified as such prior to transmission.

*Claim that CQC was unaware of certain allegations*

Although the Inspector General found evidence to the contrary, CQC denied having been informed of allegations regarding the conditions of Jonathan’s room and asserted that there was no documentary evidence to support the Careys’ claim. The Careys claimed that:

We personally found Jonathan on a visit lying naked on his bed, the bed almost completely soaked with urine, no sheet to cover him (in October), urine on the floor, Jonathan’s only window blocked with special paper to let light in, but he could not look out or anyone in. All of Jonathan’s toys and books were removed from his room. Jonathan’s pictures were also all removed from his walls.

The document transmitted to the Governor’s Office read:

- There was no documentary evidence to support the allegation and no evidence that the parents ever reported this to OMR[DD], CQCAPD, or CPS.

As previously addressed in the Taconic regional office analysis section of this report, the Inspector General’s Office identified numerous documents and Anderson School employee statements that lend support to this particular allegation. Furthermore, as previously stated, the October 13, 2004 handwritten “New Protocol” for Jonathan, which was signed by staff working with Jonathan, read, “Sometime tomorrow we will [be] having frosted adhesive put up on window to eliminate the reinforcer of looking out the window. He should have No books, horse pillows, or anything he would find reinforcing in his room when he is non compliant” (emphasis original). In addition, it
read, “If he wets again – take sheets off and don’t put clean ones on.” Hence, based on the above-referenced documents alone, the Inspector General’s Office questions the veracity of CQC’s response.

Further, the Inspector General’s Office finds the statement referencing no evidence of the Careys ever reporting this to CQC to be erroneous. The November 1, 2004, letter from the Carey’s attorney to Taconic regional office, which was copied to CQC Investigator Bowser, explained the aforementioned allegations. Attached to this letter was a copy of Lisa Carey’s handwritten statement read during the October 25, 2004, CSE meeting which expounded on the allegations in greater detail. Furthermore, a copy of the November 1, 2004, correspondence was again provided to CQC Director Keegan by OMRDD officials via facsimile on November 3, 2004.

When confronted with this seemingly inaccurate response, CQC Chairman O’Brien offered, “Yeah, I don’t know what to say about that. You know, you’d have to specifically ask Mark [Keegan] or Doreen [Bowser] if they would have gotten that information. You know, I was not involved, so I don’t know.” O’Brien’s response that he “was not involved” in CQC’s formal response to the governor, despite his position as head of the agency, is startling. General Counsel Boehlert was also shown evidence in behavior plans from CQC’s own files that seemingly supported the original allegation by the Careys. He responded, “We did not do the investigation of that allegation.”

Moreover, the Inspector General’s Office asked Director Keegan about the accuracy of the joint response statement that, “There was no documentary evidence to support the allegation and no evidence that the parents ever reported this to OMR[DD], CQCAPD, or
CPS.” Keegan acknowledged that it was not accurate and that CQC did know about the conditions in Jonathan’s bedroom at that time.

Claim that CQC was unaware of a logbook documenting Jonathan’s meals

Another example of imprecise information contained in the joint response related to the Careys’ claim that:

- OMRDD, CQCAPD and the State Education Department all failed miserably in the handling of Jonathan’s abuse and neglect.

In addition to asserting its claim of having conducted two full investigations, CQC responded to the accusation with the following:

- CQCAPD’s investigator has no recollection of having been told by the parents of a ‘logbook’ documenting withholding of food, nor of having told the parents that ‘she absolutely considered what happened to Jonathan abuse and neglect.’

As previously noted, Michael Carey told the Inspector General’s Office that he informed Investigator Bowser during an October 29, 2004 telephone conversation that he had in his possession a “logbook” which clearly said, according to Michael Carey, “meals were being withheld.” When questioned by the Inspector General’s Office, almost three years later, Bowser said that she could not recall Michael Carey informing her about a logbook. Since Bowser failed to document the conversation, the Inspector General cannot verify these statements. However, she admitted that she was made aware of the logbook during the course of the child abuse investigation in 2004, but not by the Careys. Nevertheless, she chose not to review it. She told the Inspector General, “I talked to the OMRDD [Taconic regional office] investigator about the logbook, but I did not look at it personally.”
Although the statement provided to the Governor implies that CQC did not know of the logbook, CQC General Counsel Boehlert claimed we “never suggested that we weren’t aware of the existence [of the logbook.] We said that the parents did not bring this to our attention….I think we got [the logbook] a couple of ways: via their attorney in November [2004] and via the folks at OMRDD.” CQC Director Keegan added, “I don’t know; I didn’t write it [the response]….It says that the investigator has no knowledge of it. Now that’s probably in error, because I know that she did. I don’t know who wrote it. I don’t know what basis it was. I don’t know, but you know we all know that she was told by [the Taconic regional office investigator] that there was a logbook.”

The Inspector General’s Office questioned Chairman O’Brien regarding the misleading information provided to the Governor’s Office. Despite the fact that the intended recipient of the response was the Governor, O’Brien did not recall reviewing the document until he was preparing to meet with the Inspector General’s Office, over one year after the document was drafted.

The joint response developed by both OMRDD and CQC contained factual errors, misrepresentations, and misleading information to the Governor’s Office.

**Notification of Law Enforcement**

CQC did not notify a law enforcement agency regarding Jonathan’s abuse. New York State Mental Hygiene Law reads, “If it appears that a crime may have been committed, the commission [CQC] shall give notice thereof to the district attorney or other appropriate law enforcement official.” 44 A CQC document, entitled “Checklist for

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44 Mental Hygiene Law § 45.07(f)(2).
SCR Intake/Follow-up,” that is completed by CQC to ensure all initial activities are taken when a case is received, indicated that the police were not informed of the allegation when it was first received, in late October 2004. Investigator Bowser reported that it is standard practice for CQC to ensure that law enforcement has been notified when it is believed that a crime may have been committed. When asked why the police were not contacted immediately, Bowser said, “We didn’t see anything that would…necessitate a call to the police. I mean, apparently the parents had called the police. I don’t know what happened with that.” General Counsel Boehlert also stated, “If we had seen evidence of what we thought was criminal conduct, we would have reported that. We didn’t see that.”

Given CQC’s findings, the Inspector General does not criticize its decision not to notify the district attorney or law enforcement.

**Inadequate Investigative Oversight**

The Inspector General’s Office found deficiencies in case supervision and oversight at CQC. CQC child abuse policies note that its investigators are responsible for ensuring that child abuse investigations are complete and that the investigator’s Team Leader is responsible for ensuring the record “is complete and accurate.” The investigator assigned to this case, Bowser, was also the Team Leader. Final responsibility for ensuring that the information is complete rests with the Director of Quality Assurance and Investigations, according to policy. Since two memos to the case file were never completed by Bowser, it appears that Keegan did not adequately review the file to ensure it was complete when it was submitted for review.
The oversight deficiencies were even more pronounced in CQC’s so-called care and treatment investigation. Again, according to CQC care and treatment investigation policies, the CQC investigator is responsible for the completion of the case file and its contents, while the Team Leader is responsible for reviewing the record to ensure it is complete and accurate. As in the child abuse investigation, the investigator assigned in this case, Bowser, was the Team Leader. Since the docket sheet and progress notes were blank, it appears that the oversight of the investigative case file was not sufficient.

Keegan, who is Bowser’s supervisor, reported that she played both roles as investigator and team leader and was responsible for checking her own work. Given this scenario, Keegan was asked by the Inspector General whether the responsibility for ensuring the completeness of the case file should have defaulted to him. He responded, “You can make that argument that it should, but I’m actually much too busy to be able to look at…case files…from the team leaders or investigators.”

**CQC’s Application of Child Abuse Statutes**

In making their complaint to the Inspector General, Michael and Lisa Carey asserted that CQC has misinterpreted the definitions of child abuse and neglect contained in Social Services Law § 412(8)-(9) that are detailed earlier, and that this misinterpretation results in a failure to identify and prevent child abuse throughout the system. The Careys cited as evidence of this misinterpretation the fact that CQC substantiates only approximately five percent of the child abuse allegations it investigates. The Inspector General found that CQC, in at least one case, used incorrect criteria in determining whether a child has been placed at risk of physical injury. In addition, CQC makes little effort to evaluate whether the disabled children in its
jurisdiction have experienced emotional injury as a result of abuse, and virtually no effort
to evaluate whether they have been placed at risk of emotional injury. Finally, the
Inspector General found that CQC’s practice of designating certain unfounded cases as
“institutional neglect” is contrary to the plain language of the Social Services Law and
results in requests to providers and OMRDD to review incidents that do not merit any
further attention.

**Different Rates of Substantiation Between CQC and OCFS**

As noted earlier in this report, CQC is assigned only a small percentage of child
abuse allegations state-wide. The State Central Register of Child Abuse and
Maltreatment accepts more than 140,000 reports a year of suspected child abuse or
maltreatment, most of which occur within family settings rather than to children in
institutions. Approximately one percent of reports per year deal with allegations of abuse
or maltreatment in institutional settings. Of this one percent, CQC reviews allegations
against residential care facilities operated or certified by OMRDD or the State Office of
Mental Health.

Like CQC, the Office of Children and Family Services (OFCS) also reviews
certain child abuse allegations originating in institutional settings. OCFS is responsible
to review cases of OCFS operated or licensed residential care facilities and certain
programs under the jurisdiction of the State Education Department, such as schools for
the blind and schools for the deaf. When conducting investigations of alleged abuse and
neglect of children in residential care, OCFS and CQC use the same definitions set forth
in subdivisions (8) and (9) of § 412 of the Social Services Law. The chart below shows
that OCFS’s rate of indication is approximately three times that of CQC’s, on average, over a three year period.

**OCFS vs. CQC Substantiation Rates for Institutional Child Abuse Cases 2004-2006**

<table>
<thead>
<tr>
<th>Year</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agency</td>
<td>CQC</td>
<td>OCFS</td>
<td>CQC</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>264</td>
<td>1,165</td>
<td>313</td>
</tr>
<tr>
<td>Number Substantiated</td>
<td>17</td>
<td>146</td>
<td>11</td>
</tr>
<tr>
<td>Percentage</td>
<td>6.4%</td>
<td>12.5%</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

Some of the differences between CQC and OCFS can be attributed to the differences among the children served by the respective agencies. Children with developmental disabilities or emotional disorders for whom CQC is responsible may have difficulty providing evidence to substantiate a child abuse complaint. However, the Inspector General’s investigation suggests that CQC’s conservative interpretation of child abuse and neglect statutes may in fact contribute to its lower rate of indication.

