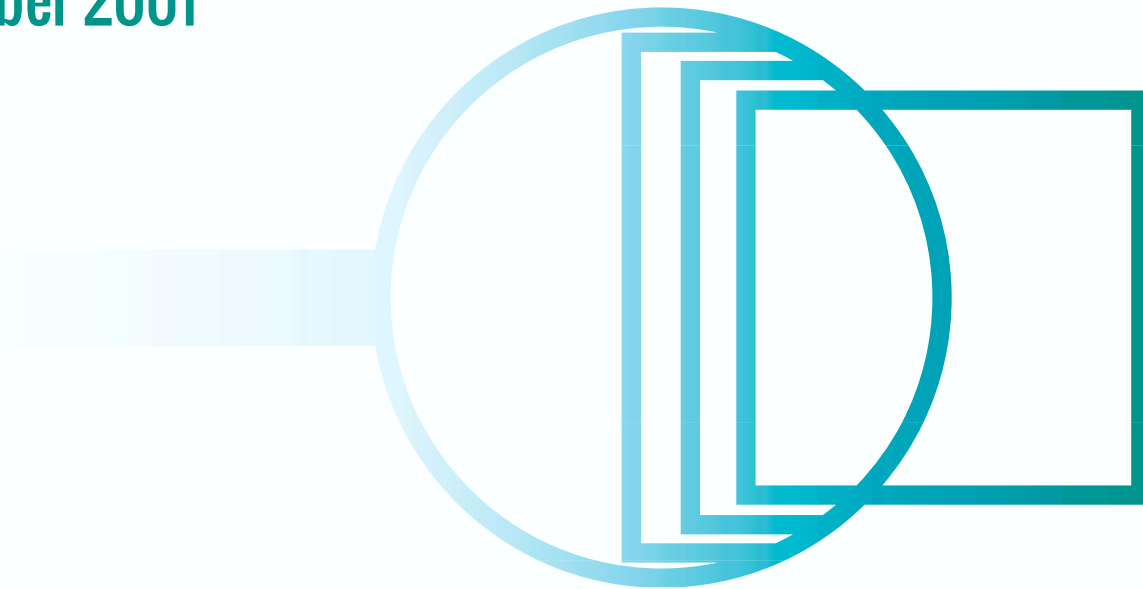


# Guidelines for Investigation of Significant Incidents in OMH Facilities

September 2001

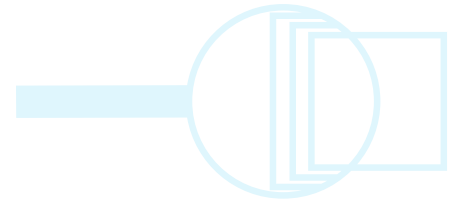




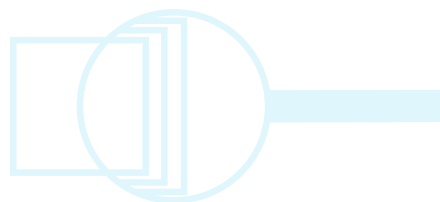
## Acknowledgments

The Office of Mental Health would like to recognize the array of people who contributed to this volume. The first *Manual for Special Investigations* was written more than 20 years ago. Major contributors at that time were Frank Garey, Robert Morrison, Philip Scott, and Antone Aboud. The current version was the product of a work group organized by Jayne Van Bramer of the Bureau of Quality Management, in collaboration with John Manning and Ned Mack of the Bureau of Employee Relations as well as Michael Dufresne of the Bureau of Investigations and Audit. In addition to these people, the work group included Peter Behm, Beth Fishner, Brenda Henderson, Robyn Katz, Kate McKee, Lynn Schuetrum, Beth Ulrich-Salvatore, David Wenger (chairperson and writer), Nancy White, and Julie Zweig. Design and layout was provided by Walter Boppert of OMH Public Affairs.

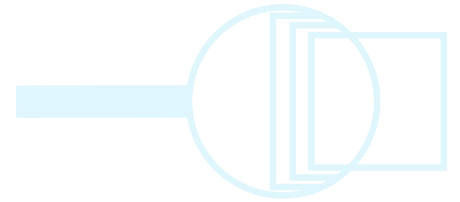
# Table of Contents



<b>Chapter 1: Introduction</b> .....	5
Purpose and Scope of Manual .....	5
Objectives of Major Incident Investigations .....	5
Staffing: Who Should Conduct the investigation? .....	6
Criteria for Conducting a Special investigation .....	8
Collateral Uses of Investigative Result .....	9
<b>Chapter 2: Principal Parties in an Investigation</b> .....	11
The Clinical Risk Manager/Clinical Risk Management Specialist .....	11
The Administrator on Duty or Administrator on Call .....	12
The Examining Physician .....	13
The Executive Director .....	16



<b>Chapter 3:</b>	
<b>Conducting a Special Investigation</b> .....	19
<b>Phase One: Preliminary Steps</b> .....	20
Actions on Receipt of Report .....	20
Actions at the Scene .....	21
Retention and Separation of Witnesses .....	23
Preserving Physical Evidence .....	24
Photographic Evidence: Production and Preservation .....	26
Medical Examination of Victim .....	27
Photographing Visible Injuries .....	28
Documentation .....	28
Incidents Involving Violations of Law .....	29
<b>Phase Two: Witness Accounts</b> .....	31
The Investigative Interview .....	31
Scheduling .....	31
Preparation .....	33
Conducting the Interview .....	35
Special Witness Categories .....	41
The Reluctant Witness .....	41
The Client.....	43
The Target of Discipline .....	44
Supervisory Witnesses .....	49
Written Statements.....	51



**Phase Three: Analysis of Evidence**.....57

    Assembling Evidence .....57

    Evaluating Witnesses .....57

    Developing a Theory of the Case .....61

    The Investigative Report .....64

**Appendices**

**A.** Sample CRM/CRMS’s Check List .....67

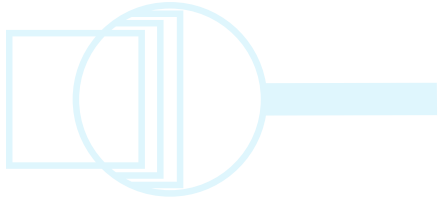
**B.** Items to Include in Witness Statement .....71

**C.** Case Study: Patient Smith’s Allegation of Physical Abuse .....73

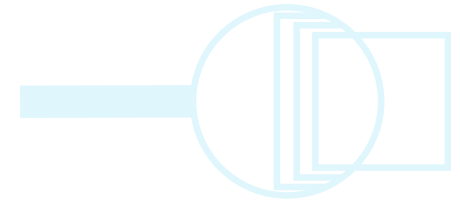
**D.** Sample Investigative Report.....77

**E.** Sample Employee Representation Form.....87

**F.** Incident Prevention, Clinical Risk Management and Quality Improvement .....89



# Chapter 1: Introduction



## Purpose and Scope of Manual

Part 524 of the Codes, Rules and Regulations of the State of New York mandates that all programs operated or licensed by the Office of Mental Health have in place viable incident management programs and take responsibility for prompt investigation of all incidents.<sup>1</sup> These regulations define “investigation” as the “systematic collection and examination of the information and circumstances surrounding an incident.”

At a minimum, a rudimentary examination of the circumstances surrounding each incident shall be completed. The need for any further investigation shall be commensurate with the seriousness and circumstances of the incident.<sup>2</sup>

OMH policy (QA-510) has further stipulated that, when certain types of incidents occur in State-operated facilities, a “special investigation” should be conducted by staff specifically trained and designated by the facility director to perform this function.

This manual is intended to serve as a training tool for the conduct of special investigations. It spells out detailed steps on how to conduct such an investigation and addresses such topics as collecting evidence, conducting interviews and interrogations, documenting discussions and observations, analyzing evidence, preparing a report, and a variety of other techniques.

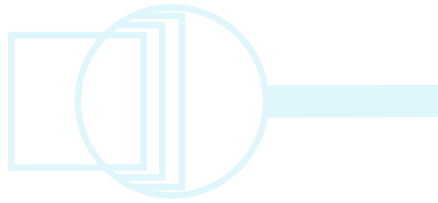
## Objectives of Major Incident Investigations

The ultimate purpose of all aspects of an incident management program, including special investigations, is to protect the health and safety of clients and enhance their quality of care. The special investigation advances this ultimate purpose through the following more immediate objectives:

- ◆ To determine the facts of what occurred regarding a particular incident. The investigator is primarily concerned with fact finding, through review and analysis of available evidence and witness accounts. It is his or her task to identify the fundamental reasons the incident occurred. These may be facts regarding the actions of specific employees, including mistakes and misconduct, or they may be facts

1 Part 524 defines Incident as “an event involving a client who receives services provided by a mental health program, which has or may have an adverse effect on the life, health or welfare of the client and/or another person.”

2 From Part 524.6(d)(1) of the Codes, Rules and Regulations of the State of New York.



regarding clinical or non-clinical systems, processes and areas of risk which preceded and contributed to the problem.

- ◆ To assist in preventing recurrence of similar incidents, to reduce risk and to improve the quality of care through analysis of facts, processes and circumstances that contributed to the situation and the identification of opportunities for improvement in the overall system of care which may be addressed through plans of correction and/or prevention. Examples might include additional training, revision of policies and procedures, the development of a new tool, etc.
- ◆ To assist the facility in preparing for appropriate administrative action, should the investigation show that one or more employees may be guilty of misconduct or incompetence.
- ◆ To assist law enforcement agencies, should the circumstances of a particular incident show that criminal investigation is warranted.

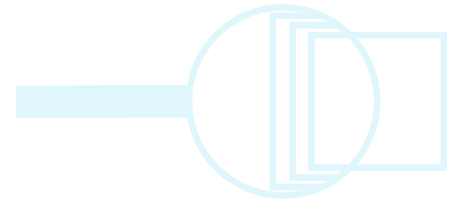
This edition of the Manual for Special Investigations envisions a shift in emphasis from the traditional focus on problematic staff behaviors to an approach that places more emphasis on systems analysis, risk management, quality improvement, and incident prevention. Although it is usually possible and appropriate to identify variations in individual performance which contributed to a particular incident, the ultimate health and safety of clients in the program are best served when the facility identifies the clinical and non-clinical systems, processes and areas of risk which precede and contribute to the human factors, notes the opportunities for improvement in these systems, processes and risk areas, and develops, implements and monitors plans of correction and prevention that reflect those opportunities. The role of the trained investigator is primary in determining underlying factors that contributed to the incident and identifying the opportunities for improvement.

## Staffing: Who Should Conduct the Investigation?

The key to quality special investigations is the investigator. A special investigation is more than the application of a series of techniques, as outlined in this manual. It is a comprehensive, objective process conducted by experienced staff persons who understand the clinical and administrative settings in which they work and who have, in addition, special skills derived from both training and experience as investigators. In addition, they are committed to quality inquiry in the interest of improved systems and reduced risk in the mental health care delivery system. This investigative process can best be accomplished when trained staff are freed to do such work unencumbered by other responsibilities and loyalties.

Previously, clinical and administrative staff in State facilities were trained as special investigators and assigned to conduct special investigations from an on-call roster on a rotational basis. After an incident had received cursory review and a decision had been made that a special investigation was needed, one of these rostered special investigators would be assigned to the case. A review of this rotational system suggested that





staff whose primary responsibilities lie outside the domain of investigation and quality improvement may experience conflicts of interest and priority which may inhibit the thoroughness, objectivity and/or timeliness of the investigation.

In light of the importance of objectivity and timeliness in the conduct of investigations, as well as in the initial stages of incident review, and in light of the essential connection between well conducted investigations and the quality improvement functions outlined in Appendix F, the Office of Mental Health has established Clinical Risk Management Teams in each of the State facilities. Each team is headed by a Clinical Risk Manager, who reports to the CEO/Designee (typically the Quality Director), and includes at least one Clinical Risk Management Specialist.

The members of the Clinical Risk Management team are engaged full time in clinical risk management and quality improvement functions and have no other clinical or line responsibilities. The Clinical Risk Manager and his/her staff have the responsibility for reviewing all incidents to determine what level of investigation is appropriate. They are also responsible for conducting all special investigations. The number of Clinical Risk Management Specialists varies from facility to facility, depending upon the size of the facility and the volume of incidents reported. Optimally, however, no facility should have less than one Clinical Risk Manager and one Clinical Risk Management Specialist, in order to provide backup coverage, provide for multiple investigations, provide mutual support, and perform other Quality Assurance/Clinical Risk Management tasks.

Clinical Risk Management staff should be experienced in clinical, administrative and information management areas, have demonstrated an ability to analyze systems and processes, identify opportunities for improvement in the delivery of care, and provide consultation in the design of workable plans of improvement, and have received formal training in the conduct of special investigations. They should also be cross trained in all Clinical Risk Management tasks and activities to ensure uninterrupted surveillance of events of significance to clinical risk management and quality improvement.

Throughout this manual, the person responsible for conducting a special investigation will be referred to as the Clinical Risk Manager/Clinical Risk Management Specialist, or the CRM/CRMS.

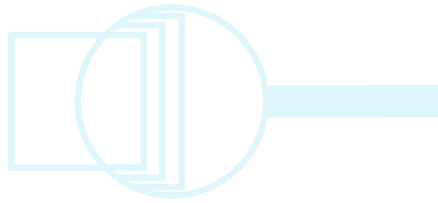
Besides the Clinical Risk Manager/Clinical Risk Management Specialist(s), several other persons may play key roles from the time an incident occurs until an investigation is completed. This Manual provides policy and procedure guidelines for each party normally involved in the investigation process:

**The Clinical Risk Manager/Clinical Risk Management Specialist.**

**The Administrator on Duty or Administrator on Call.**

**The Examining Physician.**

**The Executive Director.**



While separate discussions are included for each of the above, the reader is encouraged to become familiar with the entire Manual, so that the basis for a successful inquiry may be better understood by all concerned.

## Criteria for Conducting a Special Investigation

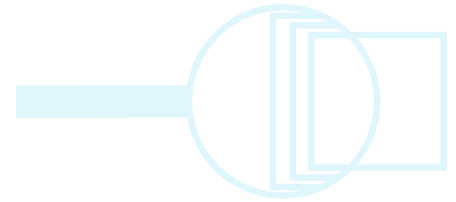
A special investigation is to be conducted for all high risk incidents: incidents involving the serious injury or death of a client or staff member, particularly those in which employee misconduct and/or incompetence is suspected or the circumstances are suspicious or unexplained, and allegations of client abuse. At a minimum the following types of incidents should always trigger a special investigation:

- ◆ Homicides
- ◆ Suicides <sup>3</sup>
- ◆ All Other Inpatient Deaths except Natural Deaths
- ◆ Homicide and Suicide Attempts by Inpatients
- ◆ Reasonably Reliable Allegations of Abuse and Neglect (Physical, Sexual, Psychological) <sup>4</sup>
- ◆ Serious Assaults<sup>5</sup> involving Inpatients, including Sexual Assaults
- ◆ All Life Threatening Injuries
- ◆ Escaped/Endangered Clients
- ◆ Other Events that Jeopardize a Client's Life

<sup>3</sup> For facilities that have historically conducted clinical reviews but not special investigations on suicides and suicide attempts, it may be advisable for the Clinical Risk Management team to consult with the staff who have been conducting the clinical reviews to generate a special investigation review that incorporates elements of both processes.

<sup>4</sup> An allegation must be considered *reasonably reliable* unless there are known facts immediately available when the statement first comes to staff attention which render all critical aspects of the statement inaccurate. For purposes of incident reporting and investigation, reasonable reliability is a judgment about a statement, not about the condition, competency or credibility of a client. Essentially, to say a statement is not reasonably reliable is to say that there is no possibility of its being true. Finally, whenever a client is injured and there is also an allegation of abuse, a special investigation should be conducted without consideration of whether or not the allegation is reasonably reliable.

<sup>5</sup> Serious Assaults are defined here as those that result in life-threatening injuries requiring emergency life saving procedures (e.g., CPR, intubation, surgery, etc.); injuries requiring treatment in an emergency room or admission to a hospital; life threatening psychiatric conditions as evidenced by suicide or homicide threats or attempts, or the need for a major change in treatment (i.e., a more intensive treatment setting or level of supervision); and/or risk for serious medical or psychiatric complications or life threatening harm.



For other types of incidents the investigation may be upgraded or downgraded at the discretion of the Clinical Risk Manager and/or Clinical Risk Management Specialist, in conjunction with the hospital administration, as the findings of the investigation unfold. For example, following a preliminary investigation of an unexplained injury, the Clinical Risk Manager may initiate a special investigation to explore questions about the origin of the injury. In this case, if evidence emerged which substantiated self injury while on pass, the Clinical Risk Manager may decide not to proceed with the special investigation. The pertinent evidence will nevertheless have been objectively collected and assessed, and the reason for downgrading the investigation justified in light of the evidence. Please note, however, that once a reasonably reliable allegation of abuse or neglect has been made, a special investigation must be conducted and cannot be downgraded.

In addition to the minimum criteria listed above, the facility Executive Director, the Chief Medical Officer, or the Central Office Director of Quality Management may request that a special investigation be conducted on any other incident. For all investigations, the Executive Director has overall responsibility and oversight, and the final report is presented to him/her.

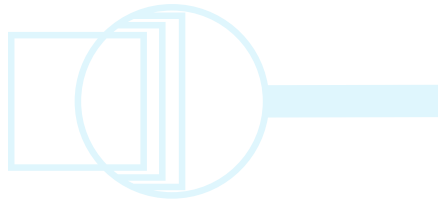
## Collateral Uses of Investigative Results

Users of this manual should be familiar with certain collateral procedures which have or may have a bearing on a particular incident investigation:

- ◆ General investigative procedures applicable to all client incidents.
- ◆ Clinical risk management and quality improvement
- ◆ Employee discipline for misconduct or incompetence.
- ◆ Investigations conducted by police or other law enforcement agencies.

Following is an overview of the above areas. You are encouraged to obtain additional information from the sources indicated, based on your particular needs.

**General Incident Review Procedures:** Part 524 of NYCRR outlines the incident management requirements of programs operated or licensed by the Office of Mental Health. The OMH Policy Manual outlines standing procedures for investigation of all significant incidents involving clients. It also specifies the criteria defining a Sentinel Event and the procedures for conducting a Root Cause Analysis. Incidents fitting the definitions set forth in the preceding section, are singled out for treatment as special investigations, and this manual provides guidelines for conducting such an investigation. However, you are encouraged to become familiar with the NYCRR regulations on incident management, the entire Policy Manual sections on both incident management (section QA-510) and sentinel events (QA-535), as well as any local incident review procedures applicable to your facility.



**Clinical Risk Management and Quality Improvement:** If clinical risk management is to achieve the goal of “preventing recurrence of incidents through analysis of facts, processes and circumstances that contribute to the situation,” as articulated above (page 6), the investigation process must be but one part of an array of risk management and quality management efforts focused on the identification of areas of risk and the improvement of processes and outcomes of care. Appendix F outlines some of the interrelated quality improvement functions performed by the Clinical Risk Management teams.

**Employee Discipline:** Employees guilty of misconduct or incompetence are subject to formal discipline, with penalties ranging up to and including dismissal. The majority of OMH employees are governed by negotiated disciplinary procedures incorporated in the State’s Collective Bargaining Agreements with the principal unions. Currently, those procedures are set forth in agreements with the Civil Service Employees Association (CSEA), the Public Employees Federation (PEF), Council 82, and the New York State Correction Officers and Police Benevolent Association. Employees of programs licensed by OMH may be governed by other collective bargaining agreements, and the CRM/CRMS will need to be familiar with the procedures applicable to the setting in which the investigation is being conducted.

**Criminal Investigations:** OMH facilities are bound by statute and agency policy to report incidents which may constitute a crime. Examples include assault, rape or other sexual abuse, and larceny. Procedures for reporting such matters are discussed in Chapter III.

## Chapter 2: Principal Parties in an Investigation

The Clinical Risk Manager/Clinical Risk Management Specialist carries the primary responsibility for the conduct of special investigations. The Examining Physician and the Executive Director, however, are also key players, and the Administrator on Duty or Administrator on Call will sometimes play a critical role. The specific roles of each of these individuals are presented below. For each player, however, the first step in responding to any incident is to ensure the well-being and appropriate care of the client and/or other persons involved in the incident and assuring the ongoing appropriate care of the other clients on site. The second step is to take immediate actions to safeguard and preserve facts and evidence regarding the incident.

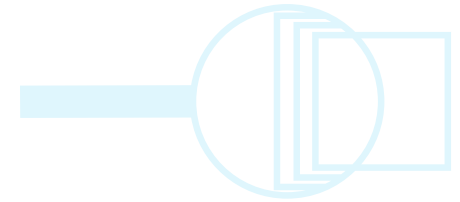
### The Clinical Risk Manager/Clinical Risk Management Specialist

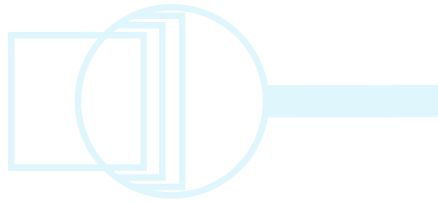
The term “Special Investigation” refers to a comprehensive, objective investigation and analysis of client-related incidents, conducted in the manner described in Chapter III of this manual. Except by special arrangement, all special investigations will be conducted by the Clinical Risk Manager or designated Clinical Risk Management Specialists (CRM/CRMS), who have received specialized training in investigative procedures.

