PROTECTION AND ADVOCACY FOR PEOPLE WITH DISABILITIES, INC.

The Protection and Advocacy System for South Carolina

Unequal Justice

For

South Carolinians with Disabilities:

Abuse and Neglect Investigations

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EXECUTIVE SUMMARY

Physical Abuse. Sexual Abuse. Neglect. Misuse of medications. *Few incidents are reported. Fewer are properly investigated. Rarely are offenders held accountable. Those who should protect people with disabilities often fail to do so. The State's response is a fragmented collection of agencies lacking the expertise to properly investigate allegations of abuse, neglect, and exploitation of vulnerable adults. It is a collective failure that needs to become a system.*

Recent media reports have disclosed extensive problems with the entities that investigate possible abuse, neglect and exploitation of vulnerable adults. The focus of these reports has been on vulnerable adults who receive services from the South Carolina Department of Disabilities and Special Needs (DDSN) or contract providers.[1] At the request of Protection and Advocacy for People with Disabilities, Inc. (P&A) a study was conducted of the entities responsible for investigating and prosecuting abuse, neglect and exploitation. P&A requested and obtained 50 cases of alleged abuse and neglect which represented a variety of programs and environments and which had taken place over a period of approximately two years. Of the cases reviewed, 18 were selected for inclusion in this report because they illustrate the issues that arose from fragmentation.

[1] The South Carolina Department of Disabilities and Special Needs (DDSN) is the state agency with the primary responsibility for serving individuals with developmental and related disabilities, including autism. S.C. Code Ann. §§ 44-20-10 et seq. DDSN provides these services through five regional centers (Whitten, Coastal, Midlands, Saleeby, and Pee Dee), through contracts with county Boards of Disabilities and Special Needs, S.C. Code Ann. §§ 44-20-375 et seq., and contracts with large private providers (Charles Lea Center, Emerald Center, and Babcock Center). Most individuals receiving residential services from DDSN are served by a county board or contract provider. DDSN exercises little control over the delivery of services by boards or contract providers. The DDSN system is highly fragmented; availability and quality of services vary widely across the state.

This report provides an in-depth review of the entities that respond, or fail to respond, to allegations of abuse, neglect and exploitation. Focus was placed upon compliance with South Carolina's Omnibus Adult Protection Act (S.C. Code Ann. §§ 43-35-5 et seq. (OAPA)), internal policies and procedures of DDSN, and the quality of the investigative responses. This report also addresses issues raised by several cases in which allegations of abuse and neglect were not reported or investigated by the appropriate body. Several allegations of abuse and neglect of P&A clients who were not directly served by DDSN were also included in the cases screened. In every instance, the investigative reports were reviewed with attention paid to the fundamentals of a quality investigation.

- Did it determine what happened?
- How did it happen?
- And, if appropriate, who did it?

The ultimate goal must be to protect the victim and, if appropriate, hold the offender accountable. The review of cases determined that in a vast majority, abuse and neglect occurred. In other cases staff may have violated polices, procedures or quality of care standards that did not reach the level of abuse and neglect.

Key issues and possible remedies were identified upon completion of the review of the cases. Overall, it was apparent that the current fragmented approach does not serve vulnerable adults well and may even place them at risk of further abuse and neglect. The response by the numerous state agencies that have some responsibility to protect vulnerable adults, investigate allegations, or provide oversight of the investigative process is cumbersome and uncoordinated. The major agency involved with these issues, DDSN, has created policies and procedures that are inadequate in some places and not followed in others. Other agencies responsible for

conducting investigations or reviewing those done by DDSN or contract providers have not exercised their responsibility effectively. In summary, immediate attention by policymakers as well as those directly responsible for the protection of vulnerable adults in South Carolina is required. The conduct of investigations by those who are responsible for the care of the victims is an inherent conflict of interest and must be changed.

The specific findings and recommendations are as follows:

FINDINGS

1. Reporting often is delayed, or in some cases non-existent. Delays in reporting present serious problems with evidence preservation and victim protection.
2. Investigations are viewed from an administrative perspective and are conducted by administrators. They seem to focus on whether or not policies and procedures were followed with little effort made to refer to law enforcement. It did not appear that sufficient effort is being made by the Long Term Care Ombudsman to review reports and make a referral for a criminal investigation when the facts support that action or to require additional effort by DDSN to address substandard investigative reports.
3. Inconsistent definitional foundations impede investigation. OAPA contains the definitions that determine the elements of abuse and neglect. DDSN has developed a set of definitions to be used in investigations that do not adhere to the ones set forth in OAPA. These discrepancies lead to confusion and often lead to conclusions not consistent with the governing statute.
4. Investigations conducted by contract agencies were seriously flawed. In one case reviewed, there was a failure to properly investigate a case of sexual abuse as well as a failure to protect the victim from further harm.

5. DDSN's documentation procedures are confusing in that DDSN does not appear to mandate their use by facilities and the forms lack sufficient information for the conduct of a criminal investigation.
6. Cases reported to law enforcement do not always receive the necessary investigative effort.
7. Cases referred to the local solicitor for review were, in almost every case, not prosecuted.
8. No single oversight process ensures that cases are screened for possible criminal behavior and that the investigative process meets a minimum standard.

RECOMMENDATIONS

1. Establishment of a state-level investigative entity within the criminal justice system, i.e. SLED, and outside of any agency providing services to vulnerable adults, with responsibility for all reports of abuse involving vulnerable adults in facilities.
2. No longer permit agencies and their contractors to investigate allegations of abuse and neglect within their facilities.
3. Establish separate policies and procedures for administrative/quality control investigations after determining that no criminal abuse or neglect took place.
4. Develop and present adequate training to criminal justice professionals charged with the responsibility of investigating and prosecuting abuse and neglect.
5. Review all agency (DDSN, contractor, and Long Term Care Ombudsman) policies and procedures to insure that they conform to all the provisions of OAPA, including definitions.

It is imperative that corrective action be taken as the current system does little to provide the appropriate protection to some of our most vulnerable citizens.

INTRODUCTION

In response to ongoing concerns about the quality of investigations of allegations of abuse, neglect and exploitation, Protection and Advocacy for People with Disabilities, Inc. (P&A) initiated a study of the investigative process. P&A is the federally and state mandated protection and advocacy system for South Carolina. It was established in 1977 by state law, S.C. Code Ann. 43-33-310 et seq., to protect the rights of people with disabilities. Each year P&A serves thousands of South Carolinians with disabilities who have been abused, neglected or denied access to services. P&A has broad authority under state and federal law to advocate for the rights of individuals with disabilities in this state and to investigate allegations of abuse and neglect when such incidents are reported to them or when they determine that there is probable cause that abuse and neglect occurred.

This report examines the South Carolina investigatory process using cases provided by P&A, reviews the Directives of the South Carolina Department of Disabilities and Special Needs (DDSN), and evaluates the involvement of other investigative entities such as the Long Term Care Ombudsman. The cases were reviewed for compliance with the statutes, quality of the investigation, and outcomes. Every attempt has been made not to single out a particular agency, location or program. While the focus of this report is primarily on those adults served by DDSN and represented by P&A in the following environments, it is important to note that similar problems exist with the investigation of abuse and neglect of children with disabilities and adults with mental illness.

- Intermediate Care Facilities for the Mentally Retarded (ICF/MR) provide 24-hour care, supervision, counseling, recreation and other activities to individuals with mental retardation. These facilities are located on large campuses or are home-like

and located in residential neighborhoods. Each facility has four to sixteen residents. These facilities are licensed by the Department of Health and Environmental Control (DHEC).

- Community Training Homes (CTH I and II) are located in residential communities and offer a homelike environment under the supervision of qualified and trained caregivers who provide personalized care, supervision and individualized training to no more than four persons. CTH I homes are operated by trained private citizens. CTH II homes are owned or rented and operated by a provider organization. These homes are licensed by DDSN.
- Community Residential Care Facilities (CRCF) are homes that offer room and board and a degree of personal care to individuals on a continuous basis. These homes are licensed by DHEC.

The investigation of possible abuse, neglect, and exploitation of vulnerable adults is a complex task. There are issues with reporting, determining what constitutes abuse, and conducting a quality investigation. Failure to properly identify, report, and investigate possible cases of abuse, neglect and exploitation can result in further harm to our most vulnerable population.

The South Carolina framework for conducting effective investigations, protecting the victim from further harm and ultimately holding an offender accountable is found in the Omnibus Adult Protection Act (OAPA).[2] Using the OAPA framework, this report addresses the legal environment for conducting investigations, policies and procedures utilized by DDSN, and case data to make recommendations for improving the system. This report is not intended to

[2] The Omnibus Adult Protection Act, S.C. Code Ann. §§ 43-35-5 et seq. The Act was passed in 1993 with the goal of improving prevention, reporting, and investigation of abuse, neglect, and exploitation of vulnerable adults.

furnish specific solutions to any particular agency, nor is it intended to criticize any particular agency or facility. Many quality investigations were included in the review. These examples provide a standard by which improvements can be made. It is also not the intent of this report to address quality management issues affecting client care. The intent is to present those recommendations that will address systemic problems documented in this report. Many of the findings and recommendations contained in this report are applicable to any system of facilities providing care and services to any vulnerable individuals, including adults with mental illness and children with disabilities and adults with mental illness. Addressing the issue of abuse, neglect and exploitation in an effective manner will lead to quality of care outcomes that enhance the lives of vulnerable adults in our state.

THE PROBLEM IN PERSPECTIVE

In a report prepared by Protection and Advocacy, Inc. of California,[3] it is estimated that people with disabilities are at least four times more likely to be victimized than people without disabilities. Individuals with intellectual impairments are at the highest risk. Of greatest concern are the studies that show people with disabilities are more likely to experience severe abuse of longer duration and to suffer multiple episodes perpetrated by multiple suspects. Most of these incidents go unreported. It is estimated that 80-85% of incidents of criminal abuse and neglect in facilities never reach the proper authorities. Studies also show an extremely low rate of prosecution and conviction.

According to the report, many factors contribute to this problem. Studies suggest that victims have:

- Cognitive deficits which may make it difficult for them to recognize unlawful activity or know their rights to safety and protection;
- Dependence on others for activities of daily living and personal care;
- Presence of communication or physical impairments which limit their ability to verbally or physically defend against a perpetrator and disclose abuse;
- Lack of training in sex education;
- Lack of experience and socialization which encourages compliance rather than self-advocacy;

[3] Protection and Advocacy, Inc.; Tarjan Center for Developmental Disabilities at UCLA; University Affiliated Program; and the State Council on Developmental Disabilities. (2003). *Abuse and Neglect of Adults with Developmental Disabilities: A Public Health Priority for the State of California*. Protection and Advocacy, Inc., California (7019.01). http://www.pai-ca.org/pubs/701901.pdf.

