Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center [Interim Report]

NYS Commission on
QUALITY
OF CARE
for the Mentally Disabled

Preface

Reflecting the importance placed upon protecting residents of mental hygiene facilities from harm, three separate laws empower the Commission to investigate cases of alleged abuse and neglect, and delineate its responsibilities.

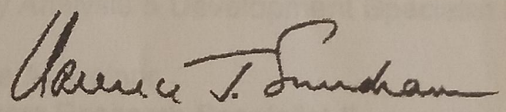
- Chapter 655 of the Laws of 1977 (MHL Article 45), which created the Commission, requires it to establish procedures for the effective investigation of allegations of patient abuse and maltreatment, and provides for the issuance of reports and recommendations.
- The Child Abuse Prevention Act of 1985, enacted by Chapter 676 of 1985, added a specific mandate to investigate cases of alleged child abuse and neglect in residential mental hygiene facilities. In each such case, the Commission is required to recommend to the State Central Register of Child Abuse and Maltreatment that the case be "indicated" or "unfounded."
- At the federal level, the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (P.L. 100-509) created a federal requirement to investigate incidents of abuse and neglect of mentally ill individuals, and to "pursue administrative, legal, and other appropriate remedies" to ensure their protection.

This interim report presents the preliminary findings and recommendations resulting from a nine-month-long investigation, conducted pursuant to these laws, into 32 cases of alleged child abuse and neglect at Western New York Children's Psychiatric Center, a facility operated by the New York State Office of Mental Health. The investigations into these individual cases, and others that have been reported subsequently, are on-going. In recognition of the likely long-term duration of these investigations and of the need for certain prompt reforms and corrective actions, the Commission decided that an interim report of its preliminary findings was warranted.

This report reflects the unanimous opinions of members of the Commission.

A draft of this report has been reviewed by the Office of Mental Health, which has concurred with the Commission's findings and conclusions. The Office of Mental Health's response to our recommendations is appended to the report.

The Commission intends to closely monitor the implementation of these recommendations and to assess their impact in improving the protection of children and the quality of the care they receive.



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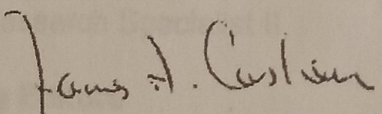

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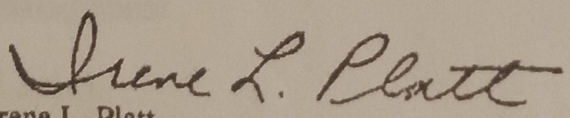

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In 1985, the State Legislature passed, and Governor Mario Cuomo signed into law, the Child Abuse Prevention Act of 1985 (Chapter 676 and 677 of the Laws of 1985). The Act responded to public concern that allegations of child abuse and neglect in residential settings required increased governmental attention and scrutiny.

The Act added a new requirement that all such allegations be investigated by trained personnel, independent of the operators of the facilities where the reported abuse or neglect allegedly occurred. This provision shifted responsibility from the Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities to the NYS Commission on Quality of Care to investigate all allegations of child abuse and neglect reported in mental health or mental retardation residential facilities (exclusive of family care homes).

In defining an abused or neglected child in a residential care setting, the Act specifies a number of actions or inactions by residential facility custodians (defined as the director, operator, employee, or volunteer in a residential facility) which constitute abuse or neglect. These actions or inactions include:

- inflicting, or allowing to be inflicted, other than by accident, an injury which causes or creates substantial risk of death, serious protracted disfigurement, protracted impairment of physical or mental health, or protracted loss or impairment of organ function;

- committing, or allowing to be committed, a sex offense against a child, as described in penal law; or

- impairing, or placing in imminent risk of becoming impaired, the child's physical, mental or emotional condition, by failing to adhere to standards for custodial care and conduct, medical and dental care, supervision, education, or the use of restraint or isolation.

The Act specifies that all staff of a residential facility are obligated to report (or cause a report to be made) to the State Central Register "when they have reasonable cause to suspect" that a child coming before them is abused or maltreated. The statute further provides that whenever a staff person of a residential facility is required to report, he/she "shall immediately notify the person in charge of such institution, school, facility or agency or his designated agent". Any staff person failing to comply with these requirements is guilty of a misdemeanor.

INTRODUCTION

This report presents preliminary findings of the Commission's investigation of 32 separate child abuse and neglect cases at Western New York Children's Psychiatric Center filed with the State Central Register for Child Abuse and Maltreatment over the seven-month period March 14, 1988 - October 17, 1988*. These 32 cases involved a total of 36 different children at the facility. Twelve (12) of these children were identified as alleged victims in more than one case.

Of the 32 individual cases filed with the State Central Register, 23 involved some kind of sexual activity; eight involved an allegation of physical abuse; and one involved an allegation of verbal abuse. Of the 23 cases alleging some form of sexual activity, 15 involved allegations of child-to-child sexual behavior. In these cases, it was alleged that the children were involved in vaginal intercourse, anal intercourse, oral sex or fondling. Most allegations indicated that the behavior was consensual; several, however, carried the implication that force, intimidation or coercion was present.

The remaining eight of these cases related an allegation of sexual contact between a child and a staff member. All of these cases have been referred to local law enforcement officials and their investigations are on-going. (In one case, an employee has been arrested and charged and released on bail.)

The Commission's obligations under the Child Abuse and Prevention Act of 1985 (CAPA) require the investigation of each case reported to the State Central Register separately to determine whether the particular allegation should be "indicated" or "unfounded". This investigation process is necessarily relatively slow and painstaking. Our investigation efforts have also directly and indirectly led to the surfacing of new allegations which require investigation. Specifically, our reviews of facility documents, including the facility's Daily Report Log and facility OMH 147 Incident Reports, have surfaced additional incidents requiring examination. In other cases, interviews with children, families, and staff at the facility have disclosed additional incidents. Additionally, children and families, upon reading press reports of allegations at the facility, have come forward with reports dating back over several months and years.

In recognition of the likely long-term duration of the Commission's investigation efforts and of the need for certain prompt reforms and changes at the facility, the Commission recommended that the Office of Mental Health conduct its own internal review of these reported incidents which the Office has initiated. The Commission also decided that an interim report of its investigation findings was warranted.

The purpose of this interim report is to provide the New York State Office of Mental Health with an overview of the Commission's preliminary investigation findings and its recommendations for specific reforms and changes which should be promptly instituted. The nature of this interim report also allows a more global presentation of the underlying issues and circumstances which appear to have contributed to the high rate of serious incidents at the facility.

