Commonwealth of Massachusetts

Disabled Persons Protection Commission

FISCAL YEAR 2013

DPPC ANNUAL REPORT

DPPC Mission Statement

"To protect adults with disabilities from the abusive acts or omissions of their caregivers through investigation, oversight, public awareness and prevention"

Report suspected abuse of persons with disabilities to the DPPC 24-Hour Hotline

1-800-426-9009 VOICE

1-888-822-0350 TTY

Inside the Report:

DPPC
300 Granite Street, Suite 404
Braintree, MA 02184
Phone: 617-727-6465
Fax: 617-727-6469
Web: http://www.mass.gov/dppc
Hotline: 800-426-9009 Voice
888-822-0350 TTY

Disabled Persons Protection Commission Staff and State Police Detective Unit

A Message from Nancy A. Alterio, DPPC Executive Director

Dear Reader:

This annual report is intended to inform you of the work and milestones of the Disabled Persons Protection Commission (DPPC). Created by the Legislature in 1987 under M.G.L. c 19C, DPPC is charged with protecting adults with disabilities from the abusive acts and omissions of their caregivers through investigation, oversight, public awareness and prevention. DPPC is in the business of saving lives of persons with disabilities throughout the Commonwealth who are victims of abuse.

Unfortunately, persons with disabilities are particularly vulnerable to abuse and victimization. Tens of thousands of stories of victimization have been reported to DPPC. DPPC cases are often highly complex and challenging, and the services needed to assist victims of abuse are not always readily available. However persons with disabilities who are victims of abuse and neglect deserve a timely and effective response to minimize their trauma, identify necessary protective services and to be provided with the opportunity to live a life free from abuse. These victims are real and they are often people who would not escape the abuse without the interventions of DPPC and our many partners.

Historically, DPPC has confronted the challenge of doing more with less. The Commonwealth's ongoing fiscal challenges have resulted in decreases in DPPC staff and resources, while at the same time DPPC has experienced unprecedented increases in its caseloads. DPPC began fiscal years 2010 and 2011 with reductions in funding. To address the reductions, DPPC reduced its workforce from 32.27 to 28 staff. DPPC's budget and resources were further reduced in fiscal year 2013 requiring an additional layoff and further reducing DPPC's staffing to 27.4.

In an effort to ensure fiscal as well as mission responsibility, DPPC has continually restructured, consolidated and eliminated functions to allow for the continued protection of victims with disabilities. The dedicated staff of DPPC, in partnership with the investigative staff of the Department of Developmental Services (DDS), the Department of Mental Health (DMH) and the Massachusetts Rehabilitation Commission (MRC), persevered the unparalleled challenges throughout fiscal year 2013 and

- Responded to over 14,000 hotline calls;
- Completed 7,986 abuse reports, 5,353 informational and referral calls and 764 death reports;
- Assigned almost 2,500 investigations;
- Completed over 1,700 investigations;
- Completed 213 petitions for review;
- Responded to 350 record requests and/or record demands;
- Oversaw protective services to over 2,000 individuals with disabilities;
- Trained 889 direct care staff, 392 medical personnel, 255 educators, 869 law enforcement; and
- Maintained operations 24 hours a day, seven days a week.

Staff's commitment to DPPC cases is apparent and noteworthy. Their devoted effort is truly making a difference in the lives of victims with disabilities.

I encourage you to take the time to review DPPC's Annual Report for Fiscal Year 2013 as it will provide you with more information about the activities of the staff involved in protecting persons with disabilities from abuse and neglect.

Sincerely,

Nancy A. Alterio

Nancy A. Alterio
Executive Director

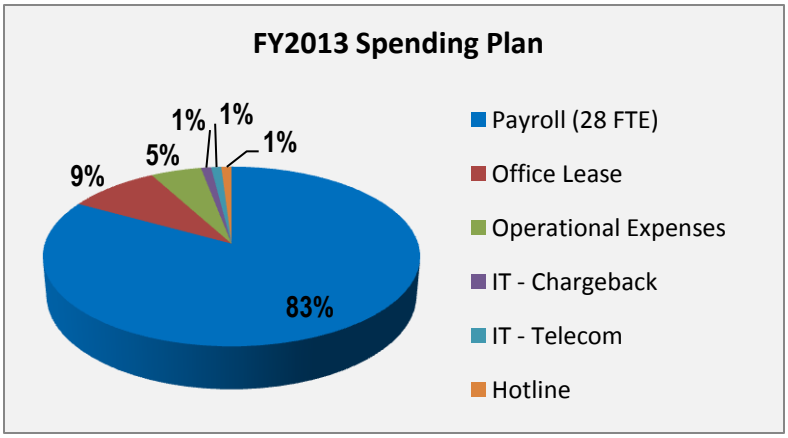
Administration and Finance

A&F Unit from left: Nancy Alterio (Executive Director), Audrey Drinan, John Brown (Manager) and Jennifer Edwards-Hawkins

The DPPC's Administration and Finance (A&F) Unit is primarily responsible for increasing the efficiency of office operations, thereby enhancing its delivery of services while ensuring a high level of transparency and accountability throughout the agency's financial operations.

DPPC develops and submits annual budgets and spending plans to the Governor's Office and Legislature to allow DPPC to provide an adequate level of services to receive reports, investigate abuse of persons with disabilities and to ensure the provision of protective services. To ensure fiscal accountability, monthly and annual fiscal reports are generated, reconciled and provided internally for the Executive Director and Commissioners.

A system of checks and balances is in place for internal control and fraud prevention purposes. DPPC's Internal Control Plan (ICP) identifies risks of fraud and addresses ways in which to mitigate those risks. The plan is reviewed at least annually and more often as operations change or other risks are identified during the course of conducting business. Upon initial completion and approval, DPPC's ICP was used by the Office of the State Comptroller as a template for other agencies seeking guidance.



Staff payroll and personnel matters are also managed within the A&F Unit. Mandatory staff enhancement in-services and training programs are provided for staff's professional and personal development. Annual in-services include diversity training, disability awareness, time and stress management, team-building exercises and other informative Human Resources Division (HRD) sponsored topics which may include insurance, retirement or general benefits information.

DPPC has proven time and time again that it is an effective and efficient organization. Every dollar received is greatly appreciated, every dollar helps in the protection of persons with disabilities who are victims of abuse and neglect and every dollar helps to **save lives**. As reflected in the pie chart above, 92% of DPPC's appropriation is dedicated to staffing and lease space. Another 5% is designated to operational expenses such as technology supports, staff travel, copier lease and maintenance agreements, postage and office supplies with 3% remaining to cover the costs of DPPC's 24 hour hotline, telephone system and ITD chargeback.

DPPC Hotline

The Disabled Persons Protection Commission (DPPC) operates a 24-hour Hotline to which citizens of the Commonwealth can report incidents of suspected abuse involving adults with disabilities by dialing 1-800-426-9009 (voice) or 1-888-822-0350 (TTY). Mandated reporters must also file a written report within 48 hours of the oral report. Deaths are also reported to DPPC's Hotline.

Intake Unit from left: Heidi Cresta (Manager), Greg Bolger, Berkys Kazimierczak and Ann Murray (Manager). (Julie Walden not pictured)

The DPPC Hotline and the Intake/Oversight Unit staff who operate it are a vital part of the DPPC's efforts to protect adults with disabilities who are dependent upon others from abuse and neglect.

Three DPPC Intake Operators staff the Hotline between 9:00 a.m. and 5:00 p.m. on business days. An after-hours vendor contracted, trained and monitored by DPPC staff, answers the Hotline after 5:00 p.m. and before 9:00 a.m. on business days. The vendor also answers the Hotline on weekends and holidays. During the time that the after-hours vendor answers the Hotline, there are DPPC staff members readily available to manage emergency or complicated situations. Bilingual (Spanish – English) Intake Operators are available to take abuse reports, and all staff members are trained to communicate via TTY and to utilize Verizon's Telecommunication Relay Service.

