JAMES E. TIERNEY
ATTORNEY GENERAL

STATE OF MAINE
DEPARTMENT OF THE ATTORNEY GENERAL
STATE HOUSE STATION 6
AUGUSTA, MAINE 04333

November 7, 1985

Commissioner Kevin Concannon
Maine Department of Mental Health
and Mental Retardation
State House Station 40
Augusta, Maine 04333

Dear Commissioner Concannon:

In the July/August issue of Coping magazine, a publication of the Maine Association of Handicapped Persons, an article appeared containing various allegations of improprieties at the Pineland Center for the mentally retarded and mentally ill at New Gloucester. Following the publication of this article, its author, Mr. Lance Tapley, requested this Office to investigate whether any of the alleged improprieties warranted criminal prosecution.1/ Accordingly, this Office, through its Criminal and Investigation Divisions, conducted an investigation of the allegations identified by Mr. Tapley as

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1/ In addition, since the receipt of Mr. Tapley's request, the Office has received correspondence from the Maine Association of Handicapped Persons which, in addition to voicing concerns similar to those of Mr. Tapley regarding the criminal prosecution of alleged improprieties, also raised issues regarding the adequacy of the current administrative structure at Pineland. However, aside from observing that the current structure appears to be identifying and responding to instances of client abuse, the report does not discuss whether the system is otherwise satisfactory. Such issues, since they do not involve law enforcement, are better addressed administratively or legislatively.

being of particular significance. In conducting the investigation, the Office interviewed relevant persons and inspected relevant documents in its possession and in the possession of your Department. Attached you will find a report of the investigation.

The report first summarizes the formal system for the identification and correction of instances of physical and verbal abuse of mentally retarded clients at Pineland Center which your Department established, pursuant to a Consent Decree entered into following litigation in the United States District Court in Portland, and pursuant to legislation enacted by the Maine Legislature in 1982. Generally, the purpose of the system is to insure that instances of possible client abuse are rapidly brought to your attention for appropriate disciplinary action and to the attention of the Cumberland County District Attorney when criminal prosecution may be warranted.

The report then examines the instances of alleged abuse identified by Mr. Tapley. This examination shows that the system is functioning well in bringing to light any arguable misbehavior of Pineland Center employees towards mentally retarded clients. In each instance examined, the allegation of possible misconduct had been promptly identified and reported to Department personnel, and a determination as to an appropriate disciplinary response had been made.

The only area in which the Department's procedures were found in need of improvement concerns the reporting of instances of abuse to the District Attorney. The Department appears to have reported some, but not all, instances of abuse where evidence of possible criminal conduct was present. Our report suggests that such reporting should be made more liberally, to allow the Cumberland County District Attorney to make an independent determination as to criminal responsibility. Consequently, the report recommends, first of all, that since the statute of limitations has not run in any unreported case, all such matters now be referred to the District Attorney's Office. Next, the report suggests that the statute governing reporting be amended to require a report upon "reasonable suspicion" rather than the possession of actual evidence of any abuse. Finally, the report makes various recommendations concerning the Department's administrative structure relating to the reporting of instances of possible abuse, to insure that the reporting process operate in the most effective manner possible.

In making these recommendations, however, we emphasize that the system as it now exists has functioned well in identifying

instances of a possible or abuse and bringing them to the attention of you and the other relevant Department personnel. No allegations of impropriety were found which had not been brought to light. Our recommendations are intended only to insure a fuller communication between your Department and the Cumberland County District Attorney so that determinations as to criminal prosecutions, if any, may be made by persons who would actually prosecute any possible cases.

I hope the enclosed report is helpful to you. Please feel free to reinquire if any clarification of it is necessary.

Sincerely,

JAMES E. TIERNEY
Attorney General

JET/ec
Enc.
cc: Paul Aranson
Cumberland County District Attorney

Lance Tapley

REPORT OF INVESTIGATION

The following report has been prepared by the Office of the Attorney General (the "Office") in response to a complaint originating in the July/August issue of Coping magazine, a publication of the Maine Association of Handicapped Persons, concerning various allegations of improprieties at the Pineland Center for the mentally retarded and mentally ill (the "Pineland Center"). It is based on an investigation conducted by the Criminal and Investigation Divisions of the Office. After setting forth the statutory and administrative structure governing the operation of the Pineland Center (Part I), the report describes the conduct of the investigation and its results (Part II), and concludes with several recommendations as to the improvement of the system already in place for the identification and prevention of possible abuse of clients at Pineland Center. (Part III).