It is important to emphasize that this interim report does *not* constitute an assessment of the general operations of Western New York Children's Psychiatric Center. Rather, it examines how this JCAH-accredited facility functioned in reaction to incidents of possible child abuse and neglect of some of the children in its custody over a period of time. It attempts to address three questions:

- *What happened?*
- *Why did it happen?*
- *Did Western New York Children's Psychiatric Center respond appropriately to treat and protect children when confronted with allegations of child abuse and neglect? If not, why?*

*Since October 17, 1988, and the date of this report, six additional cases at Western New York Children's Psychiatric Center have been filed with the Register. Information on these cases, due to their recency, is not included in this interim report.

Methods

Given the multiplicity of cases and the severity of the allegations, the Commission has maintained a regular presence at Western New York Children's Psychiatric Center since early spring 1988. Initially, the Commission's investigation efforts focused on individual cases which had been reported to the State Central Register. As additional cases were reported, and as the individual investigations revealed evidence of more widespread concerns, the Commission's investigation activities took on a broader, more systemic character. Specifically, since early March 1988, the following investigative activities have been undertaken:

- A team of Commission staff interviewed all but one of the 47 children in residence at Western New York Children's Psychiatric Center on August 2-3, 1988;*
- Commission staff have interviewed ten other children who were reportedly involved in the cases, but who were not in residence on August 2-3, 1988;
- Commission staff have interviewed 33 staff persons at the facility, including 14 direct care staff, 13 line clinical staff, and 6 senior administrative/clinical management staff at the facility. Senior administrative/clinical management staff interviewed included: the facility director, the deputy director for quality assurance, the chief medical officer, and the facility's one unit chief and treatment team leader;
- Commission staff have reviewed the clinical records of approximately 78 children who were reportedly involved or associated with the reported incidents; and,
- Commission staff have reviewed a large number of other facility quality assurance documents, including Daily Report Logs, OMH 147 Incident Reports, Incident Review Committee Meeting Minutes, Board of Visitors Meeting Minutes, and facility in-service staff training records.

* * *

Cases discussed in this report include all 32 alleged cases of child abuse and neglect which were reported to the State Central Register for Child Abuse and Maltreatment from Western New York Children's Psychiatric Center during the seven-month period March 14, 1988 - October 17, 1988. Also referenced in the report are 64 instances of sexual activity, contact, or flashing among children at Western New York Children's Psychiatric Center which were documented on the facility's Daily Report Logs for the nine-month period, November 1987 - July 1988.

It should be noted that while cases from the Daily Report Logs usually referenced a single sexual incident which occurred during the above time frame, nine of the reports to the State Central Register referenced multiple incidents of sexual activity, which reportedly occurred over a period of several weeks or months. In addition, although all of the State Register cases were *reported* during the period March 14 - October 17, 1988, alleged incidents referenced in many cases occurred before and during this time period.

*One child was not interviewed because facility staff advised that her frail clinical condition might be threatened by an interview with Commission staff.

Summary of the Findings

As reflected in this report, these investigation efforts have led the Commission to conclude:

- Over a long period of time, many young children at Western New York Children's Psychiatric Center had engaged in sexual activity with other children. Many of these incidents appear to have occurred and/or persisted because of inadequate supervision of the children by staff at the facility.
- Line staff have been aware of this sexual activity, and have generally reported it appropriately to senior supervisory, administrative and clinical staff.
- Although senior administrative and clinical staff at the facility had knowledge of this sexual activity, they took little, and often inappropriate, action to intervene to prevent the activity from recurring.
- Senior management did not seem to recognize the seriousness of the sexual conduct being reported; they did not take sufficient action to protect the children or to assure an appropriate level of supervision; and, they did not ensure that the children's behavior was addressed in the course of their treatment.
- Senior management also frequently failed to report the incidents promptly to the State Central Register for Child Abuse and Maltreatment, Office of Mental Health officials, and law enforcement authorities, when warranted.
- Most critically, many of the children involved in these incidents of sexual activity had been admitted to Western New York Children's Psychiatric Center with a prior history of either inappropriate sexual behavior or significant physical or sexual abuse. The facility virtually ignored these histories in developing treatment plans for many of the children and in assuring these children received special protections.

MAJOR FINDINGS

Frequency and Seriousness of the Reported Incidents

For a significant period of time, children at Western New York Children's Psychiatric Center have engaged in sexual activities, which were known to senior administrative and clinical staff at the facility.

- Western New York Children's Psychiatric Center utilizes a Daily Report Log for the presentation of significant untoward events and changes in children's clinical conditions at weekday Daily Planning Meetings. Regular participants at these meetings include a clinical representative of each living unit, representatives of the various clinical disciplines, psychiatry, psychology, social work, education, training, and the facility's one treatment team leader.* The meetings are chaired by the facility's one unit chief. Prior to the meeting, the complete Daily Report Log is copied and distributed, with the original going to the facility director.
- Review of the Daily Report Logs for the nine-month period, November 1987 - July 1988, revealed a total of 64 reported incidents of sexual activity, contact, or voyeurism among children at the facility.** A total of 47 individual children were involved in these incidents. Based on staff notations in the Daily Report Log, as well as subsequent interviews with staff, there is strong evidence that virtually all of these incidents, documented in the Daily Report Log, did occur.
- In the seven-month period since the initiation of the Commission's involvement in the investigations of sexual activity at Western New York Children's Psychiatric Center in March 1988, a total of 32 cases of possible child abuse and neglect have been reported to, and accepted by, the State Central Register. Fifteen (15) of these cases involved allegations of sexual activity among children at the facility; eight cases involved allegations of staff sexual abuse of children; eight cases involved allegations of staff physical abuse; and, one case involved staff verbal abuse.***
- Although facility staff did not file all of these reports to the State Central Register (See Report pp. 15), in most of the cases (81 percent), the facility was aware that the incidents had occurred prior to the Commission's investigatory activities. Indeed, prior to our investigations, 22 of these 32 cases had been documented on an OMH 147 Incident Report Form.

*Since August 1, 1988, the Director of Nursing also attends these meetings.

**This nine-month period was initially selected because it encompassed the time period of the 13 cases reported to the State Central Register and forwarded to the Commission during the first four months of its investigation (March 14, 1988 to July 30, 1988). Of the subsequent 19 Register cases, four also reportedly occurred during this period, while three reportedly occurred prior to this period, ten reportedly occurred during August-October 1988; and, the specific times of the two other cases remain undetermined.

***Unless otherwise noted, all State Central Register case data relate to cases reported to the Commission between March 14, 1988 and October 17, 1988.

The nature and circumstances of the incidents of sexual activity reported to the State Central Register or filed on the facility's Daily Report Log varied, but most of these incidents raise significant concerns about the adequacy of supervision and the protection of the children at the facility from harm.