Staff members working on the DPPC Hotline are responsible for receiving, documenting and evaluating information provided by reporters. DPPC management reviews each report of abuse to determine the response needed to ensure the safety of the individuals involved. Reports are also evaluated to determine whether the situation meets the statutory criteria that establish jurisdiction under M.G.L. c. 19C.

In order for DPPC to investigate abuse committed against persons with disabilities, the statute requires that the victim of the alleged abuse must be:

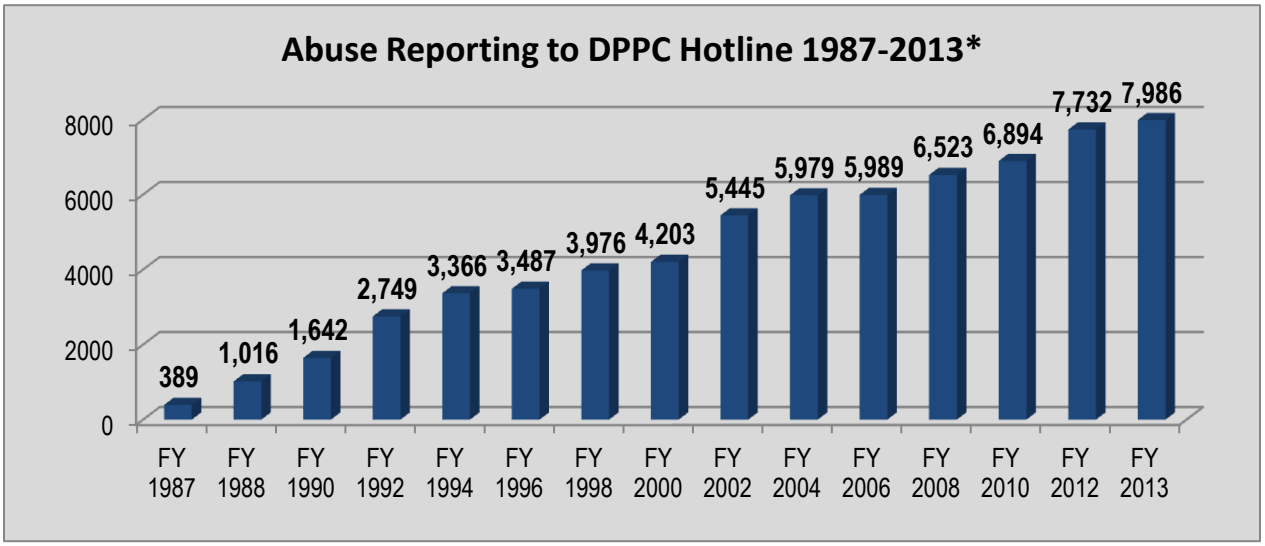
- Between the ages of 18 and 59 years;
- Disabled by means of mental illness, developmental/intellectual disability or physical impairment; and
- Require the assistance of a caregiver to accomplish daily living needs as a result of the disability.

To establish jurisdiction, the Hotline staff must also examine the nature of the incident. DPPC's enabling statute, **M.G.L. c. 19C, and the DPPC regulations, 118 CMR, require that the incident must:**

- Include an act or omission by a caregiver and
- Result in a serious physical or emotional injury.

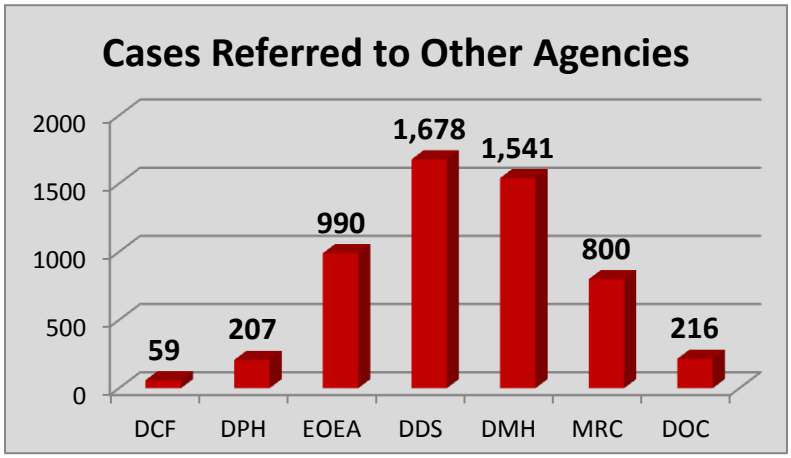
Information gathered by Hotline staff is entered into the DPPC database. The information is available for review each time a subsequent report is made involving a particular individual, alleged abuser or program. All relevant information is documented on a DPPC Intake form and is forwarded to an investigator in situations that meet DPPC's jurisdictional criteria.

During fiscal year 2013, the DPPC Hotline experienced an increase of 3.3% in abuse reports. The graph below depicts the historical increase in reporting beginning with DPPC's inception in 1987.



**Does not include death reports and information and referral calls.*

If a reported situation does not meet the criteria to establish jurisdiction under M.G.L. c. 19C, a copy of the DPPC Intake form is forwarded for review and action to the service agency appropriate to the individual's age or disability. The graph on the right indicates that in FY2013 there were 5,491 reports that did not fall under DPPC jurisdiction and illustrates to which state agencies they were referred.



A member of the State Police Detective Unit (SPDU) assigned to the DPPC reviews every report made to the DPPC Hotline. The review by the SPDU is to determine whether the information suggests a crime may have occurred and whether a criminal investigation is necessary. Suspected criminal activity is reported by the SPDU to the appropriate District Attorney's office for their review and action as needed.

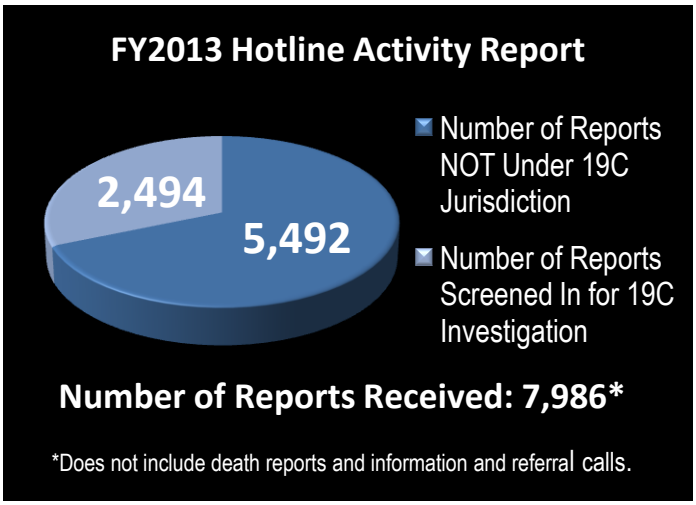
Death Reports

The DPPC statute requires that any caregiver that is a state agency or subdivision of the Commonwealth or any private agency contracting with the Commonwealth shall immediately orally notify the DPPC and local law enforcement of the death of any person under their care. A written report of such deaths must also be forwarded to DPPC within 24 hours of the death. This information is assessed to determine whether the cause of death may be related to abuse, and if so, an investigation is conducted. Each report of a death is entered into a database specifically for this purpose.

