BEYOND REPAIR

An Investigation into Serious Abuse and Death
at Northeast Supports and Services Center

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FOREWORD

This is a report about abuse and neglect at one state facility, namely Northeast Supports and Services Center (NESSC) in Ruston, Louisiana. But, in a larger sense, it is a report about the very nature of abuse. It is not the first time the Advocacy Center has issued a report about abuse. Back in December 1996, the Advocacy Center issued a report entitled "Visions of Safety". That report focused on two developmental centers - as they were then known - Pinecrest and Hammond. Here is a quote from the Executive Summary of that report:

> *This report was originally inspired by our concern for the safety and well-being of the residents of Pinecrest and Hammond Developmental Centers, the two largest institutions in Louisiana caring for persons with developmental disabilities. At Pinecrest, a U.S. Department of Justice investigation found "unlawful and unconstitutional conditions" in an environment that is "overly restrictive, not functional and fails to meet the needs of the residents.". . . As for Hammond, during this past year we received numerous complaints about abuse and neglect at that institution.. . .*
>
> *While Pinecrest and Hammond Developmental Centers have received attention from the Justice Department, policy-makers, law-makers and the media during the past year, the problems are not unique to those two institutions. . .*
>
> *After looking at the reality of life for people in Louisiana's current service system we came to the conclusion that individuals with disabilities will never be safe until they have connections to a community, and until they can exercise choice about what services they will have and who will provide them. When this happens they will be treated with respect, rather than as patients to be controlled.*

Unfortunately, abuse and neglect continue to prevail at institutions like Northeast Supports and Services Center – places that were conceived as safe havens where people with severe disabilities would be cared for and treated in a nurturing environment. The overwhelming nature of the abuse at NESSC leads the Advocacy Center to the conclusion that NESSC should be closed down. We do not want to see more investigations, more studies, more experts brought in to "fix" things. We believe that the prevalence of the abuse and the chaotic environment at NESSC makes NESSC beyond repair.

I would like to acknowledge the hard work and dedication of the AC staff who visited NESSC, researched and compiled information, and wrote the report: Barbara Washington-Davidson, Nell Hahn, Concepción Otero, Stephanie Patrick, Miranda Tait, and Sarah Voigt.

Lois Simpson
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INTRODUCTION

This report details the Advocacy Center's investigation into the abuse and neglect of residents at Northeast Supports and Services Center in Ruston, Louisiana (NESSC). The Advocacy Center, whose staff visits facilities like NESSC on a regular basis, was prompted to conduct an investigation after having received numerous reports of serious abuse at NESSC in a relatively short period of time. The Advocacy Center's investigation consisted of: reviewing medical and psychiatric records of the individuals involved, analyzing the investigations performed by other groups, interviewing witnesses and staff, and conferring with other agencies and law enforcement. After reviewing the circumstances surrounding seven cases of serious injury, including a death, the *Advocacy Center has concluded that NESSC is a facility beyond repair – NESSC must be closed in order to avoid further abuse and loss of life.*

ABOUT THE ADVOCACY CENTER

The Advocacy Center (AC) is the federally mandated agency designated to protect and advocate for the rights of individuals with disabilities and seniors in the State of Louisiana. As part of its mission, AC staff regularly visit people with disabilities and seniors in various types of residential facilities: nursing homes; group homes; board and care facilities; developmental centers; mental health hospitals and any other place where people with disabilities and seniors live and receive care and treatment. When abuse and/or neglect is uncovered by these visits, AC staff notify appropriate authorities and monitor the situation, following up with the client and the client's family to insure that justice is done. Sometimes, when the abuse is of an egregious or systemic nature, the Advocacy Center conducts its own investigation, using the authority granted it by federal law to access facilities and residents and to obtain residents' records, internal reports, and reports of investigating agencies.

BACKGROUND ON NESSC

The Louisiana State Department of Health and Hospitals (DHH) operates six "Supports and Services Centers" throughout the state. These are primarily residential facilities that are responsible for the provision of educational, vocational, medical and behavioral services to people with developmental disabilities. The purpose of such a facility is to enable people with disabilities to reach their highest potential and capacity for independent living.

Northeast Supports and Services Center (NESSC), a DHH-run facility, is located in Ruston, Lincoln Parish, Louisiana. It was formerly known as Ruston Developmental Center and Ruston State School. NESSC is responsible for approximately 89 teens and adults with developmental disabilities. Many of the residents of NESSC have been judicially committed by the State of Louisiana and do not reside on the grounds voluntarily. Further, many NESSC residents have been diagnosed with a mental illness or personality disorder along with a developmental disability.