- Fear of retribution from the perpetrator if they do report or fear that they will have to move from their home as a solution to the abuse.

It is important to note that most often these individuals are abused by the very persons who provide care and often by those whom they know and trust. The California report also discusses the problem of late reporting to law enforcement and law enforcement not receiving any reports. These incidents are initially reported to administrators and either are never referred to law enforcement or referred too late to preserve critical evidence. However, even early reporting to law enforcement could be ineffective because law enforcement personnel and prosecutors receive little or no training in working with victims with disabilities and do not have the necessary expertise to properly investigate.

The following quote addresses the key problems associated with the entire system of investigating incidents of abuse involving people with developmental disabilities:

> "It is notable that very few situations involving potential victims from the general population permit potential criminal conduct to be investigated initially by administrative agencies, as is the case with victims with developmental disabilities. This represents a separate and unequal system of justice for crime victims with developmental disabilities." (Protection and Advocacy, Inc., et al., p. 19)

The fact that these incidents are most often viewed as issues of policy and procedure and not viewed as violations of the criminal statutes is a significant impediment to holding offenders accountable. It is also an inherent conflict of interest for those who are responsible for the care of the victims to be responsible for the conduct of the investigation. It is an organizational structure rife with potential issues of organizational conflict.

THE INVESTIGATIVE ENVIRONMENT

The investigative environment in South Carolina is fragmented with varying legal mandates and agencies responsible for their implementation. The agencies that have some form of jurisdiction over allegations of abuse and neglect of vulnerable adults served by DDSN or other state agencies are:

- Local law enforcement (there are over 260 law enforcement agencies in South Carolina)
- State Law Enforcement Division (SLED)
- Department of Health and Environmental Control (DHEC)
- Department of Social Services (DSS)
- Long Term Care Ombudsman (Lieutenant Governor's Office on Aging, LTCO)
- Department of Health and Human Services (DHHS)
- Attorney General's Office, Medicaid Fraud Control Unit (MFCU)
- Department of Mental Health Public Safety (DMHPS)
- Department of Disability and Special Needs and contract agencies (DDSN)
- Centers for Medicare and Medicaid Services (United States Department of Health and Human Services, CMS)
- Department of Labor, Licensing, and Regulation (LLR)
- Various state licensing boards

These agencies may exercise regulatory authority, focus on criminal investigations, or a combination of the two. A number of agencies must adhere to both state statutes and regulations and federal statutes and regulations with respect to their authority. Any single investigation may have one or more of the agencies involved with little or no coordination and no central

management system to insure the best possible results for the victim are achieved. Additionally, there is no common data collection system that allows for shared access and assists in oversight of the quality of the process. Reporting requirements can be difficult, subject to interpretation and sometimes easily avoided. Adding to this complicated process is the existence of Memoranda of Agreement (MOA) that further delegate responsibility.[4] For instance, the MOA between the LTCO program and DDSN allows DDSN and its contractors to conduct their own internal investigations with the results reviewed by the LTCO. In practice, this is a conflict of interest that results in a system of cursory reviews of investigations with little follow-up or few challenges to the results. A copy of the MOA can be found in Appendix D.

Certain investigative standards apply to every potential incident of abuse, neglect, or exploitation. All investigations depend on gathering information in three critical areas: physical evidence, witnesses, and confessions. To be successfully prosecuted, a case must have two of the three. The initial focus must be on what happened and how it happened, ultimately leading to who did it, if appropriate. The information gathered must establish a legal basis for determining whether or not a particular incident can be characterized as abuse, neglect or exploitation. This legal basis turns on specific definitions of prohibited conduct. In other words, does the information establish all the elements of the crime? While not all cases will be criminal, not all criminal cases will be prosecuted. This standard of establishing the elements of the crime is absolute.

In South Carolina, the OAPA provides specific definitions (see Appendix A). The OAPA definitions were deliberately designed to include all the legal elements for prohibited behavior. The intent of this statute is to provide a common set of definitions for all those who

[4] These memoranda are permitted by the OAPA, section 43-35-15(A). Policies and procedures that interfere with the OAPA reporting requirements are not authorized, section 43-35-25(E). DSS was removed from the MOA in 2005.

have a role in the adult protection system and avoid varying definitions of abuse, neglect, and exploitation depending upon which agency or function drafted the definition.

Every investigation should be structured to address the elements in the OAPA in reaching a determination as to whether or not abuse, neglect or exploitation took place. It is absolutely critical that investigative entities speak the same language. To develop additional definitions that depart from the OAPA for use in investigations can only lead to confusion and gaps in the process of holding an offender accountable. Moreover, an investigator who is not very familiar with the OAPA elements will encounter difficulty in identifying abuse and neglect and gathering facts that support these elements. It is also important to gather and record facts and present the results of an investigation pursuant to a standardized system. Finally, the selection and training of investigators is the foundation of a responsive system.

During the case reviews, it became apparent that DDSN has developed definitions of abuse, neglect and exploitation that differ from those contained in OAPA. DDSN's definitions contain some of the language used in the statute, but also include definitions of abuse not addressed in the statute. Many of the definitions used by DDSN appear to be "quality of care" issues, which should not be used in the initial investigation. These discrepancies pose serious problems for an investigator whose initial goal is to determine what constitutes abuse and if it meets the initial requirement for a criminal investigation. While quality of care issues are important, they should be addressed separately and only after a determination that a specific incident was not the result of criminal activity.

Appendix A provides a comparison of the statutory definitions contained in OAPA and those outlined in DDSN Directive 534-02, Procedures for Reporting, Investigating, and

Preventing Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency (revised March 2004). Some specific examples are:

- Exploitation-the definition used by DDSN does not parallel the language in the definitions section of OAPA;
- Neglect-the DDSN definition does not contain many of the elements found in OAPA;
- Physical Abuse-the DDSN definition provides additional acts not addressed in OAPA;
- Psychological Abuse-DDSN uses additional terms such as "Emotional," and "Mental" that are not included in OAPA;
- DDSN creates additional categories of abuse not found in OAPA such as "Verbal Abuse", "Sexual Abuse", "Threatened Abuse", and "Abuse".

Another legal issue raised by the case reviews was addressed in the United States Supreme Court in *Garrity v. New Jersey*, 385 U.S. 493 (1967). Under *Garrity*, information obtained during the course of an interview where the employee can be disciplined or terminated cannot be used in a subsequent criminal prosecution. Some of the interview forms used by DDSN indicate that disciplinary action can be taken against an employee under some form of "confidentiality" agreement. DDSN Directive 534-02 also states that employees are required to cooperate with an investigation and that failure to do so could result in disciplinary action, including termination and referral for prosecution. Such action by DDSN could create a *Garrity* situation rendering any statements against interest inadmissible in a criminal case. This risk raised by *Garrity* is especially great since non-law enforcement investigators are not required by *Miranda v Arizona*, 384 U.S. 436 (1966), to advise an individual of the right to remain silent and

to request an attorney, unless they are acting as an agent of law enforcement. Several of the cases reviewed clearly raise *Garrity* issues with statements taken by internal investigators that may not be available in a criminal prosecution. One included a clear confession by the perpetrator to an act of physical abuse. This individual was terminated but no referral was made to law enforcement.

Specific examples of these issues will be presented in this report with recommendations to improve the investigative response. However, those tasked with investigative responsibilities first must recognize the importance of these issues. The lack of a commonly accepted legal framework for determining abuse and neglect can have serious implications on outcomes. The critical issue may be the inherent conflict of interest in permitting agencies to conduct their own internal investigations. It is apparent that organizational pressures may put investigators in an untenable position and lead to conclusions that are not in the best interest of the victim.

POLICIES AND PROCEDURES

This report addresses the investigative process in three specific areas: reporting, investigating and follow-up. DDSN has a detailed directive for reporting and investigating abuse, neglect, and exploitation, directive 534-02-DD (March 31, 2004) *Procedures for Reporting, Investigating, and Preventing Abuse, Neglect, or Exploitation of People Receiving Services from DDSN or a Contract Provider Agency*. Because DDSN or its designated provider agencies conduct the initial response to a reported incident, this report focuses on investigations conducted by DDSN or its contractor. However, additional documentation from follow-up investigations conducted by SLED, the Ombudsman or the Attorney General's Office (MFCU) were also included because DDSN and its contractors decide whether to report to another investigative entity based upon their initial investigation. Applicable excerpts from DDSN 534-02 are contained in Appendix E.

The DDSN policy does not conform to the requirement of the OAPA that all incidents that may be criminal in nature be reported to the appropriate criminal justice agency (local law enforcement, SLED or the Attorney General's Office). For example, the section of the directive that addresses reporting "serious physical injury" ignores the fact that any assault, whether there are visible injuries or not, is a criminal act. It is also difficult to understand why the number of victims plays a role in determining criminal behavior when the number of victims is not critical to defining criminal events.

Under the OAPA, a determination to report to law enforcement should be made by applying the elements of the definitions contained in the statute to the facts available to establish the reasonable suspicion that a criminal act took place. This determination is case specific and based upon the facts presented to an investigator. Failure to report in a timely manner very often

results in the loss of critical evidence. Several of the cases reviewed for this report should have been reported to law enforcement as the record strongly supported the fact that a criminal act took place. In other cases, late reporting to law enforcement compromised the ability to build a prosecutable case.

The section that addresses resident versus resident incidents is another issue requiring attention. OAPA excludes altercations or acts of abuse between vulnerable adults from its definition of physical abuse. The exclusion was intended to avoid the difficulty of determining criminal intent among a population group with limited cognitive abilities and to focus on abuse by providers. It does not prohibit criminal charges under other provisions of the South Carolina Code (Title 16), if appropriate.

These DDSN policies contain provisions that negatively impact the conduct of investigations. First, the section addressing the prosecution of substantiated cases states a requirement that has no basis in criminal law: "the seriousness… and nature of the injuries." (See Appendix E). It is only necessary to establish probable cause that a criminal act took place and that a suspect can be identified. Other limiting language only affords the agency an "out" for not referring cases to the appropriate investigative entity.

The second problem is the ability of specific facilities or contract providers to develop their own policies, creating a potential situation of conflict with existing DDSN policies and contributing to a lack of consistent procedures used in investigating allegations. The importance of consistent policies and procedures throughout the system cannot be overstated. Consistent policies ensure that all investigations conform to a single set of standards which can be reviewed for compliance with the goals of protecting the victim and holding the offender accountable.