All facility incidents are to be reported to the Clinical Risk Management team. The team, in turn, has the responsibility to review each report to assess the circumstances surrounding the incident, conduct a preliminary investigation, if indicated, and determine what level of investigation is appropriate. In addition, Clinical Risk Management staff should review safety reports, morning rounds reports, and change of shift reports and take other proactive measures to assure that all events that qualify as incidents are reported and investigated appropriately.

If preliminary information indicates that a special investigation is warranted, the Clinical Risk Manager/Clinical Risk Management Specialist should assume the following responsibilities, which are presented in more detail in Chapter III:

- ◆ Personally report to the incident scene and assume overall charge of the investigation.
- ◆ Secure the scene and either take or direct other actions necessary to ensure that the subsequent investigation will be comprehensive and productive.
- ◆ Carry out the investigation, securing assistance as needed from other management or clinical staff.





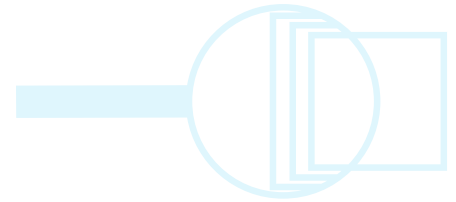
- ◆ Advise the Executive Director or designee of progress and major developments.
- ◆ Prepare a final investigative report.
- ◆ Advise and assist management in its pursuit of follow-up actions, such as identification of opportunities for performance improvement, the development of plans of corrective/preventive action, and employee discipline.

## The Administrator on Duty or Administrator on Call

Should an incident of a severe nature occur on evenings, nights or weekends, the Administrator on Duty (AOD) or Administrator on Call (AOC) is to be notified and, for incidents that meet the criteria specified on pages 8 and 9, above, the AOD/AOC should contact the Clinical Risk Manager or Clinical Risk Management Specialist on call to reach a decision whether or not a special investigation should begin immediately. If it is decided that such an investigation needs to be started, the CRM or the assigned CRMS is expected to come to the facility and begin the investigation immediately.

Until the Clinical Risk Manager or Clinical Risk Management Specialist arrives on the scene, the AOD/AOC should take the following steps to assure that critical information is preserved and necessary immediate actions taken:

- ◆ Gather preliminary information - exact time and location of incident, name and medical condition of the client, names and titles of employees who witnessed the incident or were in the vicinity when it occurred, name, title and phone extension of the person giving the initial report, staffing records, and names and identifying information on potential client witnesses;
- ◆ Secure the scene and all pertinent documents, including the medical record;
- ◆ Confirm that the physician has conducted an examination;
- ◆ Arrange for color photographs of visible injuries and, if relevant, the scene of the incident;
- ◆ Separate all witnesses from each other and instruct them to remain on duty until released.
- ◆ If an allegation of abuse or assault has been made, the alleged perpetrator must be separated from the alleged victim. If the alleged perpetrator is an employee, he or she should be removed from the unit on which the patient resides and instructed not to visit the ward. If the perpetrator needs to return to the ward for his/her possessions, an escort should be provided to assure separation from other witnesses.



## The Examining Physician

The examining physician plays a key role in the investigation and follow-up of major incidents. Essentially, that role is as follows:

- ◆ To conduct a prompt, thorough medical examination of the client or other victim of such an incident.
- ◆ To render emergency and follow-up medical care as required.
- ◆ To document findings and treatment orders in the client's record.
- ◆ To prepare a comprehensive report of medical findings, including a statement of the age, shape, color, size and stage of any injuries, whether or not a subsequent assessment needs to be made, and, if so, the nature of the subsequent assessment and when it should be conducted.

If you are called upon to serve as physician on duty or on call, review the following procedures carefully. They will assist you in fully executing your important responsibilities relative to the examination and care of a person(s) involved in a serious incident.

## Reporting to the Scene

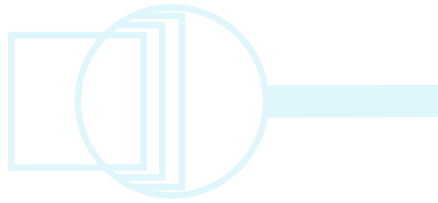
OMH and facility procedures provide for immediate notification of the physician on duty, in case of an incident involving actual or suspected injury to a client or other person. Normally, the notification will be made by telephone, by the nurse on the unit where the incident occurred. It may also come directly from the Clinical Risk Manager/Clinical Risk Management Specialist or from the person who first witnessed or learned of the incident, if a life-threatening or other serious emergency exists.

On receipt of such a report, determine the client/victim's location and apparent condition. If possible, speak with the senior clinical supervisor (e.g., Nurse Administrator or Team Leader) on duty at the scene. Issue any necessary instructions to the caller regarding first aid treatment and the client's anticipated medical needs (e.g., for transportation to a hospital emergency room), and proceed at once to the scene.

## Actions at the Scene

On arrival, examine the client and provide or order treatment as needed. Carefully review the injured area(s) to determine the following:

- ◆ The extent of presenting or suspected injuries.



- ◆ A detailed description of the injuries, including their shape, color, size and stage, to aid in determining the age of the injuries as well as their most likely cause(s).
- ◆ Whether or not the injuries are consistent with the description of the occurrence as it is being stated.

The above information will be crucial to any subsequent investigation of the incident. As the examining physician, you are in the best position to observe and make professional judgments about any medical evidence present, while that evidence is fresh. As discussed further below, the Clinical Risk Manager will use your written report, and your oral description of findings, to help determine the most probable fact pattern leading to the incident. Be prepared to cooperate fully with this person on all aspects of the case.

Use great care in handling and preserving physical evidence found in or around the site of the incident or on or about the client's person (hair, tissue, fibers, etc.). Bring these items to the Clinical Risk Manager/Clinical Risk Management Specialist's attention as soon as possible. He or she will take charge of the material and see that it is placed in containers intended for this purpose. Assist the CRM/CRMS as necessary in identifying and labeling the evidence. Each item should bear the following information:

- ◆ A brief description
- ◆ Date, time and precise location where found
- ◆ Any other identifying information

Describe each item of evidence in your report of findings. Having examined and treated the victim and preserved any physical evidence present, your next step is to prepare a written report of your findings and actions. This is done on the Physical Exam Findings Screen of the New York State Incident Management and Reporting System (NIMRS). Include the following:

- ◆ A clear, concise summary of the victim's general medical condition on examination.
- ◆ Sufficient detail about the injured area(s) to enable the reader to develop a clear picture of your observations and conclusions. As noted above, be certain to include the nature, age and probable cause of any injuries noted.
- ◆ A description of any other medical evidence found on or about the client's person (hair, blood, tissue, etc.); note the steps taken to preserve such evidence, and the location(s) where it was found.
- ◆ A brief description of treatment rendered and/or ordered.

When your section of NIMRS is complete, review the information with the Clinical Risk Manager or Clinical Risk Management Specialist. Preferably, this should be done before you leave the incident scene. If your



duties require that you leave the unit before the CRM/CRMS arrives, leave your expected itinerary with the AOD/AOC/Unit Chief. It is imperative that you meet with and brief the CRM/CRMS during your tour of duty.

## Client Statements

Ascertain the circumstances of the injury/injuries. Be alert for things the client may say in your presence regarding the incident and/or injuries. Because you will often be the first person to render substantive treatment and, because of your natural supportive role as a physician, the victim may volunteer crucial information before, during or after your examination. Listen carefully, record this information, and speak with the CRM/CRMS at the earliest opportunity about any statements the client may make to you or in your presence. The CRM/CRMS will decide on how to handle this information.

## Sample Report of Findings and Treatment

Following is an illustrative example of the elements to be included in your section of the Incident Report:

### ◆ **General Medical Condition of Victim:**

30 year old white male; conscious; oriented as to person, place, time; v/s T98.6 P60 R20 BP 120/80; ambulatory; no obvious impairment of motor or neurological functions.

### ◆ **Trauma Noted:**

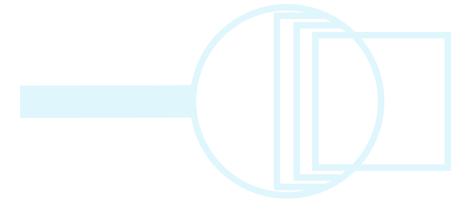
- Beginning hematoma and swelling of right eye.
- Superficial 4 cm laceration of medial aspect of right eyebrow.

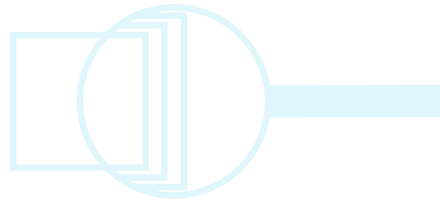
No other injuries noted. Injuries believed to have occurred within one hour of exam. Probable cause: Right occipital area struck by or against a hard, relatively smooth object.

◆ **Other Physical Evidence:** Several human body hairs removed from area surrounding laceration; apparently deposited there at time of injury. Placed in labeled plastic container and consigned to Clinical Risk Manager John Bell.

◆ **Client Comment:** Client agitated, states MHTA hit him with his key chain because the client demanded a smoking break.

◆ **Treatment:** Topical medication applied to laceration and occipital area. Skull and facial x-rays ordered to rule out fx. Client to be observed closely for signs of concussion.





## The Executive Director

### The Broader Context: Clinical Risk Management

As the Facility's Chief Executive Officer, the Executive Director carries overall responsibility for the health and safety of clients in the facility's care and for promoting improvements in performance and quality of care. The Director plays a critical role in setting the tone of the facility, including the degree of openness to opportunities for improvement. It is imperative that the Director provide solid direction and support for the facility's total clinical risk management program, including the management of incidents, the conduct of major incident investigations and root cause analyses, and the development and implementation of plans of preventive and corrective action.

The Director is thus advised to periodically review the full range of clinical risk management functions and quality improvement opportunities throughout the facility (some of which are enumerated in Appendix F), assess the facility's capability and structures for fulfilling these responsibilities, identify the variety of tasks in which Clinical Risk Management staff should participate directly, as technical resources, or in an educational, consultative or oversight capacity, and provide a staffing pattern that will equip the facility to accomplish these tasks.

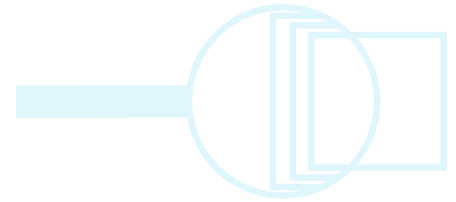
A special investigation makes an important contribution to clinical risk management efforts by identifying the fundamental reasons the incident occurred. Although it is usually possible and appropriate to identify variations in individual performance which contributed to an incident, programs interested in incident prevention will also identify the clinical and non-clinical systems, processes and areas of risk which precede and contribute to the human factors, will note the opportunities for improvement in these systems, processes, and risk areas, and will develop, implement and monitor plans of correction and prevention. The encouragement and support of the Executive Director for these clinical risk management activities is essential.

### Notification to Director when a Major Incident Occurs

The Director must be notified promptly of all serious incidents and briefed as quickly as possible on the surrounding details. Normally, the Director is notified by the Clinical Risk Manager.

### Actions on Receipt of Report

Sections A and B above describe the preliminary steps to be taken by the Clinical Risk Manager/Clinical Risk Management Specialist or, in their absence, the Administrator on Duty/Administrator on Call, immediately following an incident involving client injury and/or suspected employee misconduct or incompetence. As Executive Director, you should be thoroughly familiar with these steps. In substance, they are designed to



ensure that the client or other victim is promptly and adequately cared for; to safeguard the principal sources of evidence and testimony regarding the incident; and to assure that top management is informed promptly about incidents that may merit special investigation.

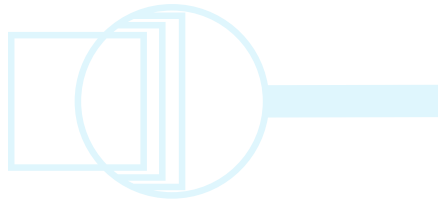
On receipt of the initial verbal report, question the CRM/CRMS to be certain all of these items have been covered. Of particular importance are the retention and separation of witnesses and the securing of the incident site to prevent removal or alteration of physical evidence.

Next, confer with the CRM/CRMS about the parameters of the incident and the necessity for further investigation. Unless the circumstances of the case are extremely obvious and straightforward, a detailed investigation is undoubtedly warranted. Steps in a typical investigation are described in Chapter III of this Manual. The CRM/CRMS is your principal designee in this matter. He or she is specially trained to carry out the various procedures, and to advise you periodically of results. However, be certain you have a clear understanding with the CRM/CRMS about what is to be done, and when you may expect to receive preliminary and follow-up reports. Indicate clearly who is to receive reports in your absence, and the limits of that person's decision-making authority. For example, you may or may not wish to authorize your designee to approve disciplinary action against an employee implicated in the incident.

### Notification of Outside Parties

The Executive Director/designee is charged with notifying the following persons or agencies in accordance with OMH official incident management policy (QA-510):

- ◆ OMH Central Office
- ◆ Local Police and/or District Attorney
- ◆ Parole/Probation
- ◆ A victim's next of kin
- ◆ Board of Visitors
- ◆ Mental Hygiene Legal Services
- ◆ Commission on Quality of Care
- ◆ New York State Child Abuse Registry, if a minor is involved
- ◆ Medical Examiner/Coroner, in cases of unexpected death, homicide or suicide.



Notification of law enforcement officials will depend upon whether or not it appears that a crime may have been committed by one or more persons involved in the incident and whether or not there is a need for investigative assistance.<sup>6</sup> If serious misconduct (e.g., assault) is suspected, it is prudent to make the notification promptly, allowing police officials an opportunity to review available evidence while it is fresh. The Mental Hygiene Law authorizes the Director to bring criminal charges against persons engaging in unlawful behavior with/against a Psychiatric Center client. As a matter of policy, OMH is committed to taking such action, particularly if the client/victim is unable to initiate it personally because of mental status or incompetency.

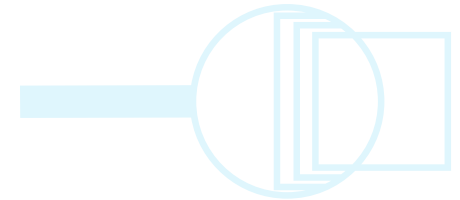
## Conduct of the Investigation

As explained above, the Clinical Risk Manager is charged with advising you periodically about the results of his/her inquiry. Such reports should be given priority attention and action. For example, a recommendation to suspend or reassign an employee who is a likely target of discipline requires immediate consideration. Keep in mind that there may be systemic factors which contributed to the incident, such as clinical practices, problems in the physical plant, education and training needs, supervision issues, or policy deficiencies, and you will need to assure that these factors are addressed. Be certain that your Personnel Officer, Deputy Director for Facility Administrative Services and other management staff likely to be involved in such decisions are aware that an investigation is in progress and are prepared to respond promptly with advice/recommendations. They should be available as necessary to advise and assist the CRM/CRMS, as the inquiry moves forward.

As Executive Director, you should expect to receive a final written report on the matter, as described on pages 64-66, below. Information in this report may indicate a need for corrective or follow-up actions. Again, your direction and support are essential if the clinical risk management tasks are to be sufficiently thorough to be useful, and if the information gathered is to be applied in ways that identify and address areas of risk, enhance performance improvement, and promote quality client care in your facility. You should play an active role in assuring the effectiveness of the entire incident management/clinical risk management system.

<sup>6</sup> For more information, see the definition of crime in the OMH Official Policy Manual, Section QA-510, as well as the footnote on crimes in QA-510 under Identification of Incidents. For detailed reporting requirements for events which may be crimes, see OMH Official Policy Manual, Section QA-530.

## Chapter 3: Conducting a Special Investigation



Media reports of a news story generally involve basic elements: *who, what, when, and where*. The task of the news reporter or commentator is to synthesize these elements as clearly and succinctly as possible, so that the reader or listener is readily able to grasp what happened.

Investigation of a major incident is an analogous process. As a Clinical Risk Manager/Clinical Risk Management Specialist conducting special investigations, you will work with all the elements normally of interest to the journalist. Your “audience” is the facility management, and/or others who must take action based on your findings. You will use several information sources to develop findings and conclusions about a particular case. Briefly, they are:

### Physical Setting

Generally, the incidents of concern here occur in locations used regularly in the course of facility operations. Examples include client bedrooms, treatment rooms and other areas of client living units. The CRM/CRMS has a twofold concern with respect to the incident site:

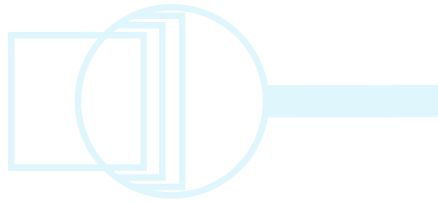
- ◆ To learn as much as possible about the probable chain of events, by studying physical features and objects, and by reviewing the placement of principal parties (witnesses, victim, etc.) at the time of the incident.
- ◆ To prevent the alteration or removal of physical features or evidence which may have a bearing on the case.

### Physical Evidence, including:

- ◆ Injuries to the client or other victim.
- ◆ Materials or objects which may have played a part in the incident, or which point toward a probable chain of events. Examples include damaged or upset furniture, blood or other spilled liquids, and potential “weapons.”

### Witnesses

- ◆ “Primary” witnesses include the victim and others who directly participated in and/or saw and heard what



happened. “Secondary” witnesses include those in the general area at the time, and other persons whose special expertise or knowledge will aid you in developing accurate findings and conclusions. The latter include clinical staff associated with the client/victim and supervisors of employee witnesses, as well as clients who may have been present or nearby immediately before, during and/or immediately after the event. Refer to *Special Witness Categories*, in Phase Two, below (beginning on page 31).

The purpose of this chapter will be to develop a series of procedures which will assist you in finding, processing and analyzing evidence relevant to special investigations.

## Investigations Supply Kit

Each facility must have readily available a series of tools and supplies which may assist the CRM/CRMS in the gathering of information. Such tools include at least two cameras (an “instant development” - Polaroid - model and a more sophisticated - 35 mm - camera), film, replacement batteries for beepers and cameras, a pocket tape measure and/or yardstick, protective gloves, containers for preserving evidence, such as plastic and paper bags, including zip-lock plastic bags, tags for labeling evidence, etc. A kit of such tools should be maintained in a central place at the facility and be available 24 hours per day seven days per week. New items should be added to the kit as you discover new tools of use in the investigation process. Routine provision needs to be made for replenishing the kit’s contents.

## Phase One: Preliminary Steps

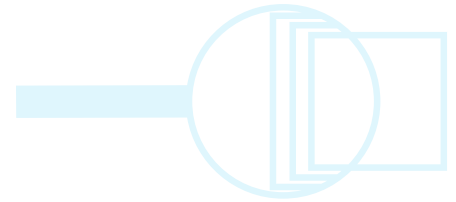
As soon as an incident is reported, someone must assume control of and begin processing information. If you are off grounds when you receive the incident report or if you cannot get to the scene immediately, you may need to contact the AOD/AOC/Unit Chief to ensure that necessary actions are being taken to assure the well-being of the client(s) involved and to safeguard and preserve facts and evidence regarding the incident.

As a Clinical Risk Manager or Clinical Risk Management Specialist, your actions must complement and build upon those that may have been taken before your arrival.

## Actions on Receipt of Report

Normally, incidents covered by this Manual will be reported to you via telephone by unit or program staff. Review the following points during this conversation:

- ◆ The location and time of the incident.
- ◆ The condition of the client(s) or other victim(s).



- ◆ Steps taken to ensure that injuries are promptly treated and appropriate medical care provided.
- ◆ Medical examination of the client/victim - Has it been initiated?
- ◆ The number and status of eye witnesses - clients, staff, visitors, etc.
- ◆ Steps taken to place the scene off limits.
- ◆ Steps taken to separate and retain witnesses and to remove the alleged perpetrator from the unit on which the alleged victim resides, as well as to assure that he or she will remain separated from both the alleged victim and other witnesses.

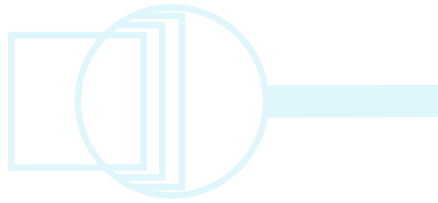
Determine whether you or some other administrator will reach the incident scene first. The administrator who is to arrive first must assume immediate charge of the scene, and must be prepared to follow through on the areas outlined above. If the AOD/AOC or Unit Chief will precede you, alert him/her that staff on the scene must be instructed to:

- ◆ Leave furnishings and other objects undisturbed.
- ◆ Refrain from cleaning up or removing spilled liquids or other physical evidence.
- ◆ Keep all employee and client witnesses separated and available until they are seen by the CRM/CRMS.
- ◆ Ensure that the incident scene is kept “off limits” to clients and staff to the fullest extent possible. If necessary, the Safety Department should be contacted for assistance.
- ◆ Secure the medical record and related documentation (assignment sheet, flow sheet, etc.), both as an information source and to assure that no insertions or changes are made in these documents after the incident is reported.