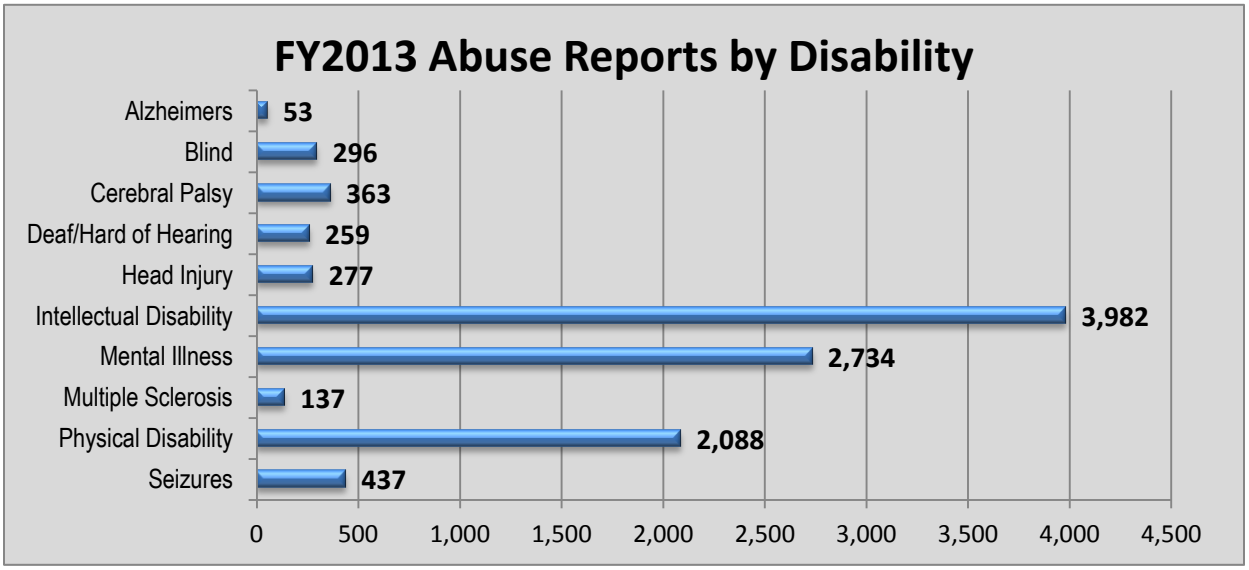
The goal of the DPPC Hotline is to provide every citizen of the Commonwealth a resource to which they can report suspected abuse of persons with disabilities. DPPC trains its staff to be efficient, effective and courteous so that reporters can feel positive about their decision to report what they suspect to be abuse or neglect.

The graphic on the right illustrates that during FY2013 the DPPC Hotline received 7,986 reports, not including death reports and information and referral calls, with 2,494 of these reports screened in for investigation.

Each month the DPPC Hotline received an average of 729 abuse and death reports and answered questions and provided information and referral services to an additional 486 callers.



The graph below categorizes abuse reports according to the person's type of disability and illustrates that some individuals have more than one type of disability.



Hotline Unit FY2013 Update

During FY2013 the DPPC Hotline Unit:

- Received information and entered intakes on 7,986 reports of abuse;
- Received 5,834 Information and Referral calls; and
- Received information and entered death intakes on 764 reports of death.

Mandated Reporting

The DPPC receives reports of abuse from various sources. Many reporters of abuse are mandated by law to make reports of suspected abuse to the DPPC.

What is a Mandated Reporter?

Mandated reporters are persons who, as a result of their profession, are more likely to be aware of abuse or neglect of persons with disabilities. Mandated reporters are required by law to report cases of suspected abuse to DPPC when they have a suspicion that a person with a disability is being abused or neglected. Other persons who are not mandated to report may choose to file reports of suspected abuse.

Who are Mandated Reporters?

- Police Officers
- Probation Officers
- Medical Personnel
- Medical Examiners
- Dentists
- Psychologists
- Social Workers
- Family Counselors
- Foster Parents
- Educational Administrators
- Public and Private School Teachers
- Guidance Counselors
- Day Care Workers
- Employees of private agencies providing services to people with disabilities
- Employees of state agencies in the Executive Office of Health and Human Services

What is Reportable?

The standard for reporting suspected abuse and neglect is “reasonable cause to believe” which means that mandated reporters need only a "**mere suspicion**" that abuse or neglect was committed against a person with a disability.

Mandated reporters are also required to report to the DPPC all cases in which an individual with a disability has died, regardless of whether or not abuse or neglect is suspected.

Protection for Mandated Reporters

Mandated reporters are immune from civil or criminal liability as a result of filing a report of alleged abuse of a person with a disability. Non-mandated reporters are also protected provided the report was made in good faith. If a mandated reporter is retaliated against by their employer for filing an alleged report of abuse, or by participating in the DPPC investigation, DPPC will conduct an investigation into the retaliation. Such retaliation is a crime and is punishable by up to a $1,000.00 fine, or up to one (1) year in jail, or both.

Consequences for Not Reporting

The failure to report can result in severe consequences for the alleged victim, other potential victims, and the mandated reporter. Victims of abuse and neglect are at increased risk of further abuse if abuse goes unreported. The frequency and severity of abuse and neglect are likely to increase over time if no intervention occurs. A failure to intervene by not reporting will likely result in other individuals being abused and neglected. In Massachusetts, mandated reporters can be fined up to $1,000 for failure to report incidents of suspected abuse and neglect of individuals with disabilities.

DPPC Investigations

Reports of alleged abuse determined to be within the jurisdiction of DPPC are immediately assigned to an Adult Protective Service (APS) investigator and a DPPC oversight officer. The APS investigator may be one of DPPC's four investigators or an investigator from the Department of Developmental Services (DDS), Department of Mental Health (DMH) or the Massachusetts Rehabilitation Commission (MRC).

The DPPC Investigation Unit and the Investigation Units of DDS, DMH and MRC conduct abuse investigations under the authority of M.G.L. c. 19C. The DPPC regulations, 118 CMR, further clarify and operationalize the criteria established by the statute.

The most important goal of any DPPC investigation is to provide protection to anyone who has been or is at risk of abuse or neglect by his or her caregiver. To accomplish this protection, the DPPC relies on the services of other state agencies like DDS, DMH and MRC. Working collaboratively with staff from these agencies, DPPC is able to develop effective protection plans for people with a range of disabilities. APS investigators also look for systemic issues that may contribute or lead to abuse.

APS investigators conduct civil investigations. They work in collaboration with DPPC oversight officers, service providers, law enforcement and others to ensure that victims of abuse are protected. Investigators collect information by interviewing witnesses, reviewing relevant documents and collecting all of the information necessary to develop an appropriate course of action to protect victims of abuse.

DPPC APS Investigators from left: Karen Manson, Genine Vasquez, Seana Miller (Manager) and David Viens, (Michelle McCue and Alina Gomes not pictured).

Based upon the collected information, the investigator completes an investigation report. In the report, the investigator documents his or her activities and presents conclusions based on the facts. When the facts indicate that an abusive situation exists, the investigator must include specific recommendations in the investigation report to resolve any circumstances that create risk for adults with disabilities who are the subject of the investigation.

Investigations Unit FY2013 Update

- APS Investigators investigated allegations of physical, emotional and sexual abuse and neglect of alleged victims with varying disabilities in private and public settings;
- APS Investigators of DPPC, DDS, DMH and MRC were assigned 2,494 investigations of which 259 were substantiated, 1,671 were unsubstantiated and 564 were still pending on June 30, 2013;
- APS Investigators completed 1,930 investigations;
- As of June 2013, 407 DPPC 19C APS investigations were overdue;
- APS Investigators from DPPC completed 4% of the 19C abuse investigations;

- APS Investigators from DDS completed 62% of the 19C abuse investigations;
- APS Investigators from DMH completed 21% of the 19C abuse investigations;
- APS Investigators from MRC completed 13% of the 19C abuse investigations;
- APS Investigators conducted 38 death investigations; 13 reports were unsubstantiated, 1 (one) report was substantiated and 24 reports were pending.
- APS Investigators from DPPC conducted 11 investigations involving the Department of Corrections (DOC);
- APS Investigators from DPPC conducted six retaliation investigations;
- APS Investigators from DPPC, DDS, DMH and MRC attended a one-day mandatory training sponsored by Essex District Attorney Jonathon W. Blodgett and Building Partnerships Initiative.