- Specifically, 16 of the 23 reported incidents of alleged sexual abuse by staff or sexual activity among children filed with the State Central Register involved reports of vaginal intercourse, anal intercourse, or oral sex. In 12 of the 15 reported incidents of sexual activity among children, preliminary CQC investigation findings have also yielded credible evidence (i.e., staff observation, confirming reports of the children involved, and/or physician findings) that the sexual activity did occur. Additionally, half of these cases involved reports of ongoing frequent sexual contact over several weeks or months.
- The following synopses of cases reported to the State Central Register illustrate the range of serious concerns they present:
  - An eight-year-old boy reported to a unit nurse that he was threatened and intimidated into engaging in oral sex and anal intercourse with a 12-year-old boy. The younger boy claimed that the older boy performed anal intercourse with him on many occasions over several weeks. Each boy had a significant history of inappropriate sexual behavior prior to admission, which was known to facility staff. Additionally, both children had also been involved in previous reported incidents of sexual activity since their admission to the facility.
  - During early August 1988, several children from Western New York Children's Psychiatric Center went to a park on an outing. During the course of the day, a 12-year-old boy allegedly repeatedly sexually abused a 15-year-old girl. The boy allegedly touched her breasts, put his hand between her legs, grabbed her vagina, and finally tried to pull her swimsuit off. Or the girl reported to keep the boy time the boy a portedly plead her. Accordi never respond tection. Facility staff repo dent to the Commission indicating that the State Central Register had refused its report. Notably, in its report to the Commission, the facility staff person initially failed to mention that the girl had reportedly asked for staff assistance repeatedly. Ultimately, this case was reported to the Register by the Commission and accepted.
  - Four children alleged to staff that over the past several months, four other girls were involved in constant and public homosexual activity with one another. This activity included touching, fondling, and kissing. This activity allegedly took place all over the unit: in the dayroom, the TV room, in bedrooms, and in bathrooms.
  - A nine-year-old boy, who was required to be on very close staff supervision, according to his treatment plan, left his alarm-equipped room and went into the bedroom of a five-year-old girl. According to both the boy and the girl, he "stuck her with his penis". The boy said he was able to go into the girl's room undetected because the staff on duty had turned off the alarm on his room and were asleep.
- The 64 reported incidents of sexual activity or voyeurism reported on the facility's Daily Report Log are not described in detail, but 43 percent appear to describe direct sexual contact between children and 33 percent describe incidents where children were "flashing" or exposing themselves to peers. Further analysis indicated that 55 percent of these reported incidents occurred on the unit of the facility which served the youngest children, ages 5-12. Addition-

Angola State Park

Unit 804

ally, the analysis showed that nearly half of the incidents (48 percent) occurred during the day shift. The remaining incidents primarily occurred during the evening shift (48 percent), with only 4 percent of the documented incidents occurring during the night shift.

Many of the reported incidents of sexual activity among children at the facility appear to have occurred or persisted due to inadequate supervision of the children by staff.

- Eight (8) of the 15 reported cases to the State Central Register relate allegations that the named children engaged in oral and anal sex on residential units of the facility for periods of time extending over two to four months. The number and duration of these alleged occurrences, most of which have been confirmed by two or more of the children involved, raise significant questions about how diligently staff supervised the children's activity, particularly in light of the known prior histories of many of the children of physical and/or sexual abuse.
- Many of the children interviewed by Commission staff also spoke directly about the ease with which children at the facility could elude staff supervision to participate in sexual activity. In particular, children remarked that staff checks of bedroom areas were usually conducted at very predictable 15-minute intervals.
- In other instances, specific deficiencies in staff supervision of the children were reported.
  - In at least two cases, the reported sexual activity was facilitated because staff had turned off alarm devices on children's rooms which would have detected their exits and entrances to other bedrooms;
  - In one case, two children confirm that the alleged incident was facilitated because staff were sleeping on duty; and
  - In one case, children were engaging in alleged oral sex in a van, with two staff persons (one the driver) on board.

Preliminary investigative findings have further indicated that some sexual activity among children at Western New York Children's Psychiatric Center was fostered through an informally organized club led by certain children at the facility. This club, which operated primarily on the living unit of the facility serving the youngest children (ages 5-12), encouraged children to participate in sexual activity.

Unit 804

- Over time, the "club" frequently changed names from the "Toy Club" to the "Kissing Club" to the "Tree House Club" to the "G.I. Joe Club" to the "Transformer Club", as the children sought to cover its identity. According to several children, parents, and staff, regardless of its current name, children seeking or encouraged to join the "club" had to first pass through an "initiation rite", which included engaging in oral and anal sex with other children.
- Staff interviews and other facility documents indicated that several senior staff at the facility had knowledge of the children's references to the "club," but took no action to explore further. Direct care staff reportedly often directed the children that "no clubs" were allowed*, but clinical and administrative staff took no direct action to determine actual club activities or to preclude them through concerted counseling and supervision of the children. Specifically,
  - A nursing note in a child's record, dated November 7, 1987, stated, "Upon questioning, both clients freely admitted to the following: Two roommates (ages 9 and 11) were encouraging a third child (age 9) to suck another child's (age 11) penis so the third child

*In interviews with Commission investigators, both children and direct care staff reported that all clubs had been forbidden. Direct care staff reported that they instituted this rule to stop the children from "congregating together" and "engaging in horseplay".

could join the club." The nurse who wrote this note told Commission investigators that she related this report to the facility's unit chief, two doctors, and the administrator-on-call. Subsequently, on April 4, 1988, when a Commission investigator discovered the note, the investigator brought it to the attention of the facility's unit chief, but he denied any knowledge of "the club", or ever hearing anything about it. Despite his denial, however, the unit chief's signature was on two Incident Report Forms referencing the club (Incident Reports #5094 and #5313).

- An incident report, dated March 16, 1988, indicated that a child (age 9) told staff members that another child (age 8) had exposed himself, and that this child, encouraged by a third child (age 9), had tried to put his mouth on the reporting child's penis. The incident report also indicated that the reporting child stated that there was a lot of talk among the children about "a sex club", but that he couldn't join because his father would disapprove. The incident report also indicated that a second child also confirmed that there was "a sex club". This incident report was reviewed by the facility director, the deputy director for quality assurance, the deputy director for facility administration, and the unit chief at the facility.

- On August 29, 1988, a parent told Commission investigators that seven days after her child's (age 11) admission to the facility, he was involved in an incident of sexual contact. She was told by the unit chief that her child was "initiated" by other children "because he was new". The parent reported that the unit chief told her it was "childish sex play", "made light of it", and said "it wouldn't happen again". Twenty (20) days later, this child was again involved in sexual activity with two boys and a girl, which was p
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- A facility OMH 147 Form dated October 17, 1988 indicated that while on a van trip on October 16, 1988, an eight-year-old boy alleged he watched two other boys, ages 8 and 10, engaging in oral sex in the back seat of the van. According to the report, the two boys were engaging in oral sex and asked the third boy to join them, so that he could "join the club". There were nine children and two staff in the van at the time. Facility staff indicated that the incident did not come to light until the next morning, when the children were overheard discussing what happened in the van at the breakfast table. The reporting child stated to CQC investigators, however, that another child had told staff on the van, but they told him just to be quiet.