*Review of CQC’s child abuse investigations opened in January 2007*

As part of the Inspector General’s examination of CQC’s application of the state’s definitions of child abuse and neglect, investigators reviewed each of CQC’s child abuse and neglect investigations opened during the month of January 2007. Following the review of CQC’s investigative files, investigators interviewed CQC General Counsel Boehlert, Assistant Counsel V. Jerome Luhn, and Team Leader Peter Behm.

During January 2007, CQC received 32 cases of alleged abuse and neglect from the State Central Register. CQC recommended that every one of these cases be
unfounded. Of the 32 cases that were unfounded for the purposes of the register, CQC classified 12 as “institutional neglect” after a preliminary investigation. In these 12 cases, CQC determined that no serious issues warranted additional investigation or it was readily apparent that the threshold for abuse or neglect could not be met. The remaining 20 allegations underwent full investigations and were recommended as unfounded.

Review of the 12 cases classified as “institutional neglect” by CQC revealed that none resulted in any subsequent activity by CQC. Interestingly, the only eight cases in which any follow up activity was conducted by CQC related to cases that were unfounded. CQC’s policies regarding the “institutional neglect” determination are discussed further below.

The Inspector General’s investigation found that, in the majority of the 32 cases, CQC’s recommendation that the case be unfounded was readily supportable under Social Services Law § 412 and warrants no discussion. For example, in one case a resident fought with another resident. During the fight, a staff member intervened and restrained one of the children. The child alleged that the staff member punched him in the mouth during the restraint, resulting in a laceration inside his mouth. Interviews with three witnesses (one staff member and two residents) failed to corroborate the allegation and undermined the child’s credibility; therefore, CQC recommended that the case be unfounded. In another case that CQC unfounded, it was alleged that a staff member grabbed a resident by his shirt and pulled forcefully, causing red marks on the child’s neck. The investigation determined that the child sustained the scratch on his neck from another resident and had lied about the staff member hurting him. It is apparent that neither of these cases amount to abuse or neglect as defined in Social Services Law.
In the following sections the Inspector General identifies problems with CQC’s application of Social Services Law § 412 in general and in the 32 cases reviewed.

**Questionable Interpretation of “Risk” Criteria**

The Inspector General found that CQC improperly has used the standard of “imminent risk” of physical injury in determining whether a child has been a victim of abuse or neglect. The term “imminent” does not appear in the Social Services Law definitions of abuse and neglect of children in residential care. In addition, in its review, the Inspector General identified one instance in which CQC appeared to have improperly applied the statutory criteria for finding risk.

In its review of investigations from January 2007, the Inspector General identified one case in which CQC’s determination could be questioned. It was alleged that a staff member had “roughly pulled and turned [a resident’s] face while giving him his medication,” “pushed [his] head against the back of his wheelchair using excessive force,” “jabbed an eye-dropper into [his] eyeballs” and “verbally threatened” him during the process. Two staff members witnessed the treatment of this profoundly mentally disabled resident and provided investigators with corroborating testimony, and the subject admitted to having “lost it” while administering the medication. A registered nurse who examined the child within hours of the incident reported that there were no unusual marks to the head, no swelling/redness to the eyes, and the child gave no indications of pain or discomfort. However, a licensed practical nurse at the facility, who was queried by CQC about the resident’s risk of harm, reported that the child “would be at risk of corneal damage, corneal scratching, corneal abrasions, or general eye irritation” if he were to “head butt or move his head while receiving eye drops.” CQC’s
investigation report noted that the child “demonstrates aggression during medication administration in the form of lowering his head [and] swinging his head.” The subject admitted the child “arched his back and his head went up” when she tried to administer the eye drops. The facility’s internal investigation, not held to the standards of Social Services Law § 412, substantiated the allegation and terminated the employee.

CQC found a breach of a duty that was owed to the resident, but not an injury or an imminent risk thereof. With the following explanation, CQC recommended to the State Central Register that the case be unfounded:

The staff member’s actions in applying eyedrops while in an admittedly exasperated state and in turn allowing the eyedropper to touch the child’s eye clearly placed the child at risk of harm. However, there is no medical evidence that this breach of duty resulted in even a slight injury to the child. Therefore, although the staff member’s actions placed the child at risk of harm, there is insufficient credible evidence that the risk was of an imminent nature.

E-mail generated during CQC’s investigation demonstrates that the issue of whether there was sufficient evidence of a “substantial risk of physical injury, excluding minor injury” was given much thought within CQC prior to the determination to unfound the case. However, CQC’s ultimate determination that the patient’s risk of corneal damage was not “imminent” is puzzling. According to the logic offered in CQC’s recommendation to the State Central Register, the child was not at risk of injury because he was not injured. This decision demonstrates a poor understanding of the applicability of the “risk” criteria in Social Services Law. Under the Family Court Act, which uses similar criteria in cases regarding parental abuse, courts have clearly stated that no physical injury need be present to make a finding of abuse.
On at least one previous occasion, the Office of Children and Family Services (OCFS) questioned the “imminent risk” standard used by CQC. After reviewing a CQC investigation involving failure to supervise a child, OCFS wrote:

The November 1, 2006 report of suspected child abuse and neglect made concerning the subject child was unfounded by CQCAPD based in part on a finding that the child was not placed at ‘imminent risk of substantial harm.’ The actual statutory standard is ‘substantial risk of physical injury, excluding minor injury.’

In response to this criticism, CQC asserted that, “The question of risk as contemplated in the statute is evaluated by Commission investigative staff in every case where that calculation is appropriate.”

**Failure to Evaluate Whether Children Experienced Serious Emotional Injury or Were Placed at Risk of Serious Emotional Injury**

In interviews with the Inspector General, CQC officials said that they rarely substantiate child abuse investigations based on serious emotional injury and virtually never based on risk of serious emotional injury as defined by the Social Services Law. In its review, the Inspector General identified one case in which CQC arguably failed to adequately consider whether a staff member’s malicious behavior towards a child put the child at risk of serious emotional injury.

*Sample case in which risk of serious emotional injury was not explored*

In one of the January 2007 cases reviewed by the Inspector General, a staff member at a children’s psychiatric center was alleged to have made a sandwich in an “unsanitary and repulsive manner” for a child in his care. Three residents witnessed a staff member who “took the slices of bread and wiped them on his arm pits, buttocks and
genital areas before spreading the peanut butter and jelly” and then “spit into the sandwich before giving it to [the unsuspecting child].” The three residents who had witnessed the incident were each individually interviewed by the facility and they gave the same account of events. The child who ate the sandwich overheard the three resident witnesses making fun of him about it, resulting in the child becoming angry and running off the unit. When asked why they did not report it sooner, the three children witnesses told staff that “they were afraid [the staff member] would do it to their food.” One resident stated, “I was afraid [the staff member] would get mad and hurt me,” describing why he did not say anything about the incident. A doctor examined the alleged victim and reported that, “No physical injury is apparent.” As to the potential for a psychological or emotional impact due to this event, the doctor maintained, “[The resident] is emotionally damaged and psychologically impaired with deviant, explosive and aggressive behaviors related to [prior] severe abuse, neglect and abandonment. This allegation, even if true, pales in comparison. Any effect would be impossible to assess particularly at this date.”

CQC unfounded the allegation and closed the case within seven days, classifying it as an institutionally neglected child in residential care case after determining that the “child sustained no injury,” and, that there was “insufficient credible evidence that the subject placed the child at imminent risk of substantial harm.”

The Inspector General acknowledges that CQC could reasonably determine that there was no serious physical injury, risk of thereof, in this case. However, there appeared to be no attempt in the investigation by CQC to establish a risk of serious emotional injury. The doctor consulted in the case opined that determining actual
emotional injury was impossible in such a disturbed child, but no opinion was sought or made by CQC as to the risk of serious emotional injury caused by an adult charged with caring for the child intentionally degrading and humiliating him in this way in front of his peers.

There is no evidence that CQC took any additional action related to the allegation, and the Inspector General’s Office learned that this individual is now employed at a secure adult psychiatric center as a cleaner.

*Statements from CQC officials*

In explaining why CQC infrequently finds that a child has suffered emotional injury, CQC General Counsel Boehlert and Assistant Counsel Luhn stated that while injury can also be a “psychiatric [or] emotional injury, in terms of the statute . . .those are pretty tough to prove” because it is very difficult to isolate specific actions or a failure to act and then show that it resulted in serious emotional injury to children who are already disabled and fragile. Luhn elaborated that evidence may be found through clinical records and histories showing decompensating activity, such as “a kid who hadn't injured himself [previously] started banging his head [and] screaming in the middle of the night; things that show that somebody set him way back.” According to both Boehlert and Luhn, evaluating emotional harm may require a clinical assessment or expert opinion to determine that the alleged abusive incident resulted in a serious emotional injury. (CQC has a medical review board available to it, which it may consult in child abuse cases.) Luhn summarized that the cases that CQC investigates involve children with previously recognized psychological disturbances and imbalances, and to “say this piece of it is what this guy did to him or caused him to react to is hard.”

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OCFS and CQC officials further indicated that adding to the difficulty of proving that a custodian’s actions caused an emotional injury in an already emotionally disabled child, the new emotional injury must manifest within the 60-day investigation window afforded CQC to recommend indication, if it is to become part of the current abuse or neglect investigation. This is often impracticable, since some emotional injuries, such as post traumatic stress disorder (PTSD), can manifest long after the incident occurred. Although it is true that CQC typically must complete its investigations within 60 days, CQC has extended the time frame for its investigations, or opened another investigation if new evidence of emotional injury is presented.

Interviews with CQC officials failed to conclusively demonstrate under what circumstances or how often CQC will substantiate a case based upon emotional injury or the risk thereof, but these instances appear to be very rare. Boehlert stated that there were only a “handful” of cases that CQC recommended indicating based on serious emotional injury. Luhn recalled one example where CQC recommended indication for serious emotional injury where the physical injury “didn’t easily fit the classic definition.” In regard to the language in the law allowing an indication if the custodian’s action “creates a substantial risk of any injury…which would be likely to cause…a serious emotional injury,” Luhn stated that “risk of emotional harm is impossible to quantify or prove so…we never indicate for that.”

Luhn described one example of an exceptional matter in which CQC indicated (substantiated) for emotional harm absent any serious physical injury to the child. Luhn described a case several years ago in which CQC did not “have to argue that one at trial [because] the person accepted it” where an autistic consumer was pricked with a pin by a
facility employee and CQC recommended to the State Central Register that the facility employee be indicated. Luhn stated that CQC established “clear breach of duty” and “we used something that we’ve never had to go to hearing on which was presumed emotional trauma of having a staff person torment you.” Although there was no “discernible psychiatric injury [or] emotional injury,” CQC reportedly decided to indicate (substantiate) because of the “cruelty” and the “outrageous behavior” exhibited by this staff member. Luhn added, “We put ourselves in the shoes of the kid and presume that, even though he can’t speak for himself, that it was traumatizing and did some injury. We’ll argue that at hearing and see where it goes.”