DPPC Oversight Unit

DPPC Oversight Unit from left: Ann Murray (Manager), Ada Diaz, Kerry Joyce, Lisa Bukow, Drew Zamagni, Kathy Bodrero, Kenneath Okoro and Heidi Cresta (Manager).

The DPPC Oversight Unit oversaw approximately 3,000 cases during FY2013. These cases are monitored according to the statute and regulations. The type of monitoring/oversight necessary for each of the cases is dependent on the nature of the case, and is determined on a case-by-case basis. The Oversight Unit also works in collaboration with the State Police Detective Unit (SPDU) assigned to the DPPC.

The overall goal of the Oversight Unit is to ensure that individuals who are identified as victims or are at risk of abuse or neglect are protected. The oversight officer is available to the investigator, service providers and law enforcement as a resource, supplementing their work and providing another perspective. An oversight officer may at times accompany an investigator on site visits or interviews during the course of an investigation.

The DPPC Oversight Unit is primarily responsible for the following:

- Assessing risk to victims throughout the investigative process;
- Backing up DPPC's Hotline staff by answering the 24-hour abuse Hotline, collecting and evaluating information from reporters and making decisions regarding the actions necessary;
- Maintaining an extensive database of reports of abuse and deaths;
- Reviewing completed APS 19C investigation reports for compliance with our governing statute and regulations;
- Evaluating recommendations and protective service actions made during and as a result of an investigation; and
- Ensuring that appropriate and adequate protective service measures are put in place.

Oversight Unit FY2013 Update

During Fiscal Year 2013, DPPC Oversight Officers:

- Were assigned a total of 2,494 new cases to monitor;
- Reviewed 1,717 investigation reports;
- Reviewed 1,182 protective service plans;
- Had 811 active cases, as of June 2013;
- Closed 2,316 cases; and
- Facilitated and monitored the appointment of guardians on four protective service cases.

DPPC Outreach and Prevention

DPPC defines prevention as: ***"Any action taken to prevent abuse or neglect from occurring …or, any action taken to protect the individual from risk of further abuse, once it has already occurred."*** DPPC is committed to addressing the problem of abuse and neglect as it relates to persons with disabilities. To accomplish this, DPPC created an Abuse Prevention Unit and included abuse prevention as part of the agency mission. DPPC uses education and awareness as primary tools in its efforts to stop abuse. However, abuse prevention encompasses a wide range of activities.

From left: Jennifer Edwards-Hawkins (Program Coordinator) and Susan Love (Abuse Prevention and Outreach Coordinator)

Some of DPPC's ongoing prevention activities include:

- Curricula development and trainings designed to educate law enforcement, mandated reporters, caregivers, persons with disabilities and other professionals regarding the identification and reporting of abuse of persons with disabilities;
- Providing consultation or information to other agencies interested in the development of abuse prevention programs;
- Collaboration with other agencies to develop presentations, programs and services related to abuse prevention and improving the quality of life of persons with disabilities;
- Development and distribution of educational materials to introduce DPPC operations, the role of mandated reporters, and indicators of abuse and neglect;
- Collecting and analyzing data from DPPC's database, which tracks over 800 pieces of information on each report to the 24-Hour Hotline. Data is provided to service providing

agencies, upon request, to assist them in identifying and correcting trends in their programs that may lead to abuse and neglect; and

- Participation in local, statewide and national conferences to increase knowledge and share information related to the protection of persons with disabilities.

Outreach and Prevention FY2013 Update

The following trainings took place to educate people about recognizing, reporting and responding to abuse and crimes committed against persons with disabilities:

- Seventy six *Awareness and Action* trainings were conducted, resulting in 1,072 individuals being trained.
- Four one-day trainings were held for new recruits within the police academy resulting in 201 recruits being trained.
- Nine other law enforcement trainings were conducted, resulting in 668 officers being trained.
- An all-day statewide conference, sponsored by Essex District Attorney Joanathan W. Blodgett in collaboration with the Building Partnerships Initiative, for law enforcement, prosecutors, adult protective service investigators, victim witness advocates and medical personnel was held in Danvers, MA, with over 400 in attendance.
- Nine trainings were held to educate 392 medical personnel.
- Nineteen local trainings were conducted to educate 899 human service providers.
- An additional 15 trainings were held at different venues, with 617 staff from various agencies being trained.
- DPPC participated in and provided outreach materials at three conferences and one legislative event with over 1,300 in attendance.
- Four presentations were conducted in other states with 560 people trained. These included Vera Conference, Louisville, KY; New Jersey Municipal Police, Seaside Heights, NJ; and two at the National Center for Victims of Crime (NCVC) Conference, New Orleans, LA.
- DPPC Program Coordinator and SPDU Sergeant Tim Grant received awards from National Adult Protective Services Association (NAPSA) at the Annual Conference, Phoenix, AZ.

IT Unit

Yusuf Karacaoglu
(IT Coordinator)

Considering the small number of staff and large responsibility the DPPC has, it would be impossible to accomplish all the things that are achieved without the contributions of DPPC's Information Technology Unit. The DPPC relies heavily on technology and consequently the DPPC IT Unit is a vital part of every activity. Every DPPC unit depends on the IT Unit to develop, modify and make available the most current and innovative technology; and by doing this the DPPC IT Unit helps to make the agency as efficient and effective as possible.

The DPPC Abuse Database is a one of a kind information management system developed at DPPC and primarily used to organize, store and report information about every abuse report, investigation, protective service action and oversight activity accomplished by DPPC staff. However, since its inception the database has evolved into an invaluable source of information not only about individual situations, but also about statewide trends regarding abuse of adults with disabilities. State agencies, media outlets, service providers and a host of others, request and receive information from the DPPC database throughout the year. This information is utilized for news articles, service planning and court proceedings, to name just some of the uses.

Document Retention Unit

The DPPC Document Retention Unit is responsible for maintaining the integrity and security of all documents created by and in the possession of the DPPC. Most of these documents are stored in one of the two DPPC databases. The Document Retention Unit is an essential piece in DPPC's successful efforts to ensure the protection of personally indentifying information as required by Executive Order 504 issued by Governor Patrick in September of 2008.

Document Retention Unit from the left: Michelle Kahler, Paula Mather, Patty Collings and Emil DeRiggi (Deputy Executive Director)

The Document Retention Unit, in conjunction with the DPPC Legal Unit, is responsible for preparing and processing the documents needed to respond to the hundreds of requests for documents and information made to the DPPC each year. The Document Retention Unit also processes the documents necessary to comply with DPPC's statutory obligation to notify all persons who have been determined to have committed abuse against a person with a disability at the completion of an investigation. There are hundreds of these substantiated investigations each year for which this type of notification must be made. Another activity of the Document Retention Unit is to work with the DPPC Legal Unit to track, process and record the documents related to the hundreds of Petitions for Review that are completed each year by the DPPC.

Although most of the work of the DPPC Document Retention Unit is done behind the scenes, without the dedication, organization and commitment of the staff of this unit, the DPPC would be unable to comply with the many demands and requirements around the security of documents and information in its possession.

Document Retention Unit FY2013 Update

During Fiscal Year 2013, the Document Retention Unit:

- Processed 213 Petitions;
- Completed 350 Record Requests;
- Made 20 Referrals; and
- Notified 293 abusers of the outcome of the investigation finding and their right to petition.

DPPC Legal Unit

Gail Quinn (Acting General Counsel and Erik Nordahl (Deputy General Counsel)

The DPPC Legal Unit provides legal advice and guidance on a variety of matters pertaining to the core functions of DPPC. This includes providing general advice and support to staff investigators from DPPC, Department of Developmental Services (DDS), Department of Mental Health (DMH) and Massachusetts Rehabilitation Commission (MRC) who conduct investigations on behalf of DPPC.