Trip to a Pumpkin Patch

There is also evidence that a subgroup of children at the facility had been repeatedly involved in incidents of sexual activity over a significant period of time.

- As noted above, the Daily Report Log revealed that 47 different children had been involved in sexual incidents over the nine-month period November 1987 - July 1988. Approximately one-third of these children had been involved in two or more reported incidents. Specifically, seven children had been involved in two incidents; five children had been involved in three incidents; and, three children had been involved in four or more incidents, including one child who was involved in 10 incidents.

- Twelve (12) children were involved in two or more allegations of child abuse or neglect reported to the State Central Register over the seven-month period, March 14 - October 17, 1988. One boy (age 12) was named in four separate reports to the Register; two boys (ages 15 and 16) had been

named in three reports to the Register, and nine other children (ages 9-17) were named in two reports.

- The frequency with which certain children were involved in sexual incidents and/or reported allegations to the State Central Register is illustrated by the chronology of incidents/allegations for two children at the facility.

Child I

A 12-year-old boy was repeatedly involved in inappropriate and aggressive sexual activity with many other children at the facility for at least the five-month period November, 1987 - March, 1988. Over this period, facility documents indicate that this child forced a younger child (age eight) to engage in anal intercourse. This child also put his finger into his 10-year-old roommate's rectum and fondled his genitals almost every day, and regularly fondled his fourth roommate. This child additionally had regular anal sex with another older child at the facility for a four-month period. With two other boys, this child was also allegedly involved in coercing a 12-year-old girl at the facility into sexual involvement. During this same period of time, this child was also involved in six reported physical assaults on children at the facility. (On April 1, 1988, pursuant to a Family Court Order, this child was placed on increased supervision.)

Child II

A 15-year-old boy was discovered to be engaging in sexual activity with other children at the facility several times over the seven-month period November, 1987 - June, 1988. Although staff were aware of this child's sexual behaviors, the offered precautions were either not sufficient, or not faithfully carried out. For example, in November, 1987, this child was discovered having oral sex in a shower room with a 16-year-old boy at the facility. Although the 15-year-old had been forbidden to use the shower room where this incident occurred, he had obviously been in the room for some time. The child later admitted that while in the shower room, the older child had also had oral sex with him, and that he had anal intercourse with the older boy. Facility documents reporting this incident described the activity as "consenting" and concluded that neither boy had been harmed.

Three months later, this same 15-year-old child was reported as engaging in anal intercourse with a younger boy, age 13. According to the younger boy, this activity had gone on, undetected by staff for "a long time". The child stated that because staff routinely turned off the room alarm system at bedtime, the children were allowed free access to one another's rooms. Approximately three and a half months later, this same 15-year-old boy was discovered having oral sex with another child (age 14) at the facility.

Many of the children involved in the reported incidents of sexual activity or sexual voyeurism at Western New York Children's Psychiatric Center had also been identified by the facility as being at particular risk of harm and, thereby, had been placed on special precautions.

- Fourteen (14) of the 36 different children involved in reported cases to the State Central Register had been on special precautions at the time of the reported incidents or soon before or after the incidents. Specifically, two children were on special precautions at the time of the reported incidents; eight of the children had been on special precautions soon before the incidents; and five children were placed on special precautions soon after the incidents.
- Among the 47 different children noted to have been involved in incidents of sexual

- In total, 21 of these 27 children (78 percent) had a prior history of sexual abuse and/or sexual activity with other children/siblings. These issues were addressed in comprehensive or periodic treatment plans of 10 of these 21 children (48 percent); for the remaining 11 children (52 percent), there was no reference to these issues in their comprehensive or periodic treatment plans. For example:

  - The clinical record of a 10-year-old boy at the facility clearly documented that he, as well as his two siblings, had been repeatedly sexually abused by his father. Due to his history, the 10-year-old child was under the protection of Child Protective Services. Although facility staff were well informed of this child's sexual abuse history, his treatment plan, while referencing his history, did not include a treatment goal or objective related to it, nor did it prescribe any special counseling or protections for the child pertinent to this history. Soon after admission, this child was involved in an incident with 8-year-old boy involving oral sex. His record also notes that this child was involved in "sexualized" behavior toward a teacher.

  - In the fall of 1987, the facility learned, approximately 11 days after admission, that a 12-year-old boy in its care had been involved in anal intercourse with a 16-year-old boy in the community. The facility was also aware that this boy had sexually abused a three-year-old boy in the community prior to his admission. Despite the facility's knowledge of these incidents, they were not addressed in the boy's treatment plan. When questioned about this omission by a Commission investigator, the child's therapist stated that some of the boy's previous sexual activities had been discussed in counseling, but no treatment goals were developed pertaining to them. The therapist also noted that there had been a family session (sometime in the past) where the father of the three-year-old "had forgiven" the boy. Soon after admission to the facility, this child was involved in an incident with an 11-year-old boy who reportedly solicited him for oral sex. There are also numerous notations in the social worker's weekly progress notes indicating concern regarding his sexual behavior (e.g., "his behavior has been more sexualized lately"....."present major concern focuses on sexuality").

  - Upon admission, facility records documented that a nine-year-old boy had been sexually abused by his older sister at home. While at the facility, there are also documented incident reports indicating that this child was involved in acts of sexual activity with other children. Despite this knowledge, the child's treatment plan failed to address this prior history.

Medical attention afforded by Western New York Children's Psychiatric Center to children subsequent to their involvement in sexual activities was not adequate to ensure the children's well-being and further protection.

- Sixteen (16) of the 23 incidents of alleged sexual activity among children or alleged staff sexual abuse reported to the State Central Register over the seven-month period (March 14, 1988 - October 17, 1988) involved alleged acts of anal intercourse, vaginal intercourse, and/or oral sex. In total, 30 different children were involved in these incidents, nine of whom were involved in two or more of the incidents.

- Only in five instances were the children involved afforded a medical exam by specially-trained medical personnel. Three children were referred to a hospital (Children's Hospital of Buffalo) with specially-trained staff for a medical exam; and two children were taken to a private physician in the community for an exam. The remaining children were either afforded no exam or an

exam by a facility physician who had received no training in the conduct of physical exams of children alleged to have been engaged in sexual activity.