The Inspector General notes that while there is scant case law in regard to CQC’s application of Social Services Law § 412 (8)-(9), there is ample case law applying related provisions of the Family Court Act. Under the Family Court Act, which has similar definitions to the Social Services Law, albeit applicable to children living in a family setting rather than an institutional setting, it is well established that actual injury to a child is not required to sustain a finding of abuse or neglect. Additionally, the New York Court of Appeals has expressly ruled that expert testimony, while critical in some cases, is not required to prove emotional injury or the risk of emotional injury. In rejecting a rule requiring expert testimony, the Court of Appeals found that requiring such testimony would undermine the societal purposes of the statute: “while older children can communicate with a psychological expert about the effects of domestic violence on their emotional state, much younger children often cannot. . . . To require expert testimony of this type in the latter situation would be tantamount to refusing to protect the most vulnerable and impressionable children.” CQC’s narrow interpretation of § 412 results in
even less protection to some of the most vulnerable children covered by the Social Services Law – those in residential care - when compared with the protections provided to children in the family setting.

**Standard of Proof**

The Inspector General discovered some evidence that CQC’s interpretation of its burden to indicate (substantiate) a case may be more stringent than required by law.

To initially indicate a case during the investigative stage, Social Services Law requires “some credible evidence” that the situation occurred. If the case proceeds to a hearing, CQC would have to prove a “preponderance of the evidence” to maintain the individual’s name on the State Central Register. CQC officials stated that in every case they try to ensure they have “substantial credible evidence” to indicate so they do not go through “dozens of useless exercises” that are then overturned on appeal.

In contrast, OCFS officials, who apply the same abuse statutes and standards of proof, stated they have less trepidation of being overruled if they feel that the “some credible evidence” standard is met. These officials admitted that there are cases that may not be clear cut, but, depending on the egregiousness of the incident and behavior of the employee, OCFS acknowledged that it might substantiate a case even if no apparent emotional injury was recognizable and let the subject explain him or herself at an appeal hearing in front of an Administrative Law Judge. The different approaches of the two investigating agencies may be partly responsible for the differing indication rates of CQC and OCFS.
Restrictive Statutory Language

Although this investigation found deficiencies with CQC’s application of the current definitions of child abuse and neglect in the Social Services Law, the Inspector General found merit in assertions by CQC officials that the definitions themselves may hamper CQC’s ability to find abuse or neglect in some instances involving egregious behavior. As discussed above, according to definitions set forth in the Social Services Law, to find child abuse or neglect CQC must determine that a child sustained, or was placed at risk of sustaining, “physical injury, excluding minor injury” or “serious emotional injury.” CQC needs to meet the aforementioned harm criteria irrespective of the actions of the employee, however inappropriate. Adding to the difficulty, “serious emotional injury” is not defined in Social Services Law. Agencies must look to the Family Court Act and accompanying case law for guidance in defining emotional injury.

The Inspector General interviewed the former Chairman of CQC, Clarence Sundram, a nationally recognized expert in the field and current President of the Board of Directors of Mental Disability Rights International. Sundram told the Inspector General that he believes the laws controlling the findings of abuse and neglect in institutional settings are fundamentally flawed, fail to protect children from abuse, and should be amended so as to focus solely on the actions or behaviors of the employee, rather than the impact or injury to the child.

Sundram reported that it was not the intent of Social Services Law to name parents as subjects on the State Central Register of Child Abuse and Maltreatment when they sent their kids to bed without dinner or spanked their children. Thus, “severity of harm” language was included in the statute to take into account the impact or injury to the
child. It allowed the Office of Children and Family Services some discretion in determining whether the subject belongs on the register.

This language, however, can be problematic when applied to claims of abuse and neglect in institutional settings involving custodians working at the facilities. Sundram believes that the “severity of harm” language should not be applied to staff members in institutional settings; any unacceptable behavior should not be tolerated regardless of the seriousness of the injuries. In an op-ed piece in the *Times Union* on March 25, 2007, Sundram wrote, “Having a ‘severity of harm’ test in the definition of abuse or neglect in this context [institutional settings] serves no valid purpose except to protect abusive workers from having their names placed in the Child Abuse Register.” He added, “Common sense definitions of abuse and neglect should focus on the conduct of the custodian rather than the ‘severity of harm’ to the victim.”

Current CQC staff members agreed that the current definitions in the Social Services Law allowed certain individuals to avoid inclusion on the State Central Register despite very bad behavior towards children in their care. As one current CQC Team Leader stated, “Perhaps one of the things that will come out of your review is that this law [Social Service Law § 412] does not cover enough.” This sentiment was echoed by Chairman O’Brien, who stated, “The Social Services Law is very, very restrictive in terms of what it requires, and rather severe in its standards.” Similarly, Director Keegan wrote to the Careys on June 9, 2005 that “the harm ‘test’ required to indicate an allegation of child abuse under Social Services Law is quite severe.”

A primary purpose of the State Central Register of Child Abuse and Maltreatment is to prevent abusive individuals from further contact with children, the Inspector General
recognizes that the determination of which individuals belong on the register is extremely important. The definitions set forth in Social Services Law §§ 412(8)-(9) should properly reflect the state’s policies to protect children from abuse. The Inspector General finds that further examination of the state’s definitions of child abuse and neglect as applied to children with disabilities in institutional settings is warranted.

**Application of Social Services Law § 412(10), Institutionally Neglected Child in Residential Care**

The Inspector General found that CQC’s policies for designating a child as an “institutionally neglected child in residential care” are contrary to the plain language of the law and the legislative intent of the statute. Instead of identifying cases that could benefit from additional monitoring by OMRDD, CQC uses this designation to quickly close cases after a preliminary investigation, regardless of whether there is need for OMRDD or the facility to follow-up.

In 1992, the legislature enacted subdivision 10 of Social Services Law § 412 defining an “institutionally neglected child in residential care” as a child whose:

- Health, safety or welfare is harmed or placed in imminent danger of harm as a result of a lack of compliance with applicable standards of the state agency operating, certifying or supervising such facility or program for the care and treatment of such child or an agreed upon plan of prevention and remediation pursuant to this chapter or the mental hygiene law, the executive law or the education law, arising from abuse or neglect of a child in residential care, including, but not limited to, the provision of supervision, food, clothing, shelter, education, medical, dental, optometric or surgical care.

If CQC makes a finding of institutional neglect related to an allegation of child abuse or neglect, it is considered unsubstantiated for the purposes of the State Central Register. Accordingly, no individual’s name will be retained as substantiated on the
State Central Register as a result of a finding of institutional neglect. However, a finding of institutional neglect results in a letter informing the provider that a designation of institution neglect “requires the facility to review the matter as directed by incident reporting regulations, and alerts the State certifying agency to take actions which it deems appropriate.”

According to the sponsors of the legislation that created this definition, the legislature’s intention was to “ensure that allegations that are related to the quality of care but do not constitute abuse or neglect are referred to the appropriate state licensing or operating agency for appropriate action.”

In contrast to the explicit legislative intent, CQC officials interviewed stated that the definition was created by the legislature to allow CQC to address some State Central Register generated allegations quickly and without extensive investigation, and then close them out as unfounded within a seven day period. CQC Assistant Counsel Luhn reported that cases are placed under this designation by CQC when they are “clearly and demonstrably not serious issues…they are not a credible abuse or maltreatment case” and there is “no injury of any consequence [to the child].”

In accordance with CQC’s interpretation of the statute, CQC’s policy instructs investigators:

Screen for Institutional Neglect (I.N.): Some cases may be closed within 7 days with a recommendation of Institutional Neglect. I.N. is a determination used to define those cases in which a preliminary investigation has determined a child has suffered no injury or an injury which is not severe enough to meet the harm threshold under §412. In addition the evidence does not establish that the child was placed at imminent risk of substantial harm…the case is closed without further investigation.
CQC policy does not require further action by the investigator upon a finding of institutional neglect of a child and the law does not require CQC to take any action after making such a determination. CQC may, at its discretion, open a care and treatment review or other further inquiry in response to a finding of institutional neglect.

An example of a report that would be classified as institutional neglect, according to Luhn, could be a situation in which a parent files an allegation with the State Central Register because “they see their child is not getting proper attention or that they heard or saw they had a skinned knee and think that somebody might have abused them….If the suspicion underlying the allegation is true, it might raise real concerns. But, in a lot of cases, it’s possible to ascertain very quickly that, no, [the child] was playing with his roommate and fell and skinned his knee and we took care of it in the infirmary….Verify that with medical records and talk to a nurse and so on. Especially if the investigator knows that facility and knows who they’re are dealing with and is satisfied with records that they get. If within two or three or four days [they establish] that it’s not a credible allegation of abuse or maltreatment they give it the so-called I.N. classification.”

While it is true that a determination of institutional neglect by CQC (as opposed to a finding of abuse or neglect) is an “unfounded report” for the purposes of the State Central Register and, as with all unfounded reports, becomes a sealed record, it is unclear why, contrary to the plain language of the law and the stated legislative intent of the enacting statute, CQC considers a determination of institutional neglect simply an expedient way to close cases.

During its review of CQC’s January 2007 child abuse cases, the Inspector General discovered that CQC classified cases as unfounded that, in accordance with the plain
language of the statute, may have more appropriately been termed institutional neglect. Likewise, CQC classified cases as institutional neglect even where there was no indication of any fault on the part of the institution or the individual caretaker.

In accordance with CQC policy, the decision to term a case as institutional neglect or as unfounded depends primarily on whether the investigator could determine within seven days that there was no injury of significance to the child. Even if the allegation is completely falsified, the case nonetheless may be designated by CQC as institutional neglect. In its review, the Inspector General found such examples. For instance, in one case the child recanted. In another case, CQC found no evidence of any injury to the child and no credible evidence of a breach of duty by staff. Nonetheless, in each of these two cases, the state certifying agency (OMRDD or OMH), the facility/institution where the child resided, and the child’s guardians were notified that there had been a finding of institutional neglect. CQC performed no follow-up investigations or monitoring in relation to any of the twelve cases designated as institutional neglect in January 2007.