I. Statutory and Administrative Structure

The Pineland Center is a residential facility for the developmentally disabled located along Route 231 in New Gloucester, Cumberland County. It is operated by the Department of Mental Health and Mental Retardation (the "Department"). 34-B M.R.S.A. § 5401 et seq. The facility

itself is supervised by a Superintendent. Independent of the Departmental hierarchy is the Office of Advocacy. 34-B M.R.S.A. § 1205. This Office was headed by the Chief Advocate Carroll Macgowan until June of this year and has since been headed by Richard Estabrook, Esq., formerly of Pine Tree Legal Assistance. The Chief Advocate reports directly to the Commissioner, Kevin Concannon. The staff of the Office of Advocacy includes a number of resident advocates, among them Jeffrey Lee who has been the Resident Advocate at Pineland Center since 1980. Mr. Lee reports directly to the Chief Advocate and is not responsible to either the Superintendent or other members of his staff.

Maine Law contains two major provisions regarding the reporting of instances of abuse of clients. The basic statute, 22 M.R.S.A. § 3477, was enacted in 1982. P.L. 1981, c. 705, Part E, § 2. In its original form, this law required certain professionals to report suspicions of abuse, neglect or exploitation of incapacitated persons[1] to the Department of Human Services, except in the instance of a mentally retarded adult, in which case the report is to be made to the Commissioner of the Department of Mental Health and

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[1] An incapacitated person is defined in the Probate Code as being a "person who is impaired by reason of ... mental deficiency ... or other cause except minority ... to the extent that he lacks sufficient understanding or capacity to make or communicate responsible decisions concerning his person," 18-A M.R.S.A. § 5-101(1).

Corrections, 22 M.R.S.A. § 3472(5).[2] The Legislature also has amended Section 3477 so as to require a report of abuse, neglect or exploitation not only of incapacitated persons, but persons reasonably suspected of being incapacitated. P.L. 1983, c. 616. This mandatory reporting requirement applies to a wide variety of professionals who work at Pineland. It is evident from the records provided by Pineland that many of those who have either made reports internally or those who have received them are among those designated as mandatory reporters.

In addition to the mandatory reporting requirement in Title 22, other specific obligations are imposed upon the Department. In particular, "[a]ny alleged violation of a client's rights shall be reported immediately to the Office of Advocacy of the Department [of Mental Health and Mental Retardation] and to the Attorney General's office." 34-B M.R.S.A. § 5606(1). The rights referred to include the right to "protection against any physical or psychological abuse." 34-B M.R.S.A. § 1430. Finally, the Department is required to notify the Cumberland County District Attorney "[u]pon finding evidence indicating that a person has abused, neglected or exploited an incapacitated or dependent [and mentally retarded] adult." 22 M.R.S.A. §§ 3485, 3472(4).

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[2] Although the statute refers to the Department of Mental Health and Corrections, governmental reorganization accomplished by the Legislature has created the Department of Mental Health and Mental Retardation as a separate entity from the Department of Corrections.

To discharge these statutory responsibilities, the Department has established the following reporting system at the Pineland Center: When an incident of client abuse is reported, it is channelled to the Superintendent's Office and to the Resident Advocate. Depending on the seriousness of the alleged abuse, the Resident Advocate notifies, either in writing or by telephone, the Chief Advocate and the Assistant Attorney General assigned to the Department. When notification is made in writing, a so-called face sheet is employed. The Chief Advocate then reports the matter promptly to the Commissioner, and, if warranted, the District Attorney. Because his office is physically close to the Commissioner's, the Chief Advocate may notify the Commissioner by personal visit or by memorandum. According to both Chief Advocate and Commissioner, the choice is determined by the seriousness of the allegation. The Chief Advocate may also consult with an Assistant Attorney General representing the Department.

When a complaint is filed, the employee is generally suspended with pay, unless the complainant has made two (2) or more unsubstantiated complaints within the past year, in which case a preliminary investigation is undertaken by the Resident Advocate. Should the Resident Advocate determine that the complaint is unsubstantiated, he reports this finding to the Chief Advocate, Commissioner and the Assistant Attorney General

assigned to the Department. Assuming that there is no objection to this finding by one of those notified, the investigation is closed.

If the preliminary investigation reveals that there is probable cause for the charge or if the complainant has not made two (2) or more unsubstantiated complaints within the past year, a four (4) person investigative team is formed. This team consists of the Resident Advocate, a representative of the Superintendent, an employee representative and a middle-management representative of the affected department within Pineland Center. The four person investigative team prepares a report, in addition to which the Resident Advocate prepares an independent report of his own. Depending on the report, the Commissioner may impose discipline on the employee in accordance with the procedures for disciplining State employees.