- In half of the 32 cases reported to the State Central Register, the children involved were not afforded any medical exam. In at least 10 of these cases, the recency and nature of the alleged incidents indicated that medical exams were warranted to assure the health and well-being of the child, as well as to obtain investigatory evidence. For example:
  - In the case of the 12-year-old and 13-year-old boys who were engaged in anal sex with each other regularly over a four-month period, neither child was afforded a medical examination when the facility became aware of the incidents; and
  - In the case of the 10-year-old boy and 13-year-old boy engaging in anal intercourse with each other several times, neither child was afforded a medical examination when the facility became aware of the incidents.
- Children alleged to have been involved in sexual activities, which may have included sexual intercourse, were often not tested (or monitored) for sexually transmitted diseases. Specifically, among the 30 children named in cases reported to the State Central Register which reportedly involved vaginal intercourse, anal intercourse, and/or oral sex, only five were tested for sexually transmitted diseases.
- A factor which contributed to the poor medical exams for children involved in sexual activity was the lack of any explicit facility expectations for the conduct, scope, and documentation of medical exams in these incidents. Specifically, there seemed to be a common misperception of many staff that if the incident was reported sometime after the fact, or if the child reported, then recanted a sexual activity, a medical exam by specially-trained personnel was not necessary. Facility staff seemed unaware of the well-acknowledged observation that children, who have been sexually abused or involved in sexual activity, often do not fully report for fear of being blamed or punished. They also did not seem to be aware that all children reportedly involved in such incidents should be afforded a medical exam to ensure that they have not been injured and that they have not contracted a sexually transmitted infection or disease.
- Senior facility administrators also confirmed that facility physicians had received no special training in the conduct of these medical exams. This issue became an especially serious concern in relationship to the reported Register cases. On at least two units of the facility, the informal practice for ensuring medical exams of children allegedly involved in sexual activity was for an on-call facility physician to examine the child. Based on this physician's visual exam findings, which involved no laboratory tests and no internal exam, the child may then have been referred to the facility's medical clinic during its regular hours of operation. Clinic physicians, who also were not specially trained in performing these exams, then reportedly had the discretion of sending the children to an outside hospital with specially-trained staff for an exam. This procedure, aside from inherently creating substantial delays in ensuring medical exams, also allowed the likely possibility that the child would shower, change clothes, etc., before being examined by a specially-trained physician. Most critically, the screening process whereby decisions made regarding referral to outside hospitals were based on exams conducted by facility physicians without specialized training, allowed little assurance that the child would be afforded appropriate exams. In fact, referrals to outside hospitals by facility physicians clearly seemed to be the exceptional practice.

Although senior facility staff were aware of the numerous incidents of sexual activity, they failed to take sufficient actions to stop the activity from occurring. Additionally, in some cases, incidents involving oral and anal sex among children were treated by clinical and administrative staff, as normal sexual experimentation among children.

- Based on the Commission's preliminary investigative efforts, senior administrative and clinical staff were well apprised of the level of sexual activity among children at the facility. As noted above, these activities were usually documented in the Daily Report Log shared with senior staff during regularly scheduled weekday meetings. In other cases, they were documented in children's clinical records or on facility incident reports. Finally, police interviews with several direct care staff at the facility revealed that these staff had directly expressed their concern about the level of sexual activity among children at the facility to these clinical supervisors. These staff stated to police that they had tried to get senior staff to do something about the constant level of inappropriate sexual activity among the children, but that senior staff told them not to be concerned, that what the children were doing was "normal behavior".
- Despite this knowledge, senior administrative and clinical staff did not effectively intervene to stop sexual activity among children at the facility. While the long-term, on-going incidence of sexual activity among children, alone, provides a significant indicator of this deficiency, reported facility actions related to specific children also depict an attitude of complacency which characterized the facility's response to many of the cases.

  - In the case of the 12-year-old girl who was allegedly involved in sexual activity one evening with three boys at the facility, although facility staff did assure that the girl received a medical exam by a specially-trained physician, the three boys were not medically examined and the facility did not follow-up on the two specific genital injuries (one old and one new) noted by the physician who examined the girl. Aside from placing all four children on 24-hour restrictions -- the girl for leading the boys on and the boys for following the girl's lead -- the facility also took no other substantive actions to explore the circumstances or cause of the incident, or to ensure the future protection of the children. Although notes on the OMH 147 Incident Report Form raised questions about staff supervision, there is no indication that this issue was actually explored. The incident was also not reported to the State Central Register. The facility did ensure an interview with the girl by an in-house psychiatrist who concluded that the incident reflected a preadolescent sexual contact game which got out of control. This impression was not reassessed after the medical exam results were available. There is no indication that the boys involved were interviewed, nor was there any attempt to ascertain the origin or cause of the older genital injury to the girl. Progress notes in the children's records provide no indication that the incident was addressed in their treatment plans or in their individual therapy sessions. (Seven months later, subsequent to the Commission's involvement, the facility did address the incident with the girl in therapy.)

  - In the case of a 12-year-old boy who reported to two therapy aides that an 11-year-old boy had solicited him to participate in oral sex, the reporting child stated to Commission investigators that the staff's first response was to accuse him of lying. The therapy aides indicated that they reported the incident to the unit social worker and that they did document it in the child's record. The documentation, however, could not be

found, and the social worker stated that she first heard of the incident the next day in a therapy session with the child and his mother. In response to this notification, the social worker did not take any steps to further explore the circumstances of the incident or to provide any added protections for the child. The social worker did, however, report the incident on an OMH 147 Incident Report Form.

- In the case of a nine-year-old boy who entered the room of a five-year-old girl while she was sleeping and reportedly "stuck her with his penis," the facility OMH 147 Incident Report Form, despite interview statements of both children to the contrary, stated that the incident involved the boy tickling the girl and then urinating on her. In response to the incident, the facility assured an in-house medical exam of the five-year-old girl approximately three hours after staff were alerted to the incident by the girl's screams. This exam report stated that there were no injuries to the child's genitalia, but did not comment on whether the child may have been involved in sexual activity or on her overall condition. No laboratory tests were done. (The physician conducting this exam also had not received any specialized training in conducting physical exams of sexually abused children.) The boy involved was not afforded any medical exam; twelve days later he was discharged to another State children's facility. Subsequently, the incident was not addressed in the treatment plan of the five-year-old girl. The child's primary therapist stated, "I was concerned about the effect interviewing had on her. She didn't present anything for concern in therapy sessions." Additionally, other specific protective actions were not taken by the facility for the girl, who was involved in another sexual incident twelve days later. Approximately 80 days after the incident, the girl was discharged home. Her mother did not receive an accurate report of the children's initial accounts of the incident, nor was she afforded any special advice or suggestions in responding to the child's recent experience.