Next, proceed to the scene, as promptly as possible. The greater the delay in your arrival, the greater the possibility that witness accounts will be distorted and/or that physical evidence will be destroyed or contaminated. En route to the area, mentally review the information already at hand. Try to form a mental picture of the conditions you will likely encounter. Remember: to be effective, you must have a basic grasp of the situation and a tentative plan of how you will organize the investigation.

## Actions at the Scene

On arrival, you will assume overall charge of the incident scene. You will also initiate certain preliminary investigative steps. Those steps will basically dovetail with the information sources discussed in the preced-



ing section. The precise order in which you carry out the tasks below will depend upon the particular circumstances you encounter:

**The Physical Setting:** As you enter the area, review the entire scene carefully, including room(s), furnishings and equipment. Be careful to avoid contaminating or destroying available evidence. Have the AOD/AOC/Unit Chief accompany you, and discuss whatever information he or she has been able to gather about the scene.

Make notes about everything. **DO NOT RELY ON YOUR MEMORY.** Cover the following points with the AOD/AOC/Unit Chief, and with the building, living unit or clinic supervisor:

- ◆ Placement of furniture and equipment before and after the incident.
- ◆ Physical evidence discovered at or near the scene, such as blood or other spilled liquids, potential weapons, etc. Have these pointed out to you at once; refer to the evidence handling and preservation procedures discussed below.

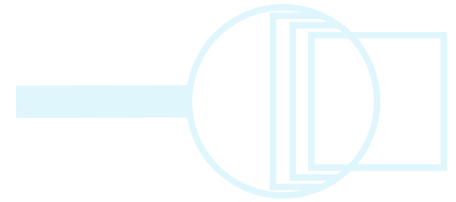
**Securing the Scene:** Next, see that your “off limits” orders are being carried out. If necessary, get assistance from the Safety Department to ensure that the incident area is secured and vacated by all persons not connected with the investigation. Ensure that staff leave furnishings and other objects undisturbed: and that they refrain from cleaning up or removing spilled liquids or other physical evidence.

**Visual Records:** Take immediate steps to visually record the appearance and features of the incident setting. Two principal methods are available; use both if the area contains significant physical evidence and/or cannot be verbally described simply and easily:

1. Photograph(s). Refer to the procedures outlined below for taking and preserving evidence photos.
2. A simple sketch of the incident scene. The sketch has several purposes:
  - ◆ To depict all significant items and conditions in and about the scene.
  - ◆ To establish a rough scale of distances and object sizes.
  - ◆ To show the placement of principal parties.
  - ◆ To assist you in the subsequent interviewing or interrogation of witnesses.

The sketch can be “roughed out” as a result of your preliminary examination of the site. Additions and refinements can be made as you gather information through the witness discussions. It is recommended that you carry a pocket tape measure to aid you in preparing your sketch accurately.





## Retention and Separation of Witnesses

In some cases, steps will have been taken to retain and separate eye witnesses and others who may have information about the incident by the time you reach the scene. Review the witness situation with the AOD/AOC/Unit Chief as you tour the incident site, to assure that all potential witnesses, both employees and clients or visitors, have been identified and retained. If necessary, speak individually with the principal witnesses to explain the need for their continued presence pending your discussions with them. As appropriate, take measures to assure that employees who are at or near the end of their shift remain on site until they can be interviewed.

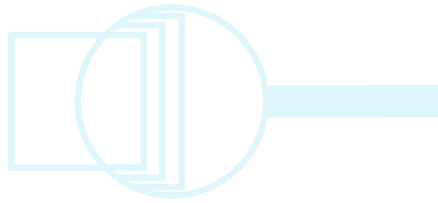
The client(s) or other victim(s) should also remain at the site, unless emergency medical treatment must be obtained elsewhere. Witnesses not associated with the facility (e.g., visitors) should be asked to remain.

**The Importance of Separating Key Witnesses:** The separation of key witnesses will reduce the possibility of collusion among employees or others who may be motivated to hide or distort the facts. It also helps preserve each party's independent recollections. You and the AOD/AOC/Unit Chief should take whatever steps are necessary to ensure that witnesses are adequately supervised pending their meetings with you.

**Separation of an Alleged Perpetrator from an Alleged Victim:** If an allegation of abuse or assault has been made, the alleged perpetrator must be separated from the alleged victim. This action should be accomplished by the person responsible for securing the scene. If the alleged perpetrator is an employee, he or she should be removed from the unit on which the patient resides. Depending upon the severity of the incident, the employee may be reassigned to another unit, assigned to an area of responsibility not involving contact with clients, or suspended from duty pending the outcome of the investigation. Instruct the alleged perpetrator not to visit the ward and, if he or she needs to return to the ward for his/her possessions, arrange for an escort to assure separation from the alleged victim as well as from other witnesses.

**Rationale for Separating the Targeted Employee:** Assuring the safety and stability of the patient must be the foremost concern. If the targeted employee is not removed from the unit, it implies that the facility may not be taking the incident seriously, sends a message to other patients that their concerns may not be heard, and discourages disclosure of abuse by staff. If the abuse has occurred and the target is not removed from the unit, he or she could offend again and would also have more opportunity to confer with potential witnesses, threaten the victim, alter medical records, etc. In addition, separating the targeted employee from the unit will allow for a more thorough and objective investigation which will ultimately protect employees from staff/patient uncertainty regarding the allegations. Further, making this a routine practice rather than a selective occurrence makes it a less stigmatizing experience. It is crucial that all allegations of abuse are taken seriously unless there is NO possibility that the incident could have occurred.

**Provision of Staffing for Ongoing Care of Clients:** Separation of staff witnesses will reduce the staffing on the site for direct client care. You will need to work with the AOD/AOC/Unit Chief to assure adequate staff



coverage. If necessary, secure staff from other units or draw on facility-wide administrative staff to provide ample coverage.

## Preserving Physical Evidence

Almost any physical object or substance associated with the incident scene may have a bearing on the case. Care and diligence are required in identifying items of possible relevance, and in handling and preserving these items. Major categories include:

- ◆ The scene itself. As discussed above, the area should be sketched and photographed during your preliminary review.
- ◆ Furniture and equipment. These items may help reveal crucial facts about the incident, by virtue of their placement and condition.
- ◆ Corroborative evidence, including hair, blood, fibers, tissue, or other materials that may be used for comparative analysis.
- ◆ Visible injuries to the client/victim or other person(s).

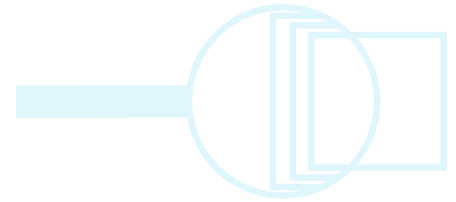
In cases in which it appears that a crime may have been committed, arrange for police officers to be contacted immediately to preserve the evidence.<sup>7</sup>

Use the following guidelines to identify and preserve pertinent items. There may be only one opportunity to skillfully perform the task of collecting and preserving physical evidence. All possible steps must be taken to prevent changes in its physical and/or chemical state and to establish the continuity of its possession and handling.

See that objects or materials are handled by as few people as possible. Preferably, the CRM/CRMS should assume possession and control of all items of evidence and retain possession at all times. The chain of evidence is weakened each time another person becomes involved. If the investigation results in a criminal or administrative proceeding, every person who handles evidence may be required to testify as to its identity, as well as the length and degree of control exercised. Do not allow staff to pass materials around for inspection.

Prepare a brief written description of each item of evidence. Attach the description to the object, or to its container. Include the following data:

<sup>7</sup> For more information, see the definition of crime in the *OMH Official Policy Manual*, Section QA-520, as well as the footnote on crimes in QA-510 under Identification of Incidents. For detailed reporting requirements for events which may be crimes, see *OMH Official Policy Manual*, Section QA-530.



- ◆ Date, time and location where the item was found.
- ◆ Date and time the item was placed in your custody or that of your designee.
- ◆ The identity of the person who first located the object.
- ◆ Brief description of the object.
- ◆ Pertinent remarks regarding its origin, connection with the incident, etc.

For example:

**Item:** Ward keys, belonging to MHTA John Smith.

**Found:** On floor of Ward 283, Building 35, near bed of Client Harold Donovan:  
8:30 p.m. September 30, 1999.

**Custody Assumed:** 9:30 p.m. 9/30/99 by Clinical Risk Management Specialist Harold Martin.

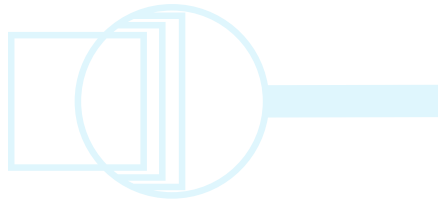
**Remarks:** “Client Donovan states that employee Smith struck him on the head with these keys. Keys have a reddish colored material adhering to them that looks like blood.”

Use great care in handling and preserving such “transitory” materials as hair, tissue, blood and chemicals. *Place each item in a clean, separate container, labeled or tagged as above.* If this material has the potential to be contaminated, standard precautions should be used when handling it.

Each OMH facility should have standing arrangements with one or more local laboratory facilities which can advise and assist in the identification, packaging and preservation of physical evidence. Contact the designated laboratory should you have questions about how to proceed with a particular item or substance.

Bear in mind that physical evidence may undergo contamination, loss or alteration for one or more reasons:

- ◆ A chemical composition change (e.g., of bloodstains), caused by touching the material and depositing perspiration on it.
- ◆ Loss by leakage, such as loss of a fine powder through a small hole in an envelope or other container.
- ◆ Evaporation or seepage of a liquid because a container was improperly sealed or was of semi-porous construction.
- ◆ Chemical or bacterial contamination, caused by using unclean containers.



- ◆ Mingling of evidence from various sources, when a common container is used.
- ◆ Alteration because of the unwitting addition of a new crease or fold in a material, or the tearing or cutting of a garment.

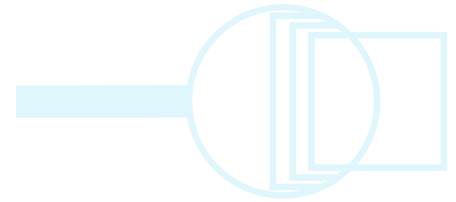
The general principle should be that physical evidence is a transitory commodity, often subject to rapid change over time. In spite of your best efforts, furniture may be moved, blood cleaned up, objects removed from a room, etc., while the investigation is still at a preliminary stage. Thus, photographic evidence may be the only feasible means of preserving vital details.

### Photographic Evidence: Production and Preservation

The Investigations Supply Kit should contain photographic equipment, accessible to the Clinical Risk Managers/Clinical Risk Management Specialists at all times. There are obvious advantages to having both an “instant development” (Polaroid) model and a more sophisticated camera (e.g., 35 mm) available simultaneously. The “instant” camera provides immediate confirmation of technique, while the latter offers improved detail and overall quality. In any case, take the time to familiarize yourself with the available equipment before your first investigative assignment. If a digital camera is used instead of a Polaroid, duplicate photos must be taken on a 35 mm camera.

Certain guidelines must be followed if investigative photos are to have any evidentiary value:

- ◆ The object(s) in the photo must be relevant and material to the facts of the case.
- ◆ The photo must accurately represent the scene or object, and be free of distortion. Different views of the same scene should be taken, with color film.
- ◆ The photo should not appeal to the emotions, but should display the scene or subject as objectively as possible. It is good practice to place a yardstick in a prominent place in the scene, to provide a sense of scale.
- ◆ The photographer must be prepared to testify about:
  - ◆ Date(s) and time(s) each photo was taken.
  - ◆ Camera location and direction.



Review these points carefully with respect to each potential photo associated with your investigation. Brief the photographer on the above criteria before he or she proceeds. Finally, see that each developed photo is properly labeled, to include:

- ◆ The date and time of exposure.
- ◆ The scene, person or object depicted.
- ◆ The identity of the photographer.

If photos require later development, the photographer should make notes about the above facts, for subsequent transfer to the developed prints.

## Medical Examination of Victim

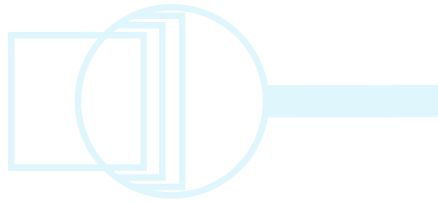
Procedures governing administrative investigation of major incidents provide that medical attention will be secured promptly in the event of injury to a client/victim. Thus, you may find that the physician on call has already examined the person and rendered treatment by the time you arrive. If so, confer with the doctor as soon as possible. The physician should be instructed to render and record the best possible medical judgment on each of the following:

- ◆ The extent of presenting or suspected injuries.
- ◆ A detailed description of the injuries, including shape, color, size and stage of development, to aid in determining the age of the injuries as well as their most likely cause(s).
- ◆ Whether or not the injuries are consistent with the description of the occurrence as it is being stated.

If no medical exam has been ordered by the time you arrive, request one immediately, to rule out the presence of injury, or to establish the above data.

Your investigation may well result in an administrative and/or criminal proceeding in which medical evidence and testimony will be crucial. The absence of a medical exam, or a simple notation that the client was “treated for cuts and abrasions,” will be of little use to the trier of fact in such a proceeding. A professional opinion about the probable age and cause(s) of any injuries is likely to be given considerably more weight, when combined with other competent testimony.

Physicians may be reluctant to render such opinions, because of the “unknowns” which prevail at the time their report is prepared. You can be of considerable help here, by explaining how the information may be



used later, and by stressing the need to “capture” medical evidence while it is fresh. If necessary, a second physician’s opinion should be sought and included with the initial exam report.

Additional guidelines regarding the examining physician’s role in an investigation are provided under *Special Witness Categories* beginning on page 41 and in the *Examining Physician* section of Chapter 2 (pages 13-15).

## Photographing Visible Injuries

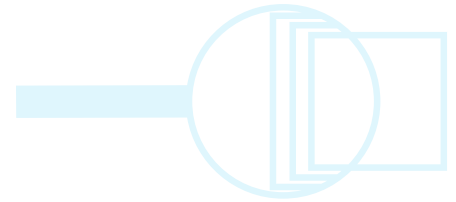
This is one of the most critical and potentially productive uses of the photographic procedures discussed above. Visible evidence of injury may change rapidly in appearance over time or, conversely, may not appear at all until a period of hours or days following trauma. If such evidence is present when you begin your investigation, see that it is photographed at once. If not, obtain competent medical advice regarding the likelihood and probable timing of its appearance, based on the information reported to you at the start of your investigation. Follow up by arranging for photos at a later time, if there is any indication that further visible evidence (e.g., edema) may appear subsequent to the initial medical examination. When a client has alleged physical abuse, it may be advisable to take pictures of the part of the body that was allegedly injured even when no injuries occur, at the onset of the investigation and again at timed intervals after visible injuries, if any, are likely to have appeared. As with all photographs, be sure to document the date and time the pictures were taken.

## Documentation

Preliminary information about a major incident is commonly recorded in two ways:

- ◆ In the NIMRS Incident Report. NIMRS must be used to document all client-related incidents. Designated screens are completed by the person with first knowledge of an incident, unit administrative staff such as a nurse administrator, Clinical Risk Management staff and the examining physician.
- ◆ In written statements prepared by each witness, with the assistance of the investigating CRM/CRMS, during phase two of the investigation.

You should ensure that appropriate sections of the NIMRS Incident Report have been/are completed. You should not ask for independent written statements from each witness, until you can interview the parties separately according to procedures described in the next section of this Manual. Statements should always be prepared and signed during the course of these discussions. This will help to pinpoint critical areas of the witness’s recollection; to make the person think carefully about what he or she actually saw and heard; and to decrease the possibility of collusion among witnesses who are motivated to distort facts. Should you find that witness statements have been prepared independently, before you arrive, such statements should be



preserved for comparison with the information gathered in the interview phase of the investigation. Discrepancies, if any, with information obtained during the interviews should be fully probed and accounted for to the fullest extent possible.

## Incidents Involving Violations of Law

Incidents covered by these procedures may involve a potential violation of one or more criminal statutes. Examples include assault and allegations of client abuse. As a matter of OMH policy, such incidents are to be reported *promptly* to local law enforcement agencies. Depending on the circumstances, it may be appropriate for the facility to file a criminal complaint against the person or persons who caused the incident.<sup>8</sup>

As a CRM/CRMS, you must be able to work effectively with the local police and/or District Attorney on such matters. The following guidelines will assist you in doing so. Bear in mind, however, that there are wide variations in the types of incidents which may constitute a crime, as well as the timing and character of the police response you may expect to receive. You are encouraged to contact the Bureau of Employee Relations and/or the Counsel's Office in Albany if you have questions on any of the following:

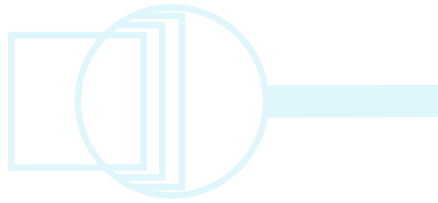
- ◆ Whether or not the incident you are investigating involves a potential violation of law.
- ◆ Whether or not to report the matter to a local law enforcement agency.
- ◆ The type of response received from such an agency.
- ◆ How to proceed with your administrative investigation, in light of a pending investigation by a police agency.

## General Guidelines:

The severity of the incident will greatly affect the timing and character of the response you may expect to receive from local authorities. Generally, police agencies will respond immediately to an incident involving death or serious injury. In other cases, the response will depend upon the agency's workload and general practice; they may decline to investigate, or advise you that their investigation will not be given high priority.

In every case, however, the facility must take prompt administrative action to ensure the continued safety and well-being of clients and staff, as well as the preservation of evidence. Those responsibilities are not

<sup>8</sup> For more information, see the definition of crime in the *OMH Official Policy Manual*, Section QA-520, as well as the footnote on crimes in QA-510 under Identification of Incidents. For detailed reporting requirements for events which may be crimes, see *OMH Official Policy Manual*, Section QA-530.



removed or diminished because the matter has been reported to the police, or because of a possible criminal investigation.

If there is to be a criminal investigation, that procedure must be closely coordinated with the facility's inquiry. Each party must take care to ensure that their actions and procedures do not conflict with or impede the other's.

For example, in the course of your administrative investigation, you may interrogate and take a statement from an employee who will likely be charged with misconduct in a disciplinary action. That person may also be guilty of a crime and subject to action under the penal law. If your statement is taken in advance of the police inquiry, it may damage much or all of the evidence required to support the criminal action.

Conversely, the facility must be in a position to promptly suspend or reassign an employee believed guilty of serious misconduct, pending the outcome of its investigation and subsequent disciplinary action, if any. Accordingly, you must be able to take the person's statement without undue delay.

### Procedures:

Whenever it is determined that a crime may have been committed, report the matter to the appropriate police agency at once, whether the criminal behavior was allegedly committed by a staff member or a client.<sup>9</sup> Make your initial contact as soon as the preliminary actions discussed above are complete (securing the scene, retention and separation of witnesses, etc.).

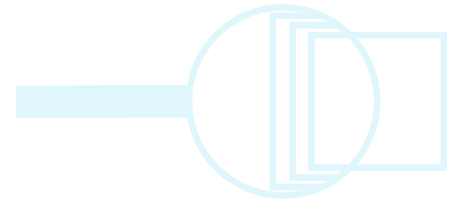
For deaths and the most serious types of incidents, you should pursue assistance from the police agency. Be prepared to brief the investigating officer(s) as soon as they arrive. Clarify what your role will be.

In the most extreme cases, such as alleged inpatient homicides or suicides, the police may request that you suspend your investigation until the police have examined the evidence and interrogated the witnesses. Establish a firm understanding with the law enforcement agency that your ability to take appropriate administrative action is contingent upon your actions to interrogate the suspects. As soon as the police interrogation is complete, proceed with the remainder of your investigation, including your own interviews and/or interrogations of all witnesses. Refer to the procedure for interrogation of a potential target of discipline (page 47, below). Your investigation should continue even if the police deem criminal charges unfounded.

In cases in which the police choose not to immediately respond to the facility, advise them that your administrative investigation will continue without delay, in accordance with procedures discussed in this Manual. Indicate that you will keep the police informed of progress, including identification of a person or persons likely guilty of criminal misconduct.

<sup>9</sup> In many facilities, such reports are handled through the Safety Department.





## Phase Two: Witness Accounts

The preceding steps should have accomplished the following:

- ◆ Rendering of necessary care and treatment to the client or other victim of the incident.
- ◆ Development of a photographic record of injuries and other pertinent evidence, for use by the CRM/CRMS and, subsequently, for any administrative or criminal proceedings arising from the incident.
- ◆ Identification, retention and sequestering of known witnesses, in a manner which will best ensure the preservation of their separate accounts.
- ◆ Preservation of physical evidence related to the case.

You should now be in a position to concentrate on the most important information: the recollections of persons on or near the scene of the incident, and the knowledge of others in a position to help piece together the facts.