Third, the section that allows DDSN's internal investigations, including DDSN contract provider investigations, to be accepted as the "official" investigation for the LTCO raises serious issues which will be addressed in the recommendations section.

It is important to note that the majority of cases reviewed for this project had little or no oversight exercised by other agencies unless they were specifically referred for investigation. We found no evidence found of any coordinated effort by DDSN, the LTCO or the AG to oversee the investigative process to determine if the cases are being reported to the appropriate entity, followed up on, and offenders held accountable. While OAPA does not contain any requirement for the Attorney General's Office to conduct investigations unless they are referred to them, some of the cases reviewed were referred to the AG and resulted in criminal prosecution. In fact, most of these cases could have been referred to local law enforcement or SLED with the same possible results. No entity has developed clear guidance as to which law enforcement agency should exercise jurisdiction or how law enforcement efforts should be coordinated.

CASE MATERIAL

Fifty cases were reviewed involving 54 victims. Some cases had more than one victim or the victim was named in more than one case. The investigations reviewed took place between 2003 and 2005. There were no specific guidelines for selection, except that the cases should not target one specific location or contract agency. The cases were from a variety of different locations and time periods and fairly represent a cross-section of possible abuse and neglect situations. The majority were allegations of physical abuse, followed by neglect. Many cases had more than one type of abuse or neglect. Personally identifiable information has been redacted to protect individuals' privacy.

It was difficult to determine the final outcome of many of the cases or establish which other investigative agencies may have been involved. While the number of cases reviewed does not provide a valid statistical sample, the selected cases do allow an evaluation of the investigative process at both DDSN facilities and one contract provider. Some of these cases were investigated in a very thorough manner and met the investigative standard for determining whether a criminal event took place. Others were incomplete or inadequate. The cases presented in this report illustrate the issues addressed in the report.

Appendix B lists each case by type of abuse, whom the abuse was reported to, and the results of the investigation. Personally identifiable information was redacted to protect the individuals' privacy. The breakdown by type of cases reviewed is summarized in the following chart:

TYPE OF ABUSE	TOTAL NUMBER OF CASES
Physical Abuse	28
Sexual Abuse	5
Psychological Abuse	2
Neglect	10
Exploitation	1
Unexplained Injury	1
Homicide	1
Death	9

Below is a brief summary of some of the cases reviewed. In each case P&A asked the facility where the abuse or neglect occurred to provide its investigative file. These files were extremely inconsistent in their content and format, making comparisons of investigations and results very difficult.

PHYSICAL ABUSE CASES:

CASE 001

Allegations: It was alleged that five victims were each physically abused in different ways by four staff members. These acts, which took place over a two week period, involved putting a victim in a cold shower, assault with a belt, slapping and choking, and assault with a

chair. After these incidents were reported by another staff member, an internal investigation was initiated along with a report to the LTCO and Attorney General's Office. One of the perpetrators attempted to obstruct the investigation by making a phone call to the investigator claiming that he was the staff member that made the initial complaint and stated he "made this up". The actual complainant was sitting in the investigator's office at the time this call was received. The employees were terminated. The report furnished by DDSN indicates that the Attorney General's Office conducted a follow-up investigation and may have charged one of the individuals. The record also reflects that DSS may have conducted an investigation as well. The record is incomplete because there is no documentation of any criminal charges filed, interviews with possible victims, or the reasons why possible victims were not interviewed.

Issues: This case should have been conducted as a criminal investigation from the beginning. It contains essential facts that would lead a reasonable person to believe that several assaults had taken place and that the suspect(s) could be identified and should have been immediately reported to law enforcement. The fact that the case was also referred to DSS demonstrates the fragmented way in which incidents are investigated.

CASE 002

Allegation: An anonymous letter was received by an administrator alleging that a staff member gave six victims suppositories (rectal) taken from a nurse's station. The internal investigation determined that the suspect inserted these suppositories as a form of retaliation against another staff member. The suspect apparently wanted the other staff member to have to clean the individuals and their beds and rooms after they were unable to control their bowels. A witness to this incident observed the suspect insert the suppositories and heard her state that this was an act of retaliation. The Ombudsman was notified of this incident.

Issues: Sufficient information presented in the initial stages to involve law enforcement. There is no record that the Ombudsman ever received a report of this incident although the internal investigation states that they were notified. The suspect was terminated but no criminal charges were filed. This case was strong enough to have been followed up by law enforcement as the record indicates that sufficient probable cause was established to charge this suspect with assault.

CASE 006

Allegation: A series of reports of abuse were initiated with respect to this victim over a period of approximately one year. One report described an incident of physical abuse where a staff member struck the victim and it was witnessed and reported by another staff member. The internal investigation substantiated this incident. A second report described an incident where both staff and a family member observed bruises in the chest area. The internal investigation stated that the Director of Nursing thought the bruising looked like the victim had been struck by "a belt or wire looped object".

Issues: The first report where there was a witness does not indicate whether or not this report was referred to any other agency such as law enforcement or the Long-Term Care Ombudsman. There was sufficient credible information to have this case referred to law enforcement or the Attorney General. The incident where the Director of Nursing rendered an opinion as to the way in which the bruise was caused should have been referred for a criminal investigation. There is no indication that the Vulnerable Adult Abuse Protocol was used, which was developed by the Adult Protection Coordinating Council (S.C. Code Ann. §§ 43-35-310 et seq.) and the medical community to document medical information and would have provided

more detailed medical data. A copy of the Vulnerable Adult Abuse Protocol can be found in Appendix C.

CASE 012

Allegation: A hospital employee reported that a staff member, who had escorted the victim to the hospital, abused the victim by pushing him down on the bed and grabbing his throat. The hospital employee reported the incident to the hospital charge nurse who then contacted the facility. An internal investigation was conducted and the suspect provided a statement that she did not abuse the victim. She did admit that she was "having problems" and was receiving mental health counseling and taking a psychotropic medication. Although the employee was offered a job that did not require her to have contact with consumers at the facility there was no documentation of the ultimate outcome.

Issues: The record does not indicate that this case was referred to any law enforcement agency. The internal investigation clearly indicates that this was a criminal case of assault which should have been immediately referred to law enforcement.

CASE 014

Allegation: It was reported that the victim had been physically abused by staff on a number of occasions, sustaining 36 injuries of unknown origin. An internal investigation was initiated and the local police department was contacted. As a result of the investigation, seven staff members were terminated for abuse and the police department subsequently charged seven individuals. No results of the criminal prosecution were indicated.

Issues: The police department record indicates that they did not charge the same seven individuals that the facility terminated, which indicates a discrepancy in investigative results between the internal investigation and law enforcement investigation. Although the overall

internal investigation was conducted in an acceptable manner, it may have been better to have law enforcement involvement at an earlier stage rather than at the conclusion to eliminate the discrepancy.

CASE 021

Allegation: A staff member observed bruises on the victim in the area of the right thigh, buttocks, rectum, scrotum and penis. From the nature of the injuries, it appeared that the victim had been kicked. It was obvious the injuries were not accidental in nature given the severity and location, which was verified by a physician. An internal investigation was conducted by staff who were unable to determine a possible suspect or suspects. As a result of the internal investigation, the case was referred to SLED, who began their investigation approximately three days after the internal investigation. SLED's investigation was also unable to determine the possible suspect or suspects and the case was closed.

Issues: The delay in involving law enforcement may have contributed to the difficulty in determining a possible perpetrator. The photographs that were included in the report did not meet basic evidentiary standards such as scaling and identification shots. Three of the employees who had the opportunity to observe the bruises 2-3 days prior to their discovery failed to report them and gave conflicting statements to the internal investigator and the SLED agents. These inconsistent statements do not appear to have been challenged by investigators. There is a strong possibility that a suspect or suspects could have been developed with earlier SLED involvement.

CASE 022

Allegation: On a trip with several residents of the facility, a staff member provoked an altercation between two residents that resulted in an assault on the victim, who was in a wheelchair. The internal investigation disclosed that the staff member verbally abused the victim

and used another resident to assault the victim stating, “I might not can get you but I can’t stop the other girls from doing so”. The victim received “minor scratches” on her arm and minor injuries to her legs as a result of the altercation. The case was reported to the Ombudsman and the record reflects that “the appropriate personnel action was taken”.

Issues: This case is clearly physical and psychological abuse under OAPA that should have resulted in a criminal investigation by the appropriate law enforcement agency. There is no record of any evidence collection such as photographs or a medical report about the possible injuries.

CASE 035

Allegation: The victim reported to his sister that he had been assaulted by a staff member. A subsequent medical examination determined that he had bruises and abrasions on both shins, bruises on both thighs, a large bruise on one hip, bruises on his buttocks, bruises under his arms and bruises on both arms. An X-ray revealed that he also had two broken ribs on his right side. An internal investigation was initiated and the victim was interviewed. He was able to identify a possible suspect. A witness also identified the same suspect. The case was referred to SLED and the Ombudsman was notified. SLED interviews of both residents and staff provided conflicting statements. Many residents supported the allegation that the suspect assaulted the victim. The staff statements stated that they did not see anything happen to the victim. An interview with the suspect produced a denial, although he did admit that he had problems with the victim in the past. The case was referred to the Solicitor and he declined to prosecute.

Issues: The case clearly illustrates the problem with these incidents. The victim and a number of residents give statements implicating the suspect, however, many of them are

conflicting. When the suspect denies the abuse it becomes his or her word against a number of witnesses with cognitive disabilities. The SLED report is very thorough and there is sufficient evidence to support an abuse case. This case indicates a broader issue of prosecutorial reluctance to pursue these cases and may be based upon their perception of victim/witness ability to present credible testimony.

CASE 038

Allegation: Staff noticed bruises under the arm of the victim and reported them to the supervisor. The victim stated that somebody at the day program grabbed him. The record does not reflect that an investigation was initiated. P&A then made a request for further investigation. Records show that additional bruises were discovered on his torso along with a scratch on his abdomen. Subsequent body checks showed a continuing pattern of bruising on the victim.

Issues: There is no indication that any internal investigation or reporting was done for this victim. Although there is a letter from the County Disabilities and Special Needs Board that the allegation of abuse is unsubstantiated, the non-existent reporting and required follow-up make it impossible to substantiate that determination.

CASE 048

Allegation: A letter to the South Carolina Department of Health and Environmental Control by the daughter of the victim details an allegation of misuse of major pain medication by the facility. This resulted in an emergency admission to the hospital with a final diagnosis of a drug overdose of the type of drug taken and dehydration. No report was made to any agency by the facility. DHEC ultimately cited the facility for overmedication and dehydration and the facility submitted a plan of correction.