Specifically, DPPC Legal Counsel provide:

- Information and assistance to other state agencies regarding protective services and guardianship; and
- Advice, support and training with regard to investigation issues and legal interpretation of the terms and mandates contained in M.G.L. c. 19C and 118 CMR.

DPPC attorneys work in coordination with legal counsel from DDS, DMH, MRC and other agencies, including District Attorneys' offices (DA), the Office of the Attorney General (AG), Executive Office of Elder Affairs (EOEA), Department of Children and Families (DCF), Department of Public Health (DPH), Division of Professional Licensure (DPL), Department of Corrections (DOC), Medical Examiner's Office (ME) and others. When requested, DPPC legal staff provide information and assistance to other agencies as justice requires.

The DPPC Legal Unit also provides information to the public about DPPC's functions and mandate and handles record requests and court interventions when necessary. In addition, the Legal Unit performs the following specific functions within DPPC:

- Obtains judicial Protective Orders when an alleged victim of abuse is at immediate risk of harm and is not able to consent to the provision of protective services due to a mental or physical impairment;
- Secures access warrants when law enforcement and/or DPPC civil investigators are unreasonably denied access to an alleged victim of abuse;
- Responds to reports of Mandated Reporters' failure to report abuse as required by M.G.L. c. 19C and other reporting issues;
- Conducts Legal Reviews of the findings and conclusions of DPPC Investigation Reports pursuant to 118 CMR 14.00;
- Acts as the DPPC's Keeper of Records and ensures that DPPC responses to written requests for DPPC records are compliant with all statutory requirements;
- Responds to formal legal demands for statutorily protected records, pursuant to court process or Court Order; and
- Assists Executive Director in advancing and advocating for legislation implicating or affecting DPPC's ability to efficiently perform its core functions.

DPPC LEGAL UNIT UPDATE 2013

- Completed 213 petitions, out of 373 petitions pending review;
- Completed 350 records requests;
- Completed 20 referrals; and
- Notified 293 abusers of the outcome of the investigation finding and their right to petition.

DPPC State Police Detective Unit

SPDU from left: Trooper Seth Newman, Trooper Lisa Washington-Brown, Trooper Kristan Peachey, Sergeant Timothy Grant and Trooper Julie Sabota.

The State Police Detective Unit (SPDU) assigned to the DPPC is comprised of a Detective Sergeant and four troopers and became fully operational on May 1, 1998. The SPDU provides a statewide mechanism to ensure an effective and rapid response to potential criminal complaints of abuse and neglect against persons with disabilities by coordinating the efforts of adult protective services (APS), human services, state and local law enforcement and the Commonwealth's District Attorneys' Offices.

The SPDU assigned to DPPC reviews 100% of all abuse reports to DPPC's 24-Hour Hotline to determine which ones constitute criminal activity. Reports identified as criminal are referred to the applicable District Attorney's office. As defined in each Memorandum of Understanding (MOU) established in each of the eleven district attorney jurisdictions, the SPDU assigned to DPPC, the state police liaisons within each of the eleven District Attorneys' Offices and the municipal police are assigned to investigate crimes against persons with disabilities as determined by the District Attorney. The SPDU at DPPC tracks the criminal investigation from intake to indictment on a statewide basis and analyzes the types of crimes involved in the abuse reports received by the DPPC Hotline. The information tracked includes, but is not limited to, the type of criminal activity, location of criminal activity, investigating officer and criminal charges brought.

Within Fiscal Year 2013, the SPDU reviewed 7,986 allegations of abuse. Of the 7,986 reports reviewed, 1,425 were referred to the District Attorneys for assignment of the criminal investigation.

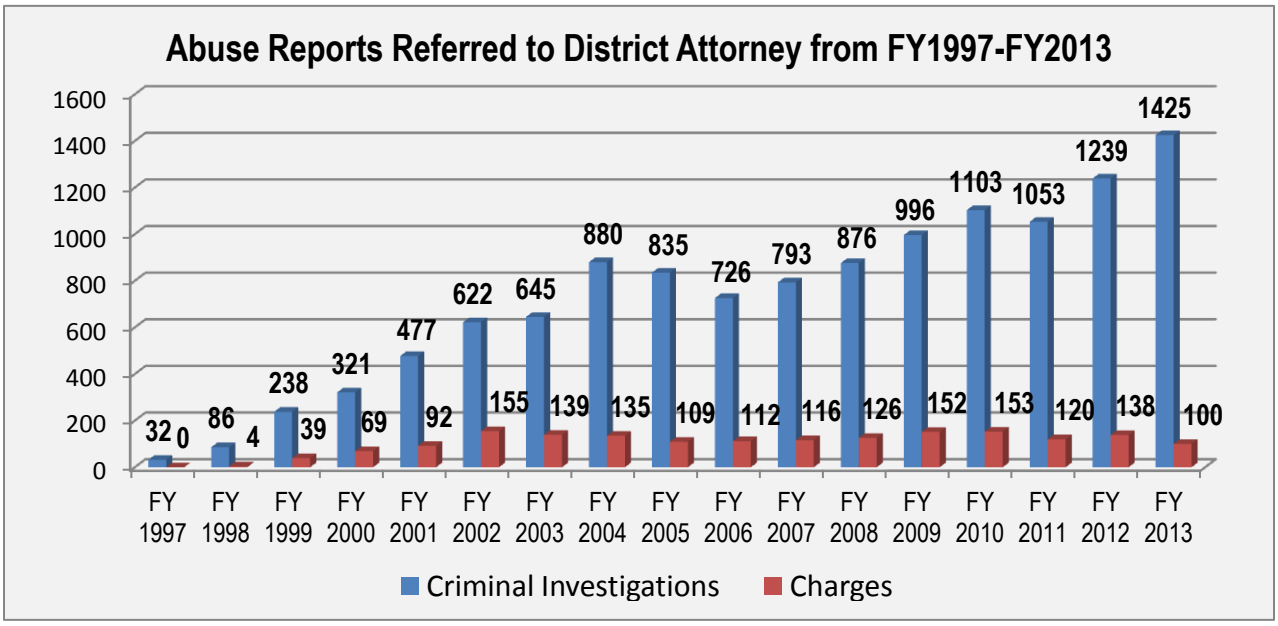
SPDU Farewell

The SPDU/DPPC said farewell to Troopers Kristan Peachey, Julie Sabota and Lisa Washington-Brown who retired after many years of service on the State Police.