If the case is referred to the District Attorney, a prosecutorial decision must then be made by him as to whether the acts reported constitute a violation of one or more of the provisions of the Maine Criminal Code. In making this determination, the District Attorney must bear in mind that Maine law allows the use of force by persons with special responsibilities. Specifically:

> A person responsible for the general care and supervision of a mentally incompetent person is

> justified in using a reasonable degree of force against such person who creates a disturbance when and to the extent that he reasonably believes it necessary to control the disturbing behavior or remove such person from the scene of the disturbance.... The justification extended [above] ... does not apply to the purposeful or reckless use of force that creates a substantial risk of death, serious bodily injury or extraordinary pain. 17-A M.R.S.A. § 106(3) & (4).

Finally, beyond the internal structure just described for the identification and reporting of instances of client abuse at Pineland, Maine law establishes several other organizations outside of the Pineland administrative structure whose responsibilities include the oversight of the operation of the facility. Principal among these are: the Consumer Advisory Board, established pursuant to a Consent Decree entered by the United States District Court for the District of Maine, which provides a personal correspondent for each Pineland client who is not actively visited by a family member or non-public guardian, which reviews all allegations of client rights violations in the possession of the Office of Advocacy, and which has the power to report such instances to the Court; the Board of Visitors for Pineland, established by 34-B M.R.S.A. § 1403, which is empowered to visit Pineland at any time and make recommendations on its management to the Commissioner; the Human Rights Committee, established by Department rule in satisfaction of federal law, which is responsible for the review of programs dealing with severely intrusive behavior

management; and the Maine Committee on the Problems of the Mentally Retarded, established by 34-B M.R.S.A. § 1210, which advises the Bureau of Mental Retardation as to the management of its institutions, including Pineland. In addition, the Department maintains a close working relationship with Pineland Parents and Friends, a private organization concerned with the operation of the facility. Thus, in addition to instances of abuse being identified by Pineland's internal organization, it is also possible that such instances might come to light through activity initiated outside the facility.

II. Investigation of Allegations of Abuse

The article in the July/August 1985 edition of Coping magazine details various instances of alleged misconduct at the Pineland Center and further alleges that these instances were not properly reported. Following the publication of the article, its author, Mr. Lance Tapley, visited this Office and requested that it investigate whether any of the alleged improprieties warranted criminal prosecution. Mr. Tapley identified nine (9) allegations of particular significance. The Office then investigated each of these instances by examining relevant documents both in its possession and in that of the Department, and by interviewing the following people: Commissioner Concannon; Chief Advocate Estabrook; former Chief

Advocate Macgowan; Resident Advocate Lee and Assistant Attorney General Linda Sibery Crawford, counsel to the Department.

Because Mr. Lee stated that he had provided the underlying data upon which Mr. Tapley based his article, the fact patterns described in the article were presented to Mr. Lee so that he might locate the files concerning the incidents. [3] It was found that while the article alleges nine (9) incidents, these are maintained as seven (7) separate matters by Pineland Center. In order to avoid errors, the Pineland Center filing system was preserved in the investigation.[4]

Following are the details of the instances investigated by this Office.

A. Death of a Patient

On January 2, 1982, a thirty-five (35) year old profoundly retarded female client died at Pineland Center as the result of asphyxia due to acute and chronic aspiration pneumonia. The client was non-verbal and blind. It was alleged that the licensed practical nurse responsible for the client's unit had been negligent in her handling of the

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[3] Apparently information was provided to Mr. Tapley without reference to client name so as to preserve confidentiality.

[4] In order to assure that the privacy interests of the mentally retarded clients are protected, the names of the clients are not included in the following discussion. However, the Attorney General's Office has been provided a copy of the actual complaint and investigation and maintains these as part of its own records, pursuant to 5 M.R.S.A. § 200-D.

case in that she failed to properly monitor the client and report to a nurse supervisor. It is further alleged that by her failures, she allowed the client to die by ignoring a life-threatening situation.

As a result of her conduct in this case, the licensed practical nurse was discharged. However, she appealed this discipline through the grievance procedure established by collective bargaining for disciplined state employees. A hearing was held before an arbitrator, who wrote a lengthy opinion in which he reduced the discipline from termination to a 30 day suspension without pay.