Issue: This case should have been referred to the Ombudsman for an initial investigation and then possibly law enforcement for additional investigation. This may be a case of physical abuse or neglect under OAPA for the misuse of the medication or neglect for the dehydration.

CASE 050

Allegation: The victim stated a staff member took a hammer to his door and knocked off the lock. The staff member then struck the victim with the hammer. The victim filed a report with the County Sheriff's Department. A staff member from P&A personally observed the damage to the victim's door as well as injuries to the victim. The middle finger of the right hand was swollen and the first joint appeared injured. This individual also observed damage to the victim's CD player. The P&A representative then questioned staff. They stated they were not aware of the injuries and had not sought medical treatment. There was no report made by the facility with respect to this incident. It has been subsequently referred to the Ombudsman by P&A and is currently being investigated.

Issues: It is clear that some type of incident took place between a staff member and the victim that should have resulted in a report and investigation.

SEXUAL ABUSE CASES:

CASE 046

Allegation: Two witnesses (staff members) reported seeing the suspect touch the victim "inappropriately" at different times. This touching was in the vaginal area and each witness observed it at a different time, indicating at least two events. An internal investigation was initiated. A medical exam was conducted with negative results. The suspect stated that he was performing a required medical procedure, a digital rectal exam for possible impaction. The witnesses both said he was not wearing gloves at the time they witnessed the incidents. In one case the suspect stated he was administering oral medication. The case was referred to SLED, whose investigation led to the suspect's indictment. The case was then closed by the Solicitor after being informed by the suspect's attorney that he had passed a private polygraph.

Issues: This case was properly investigated by both the facility and SLED and the two witnesses were very credible. However, after being informed of the polygraph results, the Solicitor declined to prosecute even though polygraph test results are not admissible as evidence in court. The dismissal of this case, which had excellent preparation, may indicate a lack of support for these cases within the criminal justice system.

CASE 004

Allegations: A number of incidents were reported over a period of several months regarding possible physical abuse of the subject. Many involved assaults by another resident. During the course of the investigation, it was alleged that the victim had been sexually abused by another resident with a history of sexual aggression. This abuse had been reported to the appropriate staff and recommendations were made to protect the victim. Facility management did not follow the recommendations resulting in possible further sexually abuse of the victim.

The record contains one report of physical abuse filed with local law enforcement but no indication of any follow-up.

Issues: The allegation of physical abuse was reported to local law enforcement with no indicated action on their part. The records do not indicate that the sexual abuse by another resident was reported to any other agency, nor did management make any attempt to protect the victim from further harm even when staff members made attempts to get them to do so. While OAPA would not support any action against the alleged perpetrator of the sexual abuse, he could have been charged under Title 16. The record does indicate that possible criminal action could have been taken against management for neglect because they did nothing to prevent further abuse of the victim after being clearly notified (in writing) of the problem by staff.

CASE 008

Allegation: An allegation was made by the victim that a staff member "reached under the covers and touched his private areas" while watching a sexually explicit video. An internal investigation was conducted and the case was referred to SLED for a criminal investigation. The victim was able to provide a statement. Based upon the internal investigation, the employee was terminated. The SLED report was provided to the Solicitor who felt there was not enough to proceed with a criminal case.

Issues: The internal investigation and the one conducted by SLED were thorough but did not provide any witnesses to this event, making this a difficult case to prosecute. The video was found in the possession of the victim but no other physical evidence was discovered that would substantiate the victim's statement. The report provided no information as to where the victim obtained the video.

DEATH CASES:

CASE 024

Allegation: A Report of Death was completed on the resident. The report and the death certificate both indicate that the death was from natural causes (respiratory arrest, aspiration of vomitus and cerebral edema).

Issues: The Report of Death was handwritten. The notes indicate some issues with the resident's eating. No autopsy was performed. The report lacks sufficient detail to determine if there was a problem with the victim's food not being finely chopped as required. While this case is probably not abuse, it may have been neglect. This demonstrates the lack of sufficient information that makes it impossible to determine if further investigation is needed.

CASE 025

Allegation: The Report of Death completed by the facility is detailed and indicates that the resident had complicated and serious medical issues and his death was a result of these conditions. The death was reported to the Coroner and an autopsy was done with the results attached to the Report. The findings of the pathologist were consistent with a natural death.

Issues: This case provided complete and thorough documentation including an autopsy. This report does not provide any findings that would lead to any allegation of abuse. When contrasted with the documentation in Case 024, it demonstrates a system that requires consistent and standardized reporting in death cases so that abuse or neglect can be ruled out.

CASE SUMMARY

The majority of cases reviewed contained evidence consisting only of victim and witness statements. Little effort was made to further investigate inconsistent statements, collect physical evidence or interview the victim. This lack of further investigation is clearly indicative of proceeding from a purely administrative view to establish that policies and procedures were followed. In many cases, the termination of an employee was the only outcome; with little thought given to holding the offender criminally responsible. Case 004 clearly documents that the facility was aware of possible sexual abuse yet the facility failed to report it to law enforcement, initiate an investigation or respond to the recommendations of staff. These lapses could have resulted in further harm to the victim. Case 006 had extensive documentation of physical abuse that was not referred to law enforcement but instead to DSS. It appears that DSS failed to report it to law enforcement or conduct a thorough investigation. Case 012 had sufficient evidence to support a possible prosecution, but the case was not referred.

Overall, it appears that individuals working in the system to deliver services to individuals with developmental disabilities do not have a clear understanding of the need to refer cases to agencies that can conduct a proper criminal investigation when there is sufficient evidence to support that course of action. The lack of oversight by the Ombudsman contributes to this problem. It did not appear that the Ombudsman was conducting a thorough screening of reports and contacting law enforcement when necessary. Not holding offenders criminally accountable sends a clear message to employees that the most that can happen to them is termination. In the cases that were reviewed, even termination was not always a response.

Two cases included the results of a SLED investigation. Neither case was referred for prosecution. In Case 021, major problems were identified with the way the case was

investigated by both the facility and SLED. Ample initial evidence shouted that the victim had been physically abused. Photographs, as well as medical opinion, left no doubt that the victim had been assaulted in the genital and anal area and that it was intentional. The initial investigation conducted by the facility made reference to "age dating" the bruises, which should not be done as there is no medical support for this technique in practice or research. The interviews conducted by the facility failed to further investigate the inconsistent statements by staff regarding the period prior to the initial discovery of the injuries. The case was then referred to SLED which conducted interviews of staff that may have had contact with the victim in the period before the injuries were discovered, particularly those who worked the prior two days. In at least three specific statements taken from staff, there were inconsistencies between what was told to facility personnel and then subsequently related to the SLED Agents. A more aggressive approach to the interview process might have provided the focus necessary to develop a suspect. All three of these individuals were in a position to have seen the injuries during the preceding 24-48 hours, yet the fact that the injuries were not reported or mentioned in their statements indicates a lackadaisical attitude on the part of the investigators to develop additional information. It appears that in the internal investigation, investigators only determined whether or not staff complied with policy and procedure. It is difficult to tell from the record why the SLED agents did not follow up on the facts about the injuries.

In summary, while DDSN policies are adequate for some purposes, they have serious flaws that interfere with the goal of protecting victims from further abuse and of holding offenders accountable. Most of the investigations reviewed seem to be focused on quality control issues. In some cases, they were specifically concerned with determining whether or not facility policies or procedures were violated and how to deal with the employee(s) that were involved in

an administrative way. Most of the files reviewed were inadequate, incomplete and did not meet OAPA's requirements for reporting to law enforcement.

The case review determined that the following issues are not adequately addressed in current investigative policies, procedures and practices.

- **Policies and Procedures**-The policies and procedures reviewed for this report clearly appear to be focused on administrative issues. They also modify and, in some cases, ignore the requirements of OAPA.
- **Documentation**-There is no consistent format used for documenting the results of an investigation. DDSN provides guidelines and suggested formats but does not mandate their usage. Therefore facilities, local boards, and contract providers use modified policies and corresponding forms which are similar to those of DDSN proper. Most of the forms used in the furnished reports were inadequate because they did not clearly indicate what physical evidence may have been gathered, such as a chain of custody form; lack of medical data, such as the Vulnerable Adult Abuse Protocol; and the necessary identification data required if the case is to be referred to law enforcement.
- **Terminology**-Definitions used by DDSN do not conform to the definitions found in OAPA.
- **Reporting**-While required reporting seems to occur most often to the Ombudsman, there is little or no reporting to law enforcement. The Ombudsman does not appear to have reviewed reports referred to them for further action. In several cases, there were clear indications that law enforcement should have been notified but were not.
- **Administrative versus Criminal Investigations**-Many of the reports that were reviewed seemed to be focused on whether procedures were followed. If the procedures were not

followed, the response was to train staff. Most of the internal investigators are administrators and come to these incidents using that perspective. Conducting a criminal investigation often requires a different mind set. If the purpose of the investigation is to see if individuals complied with policies and procedures, then the focus will be on administrative issues instead of on whether or not a criminal act took place. As previously mentioned, there is an inherent conflict of interest issue with the current situation because internal investigators can easily lose objectivity and can be intimidating to the individual who has been abused during the course of the investigation.

- **Training**-DDSN appears to have established, in policy, an adequate training program for their internal investigators. However, it is difficult to evaluate the level of expertise or effectiveness of the program because it was impossible to determine if the investigator had the training, when they had the training, the number of cases an investigator handles, or the turnover rate. If a case is referred to law enforcement, it will probably be investigated by an individual with little or no training or expertise in dealing with vulnerable adults. The only training a law enforcement officer receives in this area is a brief two hour orientation during recruit training. No documented additional training for investigators or prosecutors has been offered that would provide the enhanced skills necessary in this area. While the South Carolina Adult Protection Coordinating Council has made efforts to provide training in this area, it can be safely said that few prosecutors have attended. Ultimately, if offenders are to ever be held accountable, training must take place on a continuous basis.
- **Oversight**-Those charged with oversight of the current system, such as the LTCO and HHS, are not exercising this authority on a consistent basis.