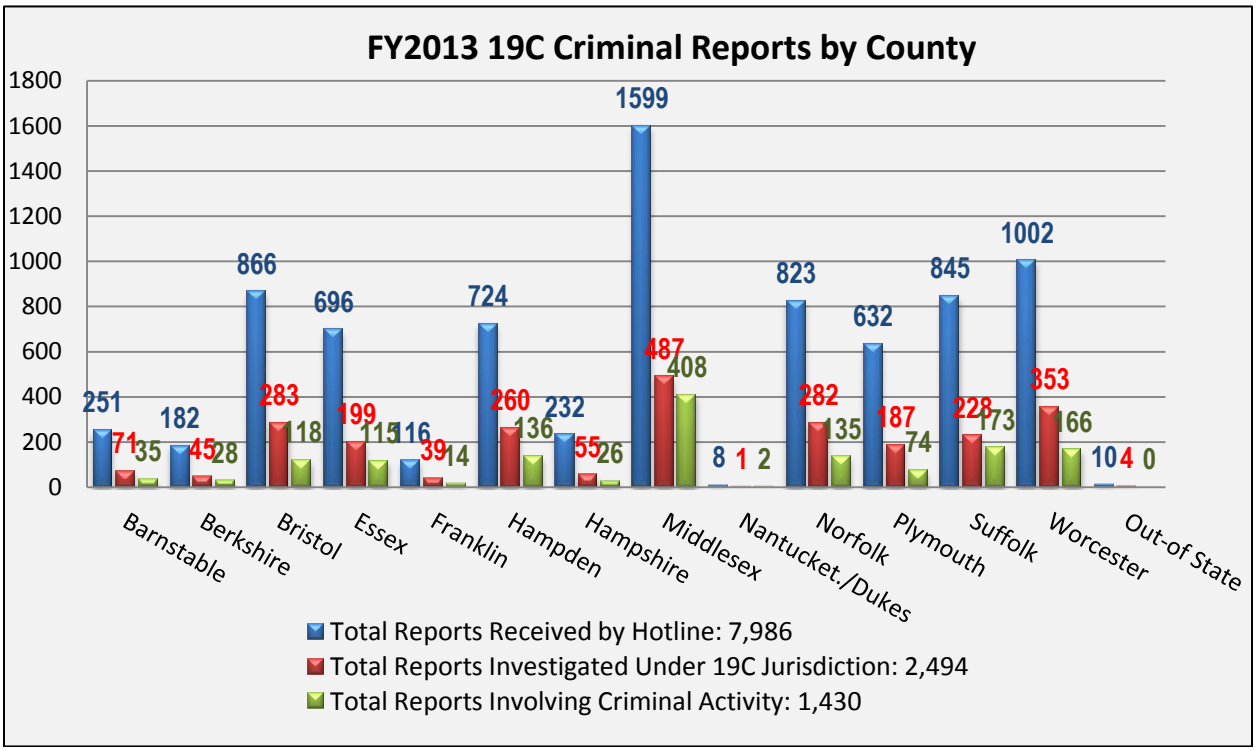
Troopers Peachey, Sabota and Washington-Brown have spent many years in the field and were instrumental in protecting the lives of adults with disabilities. They have been an absolute asset to the SPDU/DPPC.

Good Luck Troopers Peachey, Sabota and Washington-Brown! Thank You for Your Years of Service

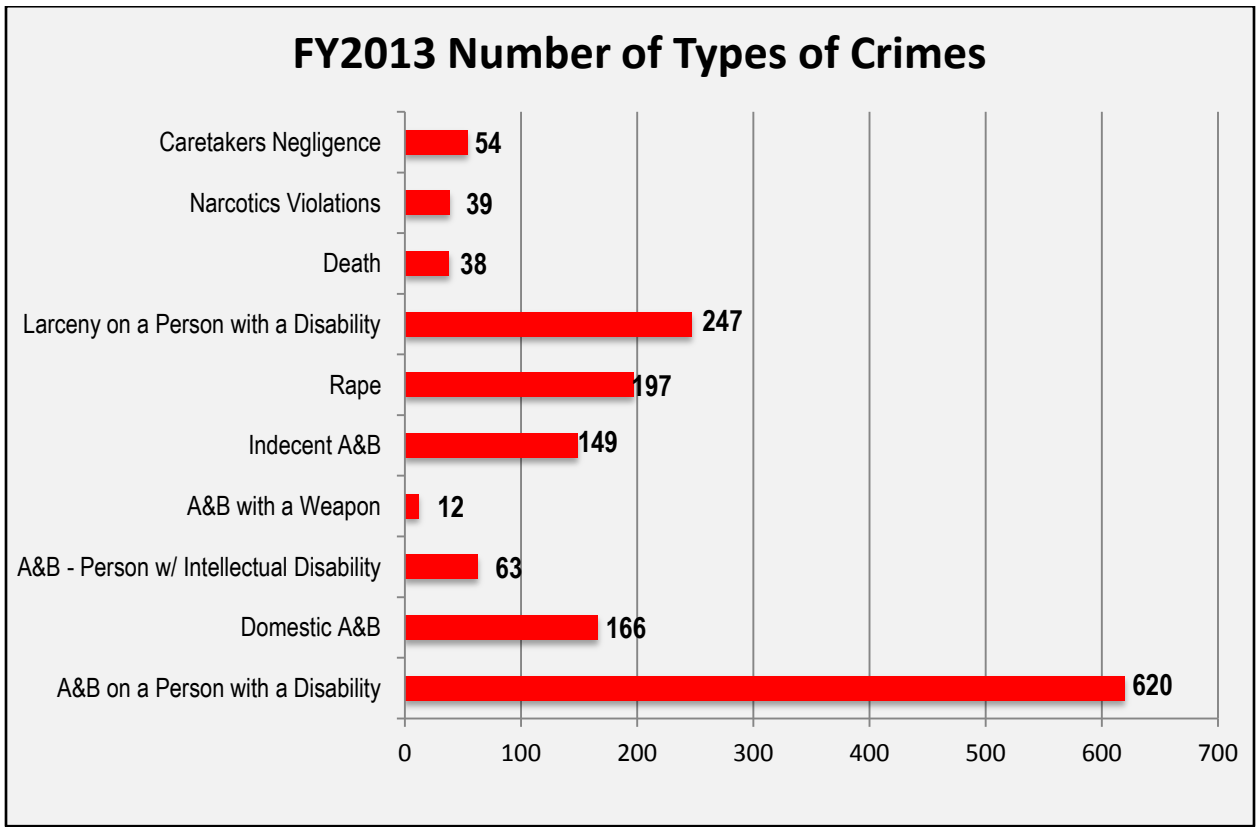
The following graph shows the number of reports referred to the District Attorney for criminal investigation and the number of criminal charges from fiscal year 1997 to 2013. In 1997 there were 32 reports referred with zero charges and in 2013 there were 1,425 abuse reports referred with 100 charges. Please note the criminal charges is a fluid number. As additional charges are taken, the number will rise to reflect the charges.



The following graph is a breakdown by county of the number of reports received by the DPPC Hotline, reports meeting the jurisdiction for 19C investigation and number of reports referred to the District Attorney for criminal investigation.



The SPDU assigned to DPPC tracks the types of crimes involved in the abuse reports received by the DPPC Hotline. The following graph presents the types of criminal activity reported during Fiscal Year 2013.



The SPDU tracks incidents of domestic violence involving persons with disabilities. Domestic violence is abuse that often takes place where the person lives. Domestic violence can be any type of abuse including sexual assault and rape, emotional, psychological or financial. Domestic violence involves family and household members who are or were married, living together, related by blood, parents of a common child or involved in a substantive dating relationship.

During Fiscal Year 2013, it was determined that 233 reports made to the DPPC Hotline involved domestic violence abuse. These reports require the State Police Detective Unit to notify law enforcement immediately to ensure the safety of the individuals involved and assist in the issuance of restraining orders and criminal prosecution of offenders if warranted.

As well as actively investigating criminal complaints committed against persons with disabilities, the SPDU continues to be involved in training agency staff, law enforcement and other professionals. Training is provided on recognizing and reporting abuse and on what to do and what not to do when abuse or a crime committed against a person with a disability is suspected. Training of recruits and seasoned officers throughout the Commonwealth continues to be provided at the request of the Municipal Police Training Committee and the State Police Academy.

DPPC Case Examples from FY 2013

The following Adult Protective Services (APS) 19C investigations depict the various types of reports that DPPC, the SPDU and municipal police investigate. The cases have been summarized and highlight the complexity of the report, the investigation process and case outcome.

PHYSICAL ABUSE OR OMISSION OF PATIENT

Allegation: It was alleged that a woman, Alleged Victim (ALV), was grabbed and bruised by hospital security, as she waited for a voluntary psychiatric screening and subsequent hospitalization.