With regard to possible criminal responsibility, the records of the Department do not reflect that this case was reported either to the District Attorney or to the Attorney General, who exercises exclusive jurisdiction over the prosecution of homicides in Maine. 5 M.R.S.A. § 200-A. However, this Office has since reviewed the case and has concluded that, although there were errors of judgment by the licensed practical nurse, and the nursing supervisor failed to act when she should have, none of their conduct meets the standard for a criminal prosecution. Maine law provides that one who recklessly or with criminal negligence causes the death of another human being is

guilty of Manslaughter, a Class A crime. 17-A M.R.S.A. § 203. The conduct which is criminally negligent or reckless must constitute a gross deviation from the norm. In addition, the standard of proof for criminal negligence is much higher than that used in civil negligence cases. In the view of this Office, the behavior described above falls well short of these standards for criminal liability and does not constitute an appropriate case for prosecution.

Finally, it should be noted that, since June 1984, a protocol has been established with the Department whereby deaths which are even remotely suspicious at state institutions are reported to the Criminal Division of the Attorney General by the Department of Mental Health and Mental Retardation, in order to allow for an immediate criminal investigation where the situation warrants. In this case, however, it is not clear that a criminal investigation would have been appropriate since the conduct appears to be so clearly non-criminal in nature.

B. Alleged Sexual Abuse

An employee of Pineland Center was alleged in February 1982 to have been found alone with a nude male client in a locked laundry room at the Center. Although the client was

known to spontaneously undress, he was not known to remove his underwear. Moreover, there was reportedly no explanation offered for the locked door. There were also allegations that this employee had inappropriately touched three (3) other clients. Following this incident, the employee resigned.

This incident was not reported to the District Attorney. Engaging in a sexual act with certain mentally impaired persons constitutes the crime of gross sexual misconduct, a Class B offense. 17-A M.R.S.A. § 253(2)(C).[5/] Although the fact that a nude client is found with an employee behind a locked door is not conclusive evidence that a sexual act took place, it is nonetheless evidence that such activity might have taken place. Although all of the evidence may later indicate that a criminal prosecution could not be sustained, the matter should have been reported to the District Attorney for further investigation and possible prosecution. Because it is not too late for such a prosecutorial decision to be made, it is recommended that such a report now be made.

[5/] In addition, the conduct in question could constitute unlawful sexual contact, a Class D offense, 17-A M.R.S.A. § 255. However, the statute of limitations for Class D (and E) crimes is three years, 17-A M.R.S.A. § 8(2)(B), and thus has run in this case. The statute of limitations for Class B offenses is six years. 17-A M.R.S.A. § 8(2).

C. Alleged Physical Abuse

In September, 1984, an employee of Pineland Center was alleged to have abused a client by directing her to a toilet by pulling her hair. He was also alleged to have restrained her by holding her between a door and a wall and then entering this in the records as a "chair restraint." Moreover, this employee was alleged to have forced a client to take a cold shower as a punishment for having wet her bed. This employee resigned.

These incidents were not reported to the District Attorney, although they raise the possibility of a prosecution for criminal assault, a Class D offense. 17-A M.R.S.A. § 207. Because there does not appear to be any independent witness to the alleged incidents, proof of the incidents may be extremely difficult. Nonetheless, incidents such as these should be reported to the District Attorney and, since the statute of limitations has not run on this incident, it is recommended that such a report now be made in this case.

D. Alleged Physical Abuse

In August-September, 1984, an employee of Pineland Center was alleged to have slapped one client across the face and then struck another in the face and pushed him across the hall. The employee was discharged.

These incidents could have resulted in two (2) charges of criminal assault, a Class D offense. 17-A M.R.S.A. § 207. On October 2, 1984, they were properly referred to District Attorney, who declined to prosecute.

E. Alleged Physical Abuse

In February, 1984, an employee of Pineland Center was alleged to have struck a client after the client bit him. Later the employee was allegedly observed picking this client up and then dropping him to the floor. This employee resigned.

These incidents could have resulted in two charges of criminal assault, a Class D offense, 17-A M.R.S.A. § 207, and one of them could possibly have been considered aggravated assault, a Class B offense. 17-A M.R.S.A. § 208. According to Mr. Lee, these matters were telephonically reported to the District Attorney, and were subsequently investigated by the Maine State Police. No prosecution was undertaken by the District Attorney.

F. Alleged Verbal and Physical Abuse

In 1983, an employee of Pineland Center was alleged to have ordered an unruly client not to leave the swimming pool

area of the Center. The employee apparently used obscene language. The use of this language allegedly exacerbated the situation to the point that the client threw several objects at the employee. A struggle ensued in which client and employee wound up in the pool. It is alleged that the employee dunked the client's head under water several times. The employee was suspended as a result of this conduct.