On the other hand, during the same time period, CQC designated cases as “unfounded” that may have been more appropriately termed “institutional neglect” in accordance with the statutory language. For example, CQC investigated a case in which it was alleged that three children with histories of sexual abuse engaged in sodomy when they were not being properly supervised. This was recommended as unfounded despite CQC’s investigation determining that patient observation documentation was conflicting, one assigned staff member had not received proper training in providing supervision, the children involved had faulty admission assessments, and the children were not supervised appropriately by staff when the incident was believed to have occurred. Additionally,
CQC wrote in its unfounded notification letter to the facility, “Unfortunately, serious incidents of patients engaging in sexual contact continue to occur.” Although the Inspector General notes that CQC did perform additional activity on this case, it nevertheless was classified as “unfounded” rather than “institutional neglect” despite the significant and serious systemic deficiencies identified at the facility. Even the case of Jonathan Carey’s treatment at the Anderson School may have been a candidate for an institutional neglect designation. Because CQC’s policies regarding institutional neglect require a determination within seven days, many cases that involve institutional deficiencies are not designated as such, and thus may not receive the follow-up envisioned by the law’s sponsors.

**Conclusion**

When asked to characterize the quality and thoroughness of CQC’s investigations of Jonathan’s alleged abuse, CQC Chairman O’Brien stated, “I think it was very thorough. We defined what we were going to do and we did it.” Similarly, CQC’s General Counsel characterized the child abuse investigation as “incredibly thorough, as all of our investigations are.” To the contrary, the Inspector General found the child abuse investigation was incomplete, and the care and treatment review simply did not happen.

CQC failed to conduct a thorough investigation and made dubious claims about having conducted two separate investigations. Although the investigative shortcomings in this case were serious and numerous, the investigator does not bear full responsibility in this matter. This case also demonstrates failures throughout CQC, from investigative oversight and case supervision to overall leadership and general philosophy.
Although the Inspector General did not find any effort to “cover up” the alleged abuse of Jonathan at the Anderson School, CQC provided misleading information to the Careys, the Governor’s Office, and to the State Senate about its investigative actions.

In addition, the Inspector General identified systemic problems with CQC’s approach to child abuse and neglect investigations. It appears that CQC underutilizes its ability to find serious emotional injury or risk of serious emotional injury, and appears to require more proof than necessary to make a recommendation to the State Central Register to indicate (substantiate) a child abuse or neglect investigation. In a review of one month’s cases, the Inspector General found one case in which CQC found both a breach of duty by the custodian and a risk of a serious physical injury to the child yet recommended that the case be unfounded. Additionally, CQC has a policy instructing its investigators in the application of Social Services Law § 412(10) that appears to be at odds with the plain language and the legislative intent of the law. This has resulted in findings of institutional neglect where there was none, and the designation of cases as unfounded that may have been more appropriately classified as institutional neglect.
INVESTIGATION BY THE NEW YORK STATE POLICE

The Careys alleged to the Inspector General’s Office that state officials including OMRDD Commissioner Maul and CQC Chairman O’Brien tampered with the investigation conducted by the State Police and the Dutchess County District Attorney’s Office, and that there may have been political influence into the decision not to criminally pursue the matter. The district attorneys of New York State are not within the jurisdiction of the State Inspector General. However, the Inspector General reviewed the investigation conducted by the State Police in conjunction with the district attorney and sought to determine whether the State Police or the district attorney discontinued the investigation or prosecution as a result of pressure from an agency or individual under the Inspector General’s jurisdiction. The Inspector General found no evidence that the State Police or the district attorney was pressured to discontinue the investigation or prosecution of the case.

On June 15, 2005, the State Police were contacted by an assistant district attorney who is the Chief of the Special Victims Bureau of the Dutchess County’s District Attorney’s Office. The assistant district attorney reported that Michael and Lisa Carey had recently called her alleging child abuse involving their son while he was a resident at the Anderson School.

The Inspector General interviewed the assistant district attorney and State Police investigator on several occasions and reviewed records obtained from the police investigation. A program director for autism that the assistant district attorney had consulted was also interviewed. Additionally, the Inspector General interviewed
executives from OMRDD, CQC, and the Taconic regional office regarding their interactions with the district attorney’s office and the State Police.

Based on the Careys’ complaint, the State Police initiated an investigation, which consisted of an interview with the Careys and a review of the documents they provided, an interview with the Director of the Taconic regional office, and consultation with a local program director at a private, not-for-profit program designed for children with special needs, including autism. In addition, the State Police investigator attempted to interview Anderson School executives, but was met with resistance from the Anderson School attorney, who advised that Anderson School staff would not speak to him about the matter.

The State Police investigator conceded to the Inspector General’s Office that it was difficult to move forward with the case due to the pending civil trial and the lack of cooperation from the Anderson School. In addition, the investigator complained that the police received the allegations almost eight months after the alleged abuse occurred, stating, “We came onto the scene, the players and the stadium had emptied out by the time we had got on the field.” To further encumber matters, he added, once preparation for the Careys’ civil case commenced, all communication with the Anderson School stopped. “That was our biggest hindrance here was that all doors were closed.”

Initial State Police records listed possible misdemeanor charges of Assault in the Third Degree and Endangering the Welfare of a Child which were based on the Careys’ original complaints.\footnote{Penal Law §120.00 and Penal Law § 260.10.} However, the State Police investigation of these charges did not
develop sufficient evidence to support criminal charges and the district attorney did not bring charges.

The Careys alleged that the district attorney’s decision was the result of undue influence from state agencies, particularly CQC and/or OMRDD, or from political pressure exerted by the Anderson School. When questioned by the Inspector General’s Office about outside influence on their investigation, both the State Police investigator and the assistant district attorney denied receiving political pressure, or pressure from any other sources, regarding the handling of the investigation. The assistant district attorney told the Inspector General’s Office that she did not recall having contact with representatives from OMRDD Central Office or CQC at any time during her investigation.
Following the conclusions of the multiple investigations detailed in this report, the Careys complained directly to the Governor’s Office that the various agencies involved had mishandled the investigation. Although the Careys did meet with staff from the Governor’s Office, as well as agency heads of both CQC and OMRDD, they found the governor’s response insufficient. The Careys alleged that former Governor Pataki and his staff were aware that Jonathan had been abused, and perhaps had collaborated with or pressured the investigative agencies to suppress their findings. After attending a meeting in which representatives from both CQC and OMRDD were present, the Careys said that they were “shocked to see both CQC and OMRDD’s attorneys [attending the same meeting]… we felt it was wrong.”

The Inspector General’s Office found no evidence that the Governor’s Office in any way pressured CQC, OMRDD, or the Dutchess County District Attorney to minimize findings of abuse, or to cover up the agencies’ investigative failures. In addition, although the Careys were upset when greeted by representatives from CQC and OMRDD in a meeting with the Governor’s staff, the Inspector General found no impropriety in inviting the agency representatives to the meeting.

The Careys’ Complaints to the Governor

Subsequent to the investigations by the Taconic regional office, OMRDD, and CQC, and after the Dutchess County District Attorney’s case was “closed by investigation,” the Careys wrote a June 2, 2006 letter to Governor George Pataki alleging:
There is not proper and safe oversight of disabled children by State agencies of schools like the Anderson School, to help insure the safety of the children. OMRDD, CQC, and the State Education Department all failed miserably in the handling of Jonathan’s abuse and neglect.

In their letter, the Careys claimed they received “watered-down” reports from both OMRDD and CQC regarding their findings in an effort to “cover-up” Jonathan’s abuse and neglect at the Anderson School. The Careys were especially critical of the manner in which CQC conducted its investigation and made reference to the fact that the CQC investigator made only one site visit to Anderson School and did not conduct a face-to-face interview with them. They also complained they had made several attempts to speak with former OMRDD Commissioner Maul and filed numerous Freedom of Information Law (FOIL) requests for documents regarding OMRDD’s investigation, but received repetitive denials. They further wrote that despite a statement to them from Taconic regional office Investigator Searle that “in all the years he has been doing this, he has never seen anything like this,” they later received “another very watered down official letter from OMRDD [Taconic regional office] of what happened to Jonathan.”

The Careys wrote that after receiving the watered-down letter, they called Taconic regional office Director Mizerak to inquire “what has happened [as a result of the investigation] with the people involved with the abuse and neglect of Jonathan.” According to the Careys, Mizerak responded, “I do not know. It is up to the [Anderson] school to do disciplinary action within the school.” The Careys also wrote to Governor Pataki, “Neither...the Anderson School or any of the State agencies involved have admitted to any wrong doing. There must be proper accountability in the schools and within the State regulatory agencies for the safety of the children.”
Governor Pataki’s Response to the Careys’ Complaints

According to ORMDD and CQC records and e-mail correspondence between those agencies and the Governor’s Office, former Governor Pataki’s staff had requested that ORMDD and CQC prepare a response to the Careys’ June 2, 2006 letter to the governor. The final joint response entitled “Confidential Draft – Internal Document (8/11/2006) Combined ORMDD and CQCAPD response to Michael Carey’s letter to Governor Pataki of June 2, 2006” was provided to the Governor’s Office via e-mail on August 14, 2006. Although the document contained information from both agencies, an ORMDD Associate Commissioner Gatens combined the responses for transmission to the Governor’s Office, as requested. The joint response identified 13 separate concerns raised by the Careys in their letter to Governor Pataki with point-by-point explanations and/or rebuttals by CQC and ORMDD. In previous sections, this report has discussed some inaccuracies or misrepresentations in the information provided by ORMDD and CQC to the Governor’s Office. The Inspector General found no evidence that the information in the document was disseminated beyond the Governor’s Office.

In September 2006, the Careys were invited to the Governor’s Office to meet with several staff members of the Governor’s Office of Health and Humans Services. CQC General Counsel Boehlert and an ORMDD representative also attended the meeting. The Director of Human Services for the Secretary of Health and Human Services told the Inspector General that the Careys provided a “stack of documents that they wanted to bring to our attention, go over all of it, and see if there was anything that could be done.” She added that the Careys were upset that they “had not had the opportunity to meet with [ORMDD] Commissioner Maul and [CQC Chairman] O’Brien.” At the conclusion of
the meeting, “We left it with them that we would review what they [Careys] had given us and see what we should do, or could do, if anything.” She noted that the joint response provided to the Governor’s Office by CQC and OMRDD in reply to the Careys’ written complaint was not discussed at the meeting.