Investigative Findings: Upon investigation, no evidence was found that ALV sustained any injury from the actions of the security staff. Staff attempted to redirect ALV to a room when she began to leave, but no witnesses reported seeing any excessive force and no injury was found. Documentation indicated that in fact it was ALV who was aggressive and that she had attempted to punch security. However, the ALV did sustain a superficial self-inflicted laceration to her wrist while in the care of an admitting nurse. The nurse allowed ALV to use the bathroom unsupervised, knowing that she was presenting with suicidal ideation. The ALV was able to cut herself with a safety razor. Hospital policy indicated that patients with suicidal ideation not be allowed unsupervised time. **Omission of care was substantiated against the nurse** and a recommendation was made that the nurse be disciplined for her failure to ensure the safety of the ALV and that she be retrained in proper hospital policy.

Protective Services: The ALV's wound was treated and she received necessary psychiatric hospitalization.

SEXUAL ASSAULT OF A WOMAN OR OMISSION

Allegation: A woman with developmental disabilities (ALV) was impregnated by a relative. The baby died and was buried on the family property. ALV was the product of incest between mother and grandfather.

Investigative Findings: The ALV lived with her mother, grandfather and other relatives. Because of the partnership with law enforcement officials, ALV was forensically interviewed and gave no indication that she had been, or was in danger of being sexually abused by family members. A review of the ALV's medical records indicated that she had not been known to be pregnant at any point in time. The family home was infested with bed bugs and the grandfather had not been cooperative in working with the town to resolve the issue. The ALV was unknown to the Department of Developmental Services (DDS). **Abuse was unsubstantiated**; there was no information found to support the allegations of sexual abuse and also no indication that ALV had been injured due to the bed bugs in the home.

Protective Services: The investigator referred the ALV to DDS for evaluation for services and notified DDS of the need for the same.

SEXUAL HARASSMENT AND INAPPROPRIATE TOUCHING OF STUDENT

Allegation: A female student with an intellectual disability (ALV) was sexually harassed and emotionally abused by an educator at her school (ALAB).

Investigative Findings: This matter was investigated both civilly and criminally. It was found that the ALAB made several comments and gestures over the course of the school term that made the ALV feel uncomfortable, anxious and emotionally upset. The ALAB had attempted to initiate an inappropriate and unwanted relationship with the ALV. The ALAB's actions involved a pattern of sexual harassment over the course of the school year, and included unwanted sexual advances and inappropriate touching. The ALAB was supposed to offer the ALV in-school supports, however the ALAB's actions were contradictory and the ALV became more anxious and fearful

of attending school and as a result ALV's school performance suffered greatly. **Abuse was substantiated.** There was adequate evidence and testimony to proceed with criminal charges, but the ALV decided not to proceed further. The criminal case was closed, with the option to reopen should the ALV wish to pursue the matter further.

Protective Services: The ALAB was suspended pending an internal review of the matter. Once told of the allegations, ALAB resigned and is not eligible for rehire with this school system. The ALV has a counselor/therapist available to her regularly, both in school and in the community.

STAFF OMISSION ALMOST RESULTS IN DROWNING

Allegation: It was alleged that a man with a developmental disability (ALV), was in the pool and went under the water for approximately 1 ½ minutes and was lifeless when pulled out from the pool. CPR and chest compressions were performed and the ALV came to.

Investigative Findings: The ALV requires 1:1 supervision at all times. At the time of the incident, the ALV had an assigned 1:1 staff and another staff was functioning as a lifeguard. The staff assigned to care for the ALV brought the ALV out to the pool and placed a life jacket on himself (staff), as he was not a strong swimmer. He did not place a life jacket on the ALV, as he thought the ALV could swim. The staff brought the ALV into the deeper part of the pool so the ALV would not be able to engage in his behaviors of hitting himself. Although the staff was supposed to be within arm's length of the ALV at all times, the staff person then swam to the side of the pool, leaving the ALV by himself. This incident is captured on video surveillance. The ALV is seen going under the water several times. At one point, the staff swam right by the ALV and did nothing to assist the ALV. The staff swam to the other side of the pool where the lifeguard was sitting. The lifeguard made the motion as if he is going to go in after the ALV and does not. Another staff came out of the house, sees the ALV and yells to the first staff and the lifeguard. The lifeguard then went into the pool and got the ALV out. It took several seconds to get the ALV out of the pool as the lifeguard lost his grip of the ALV initially. The ALV appeared lifeless when removed from the pool. Chest compressions and CPR were initiated on the ALV until EMTs arrived. The ALV was transported to the hospital for evaluation and treatment. The ALV had been under the water for approximately one and a half minutes; however ALV did make a full recovery. **Abuse was substantiated against both the 1:1 staff and the lifeguard**.

Protective Services: ALV received appropriate medical treatment and made a full recovery. Both staff involved in the incident were terminated.

DOMESTIC ABUSE, VERBAL ABUSE, OMISSION OF CARE AND SEXUAL ASSAULT OF A WOMAN

Allegation: A woman with depression, anxiety, bipolar disorder, diabetes and some physical disabilities (ALV) was physically assaulted by her personal care attendant (ALAB) who was responsible to assist the ALV with personal care and other daily living needs. The ALAB was drunk, blacked out and proceeded to punch, kick and throw the ALV around the room. The ALV left the apartment with one-week worth of clothes and moved in with a new personal care attendant (PCA). The ALAB refused to provide the ALV with the rest of her belongings and clothes. The ALAB left voice mail messages threatening to forge the ALV's name and to continue to submit timesheets because the job was his and his only. The ALAB also threatened to harm ALV and her family members.

Investigative Findings: The ALAB was an alcoholic with an extensive criminal record and had been working for the ALV for approximately a month. The ALAB did not perform his duties, was physically and emotionally abusive to ALV, and would lock the ALV in her room saying "You do everything and keep your mouth shut." The ALV stayed in bed all day, terrified of the ALAB harming her.

During the meeting with the investigator, the ALV disclosed that the ALAB had sexually assaulted her. The ALV had told no one of this incident until she met with the Investigator. The ALV agreed to file a criminal complaint against the ALAB that day. **The investigation was substantiated for physical, emotional and sexual abuse.**

Protective Services: The ALV was transported to the courthouse by a patrol officer to obtain a 209 A Restraining Order (RO) against the ALAB. A temporary RO was granted. The ALV also agreed to follow through with a medical appointment to address any potential health concerns. At the time of the medical appointment, the ALV found out she was pregnant. The ALV did agree to participate in a SANE interview; however, refused to proceed with criminal charges against the ALAB. Despite efforts by the Investigator, the ALV's PCA, and the District Attorney's office, the ALV would not reconsider, stating she had forgiven the ALAB and wished to move on. Investigator provided the ALV with resources and made several recommendations regarding her safety. The criminal case was closed.

OMISSION WITH SERIOUS INJURIES, REQUIRING HOSPITALIZATION

Allegation: A man with a head injury (ALV) was neglected by his sister and a paid Personal Care Assistant (PCA). ALV is diagnosed with Brain AVM (Malformation of the Brain) is described as non-verbal, unable to walk independently and requires the use of a catheter and feeding tube. ALV is fully dependent on others to provide him with all of his daily care needs. The ALV's caregivers (ALABs) are responsible to meet these needs. According to the medical nurse visiting the ALV at home, the ALV was in his bed and his legs were twisted. The ALV had dried stool in his buttocks and the ALV had vomited at some point before the nurse's arrival. The vomit was dried up on his face, arm and in his bed. The ALV had drainage coming from his eye and his hair was greasy with dandruff. The ALV's underarm was very crusty and his finger nails were yellow and filled with stool. The ALV had wounds on his buttock area from being in the bed for a prolonged time without being repositioned.

Investigative Findings: The two ALABs were present when ALV was found in fecal matter. The first ALAB stated she was unaware of the feces and vomit and had checked on the ALV five minutes before the nurse arrived. The second ALAB stated she stepped out to go to the store and the ALV was clean when she left. Neither ALAB took responsibility for the ALV's condition nor clearly explained the role of each in providing the needed care to the ALV. **The case was substantiated for omission by all ALABs.**

Protective Services: The ALV was placed in a long-term care facility.