## The Investigative Interview

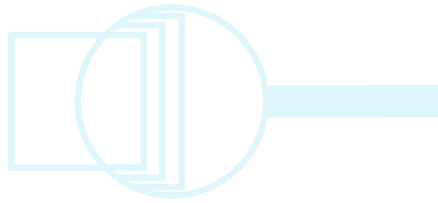
### Scheduling of Interviews and or Interrogations

Interviews should be conducted without unnecessary delay. All potential witnesses should be identified including staff, patient, supervisory and other witnesses.

Your first step is to decide on a specific order in which to interview or interrogate each witness. Based on the preliminary data available at this point, it should be possible to establish the following witness categories:

- ◆ The Victim: The client or other person injured and/or abused.
- ◆ Direct Observers: Persons present at the time who may or may not have played a role in the action.
- ◆ Others who may have relevant information about the case.
- ◆ The Perpetrator(s), if known: Person(s) whose acts or omissions probably caused or contributed to the incident.

The hard distinction is between the second and fourth categories. Those responsible for the incident, if they are employees, must receive special treatment from the outset with regard to the interview process. If they



are likely to become the target of a disciplinary action, they are entitled to representation by the appropriate union, or by an attorney, during any conversation about the incident. An interview of such a person is called an interrogation, to be conducted under special rules and procedures discussed later in the Manual (beginning on page 45).

Thus, the prior question you must answer is this: Do the preliminary facts about the case point to a person or persons who may be guilty of misconduct and/or incompetence? If so, that person's interview will constitute an interrogation, to be conducted under *Special Witness Categories* (beginning on page 41).

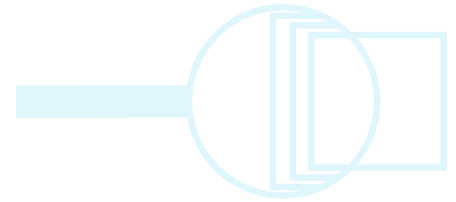
You should visualize potential witnesses as occupying different points on an “expanding circle” of events and circumstances. Closest to the center of the circle are the victim, and those in the victim's immediate vicinity at the moment of the incident. These people should be interviewed first, while their recollections are freshest and opportunities for collaboration at a minimum. The particular circumstances will dictate a specific order within this priority group; for example, the client's injuries or other difficulties may necessarily delay his or her interview while medical treatment is administered.

Next in order would be others in the general vicinity at the time of the incident; for example, a Ward Charge who was in a nurse's station down the hall from the client/victim's bedroom, the client's roommate, a therapy aide who is known to have been administering medications in an adjacent bedroom, or clients who were near the site of the incident immediately before, during or after its occurrence. It is good practice to interview every person on duty in or near the living unit at the time, applying the “expanding circle” principle (based on individual proximity to the event) to decide on a specific order.

One of the valuable reasons to interview persons indirectly involved, is that they may be able to provide evidence as to spontaneous statements made by either the victim or the “target” at the time of, or directly after, the incident. For example, the therapy aide who escorts the victim to the nurses' station may have heard the victim say who caused the injury; or the client may have told the examining physician what happened. All such evidence must be collected and documented by interviewing and taking statements from those who heard the spontaneous statements. Evidence of this kind will be perfectly admissible in a later administrative hearing, even if the victim is then unable to recall making the statements.

In addition, you may wish to see persons not in the immediate area at the time of the incident but who may have information which will support or refute specific theories of the case. Examples include:

- ◆ Clinical staff having direct knowledge of the client's mental status, physical condition, prior behavior, etc. These are discussed further below, under “client witnesses.”
- ◆ Other clients who were on-site at the time of the incident or who may have valuable information based on ongoing contacts, relationships or conversations with the victim or the employee.



- ◆ The Chief of Service, Team Leader or other supervisory staff familiar with the work records of employees closest to the incident.
- ◆ Co-workers or other employees who may have knowledge about hostility toward the victim, or prior history, and/or statements made about the victim by another employee.
- ◆ The Facility Personnel Officer, regarding background and work records of key witnesses.

Normally, these interviews need not be completed during the first phase of the investigation. They should, however, take place within a day or two of the initial inquiry.

As discussed above, the identification of a likely target of discipline is a critical point in the initial review of witnesses. Where no clear target has emerged at the outset, one may appear at any point during interviews of employee or client witnesses who were close to the scene. If and when this occurs, you are obliged to stop the particular interview and secure appropriate representation for the employee, as provided in the interrogation procedure.

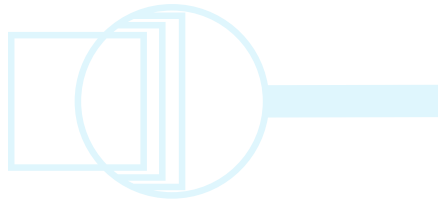
## Preparation for Interviews and or Interrogations

Assume that you have decided on a sequence of witness interviews and/or interrogations, based on the above guidelines. Before the discussions begin, there are several other preliminary decisions to be made:

**Location:** Select a site that is conducive to private discussion and a relaxed, informal atmosphere. The preceding sections have emphasized the need for promptness in pursuing each phase of an investigation. However, witness interviews are usually the most crucial phase. They should not be interrupted or contaminated by staff coming and going in their normal pursuits, phones ringing, loud background noise, etc. Take the time to locate a private office, unused room or other area that will be free of interruptions. If the discussion is to take place at the scene of an incident, make sure that normal activity in or near the area is eliminated or at least curtailed. Be absolutely certain that no other actual or potential witnesses, or associated parties, are able to overhear or observe the interview.

**Interview Objectives:** Try to set specific objectives for each discussion based on advance information about the interviewee's connection with the case. Sample objectives include:

- ◆ Confirming the person's presence on the scene when an incident occurred.
- ◆ Confirming, or ruling out, a suspected motivation to suppress or distort the facts of the case.



- ◆ Learning about others who either were present for the incident or had an opportunity to observe part or all of it.
- ◆ Learning about the work records, attitudes and behavior of eye witnesses.
- ◆ Evaluating the capacity of a witness to provide a reliable account of what occurred.
- ◆ Understanding the broader range of factors that may have contributed to the incident under investigation, such as inadequate supervision, an increase in the number of clients on the ward, a change in the staff to patient ratio, a recent change in policy or procedure about which there may be some confusion among staff, significant aspects of the physical plant or layout of the ward, etc.

**Staff Assistance:** In certain circumstances it may be helpful and/or necessary to have a second administrative staff person present with you for some or all of the witness discussions:

- ◆ If a client is reluctant to talk to you because you are a stranger to him/her you should consider asking a clinical staff person who knows the client to join you for the interview.
- ◆ If the client you are interviewing is the alleged victim of sexual assault or sexual abuse, a same-sex staff member should be present for the interview.
- ◆ It is generally preferable for a management representative to be present for an interrogation of a potential target of discipline. (For more details, see section on Target of Discipline, beginning on page 44.)

If you have a second staff person with you when you conduct an interview, you need to rule out certain potential pitfalls:

- ◆ An employee witness may be reluctant or unwilling to talk with you in the presence of a management representative who is perceived as biased.
- ◆ The representative may lack the required objectivity from your standpoint. At the extreme, a supervisor may be motivated to distort or color his or her evaluation of an employee witness and/or to supply witnesses with information which may help them resist the investigation.
- ◆ A client witness may be fearful of or prejudiced toward the management representative.
- ◆ If you are to be accompanied by a clinical staff member (e.g., the Unit Chief or AOD/AOC), question that person in advance about his/her relations with everyone on your witness list. Choose another representative, or work alone, if you detect significant positive or negative bias toward those whom you will see.
- ◆ If a witness objects to the other party's presence, try to determine the grounds for the objection: this information may be valuable to your overall assessment of the case. Accommodate the objection if you

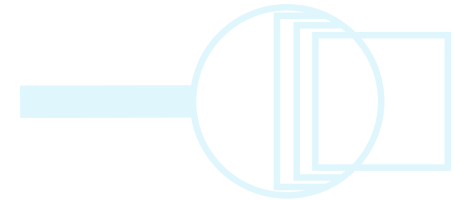
can, preferably by securing an alternative representative with whom the interviewee is comfortable. Follow up with the first representative to get his or her opinion on the objection.

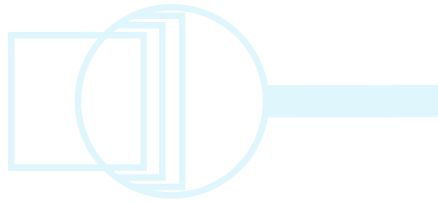
- ◆ Use great care in preparing to interview a client witness. Be especially alert for bias on the part of your assistant, particularly if that person is in close contact with the client on a regular basis. Refer to the following section on “Special Witness Categories.”

## Conducting the Interview

Attitudes formed in the first few minutes of conversation may have a lot to do with the amount of cooperation you will receive. Try to build the best possible atmosphere, from the outset:

- ◆ Make your greeting cordial and sincere. Identify yourself by name, job title and function.
- ◆ Introduce any additional people present for the interview and specify the role he or she will play during the discussion.
- ◆ Indicate the purpose and framework of the interview, stressing the following:
  - ◆ That you represent the Executive Director and have been authorized to investigate the incident on his/her behalf.
  - ◆ That any information provided will be discussed with others only to the extent required for a full and fair investigation. Do not promise that information provided will be kept “confidential,” e.g., between you and the witness. Do explain that individual witness accounts will be presented to management, in the content of your investigative report.
  - ◆ That the witness should likewise refrain from discussing the matter outside of your interview.
- ◆ Ask the interviewee to indicate his or her full name, job title, work assignment, length of service, shift and immediate supervisor.
- ◆ Attempt to place the person at ease, by spending a few moments on a brief discussion about the individual’s job and length of service at the facility. Move to the subject at hand when the interviewee’s initial anxiety has subsided. Don’t allow the conversation to drift away from the main issues. Avoid engaging in “chit chat” about personal matters.
- ◆ Keep the conversation as informal and relaxed as possible.
- ◆ Maintain good eye contact.
- ◆ Avoid the use of legal or bureaucratic sounding language; e.g., “victim,” “subject,” etc.





Basically, there are three formats for exploring a witness's knowledge of an incident:

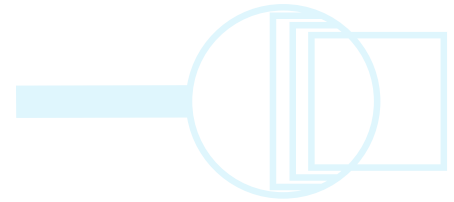
- ◆ **Free Narrative:** The witness's description, in his or her own words, of what occurred.
- ◆ **Direct Examination:** A series of specific questions which assist the witness in relating his/her account in an orderly, logical and complete fashion.
- ◆ **Cross Examination:** A series of questions designed to test the conviction, reliability and veracity of the witness's account.

All three techniques have their place in the investigation process. Most interviews will use at least "free narrative" and "direct examination." The use of "cross examination" will depend on the CRM/CRMS's preliminary conclusions about what the witness has reported.

**Free Narrative.** Begin the interview with the "free narrative" format. Give the witness a basic frame of reference, including the specific dates, times and events of interest to you. Then ask him to "tell what happened," in his own words. Interrupt with questions only when necessary to keep the person "on track" and to clarify major details. Restrict note taking to the bare minimum during this phase. You can't listen and write effectively at the same time, and the witness will be more at ease if your attention is clearly focused on what he or she has to say. Learn to be a good listener! You will have ample opportunity in the subsequent phases of the interview to go back and revisit salient points in order to solicit more detail and to record your notes.

This free narrative phase is important to your initial evaluation of the witness's reliability and credibility. Keep the following points in mind as you listen:

- ◆ Everyone is affected by numerous emotional and physical factors that color and make questionable the validity of the information they offer.
  - ◆ For example, emotion may cause a person to give prejudicial information, to lie or to conveniently forget.
  - ◆ Lighting, distance, color blindness or other physical limitations may result in the inaccurate interpretation of events observed.
- ◆ Be alert for personal motives, individual differences and limitations.
- ◆ Listen for descriptions of the workplace, characterizations of the client, employee and other witnesses, interpretations of policies, and assumptions and common practices that may explain why this event occurred as it did.



The free narrative should provide a basic picture of the witness's knowledge of pertinent events. However, you will quickly discover two major problems with this approach:

Most people, even with the best of intentions, tend to “short cut” their description of an event, omitting a host of relevant details. This is a function of memory and language. The average person forgets that the listener may not be familiar with the setting described, and also “filters out” surrounding elements (people, places, things) that are subjectively unimportant to the speaker.

The witness who intends to withhold or gloss over information can do so very conveniently in a free answer account.

The results may be as limited as the following: “About all I saw was this: John and Client Smith started arguing. Then they got into a scuffle and the client ended up on the floor. I was rushing to the med room to get something for another client, so I didn't see any more. The client seemed okay as I left.”

**Direct Examination.** You are now ready to proceed with “direct examination” questions, probably the most important phase of the interview. Use the following guidelines:

Lay a foundation for each area you want to explore. For example, begin with questions which place the witness at the incident scene, before asking what he or she saw, heard and did. Basically, your questions should move from general to specific points. Avoid questions that can be answered yes or no. Use open-ended questions beginning with who, what, where, when and why. In the preceding case, the progression might be:

“Where were you this afternoon, at about 5 p.m.?”

“What were you doing, at about that time?”

“When you first entered Ward 352, what did you see?” “Who did you see?”

“Where was client Smith when you entered?” “Where was John?”

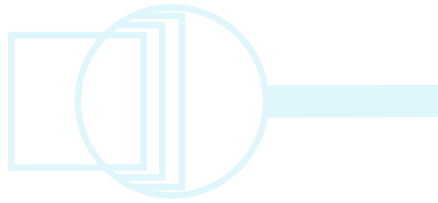
“What did you hear?”

“What happened next?”

“Where and how did John touch the client?”

“What else did you see?” “What else did you hear?” “Who else did you see?”

As you reach crucial points in the witness's account, ask questions which help him or her paint a detailed word picture of what was seen, heard and done. You literally want the person to “freeze” events frame by



frame, as you might do with a movie projector or video tape recorder. Careful notes should be taken at this point. To continue the above example:

“How far away were you?” “Was your view of Smith and John blocked by any other person or object?” “How was the lighting in the hallway at that moment?”

“Who else was present while this was happening?” “What did they say or do during the exchange you’ve described?”

“What were you doing during the described exchange?”

Try to judge the witness’s relative recall ability, and tailor your questions accordingly. Most people will not readily remember an event in the level of detail you are seeking. Some will respond readily to the “refresher” questions outlined above; others will have difficulty doing so, even if they are doing their best to cooperate. You can assist by identifying points which appear important to the individual, and framing questions around those points.

For example, if your witness in the above case recalls that the hallway was “noisy,” ask the person to focus on *what* was heard: voices, machinery, furniture or equipment being moved, etc. These associations may bring out a flow of detail which his/her mind “filed” as unimportant at the time.

Listen carefully for small details which may lead to important lines of inquiry:

**A:** “Mr. Smith, the client, was talking pretty loud, since he doesn’t hear well.”

**Q:** “You hadn’t mentioned the hearing problem before. Can Smith hear people talking in a normal conversational tone?”

**A:** “No! We always have to shout, even if we’re very close to him!”

**Q:** “Do you think the client would have heard the remarks that John made in his presence?”

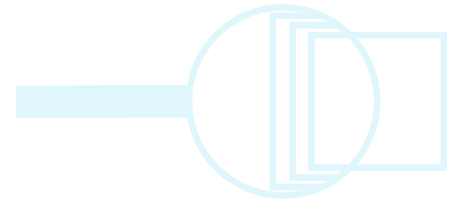
**A:** “No, I don’t see how he could have!”

Here is important information for your subsequent interviews of Client Smith and Employee John.

Be especially wary of quantitative estimates, such as distances and room sizes. Most people have trouble making these judgments. An effective technique is to verify each response against a known object or quantity:

**Q:** “How far were you from Smith and John?”





**A:** “About 30 feet.”

**Q:** “From me to that wall?”

You may find that the corrected estimate is half that of the original! The point is that verbal estimates are frequently inaccurate, and may significantly distort your perception of events. Every quantitative estimate should be verified as suggested above and/or by taking the person back to the scene for a demonstration of where people and objects were placed. Reference to a diagram of the scene can also be helpful in this regard.

◆ Avoid the use of “leading questions,” or those which suggest a specific response. Example:

“How many times did John hit the client?” (assuming your witness hasn’t said that John or anyone hit the client). Be certain the information you receive is developed from the witness, and is not provided or suggested by what you say. Do probe every relevant detail, especially at key points in the account. Remember that the witness’s mind has probably recorded a host of visual and verbal data of interest to you. Your task is to help him or her recall and express that data logically and clearly.

Try to separate facts which the witness knows first hand from inferences he or she may make about events or circumstances. In the above example, your witness may mix the two in the same question sequence:

**Q:** “What did John do after the client called him an ugly slob?”

**A:** “John pushed Smith into the wall.” (Direct Observation)

**Q:** “After the incident, what did the other employee do?”

**A:** “She called the ward charge and reported it.”

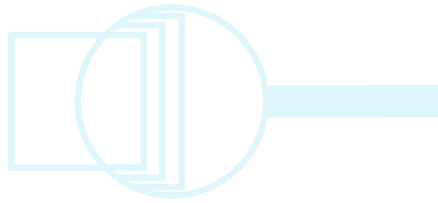
**Q:** “Did you hear or see her make the call?”

**A:** “No, but that’s what she should have done - that’s what we are supposed to do in such cases!” (Inference)

Such inferences may be reasonable, and are often accurate. However, they must be given secondary consideration, with respect to this witness’s account. Note the conclusion and discuss the point with the other employee. You are interested primarily in “first hand” information, from each witness.

Remember to explore physical factors which may have influenced the person’s observation:

◆ **Eyesight:** Does the witness wear corrective lenses? Were they in place when he or she observed the incident? Does the witness have any other physical impairments, e.g., hearing or color blindness? Keep in mind that such factors are important for both staff and client witnesses.



- ◆ **Lighting:** Was it adequate for the person to have clearly seen what he or she is reporting?
- ◆ **Distances:** Having reviewed and confirmed the witness's estimate (see above), can you rule out or confirm possible distortion of the events reported, based on placement of the parties?
- ◆ **Obstructions:** Did your witness have a clear, unobstructed view?

Be alert for personal motives having a potential bearing on the witness's responses. Follow up on observations made during the "free narrative" phase of the interview regarding personal associations, evidence of bias in favor of or against a client, etc.

**Cross Examination.** The decision to use "cross examination" during an investigative interview or interrogation is a judgment call, based on your observation of the witness during the first two phases. If the person's account squares with known facts of the case, has the "ring of truth" and is reasonably complete, this technique is probably not necessary. Its only purpose with a cooperative witness would be to prepare him or her for testimony in a later proceeding, such as a disciplinary hearing. This can be deferred until such testimony is to be given.

You *should* probe doubtful areas of the person's direct examination account, including:

- ◆ Vague or evasive answers.
- ◆ Inconsistent responses to the same or similar questions.
- ◆ Responses at odds with known facts.

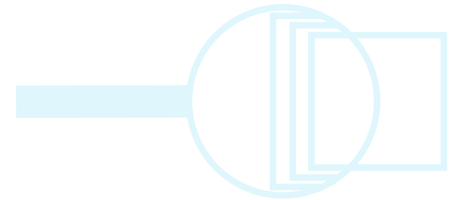
Assume that you wish to further explore some of the responses in the preceding, Smith-John example. Your "cross examination" will usually include "leading" questions, such as:

"Didn't you say that client Smith struck his head against the wall after he'd been pushed by John?"

"You said, initially, that the client appeared okay after the incident. Are you now certain you saw the fresh cut on his head which you later described?"

"Didn't the person who came out of Smith's bedroom block your view of the incident, at least momentarily?"

"You really saw quite a bit as you started for the med room, didn't you? Would you agree that your view of what happened improved as you got closer to the action?"



Bear in mind that your objectives in these interviews must be limited, by time and circumstance. If the witness willfully intends to distort or cover up material facts, do not expect to force a complete admission of everything he probably knows, through cross examination. Do remind him or her, as often as necessary, of the obligation to cooperate fully in your investigation. This is covered more completely below, under “reluctant witnesses.” However, at times you will have to be satisfied with an incomplete or evasive account. Even here, you will have tied the individual to a set of assertions he or she will find extremely difficult to repudiate later. Further, you will have assessed the weak points in the account, for later verification against the accounts of other witnesses, and for making your all-important assessment of each party’s credibility.

## Special Witness Categories

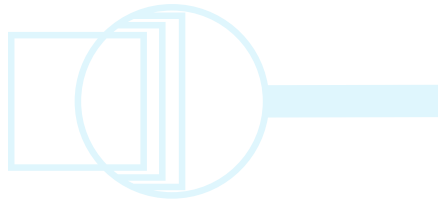
### The Reluctant Witness

The preceding discussion focuses primarily on cooperative witnesses who simply need help in recalling details of an event. Usually, the investigation will also include one or more parties who just plain evade the issue. Their behavior ranges from an outright refusal to answer questions, to vague or conflicting recollections about things they should know. The reasons for such behavior include:

- ◆ A general belief that it is not appropriate to help management; that investigations of this sort are “witch hunts” intended to hang blame for an incident on one or more employees, even if no one is guilty of misconduct.
- ◆ A belief, perhaps based on past experience or information gleaned from fellow-workers, that telling the truth will not necessarily result in appropriate administrative action or improvements in the workplace.
- ◆ The witness is friendly with another staff member whom he or she knows may become a target of discipline.
- ◆ The witness believes he or she may be disciplined for failure to stop or intervene in the incident.
- ◆ The witness caused or contributed to the incident, and knows that he or she will become the target of discipline.