FINDINGS

The current South Carolina entities for reporting and investigating allegations of abuse and neglect against vulnerable adults do little to protect victims, determine those responsible for their abuse and neglect and, when appropriate, prosecute them. The procedures seem to be designed to ensure that agencies are not adversely impacted by the victimization of their clients. There are several reasons for these failures to protect or hold offenders accountable:

1. Reporting often is delayed, or in some cases non-existent. Delays in reporting present serious problems with evidence preservation and victim protection.
2. Investigations are viewed from an administrative perspective and are conducted by administrators. They seem to focus on whether or not policies and procedures were followed with little effort made to refer to law enforcement. It did not appear that sufficient effort is being made by the Long Term Care Ombudsman to review reports and make a referral for a criminal investigation when the facts support that action to require additional effort by DDSN to address substandard investigative reports.
3. Inconsistent definitional foundations impede investigation. OAPA contains the definitions that determine the elements of abuse and neglect. DDSN has developed a set of definitions to be used in investigations that do not adhere to the ones set forth in OAPA. These discrepancies lead to confusion and often lead to conclusions not consistent with the governing statute.
4. Investigations conducted by contract agencies were seriously flawed. In one case reviewed, there was a failure to properly investigate a case of sexual abuse as well as to protect the victim from further harm.

5. DDSN's documentation procedures are confusing in that DDSN does not appear to mandate their use by facilities and the forms lack sufficient information for the conduct of a criminal investigation.
6. Cases reported to law enforcement do not always receive the necessary investigative effort.
7. Cases referred to the local solicitor for review were, in almost every case, not prosecuted.
8. No single oversight process ensures that cases are screened for possible criminal behavior and that the investigative process meets a minimum standard.

In summary, vulnerable adults, including those with disabilities, who are victims of abuse, neglect, and exploitation do not receive adequate investigative and prosecutorial responses from those charged with their protection. Most of the initial investigations reviewed were conducted by an administrator. The administrator would decide to refer possible cases of abuse and neglect to law enforcement after conducting an initial investigation. This procedure resulted in delayed reports that can only have a negative effect on evidence gathering, building a criminal case, and subsequent possible prosecution. It is also important to understand that the initial investigative response is framed by the facts presented and the need to match those facts with the elements of abuse and neglect contained in the governing OAPA statute. If the investigator uses definitions inconsistent with this statute, or those created by the agency, then the investigator lacks the analytical framework to make critical decisions regarding possible criminal behavior.

The most critical issue identified by this report is the extreme fragmentation of roles. The current process is one where numerous state and local bodies have some form of jurisdiction

but no overall supervision or coordination is in place. There is no true system. Individuals receiving services through DDSN are subject to internally developed policies which can be modified at the local level, leading to inconsistency in reporting and documentation of incidents. Throughout the state serious incidents of abuse and neglect are inadequately investigated and rarely prosecuted. Further, the lack of data makes it impossible to determine the frequency of incidents or whether they are adequately investigated and referred to law enforcement.

Virtually no oversight or coordination among entities exists. While some efforts have been made by the Attorney General's Office, although they have no mandate to do so, and the Ombudsman to meet these needs, both are understaffed and do not have the resources to do the job required. The criminal justice system (law enforcement and prosecutors) does little to improve this situation. Law enforcement personnel receive minimal or no training in the issues of abuse and neglect of vulnerable adults. There seems to be no public pressure to change this situation. Until vulnerable adults are viewed as individuals in need of an aggressive system of protection, little will improve. Vulnerable adults who have been victims of abuse and neglect are subjected to cruel and unusual punishment by the current process. Not only are they abused, neglected, and exploited, they also suffer the act again when the process fails to properly investigate and prosecute on their behalf. Until critical changes are made they will continue to be victimized and the offenders rarely held accountable.

RECOMMENDATIONS

1. Establishment of a state-level investigative entity within the criminal justice system, i.e. SLED, and outside of any agency providing services to vulnerable adults, with responsibility for all reports of abuse, neglect, or exploitation involving vulnerable adults in facilities.

South Carolina must recognize that little will improve until a specific entity is charged with the investigative responsibility for these cases, regardless of where the incident occurs. This entity should provide initial screening, investigative follow up when required and oversight of all allegations of abuse and neglect. It should have personnel assigned who have law enforcement authority and expertise to conduct these complex investigations, as well as training in the special issues associated with this population group. Personnel should have access to individuals with medical or social work backgrounds in this special population. There must be a single point of entry for these allegations with the ability to coordinate an effective response and track data. While not superseding the mandates of the Medicaid Fraud Control Unit (MFCU) of the Attorney General's Office, the entity would focus on cases that often fall outside the jurisdiction of the MFCU. Creation of such an entity may also require a review of the duties of the Long Term Care Ombudsman. Neither the Attorney General nor the Ombudsman has the mandate nor the resources to implement a system for the investigation of abuse and neglect of vulnerable adults, including people with disabilities. Law enforcement personnel and solicitors receive grossly inadequate training regarding abuse and neglect of vulnerable adults. Only a single entity with clear responsibility and specialized staff can offer accountability to some of South Carolina's most vulnerable citizens.

2. No longer permit agencies and their contractors to investigate allegations of abuse and neglect within their facilities.

Agencies and contractors should not have responsibility for conducting internal investigations. The pressure to conform to organizational expectations is too great to insure an objective investigation.

3. Develop and present adequate training to criminal justice professionals charged with the responsibility of investigating and prosecuting abuse and neglect.

It was obvious that even when cases were referred to law enforcement and prosecutors there was no guarantee that a proper investigation would be the result. These are complicated investigations which require specialized training not currently available in this state. Successful models of specialized prosecution in the areas of child abuse, sexual assault and domestic violence demonstrate the efficacy of trained professionals.

4. Establish separate policies and procedures for administrative/quality control investigations after determining that no criminal abuse or neglect took place.

Once it is determined that an allegation is not criminal in nature, then a quality control system to conduct this type of investigation needs its own set of policies and procedures. This change would reduce any confusion as to the purpose of the investigation.

5. Review all agency policies and procedures to insure that they conform to all the provisions of OAPA, including definitions.

DDSN needs to conduct a thorough review of their policies and procedures to address the issue of conformity to OAPA. The current arrangement leads to confusion about the purpose of an investigation and does not provide the focus necessary to determine if an event is criminal. Not only must DDSN ensure their policies reflect OAPA, DMH and DSS must also ensure their policies reflect OAPA.

APPENDIX A:

COMPARISON BETWEEN THE
OMNIBUS ADULT PROTECTION ACT DEFINITIONS
AND
DDSN DIRECTIVE 534-02-DD DEFINITIONS

Omnibus Adult Protection Act	**DDSN Policy 534-02 (March 2004)**
Abuse means physical abuse or psychological abuse. **Physical abuse** means intentionally inflicting or allowing to be inflicted physical injury on a vulnerable adult by an act or failure to act. Physical abuse includes, but is not limited to, slapping, hitting, kicking, biting, choking, pinching, burning, actual or attempted sexual battery as defined in § 16-3-651, use of medication outside the standards of reasonable medical practice for the purpose of controlling behavior, and unreasonable confinement. Physical abuse also includes the use of a restrictive or physically intrusive procedure to control behavior for the purpose of punishment except that a therapeutic procedure prescribed by a licensed physician or other qualified professional or that is part of a written plan of care by a licensed physician or other qualified professional is not considered physical abuse. Physical abuse does not include altercations or acts of assault between vulnerable adults.	**Abuse, Neglect, and Exploitation** Abuse is defined as any intentional physical or mental injury or harm or the threat of such injury to a consumer by any employee or volunteer of DDSN or its contract provider agencies. Abuse as defined below is prohibited. **Physical abuse** is defined as an intentional assault upon a consumer whether or not the assault causes injury. This includes but is not limited to: (a) Slapping, hitting, kicking, shaking, biting, choking, pinching, pulling hair, throwing objects, spanking, corporal punishment; or (b) Provoking, directing, encouraging, condoning, or allowing people receiving services to discipline or abuse one another; or, (c) Using medications (outside the standard of prescribed medical practice) for the purpose of controlling behavior.

Omnibus Adult Protection Act	**DDSN Policy 534-02 (March 2004)**
Psychological abuse means deliberately subjecting a vulnerable adult to threats or harassment or other forms of intimidating behavior causing fear, humiliation, degradation, agitation, confusion, or other forms of serious emotional distress. **Investigative entity** means the Long Term Care Ombudsman Program or the Adult Protective Services Program.	**Emotional, Mental or Psychological Abuse** (a) Intentionally subjecting a consumer to inhumane or unconscionable conditions or acts that cause fear or other forms of emotional distress; or (b) Subjecting a consumer to degrading, harassing, or dehumanizing conditions; or (c) Unreasonable confinement or restraint that is not a part of the consumer's approved behavior support plan. **Verbal abuse** is defined as referring, gesturing, or speaking to a consumer in threatening, degrading, or discriminatory terms which have an adverse effect on the person receiving services.

Omnibus Adult Protection Act	**DDSN Policy 534-02 (March 2004)**
(There are no more definitions of abuse.)	**Threatened abuse** is defined as an intentional offer of physical or mental abuse that causes emotional distress to the consumer or creates a well-founded fear of imminent peril coupled with the ability to execute the threat. This also includes threatened use of any of the abusive acts defined in this policy. **Sexual abuse** is defined as an employee or volunteer becoming sexually involved with a consumer or encouraging the consumer to become sexually involved with another person. **It is also considered abuse if an employee furnishes non-prescribed drugs or other illegal or harmful substances to a consumer**. **Abuse by complicity** is defined as aiding, abetting, conspiring with or covering up an act of abuse. Anyone who commits complicity is considered to be as guilty of abuse as the person who commits the abuse.

Omnibus Adult Protection Act	**DDSN Policy 534-02 (March 2004)**
Exploitation means: (1) causing or requiring a vulnerable adult to engage in activity or labor which is improper, illegal, or against the reasonable and rational wishes of the vulnerable adult. Exploitation does not include requiring a vulnerable adult to participate in an activity or labor which is a part of a written plan of care or which is prescribed or authorized by a licensed physician attending the patient; or (2) an improper, illegal, or unauthorized use of the funds, assets, property, power of attorney, guardianship, or conservatorship of a vulnerable adult by a person for the profit or advantage of that person or another person.	**Exploitation** is defined as the improper use or manipulation of a consumer or his/her resources for profit or advantage by an employee or volunteer. This includes but is not limited to exploitation for money, gifts, or other personal gains.

Omnibus Adult Protection Act	**DDSN Policy 534-02 (March 2004)**
Neglect means the failure or omission of a caregiver to provide the care, goods, or services necessary to maintain the health or safety of a vulnerable adult including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services. Neglect may be repeated conduct or a single incident that has produced or can be proven to result in serious physical or psychological harm or substantial risk of death. Noncompliance with regulatory standards alone does not constitute neglect. Neglect includes the inability of a vulnerable adult, in the absence of a caretaker, to provide for his or her own health or safety which produces or could reasonably be expected to produce serious physical or psychological harm or substantial risk of death.	**Neglect** is defined as the failure to provide for basic needs, such as food, clothing, shelter, health care, safety, or adequate supervision, and the failure results in risk to the life safety of the consumer.