The failure of the facility to assure the children involved in these cases adequate inpatient treatment and discharge support services has contributed to further serious problems for several of these children in the community. For example,

- The 12-year-old boy, referenced above, who was involved in sexual activity with his peers within seven days of his admission, while being "initiated" into the club, was discharged from the facility after an eight-month stay to his parents' custody. He remained home only a short time, as his parents could not manage him, and he was referred to another residential treatment facility for children by Western New York Children's Psychiatric Center. This facility, however, was not informed by the Western New York facility of the child's recent history of sexual activity. Within two weeks of the child's admission to the residential treatment facility, he was discovered by staff in a sexual encounter with a seven-year-old resident. Subsequently, the child also revealed to staff at the residential treatment facility that he was involved in and witnessed other sexual incidents during his stay at Western New York Children's Psychiatric Center.
- An eight-year-old boy, admitted in March 1987, was involved in at least three incidents of inappropriate sexual activity during his 13-month stay at Western New York Children's Psychiatric Center. Facility records also revealed that this child had been physically and sexually abused by a number of his mother's live-in boyfriends. The child had also been involved in a number of fire-setting incidents. The facility's planned treatment to deal with this child's past history of sexual abuse and recent

history of unusual sexual activity included individual therapy sessions once a week. Upon discharge, the child was placed in a foster family care home. While the family care provider was alerted to the child's history, she was not provided with any specific instructions or training to deal with the child's sexual behavior. Three months after the child's placement in the family care home, the provider brought the child back to the facility, reporting that the child had been involved in three incidents of sexual assaults on neighborhood children, and that he had also sexually assaulted her daughter. The child was then readmitted to Western New York Children's Psychiatric Center.

- An eight-year-old boy, admitted in September 1987, was known to have been involved in five incidents of inappropriate sexual behavior, including oral and anal sex, during his six-month stay at Western New York Children's Psychiatric Center. Facility records indicated that prior to his admission, the child had sexually assaulted his two-year-old brother and physically assaulted his nine-year-old sister. The child also had a history of fire-setting. The treatment plan for this child at the facility did not address his history of sexually assaultive behavior, although his fire-setting history was addressed. His treatment plan also did not address his first four incidents of inappropriate sexual behavior at the facility. Only after the fifth incident (when the child's parents notified the Commission) did the facility address these incidents in the child's treatment plan.

  Several months after discharge, the child moved out-of-state with his parents. Although Western New York arranged a therapist referral for the child, they made no effort to ensure that the child's new therapist received the child's treatment record or other information relevant to his discharge treatment needs. The parents notified the Commission in September 1988 (five months after the child's discharge) to indicate that the child was experiencing serious problems. The parents stated the child had become extremely fearful of his father, refusing to sit on his lap and being resistive to being hugged. The child had also been expelled from a public school program, as well as a special school program for children who are emotionally disturbed. Reportedly, the child encountered serious problems interacting with male teachers at these schools and became so emotionally distraught and difficult to manage that the schools had dismissed him.

Serious limitations in the clinical training, experience, and credentials of senior administrative and clinical staff, line clinical staff, and direct care staff at Western New York Children's Psychiatric Center cannot be ignored as a significant factor influencing the inadequate and inappropriate attention afforded to children involved in sexual activity at the facility.

- Review of the backgrounds of the four senior managers of Western New York Children's Psychiatric Center (i.e., facility director, deputy director for quality assurance, chief medical officer, and unit chief), as well as the chief psychiatrist on the Children's Unit, where most of the reported instances of sexual activity occurred, revealed that they had very limited academic training or professional experience serving children with serious emotional problems, prior to coming to work at the facility.
- Additionally, although Western New York Children's Psychiatric Center appeared to ensure an active in-service staff training program, few programs, especially in the past two years, have focused on training for clinical staff in treating children with prior histories of sexual abuse or unusual sexual behavior. Since November 1986, the facility has offered five in-service sessions on these topics and, based on the facility's records, relatively few staff attended these sessions.

- Interviews with direct care staff at the facility also indicated that they had received no training or clinical guidance in caring for children who had been victims of sexual abuse or who engaged in sexual activities with other children. As referenced above, many direct care staff had reportedly expressed concern about the level of sexual activity at the facility to their clinical supervisors. These direct care staff also expressed their frank frustration that clinical staff did not appear to take their concerns seriously and that they offered little practical assistance to prevent the sexual activity among children from occurring.

Poor Facility Reporting, Review, and Investigation Practices

Preliminary investigation revealed that many of the allegations of abuse and neglect were not promptly reported by Western New York Children's Psychiatric Center and that several were never reported to the Register despite an explicit statutory requirement that they be reported. Additionally, the facility did not uniformly comply with the New York State Office of Mental Health's policy for reporting possible allegations of abuse or neglect and other untoward events which adversely affect the safety and well-being of children.

- Ten (10) of the 32 reports (31 percent) of possible child abuse or neglect eventually filed with the State Central Register were reported by the Commission. Six of these 10 cases were discovered by Commission staff in reviewing previously-filed facility OMH 147 Incident Report Forms; three reports were made based on recently-filed Incident Report Forms sent to the Commission by the facility which the facility did not believe constituted child abuse or neglect or which the facility stated the State Central Register had refused to accept. (One report was made based on a parent's confidential report to a Commission attorney.)
- Twenty (20) of the remaining 22 cases were reported to the State Central Register by the facility. Seven (7) of these 20 cases (35 percent) were reported more than four calendar days after the facility initially learned of the incident, and in four of these seven cases, delays in reporting ranged from two weeks to one year after the facility initially learned of the incident.
- In one other case, a child's father reported the case to the Register after the facility had failed to report five calendar days after the incident was disclosed. In the last case, a child's assigned Child Protective Services worker filed the report. Although this case was not disclosed to the Child Protective Services worker until the child was discharged from the facility, the child stated that he had told two facility staff and a facility physician about the incidents prior to his discharge.
- In many cases, senior facility staff indicated that they failed to file reports of allegations or reported them late because they did not believe (or initially believe) that the circumstances of the incidents met the requirements of possible child abuse or neglect in State law. In other instances, senior facility staff reported that they had attempted to file the allegation with the State Central Register, but that the Register refused the report as not meeting the State's definition of child abuse or neglect. Notably, all of the reportedly refused cases were later accepted by the Register when filed by the Commission.
- A full explanation of the "turnaround" of the Register in refusing and then accepting these latter reports is difficult to discern. The Register maintains no record of "refused" cases, and facility staff accounts of exactly what was said in reporting these cases to the Register remain unclear. Commission follow-up interviews with Register officials and facility staff seem to indicate, however, that these cases were refused because sufficient, complete information about the allegation was not initially provided to the Register by facility staff.

This explanation was also supported by the Register's ready acceptance of the cases when they were filed by the Commission.

Review of the Daily Report Logs further indicated that many untoward events adversely affecting the safety or well-being of children at the facility were not reported as incidents on the OMH Form 147, as required by the New York State Office of Mental Health incident reporting policy.

- During the two-month period April - May 1988, seven separate instances of sexual activity among children were referenced in Daily Report Logs, but only one of these incidents was documented on an OMH 147 Incident Report Form, as required by OMH policy.
- Additionally, although a total of 24 significant and minor client injuries, including eight minor self-inflicted injuries, were reported on OMH 147 Incident Report Forms during the two-month period, five other significant client injuries requiring treatment beyond first aid, three self-inflicted injuries which appeared to be possible suicidal gestures, and one staff-inflicted client injury, were not reported on OMH 147 Incident Report Forms, as required by OMH policy.