Clearly, the last two cases are the toughest for the investigator. An interview of such an employee will have to be treated as an interrogation, either at the outset or because of information which develops during the discussion. Interrogation procedures are described in a later section. Here are some general points to be covered with all reluctant witnesses:

1. Begin by repeating your objective of getting the facts of what occurred, for everyone’s mutual protec-



tion. All employees are instructed about their obligation to refrain from any form of client abuse, and to report such occurrences promptly. Remind the witness that clients must be protected at all times from injury and/or abuse of any kind; this is a fundamental obligation of the facility and of everyone who works there. Stress also that management is equally concerned about the right of employees not to be falsely or unjustly found guilty of misconduct. Only a full and fair investigation can protect this right and ensure that justice is served.

2. If reluctance continues, you may wish to note that the State Mental Hygiene Law gives the Executive Director the right and obligation to investigate all major incidents involving clients, particularly where abuse or neglect is suspected. Facility staff are required by law to cooperate fully in such investigations.

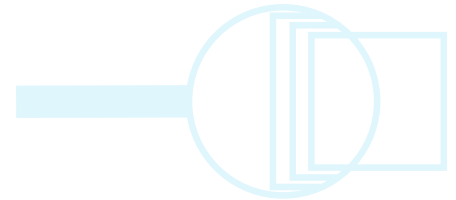
Hopefully, you will not need to progress beyond points (1) and (2) above in order to induce the witness to talk with you. If reluctance or resistance continues, however, it may be helpful to stress the following points:

3. Employees do not have “fifth amendment” protection, with regard to information in their possession about events occurring in the work place. They may not withhold such information, even though it may tend to implicate them or others in an act of misconduct.
4. Employees have “use immunity” with regard to incriminating information provided during an administrative investigation. Such information may not be used against them in a subsequent or concurrent criminal proceeding. For example, were an employee to admit during an interrogation that he assaulted a client, the admission could not be used as evidence in a subsequent criminal trial on an assault charge. It could be used in a disciplinary hearing conducted under the collective bargaining agreement, provided the interrogation had been properly done.
5. Finally, the employee witness is subject to disciplinary action, including dismissal, for failure to cooperate fully in management’s investigation of a major incident. This flows from points (2) and (3) above, as well as OMH policy.

If the appeal to the witness’s general sense of responsibility isn’t sufficient to induce him or her to talk with you, do not hesitate to reiterate the person’s absolute obligation to do so.

**Dealing with Questions Regarding the Witness’s Truthfulness.** Assume the employee has agreed to answer questions, but that you have serious doubts about the veracity and reliability of certain information provided. In such a situation you have two choices:

1. You can accept his or her account, prepare a written statement (see following section) and proceed to other facets of the investigation. This will, as pointed out earlier, lock the witness into a set of “facts” as to their own behavior and observations. For example, the person will have great difficulty coming forward later saying he or she was present for the entire incident and is positive no one struck the client, if they’ve insisted in the interview that they were nowhere near the scene.



2. Alternatively, you can probe for weak points in the account, using the following techniques:

- ◆ Question the person closely about gaps in knowledge and/or areas that conflict with known facts. For example, if you are told the witness was off the ward when an incident took place, but know or suspect otherwise, make them account for their whereabouts in great detail: Where was the witness, from when to when, with whom? What did he do, whom did he see, why was he not on the unit? Etc. This may or may not result in an admission that the initial information was false. In any case, it further locks the witness into a story he or she will find difficult to repudiate later.
- ◆ Point out obvious inconsistencies or falsehoods in the account, using cross examination techniques as appropriate. If a reliable witness has definitely placed this person on the scene at the time of an incident, tell the witness so and ask for an explanation. If he or she insists the other party is lying, ask why that person would do so. Rationalize with the witness. Ask him to assume he is an investigator, arbitrator or judge evaluating the information he's provided. Then point out the questionable areas, one at a time, asking if he thinks they have a "ring of truth." For example:

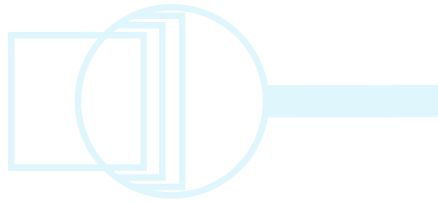
"If you were an arbitrator, what would you think of a witness who insisted he was elsewhere when others definitely placed him at a particular location at a crucial time? What if these people had absolutely nothing to gain from lying about the matter?" "What if the person had a clear, complete recollection of certain events, but almost no recall of others that occurred at the same time?"

In practice your approach should be a balance of the above techniques. Probe aggressively to break down obvious inconsistencies or false statements. However, do not expect dramatic admissions about facts which the witness intends to conceal.

## The Client

The majority of psychiatric center clients are mentally capable of accurately recalling and describing events in their daily lives. A client involved in a major incident should be regarded as a principal witness. Frequently, this person will be the only available eye witness, other than an employee whose acts or omissions may have caused the incident. Accordingly, it is especially important that the CRM/CRMS interview the person as quickly as possible. The following steps should be taken as soon as the first verbal report of an incident is received:

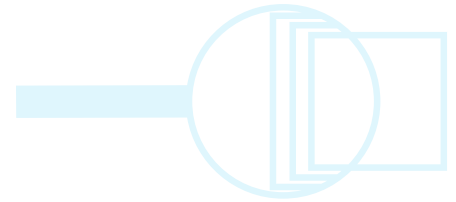
- ◆ Have a psychiatrist familiar with the client comment on the client's general mental capacity and status *at the time of the incident*. Ask the following questions: Is the client verbal? Normally oriented as to place, time and person? Has the person made any statements about what happened? Can the client write? Will his/her injuries or other factors interfere with an immediate interview? Is it safe to see the client alone? If not, who can go with you? (If you are accompanied, brief the accompanying staff member on issues of confidentiality and the importance of objectivity in conducting an investigation.)



- ◆ Unless the client must receive immediate medical treatment away from the incident site, instruct the AOD/AOC/Unit Chief to have him or her kept there until you arrive. Like any other potential witness, the client should be sequestered, or separated, from others who were involved in or who observed the incident. Staff should not discuss the incident with the client until you arrive.
- ◆ Proceed to the site as quickly as possible. Arrange to see the client as soon as the steps outlined in *Phase One* (beginning on page 20, above) are complete. You should do so even if you have been told that the person's mental capacity and/or verbal ability are impaired. You will want to know any information he or she can provide regarding the incident; it may be limited to a few words or gestures, but is probably of vital importance to your understanding of the case.
- ◆ Listen to and make notes about whatever information the client is able to provide. Unless the person's verbal ability is severely impaired, try to conduct the interview as you would that of any other witness. First have the client describe what happened, in their own words. Listen carefully and patiently. Frequently, the psychiatric client will discuss events in the limited context of the institutional environment he or she has become accustomed to. Their account of people, places and events may therefore require some interpretation. For example, the client may use nicknames of his/her own to indicate staff whom he or she sees every day, or to describe ward routines. As with staff witnesses, you will need to ask follow-up questions to be sure you understand the patient's language and references.
- ◆ Conduct your "direct" examination as you normally would; that is, try to avoid leading questions, but make your questions as precise and specific as possible. You may find that the client tires easily, or has a short attention span. If so, stop the interview, thank the client for his assistance, and explain that you will want to talk again soon. Arrange for a second interview as soon as practical, preferably within 24 hours.
- ◆ Preparation of the client's written statement will also be guided by his/her particular behavior and circumstances. If you are able to take a fairly complete account of the incident, prepare a statement according to the guidelines discussed later in this chapter and have the client review and sign it. If this is impractical, dictate or write out a complete set of notes on what you have learned from the client.

### The Target of Discipline

As a CRM/CRMS conducting special investigations, you will encounter situations in which an employee appears guilty of misconduct or incompetence regarding the incident or situation you are reviewing which could potentially rise to the level of discipline. The most obvious example is a client's statement that he or she was abused by a particular employee. Other cases, of course, will be much less clear; for example, an implication that a staff member should have reported a client as missing, or could have prevented or stopped an act of abuse committed by someone else.



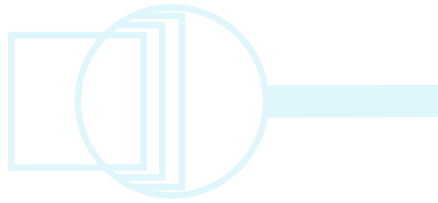
In such cases, the employee may be entitled to certain rights conferred by the union contracts or Civil Service Law, when he or she is questioned about the incident. Basically, you must be familiar with four points regarding such witnesses:

- ◆ What specific rights does the employee have, at the investigative stage?
- ◆ Why are those rights important to you and to the facility?
- ◆ When do the rights come into play?
- ◆ What must you do to see that they are protected, in carrying out your investigation?

**Interrogation vs. Interview.** When the “targeted” employee is questioned about the incident or issue which could result in discipline, the discussion is called an interrogation. While their language differs somewhat between bargaining units, all of the union contracts give the “targeted” employee the right to be represented by the union or by an attorney whenever he or she is interrogated. Section 75 of Civil Service Law also allows Management/Confidential employees to have a representative of choice present during interrogation. More specifically:

- ◆ The employee must be told before the interrogation begins that he or she has the right to be represented, and must be given reasonable time to secure representation if he or she elects to exercise this right.
- ◆ “Representation” means that the union official or attorney is allowed to be physically present during the interrogation.
- ◆ The employee must be given a copy of any verbatim transcript or tape recording of the interrogation, if he or she requests it. The employee is not entitled to a copy of the CRM/CRMS’s notes.
- ◆ The person must be given a copy of any statement signed during or subsequent to the interrogation, whether requested or not.
- ◆ Conversely, non-targeted employees should not be given copies of their statements at the time of their interviews. Further, interviewees should be encouraged not to talk to other employees about the content of the interview or the circumstances of the incident. Later, after any ensuing discipline process is completed, interviewees should be granted copies of their statements if they request them.

**Why these Rights are Important to Management.** Failure to safeguard the targeted employee’s contractual rights may severely limit the facility’s ability to pursue disciplinary action, if the investigation later shows that such action is warranted. Employees charged with misconduct or incompetence can appeal a proposed disciplinary action to an independent arbitrator, who makes a final decision on the person’s guilt or innocence and on the penalty proposed. Disciplinary arbitrators are authorized to review the circumstances surrounding the



questioning of the targeted individual, and to exclude evidence obtained during an improper interrogation. Besides excluding statements or admissions made by the employee, the arbitrator may require proof that management did not rely on those statements in bringing its case against the employee. For example, a statement wherein the person admitted striking a client could be excluded, and management would have to show that it had learned of the incident from other sources.

Thus, it is very important that you be alert for facts and circumstances which point toward misconduct or incompetence by one or more employees, and apply the procedures discussed here whenever you speak with these people.

**Identifying the Target of Discipline.** There are two ways in which you will learn about such a target:

- ◆ Through information you obtain independently during the investigation; for example, the client's statement that he or she was struck or injured by a particular person.
- ◆ As a result of something the employee says during his or her interview with you. Assume, for example, that the person reveals they were improperly absent from their duty station when a serious incident occurred.

In the first case, you will be able to control the situation quite easily, by scheduling the interrogation after the other witnesses have been seen. In the second, you will have to stop the discussion as soon as the incriminating information is revealed, and advise the employee of his or her representation rights as described below.

In either case, you should use the following guidelines in assessing potentially incriminating information about an employee:

- ◆ Be conservative. It is usually better to err on the side of offering representation rights, in "close" cases, where the person's potential liability isn't clear. It is difficult if not impossible to "reconstruct" a proper interrogation in such cases, if you first decide not to offer representation and later learn that the person is definitely a target.
- ◆ Remember that the incriminating evidence or information need not be conclusive or proven in order to tip the scales in favor of an interrogation. Any information which, if true, would cause the person to be disciplined is sufficient to trigger an interrogation of that person.
- ◆ Do not, however, be casual about granting representation. If the staff person is clearly not a target, interview without representation.

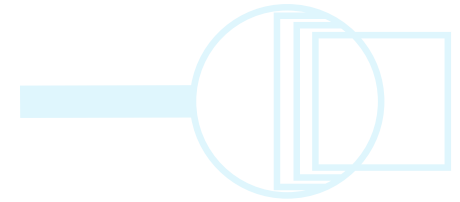
To reiterate, when the administration/CRM/CRMS has information which, if found to be true, would result in the issuance of disciplinary charges, then the employee implicated by such information must be interrogated with all attendant rights and representation. Of course, the first person on the scene of an incident is often unaware of basic information and is essentially asking staff "what happened?" But as soon as a sce-

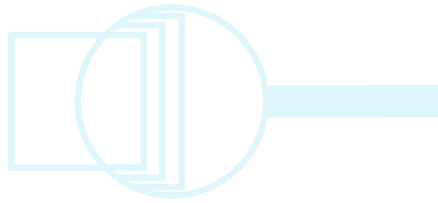


nario starts to form which points to one or more individuals who were potentially involved in misconduct, the above standard should be applied.

**Interrogation Procedure.** Assuming that a potential target of discipline has been identified, proceed as follows:

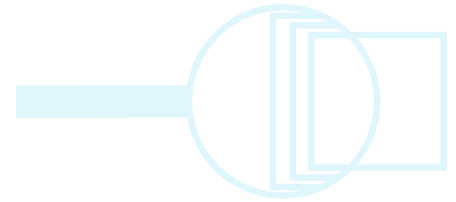
- ◆ Advise the employee that he or she may be subject to discipline, based on your investigation and/or on what the person has said during their interview. (Remember that the interview must stop as soon as the person gives you any information which is potentially incriminating.) You should not reveal the source of your information, or go into detail about the potential disciplinary action.
- ◆ Tell the person that they have the right to be represented during the subsequent investigation. In the case of a CSEA employee, read the standard “Statement of Rights” and have the person acknowledge their receipt of a copy of that statement. For PEF employees, provide a copy of the Statement of Rights and obtain the signed acknowledgment. For Management/ Confidential employees, give written notice of the right to a representative of their choosing. For employees represented by the New York State Correction Officers and Police Benevolent Association (NYSCOPBA) and/or Council 82, provide a copy of the Bill of Rights. In all instances, have the employee sign a form acknowledging receipt of a rights statement.
- ◆ Explain, in all cases, that the interrogation must take place as quickly as possible, recognizing the right to “reasonable time” to obtain representation. In the great majority of cases, the employee will elect to be represented by the union. Normally, the interrogation can be arranged quickly in such cases: the local union chapter is usually familiar with the process, and able to supply a representative on short notice. Consult in advance with the facility personnel office to familiarize yourself with local representation arrangements and practices.
- ◆ The contracts provide that an interrogation *may proceed* if the employee or union fails to secure representation within a “reasonable time.” The interpretation of “reasonable” may vary from case to case; however, your investigation should not be unduly delayed by this provision, under any circumstances. Moreover, neither the employee nor the union may insist upon the presence of a *particular* union official for representation purposes. While there is seldom a need to invoke the reasonable time provision of the agreements, you should contact the facility personnel office and/or Bureau of Employee Relations if it appears that your investigation could be materially delayed by the employee’s or union’s demands on this point. Those offices can provide the latest interpretation of contract language, and advise you on how to proceed.
- ◆ After explaining and discussing representation rights, have the person complete and sign a representation election statement: refer to the sample form in Appendix E. If the person waives representation in writing, the interrogation may proceed without delay. If the person chooses to be represented, establish a definite time when he or she is expected to return with that representation.





- ◆ If problems regarding union representation persist, the CRM/CRMS should feel free to use the Central Office Bureau of Employee Relations as a resource.
- ◆ It is good practice to have another management person present for the interrogation, particularly if the employee is to be represented.<sup>10</sup> This person can assist you in taking notes on the discussion, and also witness the employee's response to your questions. Should the employee refuse to answer some or all of your questions, he or she will be subject to disciplinary action for failure to cooperate in the investigation. Any refusal to cooperate should be witnessed by a third party.
- ◆ In high-profile cases it is recommended that the interrogation be conducted conjointly with staff from the Human Resources Department.
- ◆ It is also good practice to make a verbatim record of the interrogation. The simplest and best method is to tape record the discussion: use two machines, so that you can present a duplicate tape to the employee at the end of the interrogation. Recall that he or she is entitled to a copy of any verbatim record.
- ◆ At the start of the interrogation, again review the specific representation rights pertaining to the witness's bargaining unit. For a CSEA employee, re-read the Statement of Rights discussed above, and provide a second copy. While this procedure is a bit cumbersome, it will protect against a later claim that the rights weren't properly communicated.
- ◆ To the extent possible, follow the interview procedures outlined earlier for all witnesses. Frequently, of course, you will be faced with evasive, contradictory, or noncommittal responses. Be clear and precise about the known circumstances of the incident (date, time, location, events). Use "direct examination" questions as much as possible; however, the techniques described previously for hostile or reluctant witnesses will often be necessary.
- ◆ If you are faced with an outright refusal to answer questions, remind the person of their obligation to cooperate in your investigation, based on the Mental Hygiene Law and OMH Policy. If necessary, indicate that disciplinary action will be taken based on their failure to cooperate. At this point, you must be certain that you have given the person a *direct order* to answer your questions and that this order has been properly witnessed (see above). *Do not equivocate*. If the employee persists in refusing, advise him or her that you will be recommending discipline, and terminate the interrogation. Advise the personnel office of the situation as quickly as possible.
- ◆ "Representation" by the union or by an attorney does not mean that the representative may disrupt or interfere with your questioning.

<sup>10</sup> In some cases the Director of Employee Relations may conduct the interview.



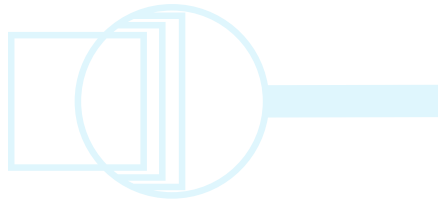
- ◆ Neither the representative of a union employee nor the target employee is entitled to:
  - ◆ know in advance the subject matter of the interrogation;
  - ◆ meet with the target employee before the interrogation;
  - ◆ interrupt to consult with the target employee when key questions are asked (though allowing consultation may be advantageous on a case by case basis);
  - ◆ act as “public defenders” by objecting, or in any way impeding the progress of the interrogation. The only exception to this is if questions go into private, personal, off-duty subjects unrelated to the point of the interrogation.
- ◆ If the representative is disruptive, interferes with the interrogation process, or insists upon rights that are not in the contract, remind the person that his or her “client” (employee) is required to cooperate, and may be penalized for failure to do so. You may wish to confer privately with the representative on this issue.
- ◆ Prepare a written statement for the employee’s signature, as discussed in the next section.
- ◆ Advise the employee that he or she will be told of the results of your investigation as soon as possible. If warranted, the person will be served with a formal Notice of Discipline, in accordance with the appropriate labor contract.

## Supervisory Witnesses

At times, you will need to interview persons whose relations with the principal witnesses may have a bearing on the outcome of the case. Clinical staff associated with a client witness are discussed on page 43, above, and in the section on Analysis of Evidence (beginning on page 57, below). Supervisors of employee witnesses are the other major category. Your purpose in talking with supervisors is to become acquainted with facts and circumstances bearing on their staff’s reliability and credibility, and to learn any information about the incident which may have reached the supervisor’s attention. Proceed as follows:

Review the written work history of each principal witness, including their personnel file and any notes or memoranda maintained by the supervisor. Preferably, this should be done before the supervisory interviews. The subsequent supervisory discussion should cover the following:

- ◆ The supervisor’s general impression of each employee witness, including overall work performance, reliability and relations with co-workers.
- ◆ The employee’s specific responsibilities.
- ◆ The employee’s relationship, if any, with the client(s) involved in the incident, including any indications of animus, or bad feelings, between them.



- ◆ Previous problems of performance and/or conduct, including oral or written counselings delivered by the supervisor, and any prior disciplinary action.
- ◆ The supervisor's judgment about the person's general veracity and credibility.

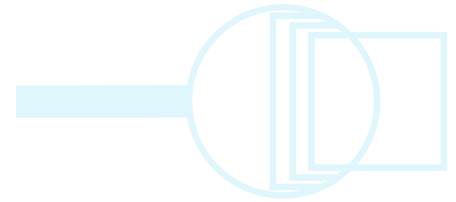
Emphasize to the supervisor that your primary purpose is to gather facts regarding this incident, not to make judgments about the general performance of his or her staff. The supervisor's comments can, however, be an important part of your fact finding, helping you to determine the relative value of each employee-witness's account.

*Stress that your mission is to gather the facts, for the mutual protection of clients and staff.* As necessary, remind the supervisor that he or she is obligated to cooperate fully in the investigation, and may be subject to disciplinary action for failure to do so.