ADVOCACY CENTER INVESTIGATION OF NESSC

Over the past 14 months, the Advocacy Center has investigated seven incidents of death or serious injury to residents at NESSC. After several of these events were reported to the Advocacy Center, a larger investigation into systemic abuse and neglect at NESSC was launched. The incidents investigated included a restraint-related homicide, a stabbing, the assault of a resident by the NESSC administrator, a broken leg left untreated for several days, an assault leading to paralysis, the assault of a resident by staff and the improper discharge of a resident later accused of murder. For each case, investigators used statutory access authority to review medical records, autopsy reports, and investigative reports from the Louisiana Department of Health and Hospitals and NESSC itself. The Advocacy Center staff visited the facility numerous times to interview witnesses and victims and to meet with staff and administration. For the most egregious cases, AC conferred with the Louisiana Attorney General's Office and the Lincoln Parish Sheriff's Office and contacted the Lincoln Parish District Attorney.

The circumstances surrounding each incident point to NESSC's inability to properly care for people with mental and developmental disabilities. NESSC's staff is not equipped to respond to the needs of NESSC residents. Further, several cases revealed that internal safety procedures were not even minimally adequate to protect residents or anyone else on NESSC grounds The cases as a whole exposed **the consistent and complete failure of NESSC to keep residents safe**:

- **from each other;**
- **from themselves and their environment;**
- **from negligence by untrained staff; and**
- **from intentional abuse by staff.**

The following seven instances of abuse were investigated. The names of the victims have been changed to protect their identity.

CASE # 1: "KATIE'S" HOMICIDE

On May 3, 2008, 21-year-old "Katie" died while being restrained by three NESSC staff members. The autopsy report classified her death as a homicide. The Advocacy Center immediately started an investigation into the circumstances surrounding Katie's death.

Eyewitnesses reported that Katie was killed by staff during an improper restraint. Initially, staff reported that Katie "simply passed out" while she was attempting to strike a staff member.[1] Later, one of the staff members recanted her original story and admitted that Katie died while being restrained by staff members. AC has concluded that, whether negligently or criminally, Katie's death was caused by NESSC staff.

How Katie Was Killed

This is a photo of the cottage where Katie lived. She was killed during the restraint in the front yard.

According to the Advocacy Center's investigation and witness statements, Katie was seated outside of the building where she lived when the event occurred. Katie was angry because she had not been allowed to go on an outing. She had refused staff orders to come inside. At this point, according to the eyewitness accounts, staff dumped Katie out of her chair. At some point after being dumped to the ground, but prior to being physically restrained by staff, Katie scratched one of the staff members in the face who yelled, "Bitch, you gonna die for that!"[2] whereupon three staff members subjected Katie to an improper physical restraint. One staff member, who weighed in excess of two hundred pounds, sat on Katie's chest; a second staff member grabbed Katie by the throat; and the third held Katie's legs at chest level.

Several residents of NESSC heard Katie scream, "I can't breathe! I can't breathe!" Rather than release Katie, the improper restraint was continued until she was no longer breathing. When staff realized that Katie was unresponsive, they requested towels to wipe Katie's face instead of beginning CPR. One of the staff members claimed she attempted to call 911 but was unable to do so because the Communication Operator at the switchboard had apparently stepped away from her post to smoke a cigarette. One of the eyewitnesses called 911, while another eyewitness ran to the nursing building for help. It was not until a registered nurse arrived on the scene that CPR was initiated. When the ambulance finally arrived, the paramedics found no

[1] NESSC Narrative Summary.
[2] Louisiana Department of Health and Hospitals, Bureau of Protective Services Investigative Report, OTIS #9443.

pulse and no respiration.[3] At the hospital, Katie was pronounced dead on arrival.

How NESSC Failed Katie

Katie's death was caused by staff who were unprepared or unwilling to properly care for someone with a developmental disability. Properly trained and supervised staff should have been able to prevent just the sort of event that occurred in Katie's case. They should have been thoroughly trained in principles of behavior management, and trained to follow Katie's "Behavior Support Plan," drawn up by a team of healthcare professionals, that described what should be done when Katie became angry, became aggressive, or did not respond to staff instructions. Further, in the event that the recommended de-escalation techniques failed and it seemed Katie was becoming a danger to herself or others, staff should have been trained on proper, non-injuring restraint techniques. Finally, NESSC should have provided an emergency protocol and adequate staffing to respond promptly to the medical emergency brought on by the staff's clearly improper actions.

The Failure to Follow Katie's Behavioral Support Plan

Katie's Behavior Support Plan (BSP) recognized that there were disruptive behaviors attendant to her disabilities. A BSP is a written plan that is developed based on a functional assessment of problem behavior. Behavioral support plans contain multiple intervention strategies designed to modify the environment and teach new skills.[4] Katie's BSP directed staff to avoid unwanted behavior by consistently praising her, by speaking to Katie in a positive tone, and by allowing her to earn "treats" by setting easily achievable goals. On the day of her death, Katie's plan was not followed: Katie died because she did not want to get up out of the chair she was sitting in. Rather than de-escalating, or even simply offering Katie a treat to bring her inside, staff members escalated the situation by dumping Katie out of the chair and then holding her down until she died.