Weaknesses in the facility's process for reviewing and investigating instances of sexual activity among children, as well as other untoward events, contributed to its neglect in attending to serious incidents and in assuring the protection of children at the facility from harm.

- The New York State Office of Mental Health has issued a revised Incident Reporting Policy (March 1987) to ensure that all State psychiatric facilities appropriately document, review, and investigate all incidents which may adversely affect the safety and well-being of the clients served. This policy sets forth clear internal reporting and external notification requirements and requires facilities to establish Incident Review Committees to review and investigate incidents and to recommend appropriate corrective and preventive action. The policy also requires facilities to establish an effective quality assurance mechanism "to analyze incidents and trends for the purpose of recommending effective preventive or corrective action on a unit and/or facility level".
- Both the Commission's own observations and a more in-depth Office of Mental Health examination of the incident reporting and review process at Western New York Children's Psychiatric Center revealed serious problems in the facility's substantive compliance with OMH policy. Specifically:
  - Documentation of incidents on Incident Report Forms was often incomplete and/or inaccurate;
  - Incidents, especially incidents of possible sexual abuse or sexual assaults, were often not reported to local law enforcement officials;*
  - Investigations of incidents conducted by unit staff and specially-trained investigators at the facility were poorly done; unit level investigations were often limited to only a clinical assessment of the child (children) involved; special investigations were also often incomplete, lacking evidence that all relevant parties were interviewed thoroughly, resulting in final investigations which did not comply with OMH guidelines; and,
  - Special investigations of incidents were often conducted by investigators (e.g., the unit chief) directly responsible for clinical treatment and services for the children involved, resulting in at least a perceived conflict of interest in the special investigation process.

**Patient Abuse and Mistreatment in Psychiatric Centers: A Policy for Reporting Apparent Crimes To and Response By Law Enforcement Agencies;* Commission on Quality of Care for the Mentally Disabled, December 1985

CONCLUSIONS

The first duty of any institution is to provide for the safety of its residents. For public mental health facilities like Western New York Children's Psychiatric Center, this duty to protect residents from harm is of constitutional dimension. (Youngberg v. Romeo 457 U.S. 307 [1982].) It must be recognized, however, that even in a well-managed facility, not all harmful incidents can be prevented. Accidents happen. Unpredictable and unpreventable incidents occur. In a well-run facility, such incidents trigger critical self-examination and a process of on-going improvement in facility performance. As required by State law and Office of Mental Health regulations and policies, these incidents are to be promptly investigated and appropriate preventive and corrective actions are to be taken. Furthermore, as a result of the Child Abuse Prevention Act of 1985, these regulations and policies have been revised and strengthened to explicitly detail facility obligations in reporting, investigating and preventing child abuse and neglect in residential programs.*

As this report indicates, when incidents which were harmful to children occurred at Western New York Children's Psychiatric Center, the facility frequently:

- failed to ensure thorough investigation of what happened or why it happened;
- failed to take necessary protective steps, such as prompt and thorough medical exams for children involved in sexual activity;
- failed to assure adequate treatment intervention or future protection for the children involved;
- failed to report these incidents as required by state laws and regulations, thereby impairing the protections afforded to children by investigative processes of external agencies, including law enforcement and child protective services; and
- failed to use these recurring incidents as vehicles for critical self-examination, correction and prevention. Instead, the facility's ineffective and incomplete responses to these incidents fostered a low level of concern about the welfare of the children and a higher level of tolerance for these harmful incidents than is comprehensible.

These failures permitted harmful incidents to continue occurring over a period of several months, often involving the same children in yet other incidents. Some children were discharged from the facility into other environments without adequate assurances of protection for themselves or for other children with whom they came in contact. In several instances, these children continued to engage in sexual misconduct with other children.

Unlike many investigations, where the primary focus is on establishing whether the alleged incidents actually occurred, in this case it became evident early in the investigation that most of these serious incidents of abuse and neglect had occurred, that direct care staff had known about them, that they were duly reported to supervisors, and that they were called to the attention of the highest levels of clinical and administrative responsibility at the facility. But, virtually none of the systems designed to provide the children with adequate diagnosis, treatment, supervision or protection from harm worked. Whether because of lack of qualifications to work with children with such histories of prior physical or sexual abuse, or a lack of appropriate training, experience, supervision or correction, the efforts of staff at this facility were simply inadequate to meet the needs of the children involved in the reported incidents of abuse or neglect.

In a number of cases, senior clinicians and administrators displayed an unsettling confusion or lack of understanding of the import of precocious sexual activity, including oral and anal intercourse, which were dismissed as "normal sexual experimentation" or "consensual".

*Mental Hygiene Law §7.29 and §29.29; Title 14 NYCRR Parts 24 and 582; Office of Mental Health Official Policy Manual, Sections QA 510 and QA 515.

Behind such explanations, which appear to have been used by some senior staff to minimize the gravity of some of these incidents, it seems that staff simply lost sight of the reality that these were children exhibiting troubling behaviors and needing treatment and protection.

While a lack of specific training or experience in working with children with such histories of prior abuse and neglect may explain some of this confusion or lack of understanding, the role of the facility as parens patriae ought to have defined their duty. Few parents would passively accept such explanations. Most would become alarmed and seek some effective response. No such sense of alarm was evident at Western New York Children's Psychiatric Center. No external assistance appeared to have been sought. Over time, the facility appeared to minimize conduct it seemed powerless to stop or to deal with. In the end, the children needing protection and help received neither.

In assessing the overall performance of Western New York Children's Psychiatric Center with respect to the children involved in these incidents, many of whom had prior histories of physical and sexual abuse, the conclusion is inescapable that the facility failed in its basic mission as parens patriae to protect these children from harm. It failed, despite abundant knowledge of serious and recurring incidents of sexual abuse and neglect of children that were regularly reported to senior clinicians and administrators at the facility.

In attempting to affix responsibility, it is tempting to look at the multiple failures at every level of the facility hierarchy and conclude that "everyone" was responsible.

- The numerous reports by children -- of direct care staff sleeping on the job, turning off door alarms, cursorily dismissing children's reports of sexual incidents -- and, indeed, the very level of on-going sexual activity among young children indicate grave problems with the adequacy of direct care staff supervision of the children.
- The failure of nurses, physicians, social workers, team leaders and other mid-level staff to respond more vigorously to continual reports of incidents, to examine why these were occurring, to check the adequacy of supervision of the children or to ensure prompt treatment and intervention, deprived the children of the protection to which they were entitled.
- Senior administrative and clinical staff received regular reports of the incidents which occurred, but did not follow through to ensure effective protective, preventive or corrective measures, including appropriate attention to the children through therapeutic intervention.