You should also take this opportunity to familiarize yourself with the workplace to which the employee is assigned, such as distinctive features of the client population or the therapeutic program, and the employee's role within this context. Who are the employee's colleagues? How are new staff oriented? Are there inter-staff variations in policy or practice on the unit? How does the supervisor characterize the relational climate of the workplace? How does the supervisor deal with tensions among staff? Be alert, as well, to program-specific or location-specific issues which may contribute to the occurrence of incidents such as the one you are investigating, e.g., doors on a "locked ward" that tend to be left unlocked at certain times of the day, areas of the ward where clients are present without staff supervision, or rules applied in such a way as to contribute to client frustration and, consequently, acting out. (The latter is often the case in children's facilities where staff get into power struggles with adolescents over telephone rights, whether or not a client should have a second glass of orange juice, etc. Well-intended rules unwisely applied can incite or exacerbate a problem, turning it into a full-blown incident.)

**Cautionary note.** Pay careful attention to conflict of interest issues that may arise when you need to interview a supervisor, senior staff member, or upper level management.

**Cabinet Members.** In those situations in which a Deputy needs to be interrogated, the Clinical Risk Manager should contact the Central Office Bureau of Investigations and Audit or Employee Relations. Central Office staff may conduct these interrogations. Clinical Risk Managers may also contact Central Office for assistance in conducting interviews with deputies.



## Written Statements

### Definition

For investigative purposes, a written statement is defined as a summary of a witness's oral account prepared during the course of an interview or interrogation.

### Purpose

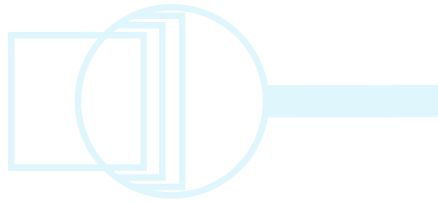
- ◆ The written statement records the witness's observations and actions with respect to an incident, as related to the investigating officer. If correctly taken, such a statement accomplishes several objectives:
- ◆ It allows the witness to review and affirm, in the statement, the details of his or her account.
- ◆ It aids the CRM/CRMS in summarizing and understanding facts and circumstances related by the witness.
- ◆ It may be used in a subsequent administrative or criminal proceeding to refresh the witness's recollection, to establish the circumstances of the investigation, and/or to prevent a witness from recanting his or her account of the incident.

### Timing and Circumstances

The written statement is to be prepared at the conclusion of an interview or interrogation, after you have explored the witness's recollection in sufficient detail using procedures discussed in preceding sections of this chapter.

You may encounter staff, including supervisors, who believe that witnesses should be asked to write statements independently, before meeting with the CRM/CRMS. This is bad practice, since it provides no opportunity for you to probe the person's recollection before their account is committed to writing. Invariably, important details will be omitted or glossed over. More importantly, this approach gives the witness a *carte blanche* opportunity to distort facts, collude with others, and otherwise misrepresent or color what happened. The chances of incomplete or distorted statements are extremely high, even with witnesses who intend to cooperate.

For these reasons, be certain that everyone associated with the investigation – particularly the AOD/AOC/Unit Chief and other supervisors – understands that *no statements are to be prepared until you or someone you authorize has spoken with the witnesses individually.*



## Format

*Statements must be legible and permanent* if they are to have any evidentiary value subsequent to your investigation. Whenever possible, they should be typewritten; if hand written, they must be in ink. Double space the document in either case, allowing room for corrections and changes.

Appendix B can be used as a resource to assure that the necessary information is always documented. Include the following in the heading of each statement:

- ◆ The witness's name, residence, home and work phone numbers, and relationship to the facility (e.g., employee, client, visitor).
- ◆ The date and time of preparation.
- ◆ For *employees*, include job title, shift, and work location.
- ◆ For *clients*, include ward and building.
- ◆ For *others*, include place of employment, if applicable, and relationship, if any, to the client or other victim.

## Procedure

When the interview or interrogation is concluded, explain to the witness that you want to summarize the information they have provided, in the form of a written statement which they will be asked to review and sign.

Normally, it is preferable for you to physically write out the statement, using the language and vocabulary of the witness. Essentially, you are taking their dictation, while helping the person to organize the material according to a logical sequence.<sup>11</sup> For example:

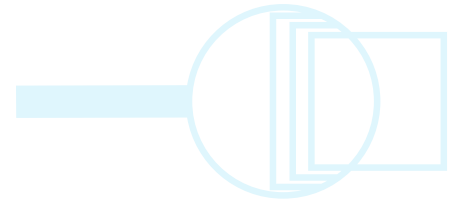
**Interviewer:** “You told me earlier that you arrived at work today at about 3:45 p.m.”

**Witness:** “Yes, I signed in at 3:45 and went to the nurse’s station to check my assignment for the day.”

**Statement:** (Written by Interviewer) “I signed in today (date) at 3:45 p.m. and went to the nurse’s station to check my assignment for the day.”

Continue in this manner, always using the first person pronoun “I,” since you are recording the witness’s first-hand knowledge.

<sup>11</sup> Alternately, if mutually agreed upon by you and the witness, the witness can write out the statement as you assist by asking questions in logical order.

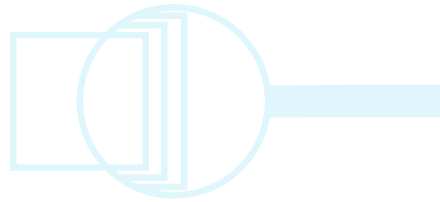


Use the person's own words as much as possible. This will help establish that they are familiar with the events and are not simply responding to your questions. A statement is more credible, and can be given greater evidentiary weight, if its language and style are those normally used by the person who makes it. Using the witness's language also eliminates grounds for a later claim that he or she did not understand portions of the document.

When the statement is finished, ask the witness to review it carefully. If changes are necessary, permit the person to make them right on the document; have the witness initial and date each change.

When all corrections have been made, ask the witness to sign the statement, noting the date and time of signature. Have the witness sign the bottom of each page in the case of a multi-page document. This will establish that there were no page substitutions after the document was signed.

Sign the statement as a witness and include the date of your signature. Have the document counter - witnessed by your management representative. In the case of an interrogation, ask the employee's representative to read and witness the statement as well, and be certain to give the employee a copy of the statement. Have him/her acknowledge receipt of the statement.



## Special Circumstances

◆ **Refusal to Sign:** If the witness refuses to sign the statement, ask why. Point out that such refusal indicates the document may be untrue in whole or in part. Ask the person to review it again and, if necessary, point out areas they disagree with. Permit him/her to make and initial changes as discussed above, if these will overcome the objection to signing. Naturally, you may want to question the witness further about the controversial points.

Employee refusal to sign can also be considered insubordination, under the previously discussed premise that the employee is required to cooperate in the investigation. Again, you should indicate this obligation clearly and unequivocally, including the possibility of disciplinary action. Give the witness a direct order to sign the document, in the presence of another management representative. If they persist in refusing, append a notation to that effect to the statement and have your management representative witness the fact of refusal. Sample wording:

“The above statement was prepared following my interview of (employee) on (date) relative to a special investigation conducted by me. Despite being ordered to do so, (employee) refused to sign the statement. (Employee) was afforded full opportunity to review the document, and to make corrections/changes he/she deemed appropriate.”

---

Name

**Clinical Risk Manager**

Signature

Date

---

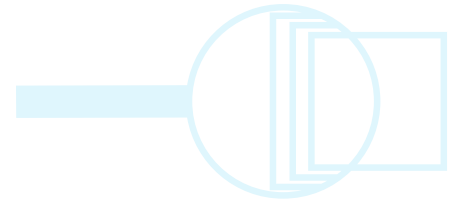
Name

**Management Witness**

Signature

Date





- ◆ **Non-English Speaking Witness:** If the person does not speak, read or write English, you will need to obtain interpreters for the interview and preparation of a statement. Prepare a statement as described above and review it with the witness through the interpreter. Following your statement have the interpreters sign a statement such as the following:

“We, the undersigned, hereby document that we interpreted the foregoing statement to PAUL V. LETKO in the Russian language exactly as that statement is written, and that PAUL V. LETKO acknowledged to us that he understood the entire statement and all parts thereof as read to him in Russian and said that it was all true.”

---

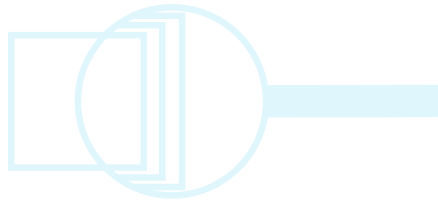
Name	Signature	Date
------	-----------	------

**First Interpreter**

---

Name	Signature	Date
------	-----------	------

**Second Interpreter**



◆ **Witness Unable to Read and/or to Write Name:** If the witness understands and speaks English but cannot read, prepare the statement as described earlier and read it back verbatim to the person. First provide a copy to another management representative and have this person follow along as you read to the witness. Following your statement have the management representative sign a statement such as the following:

“We, the undersigned, hereby document that the foregoing statement was read to (Witness), exactly as that statement is written, and (Witness) acknowledged to us that he understood the entire statement and all parts as read to him and said that it was all true.”

---

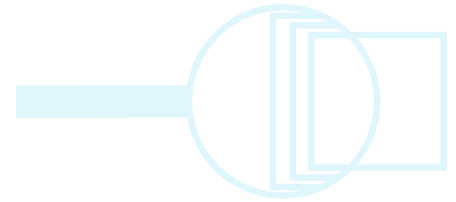
Name	<b>Interviewer</b>	Signature	Date
------	--------------------	-----------	------

---

Name	<b>Management Witness</b>	Signature	Date
------	---------------------------	-----------	------

If the person giving the statement cannot write his/her name, then you write the name and have the person make their mark after it. Have your management representative witness this, as follows:

John Smith (Written by Interviewer)  
Witness Mark (Mark)  
Management Witness (Signature and Title)



## Phase Three: Analysis Of Evidence

The preceding discussion has centered on gathering documentary, testimonial and physical evidence about a major incident. The next step is to evaluate the available information in order to arrive at conclusions about what occurred, and why.

### Assembling Evidence

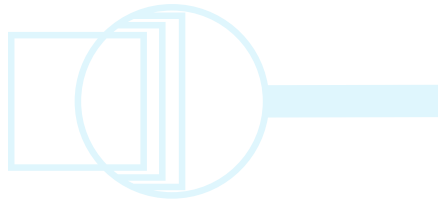
Develop a consistent procedure for assembling and summarizing evidence in a given case. This will help you to analyze material efficiently and effectively, and will also serve as a foundation for your final report. Here again are the major evidence categories:

- Witness accounts:** Write down a brief summary of what each person has told you, based on your notes and the statements you have prepared.
- Physical Evidence:** List all the items collected or reviewed, including photos and descriptions of injuries; photos and sketches of the incident scene; specimens, and furniture/objects. Make a brief note on the relevance of each item to the case.
- Background Information:** Briefly summarize what you have learned about each witness, including clients and staff, as well as about the circumstances surrounding the incident, such as systemic issues that may have contributed to its occurrence.

### Evaluating Witnesses

In nearly every case, there will be disagreements among the recollections and statements of people who saw, heard or know something about an incident. These will range from minor differences of perception to completely opposite accounts of what did or did not occur. Fortunately, there are common sense principles which will help you make judgments about the relative credibility and reliability of each description or account. (Remember to distinguish between these terms as you evaluate each witness. Credibility refers to the person's truthfulness in a given instance; reliability means the degree to which the person is able to accurately recall and describe facts.<sup>12</sup>)

<sup>12</sup> It is important to distinguish between reliable testimony, as defined here, and the special use of the term "reasonably reliable" as applied to allegations of abuse. The term "reasonably reliable" was generated by the mutual agreement of Office of Mental Health Counsel and the Commission on the Quality of Care. As noted on page 8 of this document, an allegation must be considered **reasonably reliable** unless there are known facts immediately available when the statement first comes to staff attention which render all critical aspects of the statement inaccurate. For purposes of incident reporting and investigation, reasonable reliability is a judgement about a statement, not about the condition, competency or credibility of a client. Essentially, to say a statement is not reasonably reliable is to say that there is no possibility of its being true. Once an allegation is found to be reasonably reliable, the allegation must be investigated, using the criteria taught in this manual. In addition, whenever a client is injured and there is also an allegation of abuse, a special investigation should be conducted without consideration of whether or not the allegation is reasonably reliable.



Bear in mind that there will almost always be some variation in statements, even among so-called “eye witnesses,” because of their relative physical positions, differing personal capabilities (e.g., eyesight and hearing), focus of attention, and relative recall abilities. Your first step is to sort out and deal with such differences, by carefully reviewing what you know about these factors with respect to each witness. For example, you may find that two statements, while not the same, are not really in conflict. Consider the following:

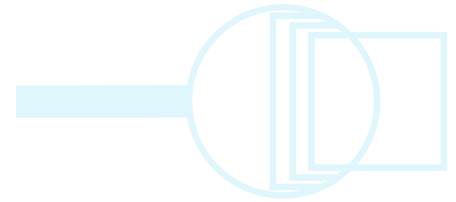
**Statement A:** “At 1:45 p.m., I saw Jones hit Smith.”

**Statement B:** “At about 1:40 p.m., I heard Smith call Jones a ‘bastard,’ but I didn’t see Jones hit Smith. In fact, Jones never even raised his voice at Smith.”

Witnesses A and B have in all likelihood given reliable, credible statements about their observations of Smith’s and Jones’s behavior. There is a logical explanation for their different perceptions, in that each witnessed a different portion of a series of events.

There will, of course, be cases where two or more statements are contradictory and no such explanation exists. Someone is lying, or withholding material facts. Here you must evaluate the **credibility** of each statement against the following elements:

- ◆ The “ring of truth.” Are the “facts” presented consistent with common sense, logic and known facts of the case?
- ◆ Motivation to lie. Is such motivation present and, if so, to what degree? For example, is the witness motivated to “cover” for a fellow employee implicated in the incident, or to suppress the fact that the matter wasn’t properly reported? Conversely, is there animus, or ill will, between witnesses, e.g., between two employees who have competed for shift/pass day assignments or a promotion?
- ◆ Is there circumstantial or corroborative evidence which tends to support one account over another? For example, assume a client alleges he was struck by an employee, while the two were alone in a bedroom. The client says this happened when he accidentally splashed water on the employee. Another employee states the alleged assailant was later overheard cursing and complaining about his shirt being “soaked” by the client. The accused employee denies both the water incident and striking the client. While not in itself dispositive of the issue, the accused employee’s comment about his wet shirt is very important circumstantial evidence, tending to support the client’s allegation.
- ◆ Past conduct. Is an employee witness generally considered truthful by his/her peers and supervisors? Is there evidence that the person has previously lied?
- ◆ Client Witness. Does the client’s background or clinical record raise a question about the ability of the client to make accurate statements? Be very careful on this point, particularly regarding statements in the



record. Do not, for example, assume the client isn't reliable simply because "the record" says that he or she has withheld information from staff, disobeyed ward routines or been otherwise identified as "difficult." The client may have good reasons, from his/her perspective, for engaging in such conduct, and be a very credible witness on the case you are investigating.

**Further Considerations Regarding Client Testimony.** Basically, you should be judging the client's testimony against the same standards applicable to any other witness. In other words, do not presume that either the reliability or the credibility of the witness is diminished simply because the person is under care for a psychiatric disorder.

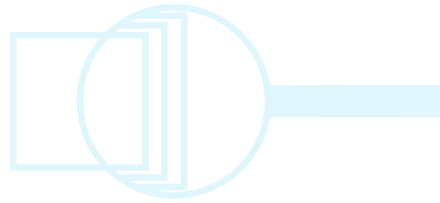
Court cases, however, have established certain rights for employees who are charged with misconduct in a client-related incident, and who subsequently appeal the proposed disciplinary action. If the client is called to testify at a disciplinary arbitration, the employee's attorney may demand that the client's clinical record be produced at the hearing, for the purpose of discovering information which could affect his or her credibility or reliability as a witness. In practice, the attorney will generally have access to that portion of the record which the arbitrator deems relevant to the case, and will be allowed to cross-examine the client from those records. It is thus essential that management be fully aware of what the record contains, in making its own judgments about credibility and reliability, and in preparing for whatever administrative action may follow the investigation. The client should also be aware of potential areas of controversy, before he or she is asked to testify.

If you anticipate potential challenges to client testimony, if you have reason to believe that the client's testimony may be questioned by administrators who read your report, by an employee's attorney, or by arbitrators involved in disciplinary proceedings, you should develop a fairly complete "profile" on the person, drawing on three sources of information:

- ◆ Your own common sense judgment.
- ◆ Observations and opinions of a clinician with expert knowledge of the client.
- ◆ The client's clinical records.

You will need to exercise your **personal judgment** in determining whether or not the testimony has the ring of truth. Your particular expertise in evaluating reliability and credibility should give you a "leg up" in assessing the client's initial and subsequent accounts of what occurred.

Depending on circumstances, you may or may not want to ask staff for their evaluation of the client's account of the incident. If so, be careful to select a **reliable, experienced clinician** and let him or her know that you need an objective evaluation. If you have confidence in the person's objectivity and judgment, tell the clinician the facts as described by the client. Ask if the clinician knows of any reason why the account should not be believed, given all the circumstances. You may wish to have this person accompany you on a



re-interview of the client, wherein he or she is allowed to ask questions based on prior knowledge of the client's attitude and behavior.

Finally, familiarize yourself with the **client's clinical record**. You should be able to discuss what the record has to say about the client's past conduct, as it relates to his/her credibility. Your primary purpose, however, is to secure information regarding the client's contemporary mental status: Can the individual relate accurately what he or she saw and heard? Does the individual know right from wrong and the importance of telling the truth? After reviewing the record, it may be helpful to explore and discuss relevant matters with the client, so that both of you can be aware of matters that may come up during a subsequent disciplinary action, if the client is called to testify.

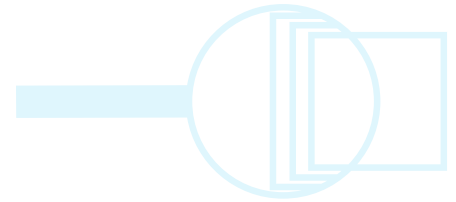
**Further Considerations Regarding Supervisory Witnesses.** Caution must be used in evaluating both positive and negative comments by supervisory witnesses. For example, there should be probing questions about the basis for formal and informal performance appraisals: What is the nature, scope and frequency of the supervisor's direct observation of work performance? Are supervisor and employee together much of the time, or does the employee frequently work independently because of shift or other factors? How much direct client contact does the employee have, and how often is such contact observed by the supervisor? With what results? Has the employee shown evidence of undue impatience with or anger toward any of the clients he deals with?

Fairly often, you will learn that the ward supervisor responsible for rating an employee's performance has relatively little contact with the subordinate. Thus, a satisfactory or even exemplary evaluation may say very little about the person's actual dealings with clients, including whether or not he or she has a propensity to commit an act of client abuse.

The supervisor should be told the basic facts of the incident under investigation and questioned about any related information in his or her possession. For example, have staff commented to him, or in his presence, about what likely happened? Has there been comment about the client's account of the incident? About that of any employee?

Finally, when evaluating the testimony of supervisory witnesses, the CRM/CRMS must be aware that individual loyalties in a serious incident investigation may be significantly affected by past/present supervisory relationships. For example, a supervisor may find it extremely difficult to accept the possibility that a staff member has engaged in misconduct toward a client. Consequently, his or her attitude toward the CRM/CRMS may vary from grudging cooperation to open hostility and resistance. As necessary, the supervisor should be reminded of the facility's absolute obligation to protect the welfare of its clients, and to fully investigate any circumstances bearing upon that welfare.

- ◆ Aside from observations about subordinates and on the incident being reviewed, supervisors may provide valuable information regarding work policies and rules relevant to the case. For example, there are detailed, agency-wide policies dealing with the subject of client abuse, including specific conduct consid-



ered abusive and employee obligations to report such matters. These are described in the policy, supervisory conferences, etc. Should disciplinary action be commenced as a result of your investigation, this linkage between written policy and the employee could be of critical importance. If the linkage is strong and clear, it will effectively forestall any disclaimer by the accused that he or she was unaware of specific obligations conferred by the policy. In any case, management must be aware of what the actual practice has been in disseminating the policy, even if that practice has not been ideal.

**Identifying Systems Issues That May Have Contributed to the Incident.** Historically, the administrative response when an incident occurs has been to focus on individual errors and impose sanctions and punishment as the corrective action. Recent literature on Sentinel Events and Root Cause Analysis, however, has emphasized the need to investigate and understand the causes that underlie major incidents and make changes in the organization's systems and processes to reduce the probability of recurrence of such events in the future. Clinical Risk Managers often find that, when incidents occur which involve staff errors or malfeasance of duty, there are many different factors that jointly contribute to these incidents. Most incidents represent a combination of problems related to policies and procedures, staff education, work assignments, supervision, information management, communication, worker attention, etc. Indeed, clinical risk management is the art of ferreting out such background causative factors and devising plans to overcome them.

The special investigation process is distinct from the root cause analysis process. In order to be effective as clinical risk management tools, however, both processes must look at the non-human, systems, and other contributing factors as well as at human culpability.