APPENDIX B:

CASE INFORMATION

Case No.	Type	Reported To:	Results
001	Physical	AG	Employees terminated
002	Physical	LTCO	Employee terminated
003	Neglect	None	None
004	Sexual/Physical	Law Enforcement/AG	Unknown
005	Sexual	Law Enforcement	Unknown
006	Physical	None	Founded/NFI
007	Neglect	LTCO	Founded/disciplinary
008	Sexual	SLED	No prosecution
009	Neglect	Unknown	No action taken
010	Physical	LTCO	Unfounded
011	Unexplained injury	None	No action required
012	Physical	Unknown	Employee terminated
013	Death/Neglect	AG	Pending
014	Physical	LTCO	7 staff terminated,/ 1 disciplinary/no results on LE
015	Physical	LTCO	Unfounded
016	Physical/Psych.	LTCO	Unfounded (related to 015)
017	Physical/Psych	LTCO	Unfounded (related to 15)
018	Death	AG	Pending
019	Physical	none	Employee terminated
020	Physical	none	Unfounded
021	Physical	SLED	No prosecution
022	Physical/Staff neglect	None	Unknown
023	Exploitation	None	Unfounded
024	Death	None	Natural
025	Death	Coroner	Natural
026	Death	Coroner	Natural
027	Death	Unknown	Natural
028	Neglect	LTCO	Employees terminated
029	Physical	None	Unfounded/staff filed compl v. resident
030	Physical	LTCO	Employee suspended
031	Sexual	DMH PS	No prosecution
032	Neglect	LTCO	Employee terminated

033	Physical	LTCO	Unfounded
034	Physical	LTCO	Unfounded (10,33,34 same subject)
035	Physical	SLED	Employee terminated/No prosecution
036	Death	None	Natural
037	Death	None	Natural
038	Physical	Contract Inv	Unfounded
039	Physical	LTCO	Employees received training in procedures
040	Physical	None	Unfounded
041	Physical	None	Employee Terminated
042	Physical	None	Unfounded
043	Physical/Staff Neglect	None	Employee Disciplined
044	Neglect	None	Unfounded
045	Physical	LTCO	Unfounded (040-045, same subject)
046	Sexual	SLED	Employee charged, No prosecution
047	Death	Law Enforcement	Traffic fatality
048	Physical/Neglect	DHEC	DHEC cited facility
049	Homicide	Law Enforcement	Suspect charged w/Murder
050	Physical	None	Pending investigation

APPENDIX C:

VULNERABLE ADULT ABUSE PROTOCOL

DEMOGRAPHIC INFORMATION:

FOR VULNERABLE ADULTS
AGE 18 OR OVER

Date of Visit: / / Time:	
Source of Intake Information:	
Relation: [ ] Adult Protective Services [ ] Medical Provider [ ] Law Enforcement [ ] Long Term Care Ombudsman [ ] Caregiver [ ] Other:	
Maltreatment Assessment: Emergency Protective Custody - [ ] Yes [ ] No Date:	
Site:	
Provider Name Group:	

DEMOGRAPHIC INFORMATION Photocopy of Agency Demographic Information May Be Substituted		
Patient Name:		Sex:[ ] Female [ ] Male
DOB:	Age:	SSN:
Race: [ ] White [ ] Black [ ] American Indian [ ] Oriental [ ] Bi-Racial [ ] Other		Migrant: [ ] Yes [ ] No
Residence: [ ] Lives Independently [ ] Residential Home [ ] Family Residence Under Care of:		
Mailing Address:		
Street Address:		
Phone:		County of residence:
Emergency Contact Name:		Contact Phone:
Legal Custodian/Relation:		
Accompanying Guardian/Relation:		
Payment Source:		Policy #:
INVOLVED AGENCIES		
Law Enforcement: County:		[ ] Police Dept: [ ] Sheriff's Dept.
Officer:	Badge #:	Phone:
Report Date:	Phone:	Ext.
Address:		
Other Agency(ies):_____ _____		
Signature of Recorder:	Print Name:	Date:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

INCIDENT INFORMATION

Previous Exam Suspicious for Maltreatment/Neglect:
[ ] No [ ] Unknown [ ] Yes - Date:

Previous Report Made: [ ] No [ ] Unknown [ ] Yes - Give Agency/Dates/Results:

_____

_____

_____

Initial Indicator of Risk:
[ ] Victim Verbal [ ] Behavioral Changes [ ] Injuries/Medical Problems

Witness: [ ] No [ ] Unknown [ ] Yes

Brief History of Allegations/Reason for Referral/Summary of Maltreatment/Description of Neglect:

_____

_____

_____

_____

_____

_____

Identity of Alleged Offender if known:

Age: Sex: [ ] Female [ ] Male Relationship to Adult:

Dates of first alleged maltreatment/neglect: Most Recent: County of Occurrence:

Other dates/places:

Date of last contact:

Access to this vulnerable adult: [ ] Yes [ ] No Access to other vulnerable adults: [ ] Yes [ ] No [ ] Unknown

Narrative of Concerns and Observations

Interviewer:

_____

_____

_____

Affect of Support Person: [ ] Cooperative [ ] uncooperative [ ] Supportive [ ] Hostile [ ] Flat [ ] Ambivalent

Examiner's Signature: Date:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

PATIENT INFORMATION

Accompanying Adult(s)/Relationship(s):
Patient's Communication Ability: [ ] Normal [ ] Impaired [ ] Non-Communicative
Personal Physician's Name: City/Address: Phone:
Current Medications: _____ _____ _____

Medical History
Allergies: [ ] N/A [ ] No [ ] Yes - Drug(s):
Medical Problems: _____ _____ _____
Major Hospitalizations: _____ _____
Surgeries: _____ _____ Trauma/Injuries: [ ] Head Injuries [ ] Fractures [ ] Burns

Gynecological History, if Applicable
[ ] LMP: Contraception: [ ] OCs [ ] Injectable [ ] Tubal Ligation [ ] Other -
Menopausal [ ] Yes [ ] No [ ] Unknown Hormonal Replacement [ ] Yes [ ] No [ ] Unknown
Sexually Active Voluntarily [ ] No [ ] Unknown [ ] Yes - Last Voluntary Intercourse:

Substance Use
Alcohol [ ] No [ ] Unknown [ ] Yes - Amount:
Tobacco [ ] No [ ] Unknown [ ] Yes - Amount:
Drugs [ ] No [ ] Unknown [ ] Yes - Amount:

Family History
[ ] Bleeding Disorders [ ] Bone disease [ ] Neurological Disease [ ] Substance Abuse [ ] Violence [ ] Mental health
Comments:
Examiners's Signaure: Date:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

PHYSICAL EXAMINATION RECORD

Examiner: Date:

Person(s) Present: [ ] No [ ] Yes - Give Name(s):

Other Person(s) Present - Give Names:
_____
_____

Behaviors Observed During Exam: [ ] Appropriate [ ] Mental Status Exam [ ] Other - Describe Below:
_____
_____

Physical Exam: Height: % Weight: % H.C.: %

	WNL	ABN	N/A	EXPLAIN
General Appearance				
CN II - XII				
Motor Strength/Tone				
Deep Tendon Reflexes				
Ears/TMs				
Eyes/Fundi				
Nose				
Mouth/Oropharynx				
Teeth: upper				
Teeth: lower				
Neck				
Breasts				
Chest				
Back				
Lungs				
CV				
Abdomen				
Hair/Scalp				
Skeletal				
Balance/Gait				
Sensory Exam				

Comments:_____
_____

Examiner's Signature: Date:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

PHYSICAL EXAMINATION RECORD, CONT

Skin findings (Describe color, configuration, measurements, and any remarks by the adult as to the etiology for each lesion. See body diagrams.)
Photos Taken: [ ] No [ ] Yes - Number Taken: Forensic Dentistry Consult: [ ] Yes [ ] No Lesions Consistent with Bite Marks: [ ] Yes [ ] No
_____ _____

_____
_____

Male Genital Exam	WNL	ABN	Describe
Inguinal Adenopathy			
Medial Thighs			
Perineum			
Penis			
Urethral Meatus			
Circumcised	[ ] Yes	[ ] No	
Scrotum			
Testes			
Female Genital Exam	WNL	ABN	Describe
Inguinal Adenopathy			
Medial Thighs			
Perineum			
External Genitalia			
Vagina			
Cervix			
Uterus			
Male/Female Exam			
Buttocks			
Anus			
Anal Tone			
Stool Incontinence			
Rectal Exam:			Stool Occult Blood Test [ ] Positive [ ] Negative
Examiner's Signature:			Date:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

LAB SUMMARY

Laboratory Specimens
(Check specimens collected)

Date:

GC/Chlamydia Culture	[ ] Throat [ ] Vaginal [ ] Urethral [ ] Rectal
Wet Prep	[ ] No [ ] Yes -
bHCG	[ ] No [ ] Yes -
Urinalysis	[ ] No [ ] Yes -
Culture	[ ] Throat [ ] Vaginal [ ] Urethral [ ] Rectal [ ] Urine [ ] Wound [ ] Blood [ ] Other -
RPR/VDRL	[ ] No [ ] Yes -
HIV	[ ] No [ ] Yes -
CBC	[ ] No [ ] Yes -
Coags	[ ] No [ ] Yes -
Chemistry Panel	[ ] No [ ] Yes -
Other:	
Treatment:	

PHYSICIAN SUMMARY

_____

_____

_____

_____

_____

_____

_____

Recommendation for Follow-Up

Medical:
Mental Health:
Other:
Examiner's Signature:

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

SEXUAL ABUSE/ASSAULT INFORMATION

(Optional Supplement to Interview)

Stamp Plate or
Name of Patient

Patient Interviewed in the Presence of:

	Described by Patient			
	Y	N	U	Comments
Vaginal Contact				
Penis				
Finger				
Foreign Object (Describe)				
Anal Contact				
Penis				
Finger				
Foreign Object (Describe)				
Oral Copulation of Genitals				
of Victim by Assailant				
of Assailant by Victim				
Oral Copulation by Anus				
of Victim by Assailant				
of Assailant by Victim				
Masturbation				
of Victim by Assailant				
of Assailant by Victim				
Did Ejaculation Occur? If yes, write adult's description.				
Describe location(s) on body:				
Where did ejaculate go?				
Describe assailant's genitals:				
Condom used				
Foam, jelly, or lubricant used (circle)				
Fondling, licking, kissing or biting (circle)				
Describe the location on the body:				
Examiner's Signature: Date:				

WHITE - HOSPITAL **PINK - LAW ENFORCEMENT** **GREEN - VICTIM COMPENSATION**

APPENDIX D:

MEMORANDUM OF AGREEMENT

MEMORANDUM OF AGREEMENT

The State Long Term Care Ombudsman Program of the Lt. Governor's Office on Aging, (hereinafter referred to as the "SLTCOP"), and the South Carolina Department of Disabilities and Special Needs (hereinafter referred to as "SCDDSN"), hereby agree to the terms of this MEMORANDUM OF AGREEMENT as revised on March 1, 2005.