Subsequently, the Governor’s Office arranged a meeting between the Careys and CQC Chairman O’Brien and then-OMRDD Commissioner Maul. No one from the Governor’s staff attended the meeting, which was held on October 20, 2006. CQC Chairman O’Brien told the Inspector General’s Office that the “Governor’s Office directed both of us [OMRDD and CQC] to meet together with them. You know, so they were asking us to meet and help.” Maul reported to the Inspector General’s Office that he thought the meeting was really to discuss confidentiality over quality assurance documents and the parents’ frustrations with this. He said that both CQC and OMRDD were dealing with the same confidentiality issues, so “it seemed appropriate” to him to discuss the issue with both agencies in attendance. Following the meeting, the Careys’ attorney sent a letter to Boehlert, with a copy to former OMRDD General Counsel Kietzman, thanking them for meeting and enclosed a copy of the aforementioned logbook, which the Careys believed provided crucial evidence that Jonathan was abused at the Anderson School. As noted above, neither CQC nor OMRDD Central Office had reviewed the logbook during their investigations.

The Former Director of Human Services told the Inspector General’s Office that following the October 20, 2006, meeting, Michael Carey made an unannounced visit to her office and expressed his dissatisfaction with Maul and O’Brien. She advised, “I heard from them, [the Careys] that they weren’t real happy with the meeting and they felt
they weren’t taken seriously.” She did not recall receiving a written report from either OMRDD or CQC regarding the meeting; however, she recalled both OMRDD and CQC expressed to her verbally that they advised the Careys they stood by their investigations.

According to the Careys, after receiving a copy of Jonathan’s logbook, CQC reaffirmed its conclusion that the allegations concerning Jonathan’s abuse was unsubstantiated, stating, “In our judgment, the information in the logbook does not support such an allegation or indication.” They received no response from OMRDD.

Michael Carey reported to the Inspector General that, having been dissatisfied with the results of his meetings and with the agencies’ response to the logbook, he requested to meet with the governor personally. He reported, “For the next two months, I was either in person or calling almost every day the Governor’s Office to get in with the governor, and was denied every time.”

Around this time, the Careys also contacted the Inspector General’s Office with their concerns. In a preliminary assessment, the Inspector General’s Office concluded that their concerns were being addressed by the Governor’s Office and top management in the relevant state agencies. In March 2007, under a new governor and new Inspector General, this office re-opened its investigation.

**Governor Spitzer’s Response to the Careys’ Complaints**

Following the 2006 gubernatorial election and change of administration, the Careys sent a letter to former Governor Eliot Spitzer’s office on January 19, 2007. Michael Carey advised he received a response from Spitzer’s office but it stated, “Although it is not possible to schedule a meeting, we appreciate you writing to us about
this important matter. Your correspondence has been forwarded on to the appropriate members of our staff.” Upon receipt of this letter, Michael Carey stated that he personally went to the State Capitol to plead for a meeting with the governor, but was denied. “And then after Jonathan died February 15th, we finally go in to see -- I met with the governor’s staff probably three weeks after the fact, and then we got a meeting with the governor a couple of weeks later,” he stated. Former Governor Spitzer’s office referred the matter to the Inspector General on March 12, 2007, requesting an investigation into the Careys’ allegations.

Inspector General’s Analysis of the Response by Governor Pataki’s Office

The Inspector General found that, in response to the complaint from the Careys, which incorporated a number of complaints against both CQC and OMRDD, the governor requested a joint response from the two agencies. Following the receipt of the joint response from the agencies, the Governor’s Office organized two meetings that included representative from both CQC and OMRDD. The joint response and the meetings, in themselves, do not indicate any improper behavior on the part of the Governor’s Office. As the Careys’ complaints related to both agencies, the Governor’s Office has the discretion to request responses and invite representatives from the agencies to discuss the Careys’ concerns. The Governor’s Director of Human Services explained that she did not find it unusual for both OMRDD and CQC to have been present at that meeting based on the nature of the complaint the Careys had filed regarding the care and treatment of Jonathan while at the Anderson School and the roles of OMRDD and CQC regarding such. Similarly, former OMRDD Executive Deputy Commissioner DeSanto
viewed the meeting as a means for the Governor’s Office to discuss the findings of each agency’s own separate investigation.

**Conclusion**

Neither the joint written response by the two agencies for the Governor’s Office, nor the joint meetings establishes or supports any of the Careys’ allegations of improper collaboration among the agencies or between the agencies and the Governor’s Office. Rather, the Inspector General’s Office found evidence to suggest that Governor Pataki’s office attempted to deal with the Careys’ complaints efficiently and to foster open discussion.
VI. RECOMMENDATIONS

The Inspector General has provided copies of this report to the relevant state agencies. In addition, copies have been provided to the Albany, Schenectady, and Dutchess County district attorneys’ offices for information and review.

**Taconic Developmental Disabilities Services Office**

1. The Inspector General recommends that the Taconic regional office of OMRDD, or any regional office, take primary responsibility for an investigation regarding a child’s care at a facility within its jurisdiction whenever the facility discloses a conflict of interest or an appearance of such a conflict that would interfere with an internal investigation.

2. The Inspector General recommends that the Taconic regional office take steps to ensure full cooperation of employees in state-certified facilities with OMRDD investigations, as required by law. These steps could include notification of the facility’s Executive Director or Board of Directors of an employee’s failure to comply with this obligation, as well as a referral of the matter to OMRDD Central Office to review the provider’s certification to operate in New York.

**Office of Mental Retardation and Developmental Disabilities**

1. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to fully incorporate all regulatory violations into a Statements of Deficiencies.
2. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to examine all available information, including pertinent documents and witness interviews.

3. In instances when a survey related to a separate investigation by one of OMRDD’s regional offices is conducted, the Inspector General recommends that OMRDD Central Office coordinate such efforts and obtain the investigative findings of the regional office.

4. In light of Jonathan’s Law which provides families with greater access to certain investigatory records, the Inspector General encourages OMRDD to re-evaluate the language used in its Statements of Deficiencies to determine whether the document should indicate when many instances occurred, even if only one instance of a violation is being cited.

5. The Inspector General reminds OMRDD Central Office of its ethical and legal responsibility to provide thoroughly accurate information to the Governor’s Office. OMRDD should take measures to ensure compliance with the fulfillment of such responsibility.

6. The Inspector General recommends that OMRDD review the conduct of those responsible for providing a response to Governor Pataki’s office that did not accurately reflect OMRDD’s actions in this matter.

7. There is no justification for a child placed in a private, state-certified facility to be afforded less protection from abuse than a child in a state-run facility. The Inspector General encourages OMRDD to re-examine draft regulations on
behavior management (14 NYCRR § 633.16) to ensure consistent safety and oversight protections for all consumers statewide.

8. The Inspector General recommends that OMRDD explicitly recommend agencies under its jurisdiction to review an employee’s conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

**Commission on Quality of Care and Advocacy for Persons with Disabilities**

1. This investigation revealed that CQC officials made inaccurate and misleading statements to Governor Pataki’s office, the Inspector General, the State Senate, and the Careys. The Inspector General recommends that the Governor’s Office review the conduct of CQC, and its leadership, with respect to the findings of this report.

2. The Inspector General recommends that CQC review the conduct of staff members assigned to investigate and oversee the Jonathan Carey investigation, and take appropriate action, given the significant and numerous deficiencies cited in this report.

3. The Inspector General recommends that CQC review its investigative policies and procedures to ensure that cases are investigated thoroughly, actions are documented appropriately, relevant evidence is obtained, and case files are completed.

4. The Inspector General recommends that CQC ensure that its child abuse investigations are not simply repackaged when it is necessary to also conduct a broader and separate care and treatment review to evaluate the overall quality of care for individuals with disabilities.
5. The Inspector General recommends that CQC utilize all aspects of the Social Services statute, including the risk of physical and emotional injury, when assessing allegations of child abuse for the State Central Register for Child Abuse and Maltreatment.

6. The Inspector General recommends that CQC, as an independent oversight agency, obtain and review the investigative findings of the investigatory bodies that it oversees when CQC is also investigating the same matter to ensure that full and appropriate inquiries were conducted.

7. The Inspector General reminds CQC of its ethical and legal responsibility to provide thoroughly accurate information to the Governor’s Office. CQC should take measures to ensure compliance with the fulfillment of such responsibility.

8. The Inspector General recommends that CQC re-evaluate its policies regarding Social Services Law § 412(10), “Institutionally neglected child in residential care,” to ensure that the law is applied in accordance with its plain language and its legislative intent to identify systemic problems at regulated institutions and ensure that the appropriate agency is aware of and addresses the problem.

9. The Inspector General recommends that CQC explicitly recommend agencies under its jurisdiction to review an employee’s conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

**Legislative Recommendation**

The Inspector General recommends that the New York State Legislature review current Social Services statutes that are used to uncover abuse or neglect of a
child in an institutional setting, including Social Services Law §412, to determine if they are adequate.
Appendix

Jonathan's Law

AN ACT to amend the mental hygiene law, in relation to incident notifications and reports, release of records pertaining to allegations and investigations of abuse and mistreatment, directing the state commission on quality of care and advocacy for persons with disabilities to serve as a clearinghouse on the right of access to records and reports relating to patient care, incident reporting, child abuse and mistreatment in residential care, and fines for violations by holders of operating certificates; and to establish a task force on mental hygiene records

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

§ 1. Short title. This act shall be known and may be cited as "Jonathan's law".

§ 2. The mental hygiene law is amended by adding two new sections 33.23 and 33.25 to read as follows:

§ 33.23 Incident notifications and reports.

(a) The director of a facility, as defined in subdivision six of section 1.03 of this chapter, shall provide telephone notice of an incident involving a patient receiving care and treatment at such facility to a qualified person, as defined in paragraph six of subdivision (a) of section 33.16 of this article. Such notice shall be provided within twenty-four hours of the initial report of such incident. For the purposes of this section, "incident" shall mean an accident or injury that affects the health or safety of a patient. Upon the request of a qualified person, the director shall promptly provide to him or her a copy of the written incident report, provided that the names and other personally identifying information of patients and employees shall not be included unless such patients and employees authorize disclosure. The director of the facility shall also offer to hold a meeting with such qualified person to further discuss the incident. In addition, within ten days, the director of the facility shall provide such qualified person with a written report on the actions taken to address the incident.

(b) Whenever federal law or applicable federal regulations restrict, or as a condition for the receipt of federal aid require, that the release of records or information pursuant to this section be more restrictive than is provided under this section, the provisions of federal law or regulations shall be controlling.

§ 33.25 Release of records pertaining to allegations and investigations of abuse and mistreatment.

Bold type indicates new language.
Strike out type indicates deleted language.
(a) Records and documents pertaining to allegations and investigations into patient abuse or mistreatment at a facility, as defined in subdivision six of section 1.03 of this chapter, including but not limited to all complaints and reports made pursuant to subdivision (c) of section 45.07 and section 45.17 of this title, shall be released to a qualified person, as defined in paragraph six of subdivision (a) of section 33.16 of this article, upon a written request by such qualified person. Such records and documents shall be made available by the appropriate office within twenty-one days of the conclusion of its investigation, provided that the names and other personally identifying information of other patients and employees shall not be included unless such patients and employees authorize disclosure.