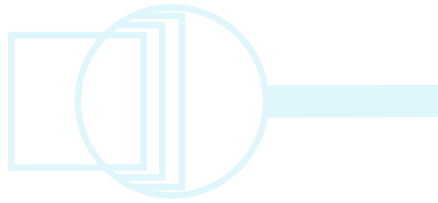
Throughout the investigation, therefore, you should be looking for the broad array of factors which may have contributed to the occurrence of the incident. As you analyze your findings, you should review these factors and include the most cogent ones in your investigation report.

## Developing a Theory of the Case

Occasionally, your data will point to an obvious fact pattern regarding a given incident. Usually, however, you will need to engage in a very careful analysis of the evidence before reaching a conclusion about what happened and why. Since you did not witness the incident first hand, the conclusions you reach are generally referred to as "theories of the case."

Obviously, the nature of the evidence will determine whether there is one theory of what happened, or several, and the weight you or others assign to each theory.

It is also obvious that a tentative conclusion could have emerged—in your own mind—at almost any point in the investigation. However, it's a good idea to follow a standard pattern in reviewing the evidence, even if the facts are fairly straightforward. Here is the preferred approach.



- Step One:** Write down every plausible fact pattern (theory) you can think of based on the available evidence.
- Step Two:** For each theory, carefully list every item of supporting evidence, including witness statements, photos, and other physical evidence. Include any facts or circumstances which materially affect the weight of each item; for example, the credibility of key witness testimony, clarity of photos, possible contamination of substances, etc.
- Step Three:** Determine any additional actions you could take to confirm or rule out a particular theory. For example, you may wish to re-interview a doubtful witness in light of all the evidence, to reexamine a client-witness's medical records, and/or to revisit the incident site.
- Step Four:** Select the fact pattern which is best supported by the evidence: essentially, your best judgment about what happened.
- Step Five:** Discuss the case with an objective third party, preferably someone who has had little or no contact with the investigation up to this point, and who does not have a direct working or clinical relationship with the principal parties. This will probably rule out supervisory staff directly associated with the incident site, including the Unit Chief and Team Leader. Presumably, you have already spoken with these people regarding their direct or indirect knowledge of the incident. Your goal at this point is to obtain an objective reaction to your best judgment about the case.

Start with other Clinical Risk Management staff and/or your facility's Quality Management Director. If you have consulted with these people throughout the investigation, you may now need to talk to someone unfamiliar with the case who can give you an objective, independent response. The most likely candidates for this exercise are the Deputy Director for Administrative Services and the Personnel Director. They should be knowledgeable about facility and OMH regulations pertaining to client safety and well-being, but do not supervise direct care staff who may be associated with the incident.

Describe the facts to the selected official as objectively as you can. Explain the basis for your tentative conclusions, but leave nothing out; include any doubtful or questionable areas of evidence or testimony. Ask the person to give you his or her frank reactions to your primary theory of the case. Encourage the listener to play devil's advocate, and to suggest any lines of inquiry you haven't considered.

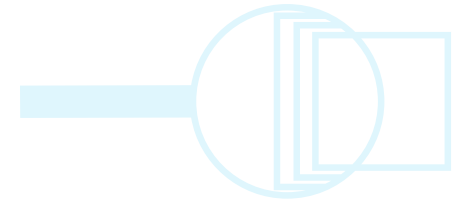
Aside from helping you reach objective conclusions about the evidence, this avenue of communication is extremely helpful in keeping management informed of your progress and work plan. In most situations, you will be dealing with Clinical Risk Management colleagues. There is no set rule on when or how often you should be in contact with this person; however, you should

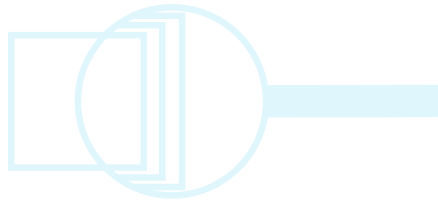


make informal (oral) progress reports whenever a management decision or action is required. The primary examples are:

- ◆ When you identify a condition affecting the welfare or safety of clients, such as inadequate staffing on a particular unit, or inadequate procedures for safeguarding controlled substances.
- ◆ When you identify a person or persons believed to have engaged in client abuse, mistreatment or neglect. This may trigger temporary reassignment or suspension of the employee(s), within guidelines established by the negotiated disciplinary procedures.

The above steps should put you in a good position to reach conclusions about the case, and to prepare a comprehensive investigative report for the Executive Director or designee. The final section of this chapter discusses the format and content of your written report. It is followed, in Appendices A and B, by two checklists provided to assist you in keeping track of the several components of the investigation process. Then follows a case study and a sample investigative report, in Appendix C and Appendix D, respectively, which illustrate the application of the special investigation methodology to a particular body of evidence.





## The Investigative Report

### Purpose

The primary purposes of an investigative report are to describe:

- ◆ The methods and procedures you used to conduct the investigation
- ◆ Your findings of fact: what occurred, when it occurred, and how
- ◆ Your conclusions
- ◆ The basis for those conclusions
- ◆ Issues raised

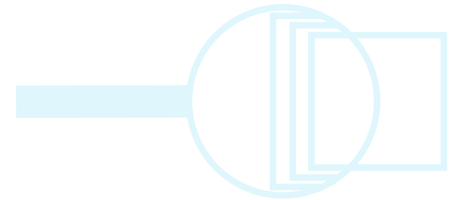
### Presentation

It is important that the investigation be documented in a clear and complete report. It is this report, the final work product of the investigating CRM/CRMS, which will be the basis of follow-up action by the facility director, the facility Incident Review Committee, OMH central office managers, hearing officers, and other external agencies who have an interest in a particular incident. Following is a recommended format for the preparation of a Special Investigation Report.

### Format

#### The Incident

- ◆ An overview of the incident or allegation giving rise to the investigation as understood at the time the CRM/CRMS began work on the case
- ◆ The name(s) of the client(s) and staff involved, the date and time the incident occurred, the date and time it was discovered or reported, the date and time it was reported to a Cabinet member, and the date and time of all external notifications



## The Investigation Process

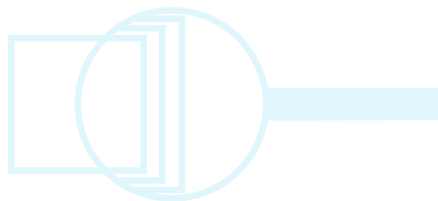
- ◆ The date and time the CRM/CRMS arrived at the scene of the incident
- ◆ Description of initial control and security of scene (evidence and medical record secured, staff held for interview, potential witnesses separated, targeted employee separated)
- ◆ Documentation of physician's examination and findings, along with date and time
- ◆ Description of the methods and procedures used to conduct the investigation:
  - ◆ witnesses interviewed or interrogated, along with dates and times
  - ◆ physical evidence recovered, secured and labeled (photos, diagrams, specimens, objects, etc.)
  - ◆ documentary evidence gathered

## Findings/Conclusions

- ◆ The investigating CRM/CRMS's conclusions and the supporting facts
  - ◆ a summary of the relevant evidence (witnesses statements, relevant history, documentary evidence, physical evidence)
  - ◆ a statement of the CRM/CRMS's theory of the case (conclusions), including a description of the systems, processes, and areas of risk that may have contributed to the incident
  - ◆ the facts and circumstances supporting the CRM/CRMS's theory of the case, including how discrepancies were resolved

## Issues Raised

- ◆ A statement of the administrative and clinical systems issues raised by this incident, for consideration by administration in devising a plan of preventive or corrective action to improve quality of care:
  - ◆ staff supervision or education issues
  - ◆ policies that may need to be clarified or changed
  - ◆ equipment or procedures that need to be reviewed
- ◆ A recommendation that facility management consider appropriate administrative action, such as discipline or counseling, for particular employees, as well as other corrective or preventive actions, such as training. The specific administrative action taken should be developed by facility management.



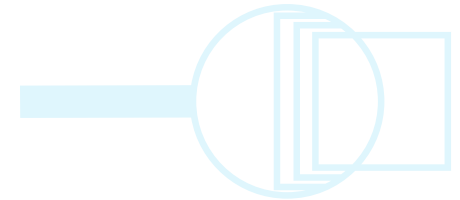
## Supporting Documentation

- ◆ Witness statements, photos, reports and other documentary evidence should be maintained in a secure file in the Clinical Risk Management office.

## Summary

Investigative report writing is a combination of art and science, just like the investigation itself. The main goal should be to present fact-finding results clearly and succinctly, in a manner which the reader can readily grasp. Findings should be consistent with, and supported by, the evidence considered. Refer to Appendix D for a sample investigative report, based on the case study presented in Appendix C.

# Appendix A: Sample CRM/CRMS's Check List



---

## I. Preliminary Information

Client or Other Victim \_\_\_\_\_

Incident \_\_\_\_\_

Type \_\_\_\_\_

Ward or Unit \_\_\_\_\_

Date \_\_\_\_\_

Building \_\_\_\_\_

Time \_\_\_\_\_

Name of CRM/CRMS \_\_\_\_\_

Location \_\_\_\_\_

---

## II. Preliminary Report to CRM/CRMS

Received: Date \_\_\_\_\_ From: Name \_\_\_\_\_

Time \_\_\_\_\_ Title \_\_\_\_\_

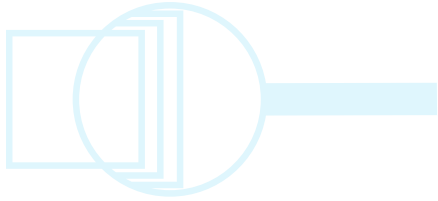
---

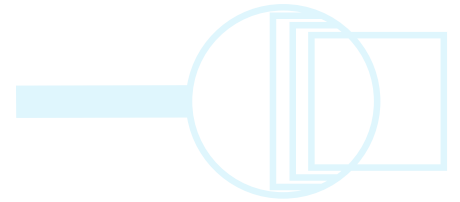
## III. Brief Description

---

---

---



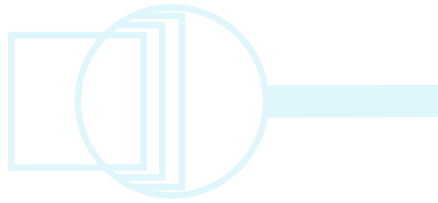


#### IV. Preliminary Actions – CRM/CRMS or AOD/AOD/Unit Chief

	Remarks
_____ Witnesses retained and separated	_____
_____ Alleged perpetrator separated from alleged victim	_____
_____ Scene secured	_____
_____ Documents secured, including Medical Record	_____
_____ Client/victim’s condition determined	_____
_____ Physician notified	_____
_____ Photos ordered or taken	_____
_____ Sketches prepared	_____
_____ Other _____	_____

#### V. Notifications Made (with date and time indicated)

_____ Executive Director	_____ MHLS
_____ Quality Director	_____ Relatives
_____ Personnel Officer	_____ Police
_____ Unit Chief	_____ Child Abuse Registry
_____ Safety Department	_____ Board of Visitors
_____ Other Internal	_____ Commission on Quality of Care
_____ OMH Central Office	_____ Other _____
_____	_____



## VI. Areas of Investigation

### Physical Exam – Report of Results

\_\_\_\_\_ Received

\_\_\_\_\_ Discussed with Physician

Remarks: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Physical Evidence:

Item	Location	Disposition	Remarks
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

### Photographic Evidence:

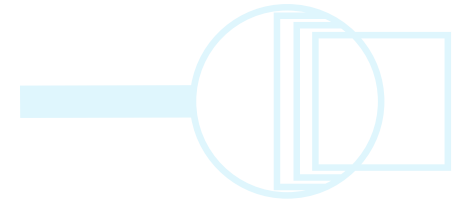
Item	Photos by	Remarks
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Witnesses: (Refer to Statements)

Name (Client, employee, etc.)	Status	Interviewed/ Interrogated	Statement Taken	Remarks
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



# Appendix B: Items to Include in Witness Statement



(Select one)

Interview Conducted by: Name \_\_\_\_\_  
 Interrogation Title \_\_\_\_\_

Date \_\_\_\_\_ Employee Representative: Name \_\_\_\_\_  
Time \_\_\_\_\_ Title \_\_\_\_\_

---

## Witness Information

Name \_\_\_\_\_

Status (check)  Client  Visitor  Employee  Other

---

## Employee Witness

Job Title \_\_\_\_\_  
Work Location \_\_\_\_\_  
Shift \_\_\_\_\_  
Work Phone \_\_\_\_\_

## Client Witness

Ward \_\_\_\_\_ Building \_\_\_\_\_  
Primary Therapist: \_\_\_\_\_  
Name \_\_\_\_\_  
Title \_\_\_\_\_

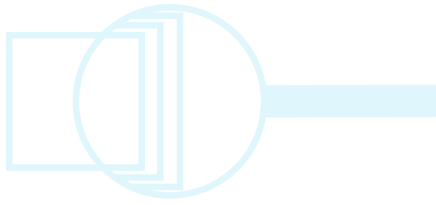
---

## Other Witness

Relationship to Client (If Applicable) \_\_\_\_\_

Home Address (If Applicable) \_\_\_\_\_  
Home Phone (If Applicable) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



---

## Content of Witness Statement

Type or write legibly, in ink. Double space. Include all essential descriptive information as provided by the witness. (Add pages as needed.)

---

---

---

---

---

---

---

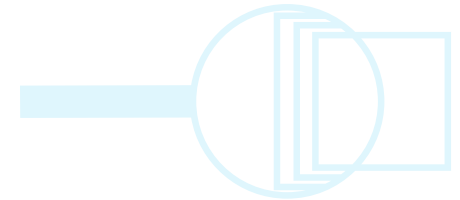
---

---

---

\_\_\_\_ All statements signed and dated by all participants.

# Appendix C: Case Study: Client Smith's Allegation of Physical Abuse



## What the Investigating CRM/CRMS Learned Initially:

At 5:15 p.m. on November 1, the Ward Charge for Ward 70 phoned the AOD to report that Client Harold Smith had sustained an injury to the head and was to be seen by the physician on call. The AOD phoned the Clinical Risk Manager who, by agreement, proceeded to the scene. The AOD informed the Clinical Risk Manager that there were three employees on duty on Ward 70 that afternoon, in addition to the Charge:

John Anderson, MHTA

Harry Walker, MHTA

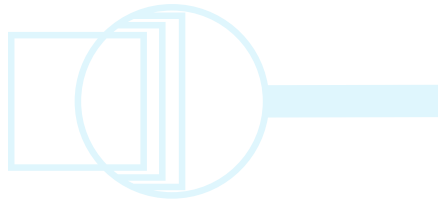
Mary Jones, LPN

## What the Investigating CRM/CRMS Learned From and About the Principal Witnesses:

**Client Smith** stated that Anderson argued with him and shoved him into a wall outside Smith's bedroom. Smith also maintained that Anderson had "roughed him up" on a prior occasion.

Smith's record states that he did complain about Anderson's behavior, about two months ago. The Unit Chief investigated and could find no basis for that complaint. The record also states that Smith has called Anderson derogatory names on at least two occasions. Three months ago, Smith was reprimanded for stealing cigarettes and money from another client. When confronted about this theft, Smith denied it.

**Anderson** claimed that the client grabbed and pushed him while he, Anderson, was en route to another client's room with an evening meal tray. Smith asked Anderson for a cigarette. Anderson said he couldn't give him one until later. Smith then cursed at Anderson and grabbed the tray, trying to pull it away from Anderson. The floor was slippery, and Smith slipped backward against the wall, injuring his head. Anderson said he was trying to keep Smith from injuring himself and others.



**Work Record:** Five years in present job. Satisfactory ratings. Counseled one year ago for poor attendance. Known as aggressive, but generally considerate of clients. Evaluation shows he has been advised not to favor some clients over others. Counseled six months ago for using harsh language with a client (not Smith).

**Walker** stated he entered the hallway as Smith and Anderson were “scuffling.” Heard Smith call Anderson a “cheap bastard.” Saw client strike head on wall; believes he was pushed by Anderson. Saw bump on Smith’s head immediately thereafter.

**Work Record:** Eight years’ experience; good work record; gets along well with all staff, including Anderson and Jones. Considered friendly and considerate with clients.

**Jones:** Says she emerged from adjacent bedroom, when she heard a “commotion” in the hall. Confirms slippery floor. Did not see employee push or shove client; believes client fell against wall when he yanked tray away from Anderson. Examined injury to the head and notified Ward Charge.

**Work Record:** Satisfactory, two years in present job.

### Other Information Gathered During the Initial Investigation:

**The unit psychiatrist** states that client Smith is oriented as to place, time and person, is capable of reliably reporting real events in his life, and understands the difference between the truth and a lie. The psychiatrist interviewed Smith the day after this incident, and received essentially the same account of it as Smith had given the Clinical Risk Manager.

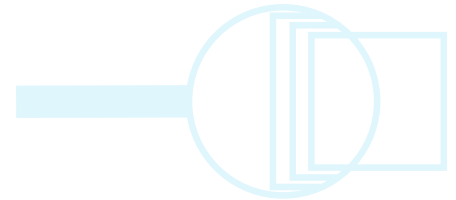
**Client John English** asked to see the Clinical Risk Manager after hearing of the incident. English stated that John Anderson has often used harsh, demeaning language when addressing Smith.

**A housekeeper** on duty at the time of the incident confirms that the Ward 70 hallway had been waxed at about 4:30 p.m. However, he didn’t consider the floor excessively slippery: the same cleaning procedure is used in that Ward every two days.

### The Clinical Risk Manager’s Theories of the Case:

**Theory A:** Employee Anderson abused the client, by shoving him into a wall. In support of this scenario are the following:

- ◆ The client’s account is clear and consistent.
- ◆ Smith is considered by the unit psychiatrist to be a reliable witness.



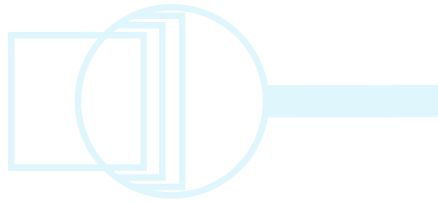
- ◆ Employee Walker’s account appears to agree with that of Client Smith.
- ◆ Anderson had a recent physical incident with Smith, according to Smith.
- ◆ Anderson is known to favor some clients over others, and has been counseled for using harsh language with a client.
- ◆ An apparently reliable client witness states that Anderson has used harsh, possibly abusive language toward Smith on several occasions.
- ◆ Walker confirms that Smith had given Anderson a reason (name calling) to be angry with him, at the moment of the incident.

**Theory B:** The injury was accidental. Anderson acted properly in trying to restrain Smith, whose actions were a potential threat to himself and/or others. Evidence in favor of this account:

- ◆ Walker, who has no apparent reason to lie, confirms that the client and employee were engaged in a “scuffle” and were exchanging harsh words. He later described the “scuffle” as an extended verbal altercation. His recollection of the client being pushed by Anderson is not strong. It is equally possible that what Walker actually witnessed was Smith accidentally falling, as Anderson claims.
- ◆ Mary Jones, who saw part of the interaction between Smith and Anderson at fairly close range, stated that Smith appeared to be pulling a food tray away from Anderson. Jones said that Smith may have slipped on the slippery ward floor.
- ◆ Client John English’s statements and the clinical record confirm that there may be animus between Smith and Anderson. Rather than supporting the theory that Anderson abused Smith, this information could just as easily support the client’s motivation to lie about or exaggerate Anderson’s actions.

### What the Clinical Risk Manager did in Attempting to Resolve the Issue:

- ◆ Re-interviewed client Smith, for the purpose of further exploring Smith’s past problems with employee Anderson, and the client’s account of what happened in this incident.
- ◆ Interviewed the Unit Chief regarding the investigation of Smith’s prior complaint about Anderson.
- ◆ Re-interviewed employees Walker and Jones, to probe their recollections of the physical contact between Smith and Anderson.



- ◆ Interviewed Anderson’s immediate supervisor regarding his general behavior toward clients, the basis for the supervisor’s impressions, and the counseling Anderson received for using “harsh” language toward a client.

### Systems issues that emerged in the course of the investigation:

- ◆ MHTA Anderson is alleged to have shoved client Smith and to have “roughed him up” in a prior incident. This follows a former situation in which Anderson was counseled for using harsh language with another client. This raises issues regarding the culture on this ward regarding acceptable staff language and behaviors. (Are staff allowed to use demeaning language to each other? With patients?) It also raises questions regarding the presence and attitude of the RN and the Unit Chief and the quality of the supervision of the ward.
- ◆ The former allegation, an allegation of abuse, was conducted by the Unit Chief rather than by Clinical Risk Management staff. Furthermore, the incident report of the allegation had never been submitted to Clinical Risk Management.
- ◆ Mr. Anderson is described as bringing a tray to a patient, presumably to an area other than the dining area. Questions need to be asked regarding meal policy on the ward. Don’t patients come to the dining area to eat? Are there any exceptions? What are they? If the location is different from where the other patients eat, what is the policy/procedure? How are clients who eat on the ward supervised? What about choking precautions? There may be a heightened risk for choking if adequate staff supervision is not provided.
- ◆ Reportedly, a slippery floor contributed to the client’s fall. The floor was waxed at 4:30 p.m. Is there a reason the floors have to be waxed at this time of day? Wouldn’t it be preferable to wax the floors when patients/staff are away, for example, at the Treatment Mall?
- ◆ The incident reportedly occurred in the context of the patient wanting a cigarette which was, presumably, denied. This raises questions regarding ward rules for smoking. Is there a facility policy/procedure? Is this policy followed by the ward? Is there a location allowed for smoking? How often can a patient go there to smoke? Is there a history of incidents on the ward associated with the denial of patients’ smoking privileges?