I. PURPOSE: It is the public policy of the State of South Carolina as reflected in the Omnibus Adult Protection Act (OAPA) to protect vulnerable adults from abuse, neglect and exploitation. The purpose of this Memorandum of Agreement is to establish relationships to implement the intent and provisions of this Act.

II. SPECIFIC OBJECTIVES: The major objectives of this Memorandum of Agreement are:

A. To provide a system for receiving and investigating reports of alleged abuse, neglect and exploitation occurring to vulnerable adults receiving services in facilities or programs and services operated or contracted for operation by SCDDSN .

B. To assist SLTCOP in the furtherance of its responsibility to receive reports of and investigate allegations of abuse, neglect, or exploitation in facilities or programs and services operated or contracted for operation by SCDDSN and to provide a system for oversight by SLTCOP by (1) independently reviewing investigations conducted by SCDDSN and its contractors; (2) conducting independent and/or joint investigations when SCDDSN or the SLTCOP deem appropriate; and (3) referring serious cases to law enforcement.

C. To identify those programs and services operated or contracted for operation by SCDDSN that should report alleged abuse, neglect, or exploitation to SLTCOP.

D. To establish cooperative relationships for the purpose of training and technical assistance.

III. RESPONSIBILITIES:

A. SCDDSN will comply with OAPA by establishing an effective system for reporting allegations of abuse, neglect and exploitation of vulnerable adults and by informing all Departmental and contractor employees of their legal responsibility to report under the Act.

B. All reports of alleged abuse, neglect and exploitation will be made to the SLTCOP for incidents occurring in facilities operated by SCDDSN or its contractors in accordance with Attachment 1.

C. Under OAPA, certain persons employed by SCDDSN or its contractors are personally responsible for making a report of alleged abuse, neglect and exploitation to

SLTCOP. By virtue of this MOA, OAPA allows employees of SCDDSN and DSN Boards or organizations serving in that role to make the required report to a supervisor, officer of the day, or other authority who will then make the required report on behalf of the employee. Contractor employees, however, must personally report the alleged abuse, neglect and exploitation to the SLTCOP as appropriate. All reports of alleged abuse, neglect and exploitation must be made to the SLTCOP within the statutory time frame of 24 hours or within the next business day. Reports may be made in writing or orally by telephone or otherwise.

D. Any individual employee of SCDDSN or its contractors having reason to believe that abuse, neglect or exploitation has occurred or having actual knowledge of the incident may make a personal and direct report to the SLTCOP. However, as a condition of employment, employees must also timely notify their employer, SCDDSN or its contractors, of the alleged abuse, neglect or exploitation.

E. Under the authority of the OAPA, the SLTCOP authorizes SCDDSN and its contractors to receive reports and conduct internal investigations of all cases of alleged abuse, neglect and exploitation of vulnerable adults occurring in facilities or programs and services operated or contracted for operation by SCDDSN when the suspected perpetrator is an employee of SCDDSN or its contractors or when the suspected perpetrator is unknown.

F. Reporting procedure shall be conducted in accordance with policies and procedures reviewed and approved by SLTCOP.

G. SCDDSN or its contractors will notify law enforcement immediately when there is a serious allegation of abuse or neglect of a resident occurring in a facility, program, or service operated or contracted for operation by SCDDSN. Serious may be defined as "needing immediate medical attention or hospitalization". The SLTCOP shall also be notified of the referral to law enforcement.

H. SCDDSN or its contractors will establish procedures to notify the appropriate occupational licensing or certification authority whenever the alleged perpetrator of abuse, neglect, or exploitation is a licensed health care professional.

I. SCDDSN or contractor representative will inform the individual or family of their right to contact SLTCOP if they have concerns regarding the outcome of the investigation. The oversight responsibilities of the SLTCOP will be explained. The SLTCOP according to the authority given them under the OAPA, may conduct an investigation of any reports made by or requested by an individual, family member or relative.

J. The SLTCOP retains the authority to investigate any allegation of abuse, neglect or exploitation occurring in a facility, program, or service. Likewise, SCDDSN may request an independent or joint investigation. Any personnel action resulting from an investigation covered by the Memorandum shall be at the sole discretion of the

individual's employer.

K. Upon review of the investigative reports, the SLTCOP may request further information to be provided or may elect to conduct an independent investigation. SCDDSN will cooperate in any further investigation conducted or arranged by SLTCOP.

L. SLTCOP will notify the SCDDSN State Director or his designee of any abuse, neglect or exploitation cases which were not reported through procedures prescribed in their Memorandum of Agreement.

M. SLTCOP will notify the SCDDSN and the appropriate contractor director whenever an alleged abuse, neglect or exploitation investigation has been conducted in a facility, program, or service operated or contracted for operation by SCDDSN. The findings of the investigation shall be forwarded to the SCDDSN State Director and the appropriate contractor director.

N. In carrying out investigative responsibilities, SLTCOP may request and receive written statements, documents, and other items pertinent to the investigation to the extent permitted by law, and shall have access to witnesses, facilities, program sites, etc., as may be necessary to complete their investigation.

O. Unless prohibited by law, SLTCOP and SCDDSN may share information related to an investigation conducted as a result of a report made under this Memorandum of Agreement. The investigation and the information contained therein are confidential and may not be disclosed to other parties. However, this does not preclude disclosure to appropriate law enforcement and regulatory licensing authority in the furtherance of their investigation or to other parties upon court order.

P. In accordance with the OAPA, SCDDSN and its contractors shall prominently display notices in its facilities to its employees stating the requirements of the OAPA concerning the reporting of abuse, neglect and exploitation.

Q. SLTCOP will assist in providing training and technical assistance for SCDDSN and contractor personnel to encourage timely and accurate reporting of actual or suspected abuse, neglect and exploitation of vulnerable adults receiving services from SCDDSN or its contractors.

R. Each party to this Memorandum will designate a person to serve as an agency contact point.

S. SCDDSN and SLTCOP agree to exercise a good faith effort of cooperation in compliance with state law and the OAPA.

T. Nothing in this agreement in any way prohibits the carrying out of OAPA or other statutes. If any portion of the Memorandum shall be determined to violate any state

or federal law, or otherwise be found to be unenforceable, such portion shall be stricken from this Memorandum without affecting any other provision.

U. Individuals receiving services from SCDDSN or its contractors are entitled to all services and assistance from SLTCOP as any other citizen of the State, including services when needed to protect a vulnerable adult from abuse, neglect, and exploitation.

IV. CONDUCTING THE INVESTIGATION: Upon completion of its internal investigation, SCDDSN and its contractors will forward a copy of the complete investigation to the SLTCOP as appropriate within ten (10) working days from completion of the internal investigation. The internal investigation will be completed in accordance with the requirements of SCDDSN policy 534-02-PD. The investigation report will contain any factual reference or determination made as a part of the investigation, including, but not limited to, a copy of any personnel action taken as a result of the investigation; all statements taken as a part of the investigation, signed by the person providing the statement; and all investigative material of documentation that assisted in the determination of abuse, neglect or exploitation.

V. COOPERATION: The parties to this Memorandum will coordinate and in good faith seek to resolve conflicts through joint meetings of appropriate agency designees.

VI. REVIEW: SCDDSN and SLTCOP shall annually review this Memorandum of Agreement.

VII. TERMINATION/MODIFICATION: This Memorandum of Agreement may be terminated by any of the parties upon 60 days written notification and may be modified as necessary through mutual written agreement. It will continue in effect until it is revised.

VIII. IMPLEMENTATION: This Memorandum of Agreement is effective upon signature and each party will take appropriate action within their respective systems to ensure the effective implementation of the terms of this agreement.

This Memorandum of Agreement is entered into this_____day of _____, 2005.

Lt. Governor's Office on Aging	Department of Disabilities and Special Needs
By:_____	By: _____
Cornelia D. Gibbons Director	Stanley J. Butkus, Ph. D. Director

ATTACHMENT 1

The parties to this Memorandum of Agreement agree to the following:

The State Long Term Care Ombudsman Program will receive reports of suspected abuse occurring in facilities operated or contracted for operation by the South Carolina Department of Disabilities and Special Needs. This includes SCDDSN Regional Centers and facilities operated directly by the County Disabilities and Special Needs Board or a contract provider agency such as Babcock Center or Charles Lea Center. For the purpose of this Memorandum of Agreement, a facility is defined as any program or service listed as follows:

1. SCDDSN Regional Centers
2. ICF/MR Community Residences
3. Community Residential Care Facilities
4. Community Training Homes - Level II

The South Carolina Department of Social Services - Adult Protective Services will continue to receive reports of abuse, neglect or exploitation occurring in all other settings.

APPENDIX E:

EXCERPTS OF DDSN DIRECTIVE 534-02-DD: PROCEDURES FOR REPORTING, INVESTIGATING, AND PREVENTING ABUSE, NEGLECT, OR EXPLOITATION OF PEOPLE RECEIVING SERVICES FROM DDSN OR A CONTRACT PROVIDER AGENCY (MARCH 2004)

These are selected excerpts from DDSN Directive 534-02 and are addressed in the report.

Reporting Requirements

Employees and volunteers of DDSN or a contract provider agency are mandated to report when they have reason to believe that a vulnerable adult may have been abused, neglected, or exploited. Through a Memorandum of Agreement among DDSN, the State Long Term Care Ombudsman (DHHS), and Adult Protective Services of the South Carolina Department of Social Services (DSS), procedures have been approved for DDSN and its contract provider agencies to receive reports of suspected abuse, neglect, or exploitation and shall forward the report to the appropriate state investigative agency on behalf of the reporter. The employee may also make a direct report to the State Long Term Care Ombudsman or DSS. Reports shall be made to:

a. Long Term Care Ombudsman (Lieutenant Governor's Office)

When an employee or volunteer of DDSN or a contract provider agency has reason to believe that a vulnerable adult has been abused, neglected, or exploited in a DDSN Regional Center, ICF/MR community residence, community residential care facility, or a Community Training Home II, a report shall be made to the Regional Long Term Care Ombudsman.

b. DSS - Adult Protective Services

Abuse, neglect, or exploitation occurring to a vulnerable adult in all other settings shall be reported to the Department of Social Services in the county where the alleged incident occurred.

c. Law Enforcement

Reports may also be made to law enforcement but this does not relieve the reporter from their responsibility to report to the Long Term Care Ombudsman or the

County DSS.