(b) Records and reports released in accordance with this section shall be released pursuant to subdivision (b) of section 33.23 of this article and shall not be further disseminated by the recipient.

§ 3. Section 45.07 of the mental hygiene law is amended by adding a new subdivision (x) to read as follows:

(x) Prepare and disseminate an educational pamphlet, and serve as an information clearinghouse, on the rights of parents and legal representatives and advocates to access records and reports relating to patient care and treatment and all other relevant documents from programs and facilities that are licensed, certified or operated by an office of the department. Such pamphlet shall include a discussion of how to appeal a decision denying a requested record or report.

§ 4. Paragraphs 1, 3 and 5 of subdivision (c) of section 45.07 of the mental hygiene law, as amended by section 6 of part H of chapter 58 of the laws of 2005, are amended to read as follows:

1. Establish procedures to assure effective investigation of complaints of patients, residents and their parents or legal guardians and employees of mental hygiene facilities affecting such patients and residents, including allegations of patient abuse or mistreatment, including all reports of abuse or maltreatment of children in residential care as defined in paragraph (g) of subdivision seven of section four hundred twelve of the social services law and made pursuant to title six of article six of such law. Such procedures shall include but not be limited to receipt of written complaints, interviews of persons, patients, residents and of employees and onsite monitoring of conditions. In addition, the commission shall establish procedures for the speedy and impartial review of patient and resident abuse and mistreatment allegations called to its attention in writing.

3. Where the office of children and family services determines that some credible evidence of the alleged abuse or maltreatment exists, the commission shall notify the parents or legal guardians of such patient. The commission also shall recommend to the office of mental health or the office of mental retardation and developmental disabilities, as the case may be, that appropriate preventive and remedial actions

**Bold** type indicates new language.

Strike out type indicates deleted language.
including legal actions, consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law, and pursuant to standards of such offices, promulgated pursuant to section 16.29 or 29.29 31.30 of this chapter and other applicable provisions of law, be undertaken with respect to a residential care facility and/or the subject of the report of child abuse or maltreatment. However, nothing in this paragraph shall prevent the commission from making recommendations, as provided for by this paragraph, even though the investigation may fail to result in a determination that there is some credible evidence of the alleged abuse or maltreatment.

5. The commission shall prepare an annual report to the governor and legislature on the protection of children in residential care from abuse and maltreatment, including the implementation of the provisions of this paragraph and other applicable provisions of law, including reports received, results of investigations by types of facilities, remedial actions taken, and efforts undertaken by the office of mental health and the office of mental retardation and developmental disabilities to provide training pursuant to standards established by such offices pursuant to section 16.29 or 29.29 31.30 of this chapter.

§ 5. Subparagraph b of paragraph 2 of subdivision (c) of section 45.07 of the mental hygiene law, as amended by section 6 of part H of chapter 58 of the laws of 2005, is amended to read as follows:

b. maintain and keep up-to-date a child abuse and maltreatment record of all cases reported together with any additional information obtained and a record of the final disposition of the report, including recommendations by the commission and action taken with respect to the residential care facility or the subject of a report of child abuse or maltreatment pursuant to section 16.29 or 29.29 31.30 of this chapter;

§ 6. Section 29.29 of the mental hygiene law, as added by chapter 765 of the laws of 1981, subdivisions 6, 7 and 8 as amended by chapter 32 of the laws of 1992, is amended to read as follows:

§ 29.29 Incident reporting procedures.

The commissioners of the offices of mental health and mental retardation and developmental disabilities of the department shall establish policies and uniform procedures for their respective offices for the reporting, compilation, and analysis of incident reports. Incident reports shall, for the purposes of this chapter, mean reports of accidents and injuries affecting patient health and welfare at such departmental facilities. These policies and procedures shall include but shall not be limited to:

1. The establishment of a patient care and safety team at the facility level which shall include but not be limited to a: physician, nurse, social worker and therapy aide, to investigate and report to the facility director on:

(i) suicides or attempted suicides;

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(ii) violent behavior exhibited by either patients or employees;

(iii) frequency and severity of injuries incurred by either patients or employees;

(iv) frequency and severity of injuries occurring on individual wards or in buildings at such facility;

(v) patient leave without consent; or

(vi) medication errors; and

(vii) recommendations for corrective actions in response to incident reports to ensure the care and safety of all patients.

2. The establishment of cumulative record keeping of incident reports which identifies patient and employee involvement.

3. A compilation of uniform and measurable information, first on a facility basis, then on an office-wide basis, that will indicate where the greatest number and types of incidents of violence and injury occur.

4. That each facility shall aggregate its data monthly for the director and that aggregated information shall be submitted, at least semiannually to the commissioner of the office of mental health by facilities listed in section 7.17 of this chapter, and to the commissioner of the office of mental retardation and developmental disabilities by facilities listed in section 13.17 of this chapter.

5. Such commissioners shall transmit a copy of any report received pursuant to subdivision four of this section to the state commission on quality of care for the mentally disabled and advocacy for persons with disabilities.

6. [FN1] Such commissioners shall promulgate regulations establishing standards for the protection of children in residential care from abuse and maltreatment, including procedures for: (a) consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law, the review and evaluation of the backgrounds of and information supplied by any person applying to be an employee, a volunteer or consultant, which shall include but not be limited to the following requirements: that the applicant set forth his or her employment history, provide personal and employment references and relevant experiential and educational information and, sign a sworn statement whether, to the best of his or her knowledge, he or she has ever been convicted of a crime in this state or any other jurisdiction;

   (b) establishing for employees, minimal experiential and educational qualifications consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law;

   ** Bold type indicates new language.**
   ** Strike out type indicates deleted language. **
(e) assuring adequate and appropriate supervision of employees, volunteers and consultants;

(d) demonstrating that appropriate action is taken to assure the safety of the child who is reported to the state central register as well as other children in care, immediately upon notification that a report of child abuse or maltreatment has been made with respect to a child's custodian in a residential facility;

(e) removing a child when it is determined that there is risk to such child if he or she continues to remain in a residential facility; and

(f) appropriate preventive and remedial action to be taken including legal action, consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law. Such standards shall also establish as a priority that:

(i) subject to the amounts appropriated therefor, administrators, employees, volunteers and consultants receive training in at least the following: child abuse prevention and identification, safety and security procedures, the principles of child development, the characteristics of children in care and techniques of group and child management including crisis intervention, the laws, regulations and procedures governing the protection of children from abuse and maltreatment, and other appropriate topics provided, however, that such offices may exempt administrators and consultants from such requirements upon demonstration of substantially equivalent knowledge or experience; and

(ii) subject to the amounts appropriated therefor, children receive instruction, consistent with their age, needs and circumstances as well as the needs and circumstances within the facility or program, in techniques and procedures which will enable such children to protect themselves from abuse and maltreatment.

The commissioners shall take all reasonable and necessary actions to assure that employees, volunteers or consultants in residential care facilities are kept apprised on a current basis of all policies and procedures of the respective offices relating to the protection of children from abuse and maltreatment, and shall monitor and supervise the provision of training to such administrators, employees, volunteers, children and consultants. Standards developed pursuant to this subdivision shall, to the extent possible, be consistent with those promulgated by other state agencies for such purposes.

7. Such commissioners shall provide necessary assistance to the state commission on quality of care for the mentally disabled in the conduct of investigations pursuant to section 45.07 of this chapter, shall consider its recommendations for appropriate preventive and remedial action including legal actions, and shall provide or direct a residential facility licensed or operated by the office of mental health or office of mental retardation and developmental disabilities to provide written reports thereon to the commission as to the implementation of plans of prevention and remediation.

Bold type indicates new language.
Strike out type indicates deleted language.
8. Such commissioners shall provide for the development and implementation of a plan of prevention and remediation with respect to an indicated report of child abuse or maltreatment. Such action shall include: (a), within ten days of receipt of an indicated report of child abuse or maltreatment, development and implementation of a plan of prevention and remediation to be taken with respect to a custodian or residential facility in order to assure the continued health and safety of children and to provide for the prevention of future acts of abuse or maltreatment; and (b) development and implementation of a plan of prevention and remediation, in the event an investigation of a report of alleged child abuse or maltreatment determines that some credible evidence of abuse or maltreatment exists and such abuse or maltreatment may be attributed in whole or in part to noncompliance by the facility with provisions of this chapter or regulations of the respective offices applicable to the operation of such residential facility. Any plan of prevention and remediation required to be developed pursuant to paragraph (b) of this subdivision by a facility supervised by either office shall be submitted to and approved by such office in accordance with time limits established by regulations of such office. Implementation of the plan shall be monitored by such office. In reviewing the continued qualifications of a residential facility or program for an operating certificate, the office having supervisory responsibilities shall evaluate such facility's compliance with plans of prevention and remediation developed and implemented pursuant to this subdivision.

§ 7. The mental hygiene law is amended by adding a new section 31.30 to read as follows:

§ 31.30 Child abuse and maltreatment in residential care.

(a) The commissioner shall promulgate regulations establishing standards for the protection of children in residential care from abuse and maltreatment, including procedures for:

1. reviewing and evaluating the backgrounds of and information supplied by any person applying to be an employee, a volunteer or consultant, consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law. Such review and evaluation shall include, but not be limited to, the following requirements: that the applicant set forth his or her employment history, provide personal and employment references and relevant experiential and educational information and, sign a sworn statement whether, to the best of his or her knowledge, he or she has ever been convicted of a crime in this state or any other jurisdiction;

2. establishing minimal experiential and educational qualifications for employees that are consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law;

3. assuring adequate and appropriate supervision of employees, volunteers and consultants;
4. demonstrating that appropriate action is taken to assure the safety of the child
who is reported to the state central register as well as other children in care,
immediately upon notification that a report of child abuse or maltreatment has been
made with respect to a child's custodian in a residential facility;

5. removing a child when it is determined that there is risk to such child if he or she
continues to remain in a residential facility; and

6. taking appropriate preventive and remedial actions, including legal action,
consistent with appropriate collective bargaining agreements and applicable
provisions of the civil service law. Such standards shall also establish that:

   (i) administrators, employees, volunteers and consultants receive training in at least
   the following: child abuse prevention and identification, safety and security
   procedures, the principles of child development, the characteristics of children in
care and techniques of group and child management including crisis intervention,
the laws, rules and regulations and procedures governing the protection of children
from abuse and maltreatment, and other appropriate topics; provided, however,
that either office may exempt administrators and consultants from such
requirements upon demonstration of substantially equivalent knowledge or
experience; and

   (ii) children receive instruction consistent with their age, needs and circumstances
as well as the needs and circumstances within the facility or program, in techniques
and procedures that will enable such children to protect themselves from abuse and
maltreatment.