OMISSION BY A CAREGIVER

Allegation: A woman with Spina Bifida (ALV) was transported to the Emergency Room and admitted for malnourishment and dehydration. The ALV had a stage five ulcer, which was infected and the ALV's electrolytes were imbalanced, which caused her to have a seizure at the hospital. The ALV was hospitalized a year prior to this incident being reported with the same medical issues. The ALV's mother (ALAB) was her primary caregiver. ALV has a history of chronic urinary tract infections, and decubitus ulcers.

Investigative Findings: At the time of the investigation, both the ALV and the ALAB were attempting to cope with the recent loss of the ALV's father, ALAB's husband. The ALAB reported being depressed and having difficulty getting out of bed. The ALAB stated she was seeing and would continue to see a therapist to address these issues. The ALV was refusing to have any additional care via a personal care attendant agency. Although, the ALV had the ability to self-catheterize and administer her own medications, she had trouble remembering to follow through. Though some self-neglect issues were present, the ALAB was unable to assist the ALV, which led to the ALV's serious injuries and consequent hospitalization. **The**

investigation was substantiated for omission of care.

Protective Services: The ALV was treated and spent approximately six months in the hospital and in Rehabilitation Care. The ALV signed a service plan and agreed to several recommendations made by the investigator to ensure her safety upon her return to the home. The ALV has since been discharged from the Rehabilitation Care with additional supports.

OMISSION BY NURSE

Allegation: A man diagnosed with a Traumatic Brain Injury (ALV) was admitted to the hospital for kidney pain. During his hospitalization, the ALV was given Opiates, which caused an allergic reaction. As a result, the ALV went into respiratory arrest. The ALV was transferred to the intensive care unit and placed on a ventilator.

Investigative Findings: Several interviews were conducted with nursing staff, direct care staff and family members and the ALV's medical records were reviewed. It was determined that the nursing staff failed to note the ALV's allergy sensitivity in his record before he went into the hospital for the kidney pain. Some records clearly documented the ALV's allergy to opiates; however, the information was not carried through in all of his records. **The investigation was substantiated against four staff who failed to ensure that accurate medical information was documented in the ALV's medical book and records.**

Protective Services: The ALV recovered fully and returned to his home. The ALV's medical records and the ALV's medical workbook at his residence were all updated. In addition, one nursing staff was demoted.

DPPC FY 2013 Annual Update

During the DPPC annual all-staff meeting of September 13, 2012, the initiatives described below were generated to enhance DPPC's overall operations throughout the 2013 fiscal year. To ensure objectives were addressed and met, the activities were incorporated into staff performance reviews. At the end of the fiscal year, staff came together to review the progress toward their established objectives. Of the 18 objectives created, DPPC staff successfully completed all of them in addition to other milestones thanks to their dedication and perseverance.

- Organized a Statewide Inter-Agency Training with the Building Partnerships Initiative for the Protection of Persons with Disabilities. The statewide conference, *'From Crime Scene to Sentencing and Beyond: Addressing Crimes Against Persons with Disabilities and Elders'*, was held on November 29, 2012 at the DoubleTree by Hilton in Danvers. The training was sponsored by Essex District Attorney Jonathan W. Blodgett in collaboration with BPI.

- Revised the Protect, Report, Preserve (PRP) Training Curriculum.

- Conducted 19 local trainings to educate human service providers on effectively responding to abuse of persons with disabilities, resulting in 899 individuals being trained.

- Held 15 additional trainings with over 2,317 staff from various agencies being trained.

- Provided outreach materials at four conferences with over 1,300 conference participants.

- Oversaw 76 Awareness and Action Trainings resulting in 1,072 individuals

being trained. Department of Developmental Services, Essex District Attorney Jonathon W. Blodgett, Hampden District Attorney Mark G. Mastroianni and Personal and Home Care Aide State Training (PHCAST) funded the A&A trainings.

- Planned mandatory and other in-service trainings.
- Developed a policy to respond to outages.
- Revised DPPC Intake Form.
- Developed a training manual for use by after-hours hotline.
- Developed alternative methods of transferring documents.
- Developed method to identify ALV's not served by a provider.
- Identified percentage of sexual assault victims referred for therapeutic treatment.
- Digitized retaliation investigation report.
- Conducted guardianship training.
- Conducted administrative reviews of 19C investigations.
- Pursued and secured increased funding to reinstate staffing level of 28 into fiscal year 2014.
- Responded to a 3.3% increase in reports of abuse to DPPC's 24-hour Hotline.
- Received an 8.4% increase in the number of investigations.
- Secured funding from the Hampden District Attorney's Office for Awareness and Action trainings and a Protect, Report and Preserve training.
- Secured funding from Personal and Home Care Aide State Training (PHCAST) for Awareness and Action trainings.
- Conducted numerous IT updates and improvements.
- Renewed After-hours vendor's contract to answer and respond to Hotline calls.
- Maintained operations with fewer staff.
- Provided internship opportunity to two Massachusetts Commission for the Blind (MCB) individuals.
- Provided internship opportunity to a master's level forensic student through Boston College.
- Pursued and obtained protective orders to stop abuse of victims with disabilities.
- Replaced IT coordinator.
- Exceeded AMP benchmark.
- Increased understanding on when to use a Certified Deaf Interpreter (CDI).

2013 Pride in Performance Award Winners

OVERSIGHT UNIT

Ada Diaz, Kerry Joyce, Lisa Bukow, Andrew Zamagni, Kathy Bodrero, Kenneath Okoro

The six members of DPPC's Oversight Unit were recognized by their peers for going above and beyond during this past year. The Oversight Unit works as a team and is committed to ensuring all functions of the unit are performed seamlessly and according to the statute, regulations and policies and procedures.

During 2013, the members of the Oversight Unit were responsible for an unprecedented number of cases to monitor, up 27% from just five years ago. In addition to this great responsibility, the Oversight unit also assisted in providing backup coverage to DPPC's Hotline, which has also had its busiest year in DPPC's history with no additional resources, and the Oversight unit's ability to handle the overflow has made it possible to handle this increase in call volume. The Oversight unit is also the gateway for all documents sent to DPPC, including written reports of abuse, initial responses to investigations, investigation reports and protective service plans. Documents from many agencies and individuals are handled with care, data entered in a timely manner and distributed to appropriate parties for action.

The contributions and dedication of each of the members of the Oversight Unit has kept many individuals safe from harm during this fiscal year, has made it possible for both the Hotline and Oversight units to handle a significantly larger workload with no additional resources and has allowed the Commission to continue to meet its mission. Kathy, Lisa, Ada, Kerry, Kenneath and Drew exemplify the meaning of the word "teamwork". Their dedication to their work and the individuals we strive to protect from harm is commendable and they are well deserving of this 2013 Pride in Performance Award.

DPPC COMMISSIONERS

IN CLOSING

The Commissioners of the Disabled Persons Protection Commission would like to take this opportunity to thank Governor Deval L. Patrick and the House and Senate members for their ongoing commitment and support in protecting adults with disabilities within the Commonwealth of Massachusetts against abuse and neglect. We would also like to recognize and thank the many hard-working men and women who dedicate their work to enhancing the quality of life of people with disabilities. Your dedication is immensely appreciated.

Gail Varrasso
Chairperson

Yndia Lorick-Wilmot, Ph.D.
Commissioner

Maurice Medoff
Commissioner

The DPPC staff thanks you for taking the time to review DPPC's FY2013 Annual Report. If you have questions or require additional information, please contact the DPPC at (617) 727-6465.

Deval L. Patrick
GOVERNOR

Nancy A. Alterio
EXECUTIVE DIRECTOR

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