The Improper Use of Restraint[5]

Katie died as a result of a grossly improper restraint. Physical restraint is the application of physical force by one or more individuals that reduces, restricts, or immobilizes the ability of an individual to move his or her arms, legs, or head freely.[6] According to federal law, programs that serve people with developmental disabilities, like NESSC, are prohibited from using physical restraint unless it is absolutely necessary to ensure the physical safety of the individual restrained or others.[7] Once the physical danger passes, the restraint must cease.[8] Restraint should only be employed when all other de-escalation techniques or less restrictive interventions have failed.[9]

[3] Ambulance Run Report.
[4] Research, Rehabilitation and Training Center on Positive Behavior Supports, "Positive Behavior Support Glossary", May 30, 2009, http://rrtcpbs.fmhi.usf.edu/rrtcpbsweb/glossary.htm.
[5] It is an Advocacy Center priority to prevent the unnecessary use of restraint and seclusion on people with disabilities.
[6] Child Welfare League of America (2004) CWLA Standards for Excellence for Residential Services, Revised Edition. Washington, DC: Author.
[7] 42 U.S.C. §15009(a)(3)(B)(iii), 42 C.F.R. §483.450(d)(1)(ii).
[8] 42 C.F.R. §483.450(d)(4).
[9] 42 C.F.R. §483.450(b)(1)(iii).

At no time is a restraint to be used to discipline, coerce or as retaliation.[10] Further, if a restraint must be employed, it can only be employed by staff trained in proper restraint technique.[11] The “restraint” used against Katie could not be farther from what is legally permissible.

The circumstances of Katie’s death are so egregious, it is questionable whether or not staff were even briefly trained in appropriate restraint techniques. As discussed above, staff attempted no de-escalation of behavior and tried no other method to convince Katie to obey their command to come inside. Further, at no time was Katie a danger to herself or to those around her. In fact, one eyewitness stated that Katie was sitting quietly in the chair until she was told to get out of the chair.

Not only was the restraint unnecessary, it was executed improperly. Facilities are required to train their employees in safe, recognized methods of physical restraint. According to the Government Accountability Office, “restraint or seclusion can be dangerous to individuals in treatment settings because restraining them can involve physical struggling, pressure on the chest, or other interruptions in breathing.”[12] Restraining someone by having a person sit on the individual’s chest, while another holds the person’s throat, and a third person holds the individual’s legs up at chest level, is not a recognized restraint method.

The Failure to Respond to An Emergency

It is unclear whether or not prompt help could have saved Katie’s life. However, the lack of appropriate staffing and emergency protocol ended that possibility and sealed Katie’s fate. Instead of beginning CPR, the staff present at Katie’s death panicked and toweled off her face; then, no 911 call could be made because the sole employee responsible for telephone communication was away from her desk. A resident had to run across campus to locate a registered nurse able to administer CPR.

The Cover-up

Despite the fact that Katie’s cause of death is clear - she died as a result of a physical restraint and her death was classified a homicide by the coroner[13] - her death has never been properly addressed by NESSC or by the Department of Health and Hospitals. In a December 2008 letter to the NESSC administrator, the Advocacy Center documented the numerous failures that led to Katie’s death and demanded a review of NESSC’s restraint trainings along with corrective measures for the emergency protocol. AC also pointed out NESSC staff’s consistent failure to follow resident BSPs to prevent symptomatic behavior. Since then, NESSC has refused to respond to any of AC’s requests regarding Katie or the circumstances that led to her death. They cite an ongoing investigation by the Louisiana Attorney General and Lincoln Parish District Attorney. These offices have yet to take action.

[10] 31 La. Register §31303(A)(1-3).
[11] 31 La. Register §31303(E)(3)(vi).
[12] GAO/HEHS-99-176, Improper Restraint or Seclusion Procedures Places People at Risk (Sept. 1999), http://www.gao.gov/archive/1999/he99176.pdf.
[13] The Lincoln Parish Coroner listed the cause of death as “Restraint and Compression Asphyxia during Physical Altercation.” The manner of death is classified as a homicide. (Boykin Autopsy Report, Case No. LA 252-08, May 4, 2008)

A representative of NESSC confirmed to the Advocacy Center that the three staff members who restrained Katie, failed to administer CPR, and subsequently lied about the incident, were not fired. They were allowed to resign voluntarily. The individuals involved in Katie's death may be working with other vulnerable people right now. In fact, one employee's letter of resignation said she was accepting a position at another facility.[14] In addition, one of the eyewitnesses to Katie's death, a NESSC resident, told AC that one of the same former staff members frequently visits the NESSC campus to see a relative employed there. The residents who were eyewitnesses to Katie's death, and who described what they saw to AC and other investigators, fear retaliation from this former staff member, yet nothing has been done to prevent her continued presence at NESSC. The Advocacy Center has contacted the Louisiana Attorney General's Office, the Lincoln Parish District Attorney's Office and the Lincoln Parish Sheriff. Despite the fact that it has been more than a year since Katie's death, no charges have been filed against any of the three staff members who were involved in Katie's death.