The commissioner shall take all reasonable and necessary actions to assure that
employees, volunteers or consultants in residential care facilities are kept apprised
on a current basis of all policies and procedures of the office relating to the
protection of children from abuse and maltreatment, and shall monitor and
supervise the provision of training to such administrators, employees, volunteers,
children and consultants. Standards developed pursuant to this subdivision shall, to
the extent possible, be consistent with those promulgated by other state agencies for
such purposes.

(b) The commissioner shall provide necessary assistance to the state commission on
quality of care and advocacy for persons with disabilities in the conduct of
investigations pursuant to section 45.07 of this chapter, shall consider its
recommendations for appropriate preventive and remedial action including legal
actions, and shall provide or direct a residential facility licensed or operated by the
office of mental health to provide written reports thereon to such commission as to
the implementation of plans of prevention and remediation.

(c) The commissioner shall provide for the development and implementation of a
plan of prevention and remediation with respect to an indicated report of child abuse or maltreatment. Such action shall include:

1. within ten days of receipt of an indicated report of child abuse or maltreatment, development and implementation of a plan of prevention and remediation to be taken with respect to a custodian or residential facility in order to assure the continued health and safety of children and to provide for the prevention of future acts of abuse or maltreatment; and

2. development and implementation of a plan of prevention and remediation, in the event an investigation of a report of alleged child abuse or maltreatment determines that a report of child abuse or maltreatment is indicated and such abuse or maltreatment may be attributed in whole or in part to noncompliance by the facility with provisions of this chapter or regulations of the respective offices applicable to the operation of such residential facility. Any plan of prevention and remediation required to be developed pursuant to this subdivision by a facility supervised by either office shall be submitted to and approved by such office in accordance with time limits established by rules and regulations of such office. Implementation of the plan shall be monitored by such office. In reviewing the continued qualification of a residential facility or program for an operating certificate, the office having supervisory responsibilities shall evaluate such facility's compliance with plans of prevention and remediation developed pursuant to this subdivision.

§ 8. Section 16.29 of the mental hygiene law, as added by chapter 719 of the laws of 1986, subdivisions (a), (b) and (c) as amended by chapter 32 of the laws of 1992, is amended to read as follows:

§ 16.29 Child abuse and maltreatment in residential care.

(a) The commissioner shall promulgate regulations establishing standards for the protection of children in residential care from abuse and maltreatment, including procedures for:

(1) consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law, the review of and evaluation of the backgrounds of and information supplied by any person applying to be an employee, a volunteer or consultant, which consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law. Such review and evaluation shall include but not be limited to the following requirements: that the applicant set forth his or her employment history, provide personal and employment references and relevant experiential and educational information and, sign a sworn statement whether, to the best of his or her knowledge, he or she has ever been convicted of a crime in this state or any other jurisdiction;

(2) establishing for employees, minimal experiential and educational qualifications for employees that are consistent with appropriate collective bargaining agreements and
applicable provisions of the civil service law;

(3) assuring adequate and appropriate supervision of employees, volunteers and consultants;

(4) demonstrating that appropriate action is taken to assure the safety of the child who is reported to the state central register as well as other children in care, immediately upon notification that a report of child abuse or maltreatment has been made with respect to a child in a residential facility;

(5) removing a child when it is determined that there is a risk to such child if he or she continues to remain in a residential facility; and

(6) taking appropriate preventive and remedial action to be taken, including legal action, consistent with appropriate collective bargaining agreements and applicable provisions of the civil service law. Such standards shall also establish as a priority that:

(i) subject to the amounts appropriated therefor, administrators, employees, volunteers and consultants receive training in at least the following: child abuse prevention and identification, safety and security procedures, the principles of child development, the characteristics of children in care and techniques of group and child management including crisis intervention, the laws, regulations and procedures governing the protection of children from abuse and maltreatment, and other appropriate topics provided, however, that the office may exempt administrators and consultants from such requirements upon demonstration of substantially equivalent knowledge or experience; and

(ii) subject to the amounts appropriated therefor, children receive instruction consistent with their age, needs and circumstances as well as the needs and circumstances within the facility or program, in techniques and procedures which will enable such children to protect themselves from abuse and maltreatment.

The commissioner shall take all reasonable and necessary actions to assure that employees, volunteers and consultants in residential care facilities are kept apprised on a current basis of all policies and procedures of the office relating to the protection of children from abuse and maltreatment, and shall monitor and supervise the provision of training to such administrators, employees, volunteers, children and consultants. Standards developed pursuant to this subdivision shall, to the extent possible, be consistent with those promulgated by other state agencies for such purposes.

(b) Such The commissioner shall provide necessary assistance to the state commission on quality of care for the mentally disabled and advocacy for persons with disabilities in the conduct of investigations pursuant to section 45.07 of this chapter, shall consider its recommendations for appropriate preventive and remedial action including legal actions, and shall provide or direct a residential facility licensed or operated by the office of mental retardation and developmental disabilities to provide written reports thereon to
the commission as to the implementation of plans of prevention and remediation approved by such office.

(c) Such commissioner shall provide for the development and implementation of a plan of prevention and remediation with respect to an indicated report of child abuse or maltreatment. Such action shall include:

(i) within ten days of receipt of an indicated report of child abuse or maltreatment, development and implementation of a plan of prevention and remediation to be taken with respect to a custodian or the residential facility in order to assure the continued health and safety of children and to provide for the prevention of future acts of abuse or maltreatment; and

(ii) development and implementation of a plan of prevention and remediation, in the event an investigation of a report of alleged child abuse or maltreatment determines that some credible evidence of abuse or maltreatment exists and such abuse or maltreatment may be attributed in whole or in part to noncompliance by the facility with the provisions of this chapter or regulations of the office applicable to the operation of such residential facility. Any plan of prevention and remediation required to be developed pursuant to paragraph (ii) of this subdivision by a facility supervised by the office shall be submitted to and approved by such office in accordance with time limits established by regulations of such office. Implementation of the plan shall be monitored by such office. In reviewing the continued qualifications of a residential facility or program for an operating certificate, the office shall evaluate such facility's compliance with plans of prevention and remediation developed and implemented pursuant to this subdivision.

§ 9. Task force on mental hygiene records. (a) There is hereby established in the executive department a task force, to be known as the "task force on mental hygiene records", hereinafter referred to in this section as the "task force". The task force shall study and make recommendations regarding access to patient records and reports, including but not limited to incident reports, medical review board reports, and other records and reports concerning minor patients and other patients with legal guardians or designated surrogates, who are receiving services in programs and facilities that are licensed, certified or operated by the office of mental health or the office of mental retardation and developmental disabilities.

(b) The task force shall be comprised of sixteen members. Such members shall include the following six agency representatives: the commissioner of mental retardation and developmental disabilities, the commissioner of mental health, the commissioner of children and family services, the commissioner of health, the commissioner of education, and a representative from the commission on quality of care and advocacy for persons with disabilities. In addition, the governor shall appoint ten members as follows: two representatives from provider agencies, two representatives of employee labor organizations, two mental hygiene patient advocates, and four parents or legal guardians of patients who are or were receiving mental hygiene services.

(c) The commissioner of mental retardation and developmental disabilities shall serve as

Bold type indicates new language.
Strike out type indicates deleted language.
chair of the task force, and shall designate such employees of the office of mental 
retardation and developmental disabilities as are reasonably necessary to provide support 
services to the task force. All state agencies shall provide assistance as may be 
reasonably requested by the task force. The members of the task force shall receive no 
compensation for their services as members, but shall be allowed their actual and 
necessary expenses incurred in the performance of their duties. Members of the task 
force shall be considered public officers for purposes of section 17 of the public officers 
law. A quorum shall consist of a majority of the members of the task force. Approval of 
any matter shall require the affirmative vote of a majority of the members voting thereon.

(d) The purpose of the task force shall be to identify the records and reports that are 
produced with respect to each patient receiving care and treatment in a mental hygiene 
facility or program, examine current disclosure practices with regard to these materials, 
and determine whether improved access to these materials should be legislated. The task 
force shall focus on, but need not be limited to, examining currently confidential reports, 
such as medical review board reports, and other documents to which patients and their 
legal guardians have limited access. In addition, the task force shall identify alternative 
means of sharing information with parents and legal guardians, such as regular telephone 
calls or meetings.

(e) The task force shall provide a report with its findings and recommendations on 
increasing and improving access to records and reports concerning minor patients and 
other mental hygiene patients with legal representatives, together with proposed 
legislation and regulations relating thereto, to the governor and the legislature no later 
than September thirtieth, two thousand seven.

§ 10. Subdivision (g) of section 16.17 of the mental hygiene law, as added by chapter 
786 of the laws of 1983, is amended to read as follows:

(g) The commissioner may impose a fine upon a finding that the holder of the certificate 
has failed to comply with the terms of the operating certificate or with the provisions of 
any applicable statute, rule or regulation. The maximum amount of such fine shall be one 
thousand dollars per day or fifteen thousand dollars per violation.

Such penalty may be recovered by an action brought by the commissioner in any court of 
competent jurisdiction.

Such penalty may be released or compromised by the commissioner before the matter 
has been referred to the attorney general. Any such penalty may be released or 
compromised and any action commenced to recover the same may be settled or 
discontinued by the attorney general with the consent of the commissioner.

§ 11. This act shall take effect immediately.
Agency Responses to the Inspector General’s Report

The two primary agencies reviewed in this report, OMRDD and CQC, were asked to respond to the Inspector General’s findings and recommendations. Those responses are included in the following pages.
June 2, 2008

William Hebert
Chief Investigator
Office of the Inspector General
Empire State Plaza
Agency Building 2, 16th Floor
Albany, NY 12223

Dear Mr. Hebert:

I was appointed Chief Operating Officer of the Commission, effective Tuesday, May 27, 2008, upon the resignation of Gary O’Brien as Commissioner and Chair. As such, I have had a limited opportunity to review the draft findings and recommendations of the Inspector General concerning the various investigations of the allegations of abuse of Jonathan Carey at the Anderson School in 2004. Notwithstanding that limitation, I have determined I can best respond to the draft report by describing the affirmative steps which the Commission has taken, and will take, to improve the quality and scope of its investigations into allegations of child abuse and maltreatment. This approach will address issues and concerns raised in the report and better serve and protect children with disabilities and their families.