It is ultimately the director of the facility, however, who creates, embodies and communicates values. Particularly in a small facility like Western New York Children's Psychiatric Center, the director has the opportunity to teach powerfully by example -- by being regularly visible on the wards to children and staff, by actively communicating concern over children who are abused or neglected, by taking aggressive action to remedy inevitable problems that arise in the life of any facility. Such behaviors shape the attitudes, expectations and values which guide the conduct of other staff and eventually inure to the benefit of the children entrusted to their care.

In this instance, although virtually every incident was reported to the director, both in writing and verbally, there is little evidence of active intervention on behalf of the children involved, even in the most serious incidents. There is no evidence of aggressive preventive or corrective actions taken in response to any of the incidents. Indeed, few were taken. While staff were reportedly asked to follow up on aspects of some cases, the Director did not ensure that such follow-up had occurred and, months later, was unsure whether anything was done or what effect staff actions had had.

As the Director presided over this evidently troubled situation, her behavior apparently set the tone for the rest of the senior staff. Sporadic actions were initiated in response to incidents. Cursory investigations were done. Some incident reviews took place. However, no attempt was made to determine the efficacy of these actions or their impact upon the children needing protection and treatment or upon the direct care staff needing guidance and

attention. The recurrence of incidents of sexual activity among the children, sometimes involving the same children, did not cause them to re-examine the manner in which they responded.

In formulating recommendations to the Office of Mental Health, the Commission must begin by addressing the need for stronger qualifications for clinical and administrative leaders of children's psychiatric centers, qualifications which will help ensure vigilant protection of the children entrusted to the care of the State.

RECOMMENDATIONS

1. The Office of Mental Health should review its existing policies and practices regarding the qualifications for directors and senior staff of children's psychiatric facilities, and ensure that the senior management and clinical staff of such facilities have adequate and appropriate education, training and experience in working with children with mental disabilities to warrant entrusting the care of such children in their hands.

2. The Office of Mental Health should immediately review the suitability of the current senior management and clinical staff at Western New York Children's Psychiatric Center to provide the management and clinical leadership needed to achieve significant changes in the values, attitudes and expectations that shape the quality of services and the protection of children at this facility. If necessary, the Office of Mental Health should consider augmenting the senior management of this facility with strong and capable clinical leadership.

3. The Office of Mental Health should convene the directors and senior management and clinical staff of all children's psychiatric centers to review the issues raised by this investigation with a view toward: (a) clarifying basic values that should guide the care, treatment and nurturance of their children; and (b) developing appropriate policies, procedures and training programs for staff of facilities serving mentally ill children. In particular, there is a need to provide guidance to staff on appropriately responding to sexual behavior among children.

4. The Office of Mental Health should require that each state-operated and licensed mental health facility designate a specific official on each shift to be responsible for reviewing all incidents and for making external notification of incidents required to be reported pursuant to law or Office of Mental Health regulations, including notifications to law enforcement officials and the statewide Central Register for Child Abuse and Maltreatment. If reports to the latter are not accepted, Office of Mental Health policy should require direct reporting to the appropriate Office of Mental Health Regional Office and the Commission on Quality of Care for the Mentally Disabled.

5. The Office of Mental Health should take steps to ensure that each of the children's psychiatric facilities has the capability to obtain adequate histories of the children admitted, including histories of prior physical and sexual abuse and neglect, to enable appropriate diagnosis and treatment. If there is a need to augment facility capabilities through the use of consultants with specified areas of expertise, the Office of Mental Health should make provision to obtain such consultants. Quality Assurance staff should periodically monitor clinical records to ensure that such comprehensive assessments are being performed and that children's histories of abuse, neglect or sexual activity are appropriately addressed in their treatment plans.

6. The Office of Mental Health should promptly develop and implement a policy and procedure to assure that any inpatient in a state-operated or licensed mental health facility, who is the subject of a report of sexual activity, is immediately examined by qualified and specially-trained medical personnel. Such personnel should have evidence kits readily available to preserve physical evidence of sexual activity which may be needed in future legal proceedings. The policy should ensure that all such patients receive appropriate follow-up treatment and counseling as needed. In developing this policy and procedure the OMH should consider the applicability of adopting pre-existing guidelines which have been issued by the Department of Health for these purposes.

7. The Office of Mental Health should offer refresher training for senior administrative and clinical personnel of Western New York Children's Psychiatric Center in the reporting, review, investigation, and follow-up of all untoward events occurring at the facility, and particularly of all such untoward events which may have involved sexual contact or sexual activity among children or allegation of staff sexual abuse. This training should ensure that all such personnel are fully informed of:

   - requirements for promptly reporting untoward events on the OMH 147 Incident Report Form;
   - requirements for reporting certain untoward events to the State Central Register;
   - key standards for appropriate facility investigations of untoward events;
   - the appropriate role, responsibilities, and activities of the facility's Incident Review Committee in assessing the possible causes, handling, and investigation of untoward events, and in recommending preventive and corrective actions to prevent such events from recurring; and,
   - the need for diligent management monitoring and oversight of untoward events occurring at the facility.

8. The facility director of Western New York Children's Psychiatric Center should ensure that all children discharged from the facility are afforded comprehensive discharge plans which address their treatment needs and concerns, including their histories of sexual abuse and/or unusual sexual activity with other children or siblings. In conjunction with developing these plans and in ensuring that they will be carried out appropriately, the facility must also ensure that all designated community service providers receive appropriate records and other documentation relating to the child's service needs.

9. The Office of Mental Health should review environmental and physical plant conditions at Western New York Children's Psychiatric Center that impair adequate supervision and monitoring of children at the facility and develop a plan to correct such conditions. In particular, the Office of Mental Health should examine the practice of congregating very young children (ages 5-8) with older children (9-12).

10. Given the seriousness of the events which have transpired at Western New York Children's Psychiatric Center over the past year, the Office of Mental Health should seriously consider assigning an independent clinical monitor in the facility for the coming year to review and critique professional judgements, to evaluate assessments, treatment plans and discharge plans for children, and to oversee the facility's practices for reporting, handling, investigating, and monitoring untoward events occurring at the facility. This monitor should be present at the facility regularly, but should be directly supervised by the Commissioner of the Office of Mental Health or his designee in Central Office.

11. The Office of Mental Health should consider the extent to which its actions in implementing the preceding recommendations should be extended to other state-operated and licensed mental health facilities.

12. The Department of Social Services should amend its existing practices by instituting a procedure to maintain a log of all calls to the State Central Register concerning child abuse and neglect, even if such reports are not accepted. The absence of such a log renders the existing provisions of law, that make it a crime for specified officials and professionals not to report an allegation of child abuse and neglect, practically unenforceable.