[14] This information was not included in the records NESSC produced to Advocacy Center. This is according to a licensing report for the Department of Health and Human Services, Centers for Medicare and Medicaid Services. 08/13/2008.

CASE #2: "MOLLY'S" INJURY

"Molly" was hospitalized for a fractured leg that had gone untreated for at least four days. Medical attention was not sought until Molly slumped over in her wheelchair, her leg swollen several times beyond its normal size. It was only at that point that the responding nurse left a message for the doctor and Molly was taken to the emergency room – at least four days after her injury.

Before finally being hospitalized, Molly complained of pain and exhibited an extreme change in behavior. Still, staff ignored her. Molly was a resident that staff considered annoying – she was always crying and needy for attention from staff. To the extent NESSC staff was responsive to the needs of any resident, they were less so to Molly because of this perception. As a result, a fractured leg went untreated for days before NESSC staff took notice. According to the advocate, Molly now uses a wheelchair and is unlikely to be able to walk again.

How Molly Was Injured

While at a NESSC meeting, Advocacy Center staff discovered that Molly had been hospitalized for a spiral leg fracture. The AC staff member spoke to Molly after the meeting and was told by Molly that she had fallen in the bathroom and that when she called for help she was told by staff to get up or to just lay there. Molly said that she had to wait until another resident helped her up off the floor. The advocate found this strange, as Molly was known to be weak and unsteady on her feet. Staff were well aware of Molly's weakness and were required to provide constant supervision to prevent falls – especially in the bathroom.

How NESSC Failed Molly

Staff Ignored Molly's Injury

It is important to note that although Molly required supervision to prevent falls, AC's advocate observed that Molly was able to walk with some assistance. However, at some point shortly before her hospitalization and without documented explanation, Molly required a wheelchair. A review of Molly's "Chronological Record of Medical Care" revealed documentation by the staff nurse of:

- **complaints of leg pain, April 10, 2008;**
- **right knee swelling with pain, April 11, 2008;**
- **Molly asked the nurse to assess her right leg because it was swollen, April 13, 2008;**
- **it was not until April 14th that emergency treatment was sought when Molly's leg was swollen from groin to toes and a large bruise on her inner right thigh was discovered.**

Four painful days passed between Molly's first documented complaint and her trip to the ER. At the emergency room, Molly was diagnosed with a femoral spiral fracture and surgery was required to implant a rod into her right leg.

When questioned, NESSC staff could not tell AC's advocate how or when the injury occurred. It was clear to the advocate that the injury could have been prevented or at least treated earlier. In the past, the advocate had observed staff ignore Molly. Staff also characterized Molly as whiney and "overly dramatic." In an effort to uncover when the accident occurred and why it went untreated, AC looked more closely at Molly's records.

Staff Ignored Molly's Behavior

Along with many other NESSC residents, Molly exhibited certain behaviors associated with her disabilities. She is described as being "disruptive" and her behavior is documented on "Antecedent-Behavior-Consequence" or "ABC" sheets. These ABC sheets are typically intended to be therapeutic - to assess behavior and identify the causes of disruptions.[15] In other words, ABCs are not simply punitive measures or recordkeeping paperwork; they are teaching devices and important indicators of the mental and physical health of people who may not be able to verbalize what is wrong with them or otherwise control their behavior.

The Advocacy Center reviewed Molly's ABCs from January 1, 2008 to her hospitalization on April 14, 2008. Her records revealed that not only did nursing staff ignore Molly's complaints of pain and her visible symptoms, but staff also failed to notice a shocking change in Molly's behavior in the days prior to her hospitalization. In January, February and March, Molly received 60 ABC's for acting out – about 20 disruptive behaviors per month. In the mere *week* before her hospitalization, Molly received a startling 42 ABCs – almost *ten times* more than any prior week. This is a clear sign that something is wrong. Even more disturbing, many of these citations were for crying "for no reason." [16]

The Advocacy Center concluded that NESSC staff failed Molly twice: 1) they failed to ensure the physical safety of a resident who clearly required assistance walking; and 2) they ignored her complaints and the striking change in her behavior after she was seriously injured. Molly now resides at another facility that is accessible to people in wheelchairs and is very happy that she does not have to return to NESSC.

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[15] Dennis C. Russo, Erin Dunn, Gary Pace and Alex Robin Codding, "Pediatric Brain Injury," in John W. Jacobson, James A. Mulick and Johannes Rojahn, eds., *Handbook of Intellectual and Developmental Disabilities* (New York: Springer, 2007) 103-105.

[16] Molly was written up for "crying for no reason" a little over once per month before April. In the week before her hospitalization, she received six times that amount.

CASE #3: "MELISSA'S" STABBING

"Melissa" was stabbed in the head with a pair of scissors as she waited for her medication on the morning of August 5, 2008. The scissors had been left unattended and easily accessible to another resident, "Cindy," who was angry with Melissa. With even minimal attention, staff could have prevented the incident.