First, the Commission acknowledges that the demarcation between Commission SCR investigations and care and treatment reviews is not clearly articulated. This has contributed to a lack of clarity regarding the nature and scope of both types of Commission reviews. I have directed senior staff to revise protocols and train employees to better delineate and document activities when conducting SCR investigations and/or care and treatment reviews. Further, I have instructed senior staff to ensure that an independent supervisory review of each SCR investigation and/or care and treatment review is completed and documented. In addition, I can assure the Inspector General that a site visit to the residential program in which the SCR incident is reported to have occurred is now conducted as part of every SCR investigation. Also, OCFS has been conducting a detailed review of each SCR investigation summary completed by the Commission since December 2007, and I am pleased to note that OCFS has confirmed all 111 Commission findings reviewed to date.

Second, the Commission will develop a plan for the phased implementation of a new protocol for the investigation of allegations of child abuse or maltreatment. Currently, every SCR allegation referred to the Commission must trigger a review by the residential program in which the
incident is reported to have occurred. In some cases, a separate review may be undertaken by the certifying agency (OMH or OMRDD). Going forward, every such allegation will result in: (1) a Commission investigation of the SCR allegation, with the consistent application of all relevant provisions of the Social Services and Mental Hygiene Laws, including those requiring evaluation of the risk of physical and emotional injury and recommendations that employee discipline be considered, where warranted; and (2) a broader review, which will look at all of the criteria and factors which affect the care of the child named in the SCR report, not only those which are specifically referenced in the SCR allegation, and also issues which may affect the care of other children in the program and/or which may have wider systemic impact. This review will be completed after all other relevant investigations by other entities (e.g., the facility and/or certifying agency) have been finalized, and will evaluate the adequacy of other investigations and the extent to which any recommended corrective action have been implemented. The review will be conducted by an experienced investigator, and not by the same investigator assigned to conduct the SCR investigation. As we proceed, I will be reaching out to a variety of stakeholders, within and outside of State government, to seek their advice and counsel to assure the efficacy of this approach.

Reflecting the high priority which I have assigned to this issue, the Commission has established criteria to guide the phased implementation of this protocol, beginning with allegations which raise the most serious concerns. We will be training staff to carry out this new protocol, with particular attention to several of the issues raised in the Inspector General’s report; e.g., adhering to investigative policies and protocols; securing and reviewing all relevant information; and, thoroughly documenting investigative activities; etc. The protocol will be initially implemented through the realignment of existing staff resources. I am in the process of preparing a plan which will address options for identifying the resources necessary to support full implementation.

I believe that the implementation of this protocol will better serve the interests of children and families throughout the system. Equally important, it will afford greater transparency and accountability in oversight.

In closing, I want to express my appreciation for the thoroughness of your investigation. I welcome the opportunity which this review has afforded the Commission to analyze its operations and take steps to improve the quality of the oversight and advocacy which it provides to New Yorkers with disabilities, their families, advocates and service providers.

Sincerely yours,

Jane G. Lynch
June 5, 2008

Joseph Fisch, Inspector General
Empire State Plaza
Agency Building 2, 16th Floor
Albany, New York 12223

Thank you for the opportunity to comment on the Office of the State Inspector General (OSIG) Draft Report, “A Critical Examination of State Agency Investigation into Allegations of Abuse of Jonathan Carey”. I have waited with great anticipation for the results of this comprehensive and in-depth investigation of activities and conduct which occurred prior to the start of my administration. I am committed to thoroughly analyzing the results of this report to identify opportunities for improvement in mission-driven, quality management and outcomes.

This independent investigation, while providing assurances that work performed by the Office of Mental Retardation and Developmental Disabilities (OMRDD) Central Office and its Taconic Developmental Disabilities Services Office (DDSO) was conducted completely and in compliance with rules and regulations then in place, indicates that there are still opportunities to improve our approach to investigations and our quality reviews. I can not help, however, being disturbed by the information and findings related to the standard and practice of care for Jonathan Carey while at the school and continue to appreciate the family’s frustration and sadness, now amplified in the context of the subsequent tragic death of their son. While I was particularly relieved with the conclusion that there was no evidence to corroborate allegations of a cover-up of information, I know we should continue to work to do better. Accordingly, over the last year, OMRDD has advanced a number of improvements in quality management, oversight and transparency and we will be aggressive in addressing the additional recommendations so thoughtfully provided by you in this report.

Turning specifically to the OIG’s findings as they relate to OMRDD, I agree with the finding that the Taconic investigation was “comprehensive and competently executed” and that it “addressed every allegation raised,” finding “mistreatment” and “neglect” at the Anderson School. I also agree that the Central Office quality assurance survey was adequate and the follow-up extensive.

The report does question the adequacy of the information which was provided to the Carey’s concerning the findings of the investigation of the Anderson School by Taconic. After I became Commissioner, I did ask my Counsel to examine that particular issue and we decided that OMRDD could have done a better job of sharing information with Jonathan’s parents. Consequently, on May 25th of last year, my Counsel sent the Carey’s a copy of the letter which had been previously sent to the Anderson School
containing greater detail about the investigative findings. I believe that this report should reflect that this information was subsequently provided at my direction.

The past 15 months have been difficult for the OMRDD system; for its many, many dedicated workers, the families of people served by the OMRDD system and the individuals themselves. All are hurt when the system is tainted. There is much that is good in the system, and of course, still much that can be improved. Thank you for providing resolution to this outstanding matter and for providing me an opportunity to further advance my agenda for greater quality of care at the Anderson School and applying lessons learned across my entire service system.

Attached you will find OMRDD's responses to the specific recommendations provided in the report. Again, thank you for bringing closure to this matter.

Sincerely,

[Signature]
Diana Jones Ritter
Commissioner
DETAIL OMRDD COMMENTS IN RESPONSE TO OIG RECOMMENDATIONS

The following are our point by point comments to OIG’s recommendations to OMRDD:

Taconic:

Recommendation: The Inspector General recommends that the Taconic regional office of OMRDD, or any regional office, take primary responsibility for an investigation regarding a child’s care at a facility within its jurisdiction whenever the facility discloses a conflict of interest or an appearance of such a conflict that would interfere with an internal investigation.

Response: I intend to advise all DDSOs of their obligation to assume responsibility for an investigation of a voluntary provider whenever it would present a conflict of interest for the voluntary provider to investigate incidents or abuse at its own facilities or programs, such as when the administration of a provider is the target of an investigation. As the report notes, this is OMRDD’s policy now, and it should be consistently followed.

Recommendation: The Inspector General recommends that the Taconic regional office take steps to ensure full cooperation of employees in state-certified facilities with OMRDD investigations, as required by law. These steps could include notification of the facility’s Executive Director or Board of Directors of an employee’s failure to comply with this obligation, as well as a referral of the matter to OMRDD Central Office to review the provider’s certification to operate in New York.

Response: I intend to advise all DDSOs that they must persist if they do not get cooperation by a witness at a voluntary provider and that this might include seeking the assistance of OMRDD Central Office and/or the Executive Director or the Board of the voluntary provider. In fact, OMRDD has already included this admonition in its communications to voluntary providers as part of its focus on improving board governance.

OMRDD:

Recommendation: The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to fully incorporate all regulatory violations into a Statements of Deficiencies.

Response: I will advise the Division of Quality Management that all violations found in a survey should be included in a Statement of Deficiency, even if the survey was triggered by the care of a particular individual.
Recommendations: The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to examine all available information, including pertinent documents and witness interviews.

Response: This is the current expectation. However, I will direct the new OMRDD Deputy Commissioner for Quality Management to reinforce the expectation in training sessions and staff meetings to examine all pertinent documents and information when conducting a survey.

Recommendation: In instances when a survey related to a separate investigation by one of OMRDD’s regional offices is conducted, the Inspector General recommends that OMRDD Central Office coordinate such efforts and obtain the investigative findings of the regional office.

Response: I have already advised the Division of Quality Management of the need to coordinate efforts with the internal investigative unit. In addition, I believe the new organizational framework which I have adopted at OMRDD will help ensure the integration of investigations and programmatic and licensure and fiscal reviews.

Recommendation: In light of Jonathan’s Law which provides families with greater access to certain investigatory records, the Inspector General encourages OMRDD to re-evaluate the language used in its Statement of Deficiencies to determine whether the document should indicate when many instances occurred, even if only one instance of a violation is being cited.

Response: I will advise the Division of Quality Management of the need to clarify the policy on how to address multiple deficiencies. There is significance to the number of times a deficiency occurs and this needs to be addressed when a survey takes place.

Recommendation: The Inspector General reminds OMRDD Central Office of its ethical and legal responsibility to provide thoroughly accurate information to the Governor’s Office. OMRDD should take measures to ensure compliance with fulfillment of such responsibility.

Response: I have made transparency a hallmark of my administration. For reasons of transparency, I have already made this position clear to my leadership team, managers and workforce in general and will remind my staff of the obligation to provide the Governor’s Office and all public officials and members of the public with accurate information.

Recommendation: The Inspector General recommends that OMRDD review the conduct of those responsible for providing a response to Governor Pataki’s office that did not accurately reflect OMRDD’s actions in this matter.

Response: It is difficult to reconcile what was written in the excerpts you cited and the greater context of what the agency was doing and what the Governor’s office knew the
agency to be doing. We know that there was an investigation conducted and that Governor Pataki knew of the investigation. In addition, these comments were provided to the Governor Pataki almost two years ago, and unraveling the dynamics of the relationships and expectations that existed at that time would now be difficult. However, it is worth noting that the individual at OMRDD who prepared that response, in conjunction with CQC, is no longer with our agency. As to the other individuals who were involved with the briefing of the Governor, I will discuss the matter further with them.

Recommendation: There is no justification for a child placed in a private, state-certified facility to be afforded less protection from abuse than a child in a state-run facility. The Inspector General encourages OMRDD to re-examine draft regulations on behavior management (14 NYCRR section 633.16) to ensure consistent safety and oversight protections for all consumers statewide.

Response: I have made the promulgation of the behavior management regulations a priority. You also recommend that OMRDD re-examine the behavior management draft regulations, which were never promulgated and therefore provide only guidance to voluntary providers. As stated in the investigation, getting behavior management regulations promulgated is a priority of my Administration. However, it is important that these regulations reflect OMRDD’s mission and commitment to quality of care, and with that in mind, I have directed that my staff take a diligent step backwards to make sure that the regulations are consistent with the overall mission and goals of OMRDD and its person centered perspective.

Recommendation: The Inspector General recommends that OMRDD explicitly recommend agencies under its jurisdiction to review an employee’s conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

Response: I will advise all investigative staff that they should include, when appropriate, recommendations to voluntary providers that disciplinary action be taken against employees.

Once again, I would like to thank you for the opportunity to comment on this investigative report.