Acts of Assault Between People Receiving Services

Reporting requirements pursuant to the state laws do not apply to altercations or acts of assault between people (consumers) protected by these laws except as noted below. However, corrective/preventive action should be taken to protect and intervene whenever people receiving services may be harming themselves or others. All injuries should be thoroughly reviewed and appropriate action taken including the filing of a Critical Incident Report where indicated. (See DDSN policy 100-09-DD).

Failure to provide proper supervision to prevent people receiving services from assaulting each other could be a form of neglect if the employee fails to intervene or provide proper supervision when they clearly have a duty to do so. Each situation should be reviewed and if it is determined that the employee failed to provide appropriate supervision which resulted in risk to the life safety of the person receiving services, the incident should be reported as suspected neglect and investigated by established procedures as outlined in this policy and in compliance with state law.

If it is determined that an employee provoked, directed, encouraged, or allowed a person receiving services to discipline or abuse another person, it is considered abuse and should be reported and investigated.

Referral to Law Enforcement

Local and state law enforcement agencies may investigate an allegation of abuse, neglect, or exploitation. A referral to law enforcement does not relieve DDSN or contract provider agencies from also reporting the allegation to the State Long Term Care Ombudsman, DSS, or

State Ombudsman. The state investigative agency should be informed whenever a referral has been made to law enforcement.

A referral should be made to law enforcement in the following cases:

(a) All sexual assaults between consumers and staff, volunteers, or other persons responsible for their care.

(b) There is serious physical injury (such as fractures, burns, serious lacerations, death, etc.) and there is reason to believe the injury was caused by possible abuse or neglect, or when a physician documents that the injury was due to abuse or neglect.

(c) There are multiple victims.

(d) Abuse or neglect was inflicted on a child (age 17 and under) by a person who is not a parent or a childcare worker.

(e) Serious abuse, neglect, or exploitation occurred and there is a cover up or failure to report when clearly an obligation existed to report.

(f) Intimidation of the victim or witness, or impediment to an investigation.

(g) Time sensitive evidence.

(h) When the victim or victim's family requests a referral to law enforcement.

Referral to SLED

DDSN operated services and supports and Regional Centers may refer a case to the State Law Enforcement Division (SLED). SLED has jurisdiction to conduct investigations in state agencies and to assist local law enforcement agencies, upon request.

Executive Director/ Facility Administrator

If the allegation of abuse, neglect, or exploitation falls into the suggested criteria for law enforcement investigation, a referral will be made immediately.

Internal Investigations

All allegations of abuse, neglect, or exploitation occurring in services and supports operated by DDSN, Regional Centers and contract provider agencies will be thoroughly investigated and an internal investigation conducted according to procedures outlined in the most current DDSN Abuse Investigation Manual. In addition to the finding of substantiation or non-substantiation, the internal investigation will be used as a management tool to identify corrective and preventive actions that may lead to abuse prevention. The Executive Director/Facility Administrator is responsible for ensuring that an internal investigation is conducted according to procedures contained in this policy. An investigative protocol has been established for conducting a thorough investigation based on facts.

State investigative agencies, as well as law enforcement, may conduct their own investigation in order to substantiate or not substantiate abuse, but an internal investigation is still required by the provider agency to identify personnel and management actions that may be required. DDSN and contract provider agencies will cooperate with all external investigations. External investigations, particularly law enforcement, take precedence over an internal investigation. Before pursuing an internal investigation, the investigator should coordinate with the external investigator to ensure that the external investigation will not be jeopardized if the internal investigation proceeds. In some situations the external investigator may want to do joint interviews or investigations.

Authority for Conducting Internal Investigations

Through a Memorandum of Agreement with the State Long Term Care Ombudsman and Adult Protective Services of the South Carolina Department of Social Services, DDSN and its County Boards of Disabilities and Special Needs and designated non-profit agencies whose

contractual relationship with DDSN is similar to that of a County DSN Board are authorized to conduct internal investigations of suspected abuse, neglect, or exploitation occurring to vulnerable adults in its services and supports. The State Long Term Care Ombudsman and DSS Adult Protective Services will review the investigation and may use it as the official investigation. The State Long Term Care Ombudsman and DSS Adult Protective Services, however, retain the right to conduct an independent or joint investigation, request additional information, or refer serious cases to law enforcement.

Prosecution of Substantiated Cases

When law enforcement conducts an investigation, their findings will be reviewed by the solicitor to determine if there is sufficient evidence to bring criminal charges. Prosecution is at the discretion of the solicitor.

In other cases, where abuse, neglect, or exploitation is substantiated, the Executive Director or DDSN may make a referral to the local solicitor, taking into consideration the seriousness of the incident, the nature of the injury, and possible violations of criminal statutes. Whether or not a case will be prosecuted will ultimately rest with the solicitor.

Internal Investigative Report to State Investigative Agency

Pursuant to the Memorandum of Agreement, the State Long Term Care Ombudsman's Office, DSS Adult Protective Services, and the State Ombudsman's Office, will accept the internal investigation of DDSN, the DSN Board, or designated non-profit agencies whose contractual relationship is similar to that of the DSN Boards as the official investigation, subject to the state investigative agency's oversight review.

Sexual Assaults between People Receiving Services

All sexual assaults between consumers will be reported and investigated according to DDSN policy 533-02-DD “Sexual Assaults, Prevention and Follow-up” and DDSN policy 100-09-DD “Reporting of Critical Incidents”. Referrals will be made to law enforcement as indicated. The Executive Director/ Facility Administrator will also review the sexual assault incident to determine appropriate corrective/preventive action.

APPENDIX F:

"GREATER PROTECTION NEEDED FOR VULNERABLE ADULTS"

THE STATE NEWSPAPER

JULY 12, 2005

Greater protection needed for vulnerable adults

A RECENT REPORT OF abuse at a state-run residential care facility in Columbia, coming on the heels of similar reports at the state-subsidized Babcock Center facilities, raises serious questions about whether the state has appropriate safeguards in place to protect vulnerable adults. The latest report involves allegations that employees at the Midlands Center kicked, pushed down and beat a 26-year-old mentally retarded woman and attempted to hit her with a wall sconce. The attorney general's office is investigating, and three employees have been fired, but officials at the residential home weren't even aware of the assault until police showed up, called by the woman's mother. That means there probably wouldn't have been an investigation, and the people alleged to have assaulted the woman would still be caring for her and other people with mental retardation, autism and other developmental disabilities, if the woman's sisters had not happened by for a visit the day after the assault. As bad as it is that such an assault could occur, it's even worse that it could happen and no one in the facility would report it, or even raise questions about the woman's injuries. That suggests a serious problem in the culture of such institutions, which could be putting other people in the care of the state Department of Disabilities and Special Needs at risk. Changing such a culture starts with passing laws that make not reporting abuse or neglect a crime comparable in seriousness to the abuse itself. That type of "incentive" to report crimes is particularly important in situations in which the victims are unable to speak up for themselves.

Lawmakers should put that change near the top of their "to do" list when they return to work in January. Lawmakers also need to make sure that the people who investigate allegations of abuse are independent of the agency where the abuse occurred. That doesn't automatically happen in South Carolina, where the state's long-term care ombudsman has contracted out to the

Department of Disabilities and Special Needs and to the Department of Mental Health the duty of investigating problems within their own agencies. An independent investigator is more likely to make sure possible criminal activity is referred to law enforcement, and to make sure appropriate steps are taken when problems don't rise to that level. As Columbia attorney Patricia Harrison told The State's Roddie Burris, it's not uncommon for abuse to go unnoticed and, even when it is noticed, for abusers to be quietly fired without facing criminal prosecution. Ms. Harrison and other advocates for the mentally disabled are calling for the state to establish a central registry of people who have abused or neglected vulnerable adults, so that abusive employees would not be able to move from facility to facility. Such a registry could serve the dual purpose of offering some level of protection to the mentally ill and the elderly in nursing homes, who likewise are vulnerable to abuse and neglect. It is simply inconceivable that the state doesn't already operate such a registry, and that institutions that provide care for those who cannot report their abuses — be they public or private — are not required to vet their employees. We maintain a registry to keep up with people who have abused or neglected children. Adults with developmental disabilities, mental illnesses and age-related vulnerabilities deserve, and need, every bit as much protection from abuse.

APPENDIX G:

AUTHOR BIOS

Randolph W. Thomas, MA, Consultant

RANDOLPH W. THOMAS is a retired police officer having served for over 26 years in the law enforcement profession. His experience encompasses patrol, investigations, planning and research and over 14 years as a law enforcement trainer. He develops and presents training material relating to the investigation of child and elder abuse and juvenile crime. Mr. Thomas was the Project Director for South Carolina's law enforcement domestic violence training program. He was a member of the South Carolina Adult Protection Coordinating Council andhas served on a number of committees in the area of Elder Abuse. He is currently the President-Elect, National Committee for the Prevention of Elder Abuse and serves in an advisory capacity to the United States Department of Justice in the area of elder abuse. He has been an adjunct professor at the University of South Carolina, Department of Criminology and Criminal Justice in the area of juvenile delinquency, crime prevention and child abuse. Mr. Thomas currently presents training to law enforcement and social service personnel in the area of elder abuse investigations throughout the United States. He provides consulting services to law enforcement and others in the investigation of elder abuse cases. Mr. Thomas is a retired Colonel (United States Army) with over 37 years experience (active and reserve) as an intelligence officer. He received his undergraduate degree in Political Science from Chaminade University (Honolulu, 1971) and his Master's degree in Political Science from the University of South Florida (Tampa, 1974).

Nikki E. Fair, MSW, MHR Candidate

NIKKI E. FAIR has been employed with Protection and Advocacy for People with Disabilities, Inc. since August 2001. Her experience encompasses conducting institutional inspections and advocating for persons with disabilities who have been abused, neglected, or excessively restrained. Prior to her joining the organization, she worked with children with special health care needs teaching independent living skills. Ms. Fair received her undergraduate degree in Biology from Francis Marion University (Florence, 1996) and her Master's degree in Social Work from the University of South Carolina (Columbia, 2001). She is currently a candidate for her Master's degree in Human Resources from the University of South Carolina (Columbia, 2007).