How Melissa Was Injured

According to the investigation completed by DHH, when another resident, Cindy, woke up on August 5, 2008, she was angry – she immediately began complaining to a NESSC aide about Melissa, another resident in the home. According to witnesses, Cindy was furious with Melissa for pouring milk on her the day before. She refused to take her medication and continued to complain to the staff member. In a serious lapse of judgment, the aide ignored Cindy, a resident with a history of assault, and told her to stop talking about the incident. Cindy then simply walked up to an unlocked, unmonitored medical cabinet, retrieved a pair of suture scissors and stabbed Melissa in the head with them. Melissa received two staples to close the wound in her head; Cindy was arrested by the Lincoln Parish Sheriff's Department and taken to jail. These are results that could have been completely avoided with properly-trained, attentive staff.

How NESSC Failed Melissa

Staff Failed to Keep Melissa Safe from Dangerous Behavior

Cindy was known to be aggressive toward her peers; verbal and physical aggression are symptoms of her disability. A Behavior Support Plan was developed by Cindy's doctors to help Cindy avoid triggers to aggressive behavior. Specifically, staff was directed not to ignore Cindy when Cindy wanted to talk about a distressing situation. The plan called for staff to be aware of recent conflicts with peers (a common trigger for Cindy) and to encourage Cindy to discuss things or people who are bothering her. Before Melissa was stabbed, and in direct opposition to the directives of Cindy's doctors, staff refused to talk to Cindy about her conflict with Melissa. Indeed, in statements to investigators, the staff member made no mention of Cindy's behavior plan.[17]

Further research into licensing reports made for the Department of Health and Human Services indicate NESSC could have prevented this incident well before the events of August 5, 2008. NESSC was placed on notice regarding Cindy's proclivities and need for enhanced supervision from the time she entered the facility.[18] In the past year, Cindy had threatened to kill several people, hit someone in the head with a lamp and was restrained twelve times for aggression.[19] Just two months before she stabbed Melissa, Cindy grabbed a sharp knife from the kitchen where it lay unattended and ran off with it, intending to attack a staff member. A month before the stabbing, Cindy was admitted to a psychiatric crisis center for homicidal ideation. A letter from

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[17] BPS Investigative Report, OTIS # 11301.

[18] Department of Health and Human Services, Centers For Medicare & Medicaid Services, Statement of Deficiencies and Plan of Correction, 08/13/2008.

[19] Department of Health and Human Services, Centers For Medicare & Medicaid Services, Statement of Deficiencies and Plan of Correction, 08/13/2008.

her treating psychiatrist to NESSC administrator warned that Cindy made a plan to kill and was physically and intellectually capable of carrying it out. Despite this warning and numerous violent incidents, her level of supervision was not increased. In fact, after her discharge from the crisis center, a month before Melissa's stabbing, NESSC moved Cindy from a residential placement with only three other residents, to a placement with eleven others. This made it even more difficult to supervise Cindy and to protect the other residents.

Staff Failed to Keep Melissa Safe from Dangerous Objects

Advocacy Center did not have to point out to NESSC administration that people with self-injurious and aggressive behavior should not have access to scissors; NESSC did take some action to tighten the procedures for medical storage by requiring that medicine cabinets be locked and staff not leave scissors unattended. NESSC apparently considered these basic changes to be sufficient. NESSC found no neglect on the part of staff. Once again, residents were injured because NESSC failed to provide properly trained or qualified staff.

Since being attacked, Melissa has expressed fear of the very real possibility that Cindy will return to NESSC after she is released from jail; she has nightmares about the stabbing and has tried to kill or hurt herself several times, by swallowing a tack and tying shoe-strings around her neck. As for Cindy, she probably will return to NESSC. NESSC has a program for recently incarcerated residents. The policies of that program state that Cindy will be housed apart from the rest of the residents until she is no longer a threat. However, the Advocacy Center has no confidence that NESSC will staff this program appropriately and keep Melissa safe. Neither does Melissa.

CASE # 4: ATTACK ON "JAKE" BY NESSC ADMINISTRATOR

How Jake Was Injured

At approximately 8:30 a.m. on January 18, 2009, "Jake," a person with severe disabilities, was attacked by NESSC's administrator, Fred Williford. Jake told the Advocacy Center's advocate that he had gone to the administrator's home on the NESSC campus to report that a staff member had hit him. He stated that Williford walked outside and yelled for him to get away from his house.[20] Jake continued to try and report what had happened to him when Williford pushed him, told him to "shut the f--k up," and to get away from his house. Angry, Jake picked up a stick and hit the windshield of Williford's truck, cracking the windshield. In response, Williford grabbed Jake, hit him, choked him, then threw him down and dragged him along the ground. Four staff members and a passerby witnessed the altercation. The passerby was so appalled by what she observed that she later reported the incident to the Department of Health and Hospitals Abuse Hotline. Apparently, staff members made no report and did nothing to help Jake.