In addition, another employee is described in the institution's files for this incident as routinely using obscene language toward many clients. This employee is also alleged to pull hair and use other inappropriate contact to effect simple tasks. This other employee was also suspended as a result of these allegations.

These incidents were not reported to the District Attorney, although they raise possibility of charges of criminal assault, a Class D offense, 17-A M.R.S.A. § 207, or disorderly conduct, a Class E offense, 17-A M.R.S.A. § 501. All of the evidence may later indicate that the force used may have been within that allowed by law under the circumstances, and a prosecutor might justifiably conclude the isolated use of obscene language alone should

not result in a criminal charge. Nonetheless, these incidents should have been reported to the District Attorney to allow him to make the appropriate prosecutorial determinations. Since the statute of limitations has not run, it is recommended that such a report be made in this case.

G. Alleged Physical Abuse

In August, 1983, an employee of Pineland Center was alleged to have dropped from a standing position to his knee, pushing into the abdomen of a client. Another employee is alleged to have witnessed this incident. The employee was suspended as a result of this conduct.

This incident was not reported to the District Attorney. It raises, however, the possibility of a charge of criminal assault, a Class D offense. 17-A M.R.S.A. § 207. Because the statute of limitations has not yet run, and it appears from the reports available that the alleged assault was witnessed by at least one other employee, it is recommended that the matter be forthwith reported to the District Attorney.

CONCLUSIONS

From the seven (7) cases reviewed, it is readily apparent that the system established by the Department for the identification of instances of client abuse is working satisfactorily. Each instance was properly reported to Departmental officials and a disciplinary determination was made or the employee resigned. As to criminal prosecution, the Department reported two (2) cases to the District Attorney. Of the remaining five (5), this Office recommends that four (4) should have been reported, although the evidence in some or all of these cases may not be strong enough to warrant actual prosecution. In any event, since the applicable statute of limitations has not run in any of these cases, this Office recommends that a report in each case now be made. The final case, involving the death of a client and thus falling directly within the Attorney General's jurisdiction, was reviewed and found not to involve criminal conduct.

With regard to the differences between the Department's actions and this Office's recommendations as to reporting incidents to the District Attorney, this Office emphasizes that these appear to be the product of differing views of the controlling statute, rather than any misconduct by the Department. As indicated above, 22 M.R.S.A. § 3485 requires that a report be made by the Department "upon finding evidence

indicating that a person has abused, neglected or exploited an incapacitated or dependent adult." In some cases, the Department has apparently made the judgment itself that, although evidence exists as to possible criminal conduct, such evidence was not strong enough, or the conduct itself was not serious enough, to warrant prosecution. Consequently, it made no report. In the view of this Office, such a judgment, under the statute, should be made by the District Attorney. Thus, the Department should in the future be more liberal in advising the District Attorney of instances of abuse.

In order to effect these recommendations, this Office proposes the following:

1) The Department should consider seeking an amendment to 22 M.R.S.A. § 3485 to make the standard for reporting one of "reasonable suspicion," rather than the possession of actual evidence. Even absent a statutory mandate, such a standard should be adopted as a Department policy to insure that information as to possible criminal behavior is brought promptly to the attention of the District Attorney at least for further investigation, if not prosecution.

2) A written policy and form for the reporting of possible criminal violations should be developed by

the Department in conjunction with the Cumberland County District Attorney. The form should provide the basic information required by a police investigator to commence an investigation.

3) The duty to transmit this form to the District Attorney should be placed upon the Resident Advocate, although the Resident Advocate's decision not to report should be reviewied by the Chief Advocate, Commissioner, and the Assistant Attorney General assigned to the Department, and that these three officials constitute a permanent working group for the supervision of the entire reporting system. In any event, where no report is made, a memorandum should be included in the file stating why no report was made, and a copy of the memorandum should be sent to the Consumer Advisory Board.

4) In any case where physical evidence may be important, the duty to notify the District Attorney should also fall to the senior person on duty at Pineland Center at the time. Such notification may include telephonic notification to the duty officer for the District Attorney. However, telephonic notification should not be used as a substitute to formal written notification by the Resident Advocate.

This Office views these recommendations as helpful refinements to a system which has already shown itself on the whole to be reliable in bringing instances of possible abuse to light. They are made only to insure that the system operates in the most effective possible manner.

Finally, we wish to acknowledge the complete and unimpeded cooperation which we received from everyone employed by the Department of Mental Health and Mental Retardation in providing to us the files, papers, and other information necessary for the preparation of this report. The dedication of the Department to the well being of the residents of Pineland is apparent to everyone involved.