After the attack, Jake reported an injury to his right knee and reported not being able to hear out of his left ear.[21] At a meeting with Advocacy Center staff months later, Jake reported that he still had problems with his right knee. In addition, a staff member reported to AC's advocate that she had never seen Jake as afraid as he was after the incident.

AC launched an investigation. The incident as reported by NESSC varies: the attack on Jake is either not mentioned at all or is described as a "physical restraint" resulting from Jake's aggressive behavior.[22] The Sheriff and District Attorney saw things differently - Williford was arrested on March 13th, 2009 and charged with cruelty to the infirm.

How NESSC Failed Jake

That NESSC failed to keep Jake safe in this instance is obvious – the representative of NESSC himself attacked Jake. NESSC staff further failed by not reporting the incident, making it clear to Jake and the rest of the residents that abuse by staff was acceptable.

Williford is no longer the administrator of NESSC- whether he resigned or was fired is not clear. AC spoke to a clerk with the Lincoln Parish Criminal Court, as well as to the Lincoln Parish Sheriff's Department, and was told that Williford's arraignment has been set for June 16, 2009.

[20] The Administrator position at NESSC includes the option of living in a private residence on NESSC grounds.
[21] NESSC-OCDD Accident/Incident Report Data Form #127.
[22] NESSC Memorandum dated 1/18/09.

CASE # 5: NESSC ABANDONS "TOMMY"

How Tommy Was Abandoned

"Tommy" was taken into state custody when he was an infant due to abuse and neglect by his mother. Tommy's mother is believed to have used drugs throughout her pregnancy. Tommy exhibited serious problems by age two. By the age of 23, he had lived in over twenty hospitals and group homes, with an occasional night or week in the local jail. Throughout this time, Tommy received various diagnoses including mental retardation, explosive personality disorder, hyperactivity and seizure disorder. Due to his disabilities, Tommy has never successfully functioned outside of an institution and has been in state custody for his entire life.

How NESSC Failed Tommy

Despite the fact that Tommy had grown up in state custody, in 2008 the Office for Citizens with Developmental Disabilities found that Tommy no longer qualified for state services. NESSC decided to discharge Tommy to live in the community. NESSC acknowledged that Tommy was not a good candidate for community living because of the complete lack of support services for him outside of the institution. It was clear to everyone who knew Tommy that he lacked the skills necessary to make it on his own; indeed, years of state custody had not prepared him to care for himself. Further, Tommy had nowhere to go but back with family members. Despite all of this, Tommy was discharged. Within a few months of being discharged, AC's client advocate learned that Tommy "fell into the wrong crowd." He is now incarcerated and accused of murder.

NESSC failed to teach Tommy how to live independently, failed to treat his mental illness, and failed to implement a plan for him to get appropriate services and treatment on discharge. After a lifetime of institutionalized care, Tommy was helpless on his own. He lacked any independent living skills and was particularly vulnerable to negative social influences. NESSC abandoned him to a world in which he was simply unable to cope.

CASE # 6: "JIMMY'S" ATTACK LEADING TO PARALYSIS

As a direct result of a vicious attack by another resident, "Jimmy" was paralyzed from the chest down. Although one NESSC staff person was present when the assault began and ultimately physically removed the perpetrator from Jimmy's bloody immobile body, witnesses' descriptions of the incident to AC indicated that he did not react quickly enough. Again, the incident should have been prevented by proper staffing, appropriate behavioral monitoring, and adherence to residents' behavior support plans.

How Jimmy Was Injured

On March 25, 2008, Jimmy was attacked by another resident – a resident known to be violent. In fact, this same resident had just attacked someone else several days before the assault on Jimmy. Despite this, the one staff member present at the time of the assault was in charge of numerous residents and was not closely supervising anyone.[23] The attacker was able to chase Jimmy out of the building, across the yard and into the shed, beating him all the while. Jimmy was found slumped on the floor with the resident sitting on top of him continuing the beating. Only then did the staff member pull Jimmy's attacker away. By that time, Jimmy had been permanently paralyzed by a spinal cord injury.

How NESSC Failed Jimmy

Residents stated that the staff initially sat and watched because staff felt that Jimmy deserved to be beaten. According to the client advocate, it is common knowledge that staff members allow the residents that they do not like to be "beaten up" as punishment. As a result of his injuries, Jimmy now lives in a nursing home. The attacker was arrested by the Lincoln Parish Sheriff's Office and is still incarcerated.

Jimmy was chased out of this room by his attacker.

[23] According to a licensing report in which NESSC was cited for one of many failures to keep residents safe. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Statement of Deficiencies and Plan of Correction, 08/13/2008.

CASE # 7: JOEY'S ATTACK

Attorneys from the Investigations Unit went to NESSC on May 8, 2009 in order to review documents and meet with clients. While there, they met with Joey. Joey presented as a well-dressed and very friendly young man. Joey wanted to speak with Advocacy Center staff about an incident that had occurred the week before. Joey said he had been attacked by staff and NESSC had yet to respond to his complaint.

How Joey Was Attacked

Joey told investigators that the previous week he was kneed in the head by a staff person after an argument about a cigarette. Joey claimed that the staff person had taken Joey to the ground from a standing position, slamming his head into the concrete with his knee. Joey showed AC an injury that a week later was still very severe. Joey's eyelid was stitched, and the white of his eye still bloodied.

How NESSC Failed Joey

Joey explained that after the injury he was very upset; blood was streaming down from his eye to his face, neck and shirt. He wanted to see the administrator of NESSC[24] in order to make a complaint against the staff person who had assaulted him. He sat down outside the administrator's office in order to calm down or "de-escalate". When the door opened, he went inside and the door locked behind him, locking him in the conference room with two other administrative staff. Joey said two staff persons then approached him very closely. Joey felt threatened and "head butted" both men in an attempt to get away. He was then pushed down on the ground and restrained. After the restraint, Joey was taken to the hospital for his prior injuries. At the time of meeting with Joey, the Bureau of Protective Services had not been alerted to Joey's allegation of assault or his major injury. This matter is still being investigated by the Advocacy Center.

[24] At that time the temporary administrator of NESSC was David Gil.

THE OTHER COSTS OF NESSC

The incidents of abuse detailed in this report speak to the cost paid by some of the unfortunate residents of an institution like NESSC. But the State of Louisiana, and thereby all of us, also paid for the substandard care provided by NESSC to a vulnerable population. Despite proving over and over again that it was not qualified for the job of caring for individuals with developmental disabilities, NESSC was paid and continues to be paid. For the fiscal year of 2007-2008, NESSC cost Louisiana $13,240,097.00.[25] Its existing operating budget is $14,653,010.00 and NESSC has requested a budget of $14,726,742.00 for 2009-2010.[26] This report reveals a sampling of what Louisiana is getting for its money. The Advocacy Center believes that Louisiana can do better than this.

The Advocacy Center supports the nationwide trend to move people with disabilities out of institutions like NESSC and into community settings that can provide them with better care. The move from institution to the community is simultaneously less expensive for the government and more therapeutic to the residents. Research shows "evidence of enhanced quality of life" as well as "a significant decrease in the average public dollars spent to support the participants."[27] The trend has been so positive that the population of developmental centers nationwide is falling; in fact, many states do not even have developmental centers.[28] States have found that moving people from institutions to community homes to be "excellent social policy that benefited thousands of people."[29]

Louisiana has the fourth highest percentage of people in institutions per capita in the nation.[30] Even though the number of people in institutions is decreasing in Louisiana, it is doing so at a rate significantly lower than those in other states.[31] This means that Louisiana developmental centers, including NESSC, are not opting for transition to community homes - the cheaper alternative with the higher quality of life for participants. Instead, they are doling out substandard care at best and abuse and neglect at worse and, at a higher cost - the only beneficiaries are the institution and its employees.

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[25] Louisiana Department of Health and Hospitals, Executive Budget Supporting Document [FY 2009-2010].
[26] Id.
[27] Conroy, J. Fullerton, A., Brown, M., & Garrow, J. (2002, December). *Outcomes of the Robert Wood Johnson Foundation's National Initiative on Self-Determination for Persons with Developmental Disabilities: Final Report on 3 Years of Research and Analysis*. Narberth, PA: Center for Outcome Analysis.
[28] Prouty, R., Smith, G. and Lakin, K.C. (eds.) (2007). *Residential Services for People with Developmental Disabilities: Status and Trends Though 2006.* Minneapolis: University of Minnesota, Research and Training Center on Community Living.
[29] Center for Outcome Analysis (2001, July). *Eight Years Later: The Lives of People Who Moved From Institutions to Communities in California. Year 2001 Report of the Quality of Life Evaluation of People with Developmental Disabilities Moving from Developmental Centers into the Community (The "Quality Tracking Project").* Final Report (Year 2) submitted to The Honorable Gray Davis, Governor, State of California, California Legislature. Narberth, PA: Center for Outcome Analysis.
[30] Prouty, R., Smith, G. and Lakin, K.C. (eds.) (2007). *Residential Services for People with Developmental Disabilities: Status and Trends Though 2006.* Minneapolis: University of Minnesota, Research and Training Center on Community Living.
[31] *Id.*

RECOMMENDATIONS

Louisiana has a total of six developmental centers located throughout the state. While the Advocacy Center is advocating for the closure of NESSC, steps must be taken to insure the health and safety of the residents in the remaining five state operated institutions. At a minimum, the Department of Health and Hospitals, Office for Citizens with Developmental Disabilities should be required to:

Close NESSC – despite the millions of dollars paid to NESSC to care for its vulnerable population, overwhelming abuse and neglect point to a facility that is beyond repair

- Staff unable/unwilling to properly respond to the needs of residents they were hired to serve
- Administrator failed in his duty of leadership and supervision
- Residents fearful and powerless due to the unsafe environment created by staff and administration

Develop and maintain independent interdisciplinary teams of monitors to ensure the safety and well-being of residents at each developmental center

- Teams to be jointly chosen by OCDD, the Advocacy Center, and other advocacy groups such as the DD Council, the University Center for Excellence in Developmental Disabilities
- Teams would be required to have an expert in best practices for individuals with developmental disabilities residing in intermediate care facilities
- Teams would be required to produce quarterly reports regarding conditions at the centers, resident complaints, instances of abuse and neglect, number of restraints and reasons, review staff trainings and manuals, etc. and make recommendations
- Teams to release observations and accompanying recommendations to the Advocacy Center, DHH, OCDD, and other agencies
- DHH-OCDD required to develop and implement next steps to ensure the health and safety of residents through quality services and medical care

Report all deaths and serious injuries resulting from restraint and/or seclusion to the Advocacy Center and other designated agencies within five days

Develop and maintain a team of independent medical experts from the private sector to examine all deaths at developmental centers statewide

- Team to be jointly chosen by OCDD, the Advocacy Center, and other advocacy groups such as the DD Council, the University Center for Excellence in Developmental Disabilities

- Team to include forensic pathologists, doctors, and nurses
- Team to design protocol for determining when an autopsy is required
- Team to render findings regarding the adequacy of medical care and treatment
- Team to render report to the Advocacy Center, DHH, OCDD, and other agencies

DHH and OCDD required to report to the Advocacy Center and other identified agencies on next steps and/or steps taken as a result of the recommendations made by the individual teams

- Ensures continued monitoring of system by outside agencies
- Ensures accountability

Expand community-based system of services

- Increase funding to improve and enhance waiver services so that individuals capable of transitioning can receive services in the community
- Monitor providers to ensure services meet the needs of those individuals living in the community

CONCLUSION

NESSC's failures are so serious, widespread, and constant as to indicate that the facility is beyond rehabilitation. Despite the millions of dollars it is paid each year, NESSC has proven that it is consistently unable to provide adequate care to its charges. An ill-equipped staff unable and/or unwilling to respond to the needs of individuals with developmental disabilities has been allowed to abuse and neglect a vulnerable population without even the most minimal safety procedures in place. *NESSC should be closed* and the funding redirected to a source that can adequately address the needs of the people currently at NESSC as well as all people with disabilities in Louisiana.

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APPENDIX - THE NATURE OF ABUSE

Abuse is a crime committed by a stronger person against a weaker person. Whether the strength is physical, mental, or due to authority and resources, it makes abuse possible.

Certain kinds of people are likely to be abused: children, seniors, people with disabilities. The law recognizes this truth by establishing protective services for these groups of vulnerable people.

The perpetrator of abuse, especially one who is a caregiver, may believe that he or she has done nothing wrong. Abuse is excused by re-naming it "discipline" or "control" or "teaching."

Often the abuser has a relationship of responsibility (which may be perceived as ownership) to the victim. Sometimes the abuser sees the victim as guilty of wrongdoing, that is, deserving of punishment.

People who are isolated are more likely than others to be abused. Most abusers do not like audiences.

Sometimes abuse is hidden from the rest of the world, but those behind the closed doors may know the abuse is occurring. Sometimes they keep silent about the abuse. They may be silent because of fear for their own personal safety or job security, or because they believe the abuse is acceptable or necessary.

Threats and intimidation are so common in child abuse that they are the rule rather than the exception. The abuse itself instills fear; the abuser threatens worse things to come if the victim tells what has happened. Of course, if the victim cannot speak – as is true for some people with disabilities – the abuser can count on silence.

Children are more likely to be abused by parents, step-parents, or other adults with responsibility for their care. The same is true for elderly persons and individuals with disabilities; most often, if they are abused, the perpetrators are their caregivers. "Care-givers" include persons paid to provide services, as well as family members."

Of course most family members and other caregivers would never abuse anyone. And, some instances of abuse are committed by people with no care-giving responsibilities for the victims.

In a residential facility, the staff are stronger than the residents. They may not in all cases be physically stronger, but they do in all cases have more power and authority.

Institutions have closed doors. Rarely does anyone, except staff and other residents, have opportunity to abuse residents or to witness abuse.

Direct care staff in an institution, charged with control of a group of residents, may abuse a resident who is perceived to be "out of control." The abuse may be called "discipline" or something similar. Other staff who know about the abuse may approve it, or at least excuse it as "necessary." The same staff may believe it wrong to abuse a resident who is "well behaved."

We have imagined that the purpose of institutions is to protect people. The reality is that the purpose of institutions is to control people. This is reality because this is the understanding of the staff on a basic, everyday level: if the residents are out of control, staff are in trouble. The emphasis on control and conformity in congregate settings facilitates management of groups of people but necessitates oppression of individual expression and uniqueness and fosters abuse.

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