Clearly, there is nothing magical in this approach. The main requirements are patience, persistence and willingness to focus on the details of the case. The CRM/CRMS should now be in a position to make a definitive choice between the two hypotheses discussed above. Appendix D contains the final investigative report on this case, submitted to the Executive Director.

# Appendix D: Sample Investigative Report



## Confidential

TO: George Hamlin, M.D., Executive Director  
FROM: Sheila Smith, Clinical Risk Manager  
SUBJECT: Investigation of Incident—Ward 70

### The Incident:

At approximately 5:00 p.m. on November 1, 2000, Client Harold Smith sustained a minor injury to the head. This happened in the hallway outside his bedroom on Ward 70. The client accused Mr. Anderson, a Therapy Aide, of pushing him into a wall, causing the injury. At 5:15 p.m. the Ward Charge reported the incident to the AOD, who phoned me at 5:30 p.m. to notify me of the incident. I notified Ms. Johnson, the DQA, of the incident at 5:35 p.m. and told her I planned to conduct a special investigation.

### The Investigation Process:

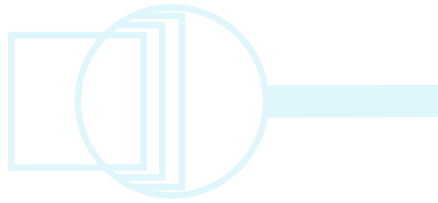
I arrived on Ward 70 at approximately 6:30 p.m. on November 1. The AOD, who had preceded me to the scene, had secured the area, separated Mr. Anderson from Mr. Smith and the other witnesses, and placed the primary witnesses under supervision. The physician on call had examined Mr. Smith at 5:20 p.m. and entered his findings on the NIMRS Physical Exam Findings Screen (hard copy attached).

I took color photos of the client's injury, prepared the attached sketch of the incident site, and proceeded to interview or interrogate the following:

- Harold Smith, the injured client (6:45 p.m.)
- Harry Walker, MHTA on Ward 70 (7:15 p.m.)
- Mary Jones, LPN on Ward 70 (8:00 p.m.)
- John Anderson, MHTA on Ward 70 (8:45 p.m.)\*

These initial discussions were completed on the evening of the incident.

\* Interrogation



Between November 2 and 5, I spoke with the following:

Michael Peters, M.D., Unit Psychiatrist (Nov. 2 at 10:00 a.m.)

John English, another Ward 70 client (Nov. 2 at 2:00 p.m.)

Maria Fernandez, Unit chief for this building (Nov. 3 at 11:00 a.m.)

George Hammond, Ward charge for Ward 70 (Nov. 5 at 10:00 a.m.)

Henry Cabot, Housekeeper for this building (Nov. 5 at 3:00 p.m.)

As discussed further below, these subsequent interviews as well as re-interviews of Smith, Walker, and Jones on November 4, were conducted in order to resolve conflicts in the initial phase of my investigation. Those conflicts resulted, essentially, in two potential explanations for Mr. Smith's injury:

- ◆ Therapy Aide John Anderson deliberately shoved or pushed the client, causing Smith to strike his head against the hallway and sustain the injury.
- ◆ That injury occurred accidentally, when Anderson attempted to prevent the client from grabbing a tray of food Anderson was carrying.

### Findings/Conclusions:

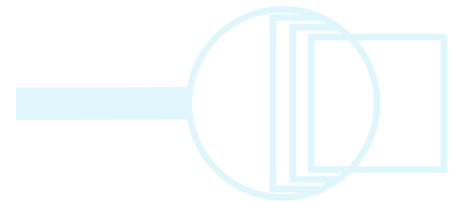
**Summary of relevant evidence.** The physician's examination revealed a swelled circle one and a half inch in diameter on the left parietal region consistent with an injury resulting from impact with a hard surface, such as a wall or floor.

Following is a summary of the principal witness accounts, supplemented by other relevant information about each person:

Client Harold Smith claimed in both of my interviews that John Anderson pushed or shoved him into the hallway wall, when Smith asked Anderson for a cigarette. Smith had complained two months ago that Anderson "roughed" him up after Smith asked for a cigarette. The Unit Chief investigated and found no basis for that allegation. Three months ago, Smith allegedly stole several articles from another client; he denied doing so when confronted by staff. Dr. Peters describes Smith as capable of making a competent statement, which is confirmed by my own observation of his verbal capacity, demeanor and general behavior.

Aide Harry Walker is an eight-year employee with a good work record and satisfactory relations with all concerned. He stated in his first interview that Anderson appeared to push Smith toward the wall. However,





the second discussion confirmed that Walker had viewed the Smith-Anderson interaction from a distance of about forty feet (see attached sketch).

Aide Mary Jones has two years of satisfactory service. She was in a bedroom across the hall from Smith's at the time of the incident, working with another client. Hearing a commotion in the hall, Jones stepped out of the bedroom. At that moment, Anderson and Smith were "holding onto" a food tray; Smith then fell, hitting his head on the wall as he did so. Jones said that the recently waxed hallway floor was slippery. It is her position that Smith fell when he grabbed the tray from Anderson.

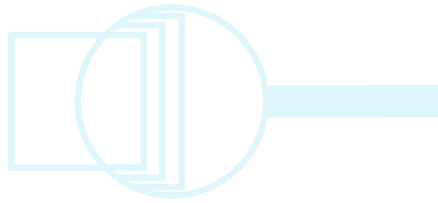
Client John English, who asked to see me on hearing about the incident, states that Mr. Anderson had used demeaning, possibly abusive language when addressing Smith.

Aide John Anderson maintains that Smith grabbed a tray of food Anderson was carrying, when the employee refused to give Smith a cigarette. Smith, according to Anderson, lost his balance on the recently waxed hallway floor and stumbled backward against the wall. Anderson has five years' satisfactory service. His supervisor has cautioned him in previous performance evaluations about "favoring" certain clients over others. He tends to be somewhat impatient with clients who are overly dependent on staff. Six months ago, Anderson was counseled about his manner of addressing a particular client (not Mr. Smith). Finally, Mr. Anderson received a commendation two years ago for his prompt action in saving a client from choking.

**Conclusions.** After carefully considering all of the available evidence, it is my conclusion that Mr. Smith's injury was accidental. I don't discredit the client's belief that he was "shoved" by the employee. However, when I asked Smith to demonstrate what happened between him and Anderson, it was clear that the client had grabbed aggressively for Anderson's tray and tried to wrestle it away from the employee. Mr. Smith is not steady on his feet, and stumbled slightly, during this demonstration. Given the forcefulness with which both men say the tray was grabbed, it is easy to see how the client could have lost his equilibrium and struck the wall behind him.

**Facts and circumstances supporting the conclusions.** Neither of the eyewitnesses to the incident could confirm Mr. Smith's allegation. Mr. Walker's vantage point was simply too far away to give a clear view of what happened between Smith and Anderson. From where he stood (see sketch), Walker could easily have formed the belief that Smith was "shoved," as Walker stated in our first interview. Ms. Jones confirms that Smith yanked at Anderson's food tray. Although she apparently entered the hallway a second or two after Walker, her view of the situation was notably better than his. Jones also confirmed, independently, that the recently waxed floor may have contributed to Smith's fall. While the floor was clearly not slippery by the time I arrived on the Unit, there was no opportunity for Jones and Anderson to collaborate on this explanation, because of the AOD's prompt action in separating the witnesses and placing them under supervision. Further, I was able to confirm through the Housekeeping Department that the floor had, in fact, been waxed, about a half hour before this incident.

I have also carefully looked at John Anderson's work record, including the allegations of harsh or demeaning language referred to above, and Mr. Smith's prior complaint. The prior investigation found no evidence that



Anderson's manner of addressing clients was at any time abusive or demeaning. That investigation did find that he works aggressively to encourage self reliance among clients on this ward, and that at times, some clients, including Mr. Smith and Mr. English have been intimidated or annoyed by his brusque manner and demeanor. This was the basis for the supervisor's counseling referred to above.

I am concerned that the former allegation, an allegation of abuse, was conducted by the Unit Chief. All allegations of abuse are to be investigated by Clinical Risk Management as special investigations. In my review of the case I discovered that the incident report of the allegation had never been submitted to Clinical Risk Management.

However, the weight of evidence in this investigation supports the conclusion that Mr. Smith stumbled or slipped and fell backward against an adjacent wall surface, when the client attempted to take control of a food tray carried by Mr. Anderson. Smith was apparently perturbed by Anderson's failure to immediately grant the client's request for a cigarette.

I am free to discuss these findings at your convenience.

### Issues Raised

- ◆ Mr. Smith's prior allegation of abuse was conducted by the Unit Chief, and the incident report of the allegation had never been submitted to Clinical Risk Management. This suggests the need for continuing education for administrative, clinical and ward staff regarding the reporting of incidents and the criteria for the conduct of special investigations.
- ◆ Mr. Anderson has been known to favor some clients over others and has on occasion used language perceived by some patients to be harsh and demeaning. At a minimum Mr. Anderson should receive remedial training or counseling addressing these issues.
- ◆ Mr. Anderson's behavior seems to be regarded by unit management as appropriate for some clients but not others, and it is not clear whether the culture on this ward differs from that of other wards at the facility. There may be a need for the facility to consider staff training on appropriate staff language and behaviors, not only for Mr. Anderson but for all direct service staff. The facility should also provide a forum for addressing issues of transference and counter-transference.
- ◆ The ward's meal policy and procedures should be reviewed, with particular regard to the feeding of individual clients on the ward.
- ◆ As the condition of the floor may have contributed to Mr. Smith's fall, it is recommended that the Chief Housekeeper review floor-waxing procedures with his staff, cautioning against causing excessively slippery conditions. Both how the floor is waxed and when should be reviewed, as this floor was waxed at a particularly busy time of the clients' day.

## Witness Statement

Name: Harold Smith

Ward 70

Building F

My name is Harold Smith. I've been a client on ward 70 since last summer. Today, just before dinner, this guy Anderson came in and started arguing with me. Then he shoved me into the wall and I fell down. I got a lump on the back of my head. The doctor took a look at me and said I should take it easy for a while. Anderson roughed me up a while back. That's the time I asked to go to supper early because I had a visitor.

Witness:

*Signature*

Harold Smith

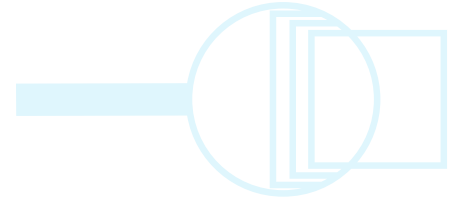
Clinical Risk Manager:

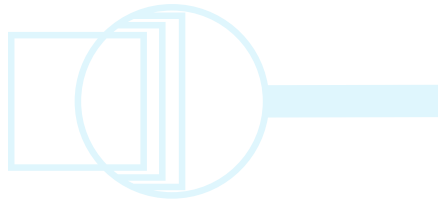
*Signature*

Sheila Smith

Date: November 1, 2000

Time: 6:45 p.m.





## Witness Statement

Name: Harry Walker, MHTA evening shift

Work Location: Ward 70, Building F

Immediate Supervisor: Sally Green, Nurse II

This afternoon I witnessed an incident between John Anderson, an aide who works on my ward, and client Smith. I had just walked into the Ward at the time - I came in from the end opposite from where Harold and John were. As I did so, I heard Mr. Smith yell "you cheap bastard". It seemed from where I stood that John then pushed Harold away from him and toward the wall. John had a food tray in one hand. Smith's head hit the wall, pretty hard. The client slumped to the floor.

I walked over to the two men. John seemed upset, and I advised him to go on with his work, which he did - he left the ward right then. I helped Mr. Smith to his feet. He seemed shaken up and had a bump on his head, so we called the doctor on duty.

Witness:

*Signature*

Harry Walker

Clinical Risk Manager:

*Signature*

Sheila Smith

Date: November 1, 2000

Time: 7:15 p.m.

## Witness Statement

Name: Mary Jones, MHTA evening shift

Work Location: Ward 70, Building F

Immediate Supervisor: Sally Green, Nurse 11

I was working my regular shift today on Ward 70. Just before supper, I was with client Sally Brown, giving her evening meds. Sally is unable to come to the nurse's station for her meds. I heard a commotion in the hall. When I looked out, John Anderson and Harold Smith were holding onto a food tray - it looked like Harold was trying to pull the tray away from John. Then Harold fell down. He hit his head on the wall as he went down. I came over and examined the client briefly. He had a swelled area near the top of his scalp, so I called Dr. Weitzman, who was on call at the time. He came and saw the client, who was conscious and seemed basically O.K. I also informed the Ward Charge.

The floor in the hall had apparently been waxed a little while before this, and was hard to walk on without slipping. I think Harold must have slipped when he grabbed for John's food tray.

Witness:

*Signature*

Mary Jones

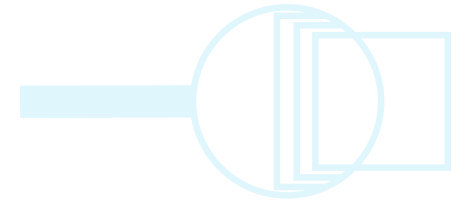
Clinical Risk Manager:

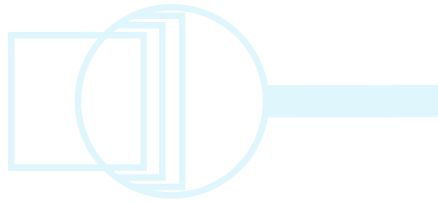
*Signature*

Sheila Smith

Date: November 1, 2000

Time: 8:00 p.m.





## Witness Statement

Name: John Anderson, MHTA evening shift

Work Location: Ward 70, Building F

Immediate Supervisor: Sally Green, Nurse 11

This statement was taken as part of an interrogation, under Article 33 of the State/CSEA contract. Mr. Anderson was represented by CSEA grievance representative Thomas Larkin.

At 5:00 p.m. today, November 1, 2000, I was walking through Ward 70 on my way to Ward 72. I was carrying a supper tray for a diabetic client. As I opened the ward door, client Harold Smith stepped up to me and asked for a cigarette. I told him I couldn't give him one right then, but would see him on the way back. He became abusive and cursed at me. Then he grabbed the tray I was carrying and tried to yank it away from me. Then he slipped backward and banged his head against the wall, falling down as he did so. The floor was slippery - I think it had been waxed just before I came in. I think Mary Jones was in the hall at the time. Ms. Jones called the charge nurse to take care of client Smith. Harry Walker and I helped Mr. Smith to his feet. I continued on to Ward 72.

Witness:

*Signature*

John Anderson

Clinical Risk Manager:

*Signature*

Sheila Smith

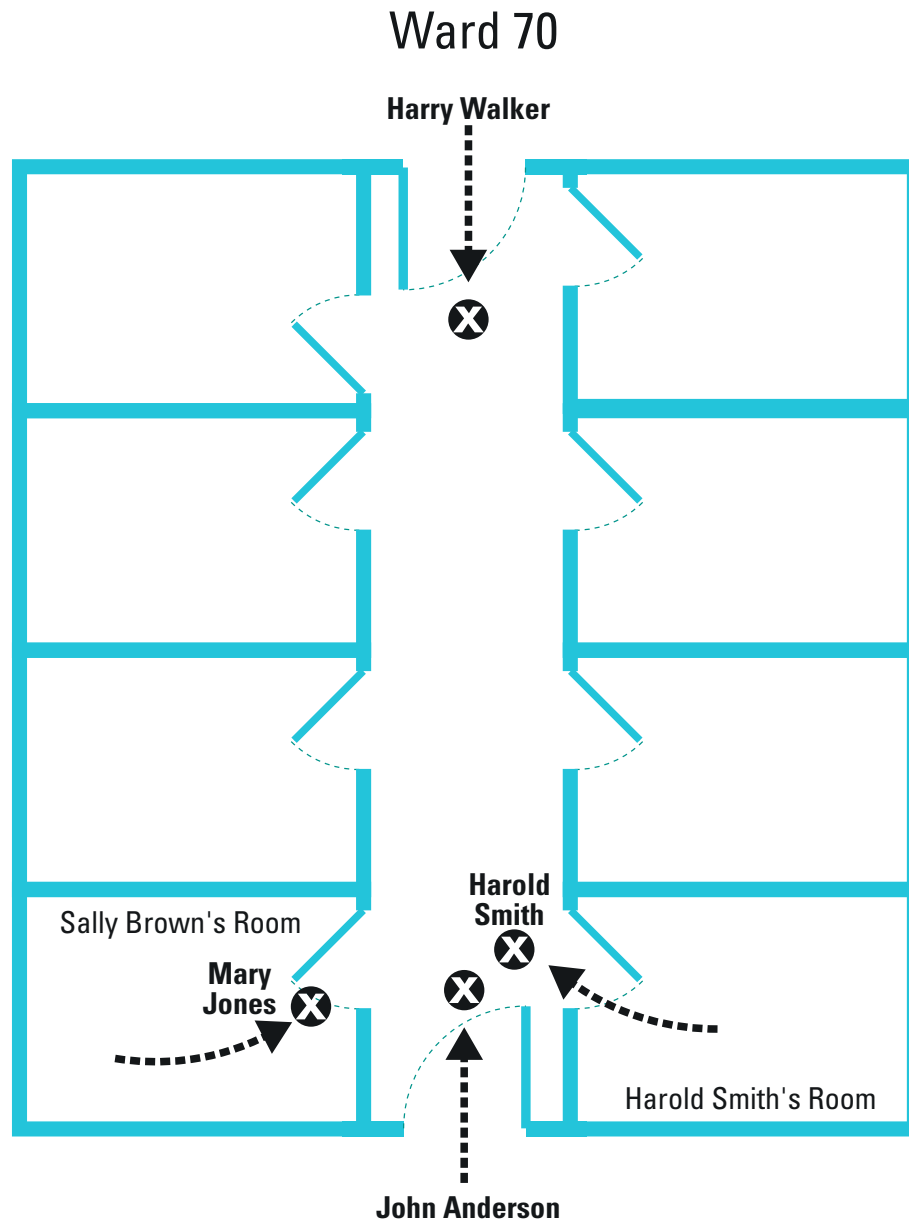
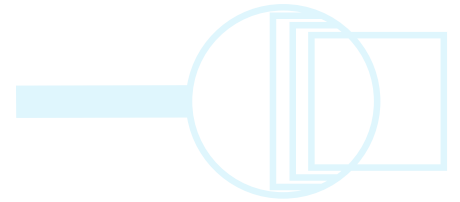
CSEA Representative

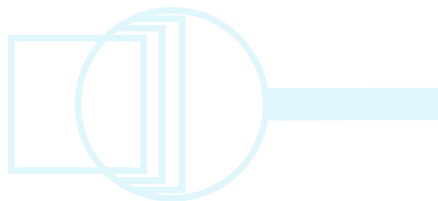
*Signature*

Thomas Larkin

Date: November 1, 2000

Time: 8:45 p.m.







## Appendix E: Sample Employee Representation Election Form

I understand that I have been identified as a potential target of disciplinary action, as a result of an administrative investigation. I further understand that I am entitled to representation when I am questioned by management in connection with this investigation. If I elect representation, I will be given reasonable time to secure it.

Having considered my rights in this matter, I elect as follows:

- I do not wish to be represented during the interrogation.
- I do wish to be represented during the interrogation, as follows:

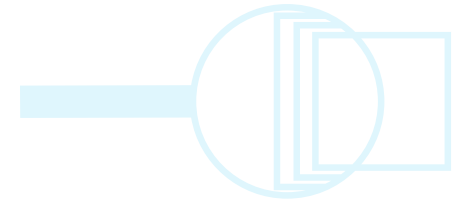
*(check one)*

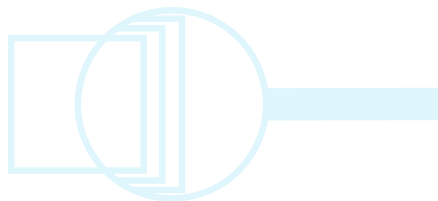
- By my Union representative (non-management/confidential employees)
- By my Attorney ( I understand that I am responsible for any attorney's fees in connection with this representation.)
- By other (management/confidential employees only)

Employee's Name: \_\_\_\_\_

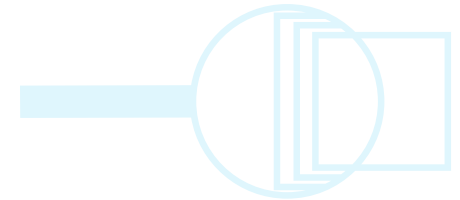
Signature: \_\_\_\_\_

Date: \_\_\_\_\_





# Appendix F: Incident Prevention, Clinical Risk Management and Quality Improvement



## Incident Prevention, Clinical Risk Management and Quality Improvement

Following the Special Investigations Task Force Final Report in March 1998, OMH has advocated a shift in thinking about incidents and investigations, from an approach focused primarily on targeting delinquent staff for disciplinary action toward a more systems-oriented approach that focuses on incident prevention, clinical risk management and quality improvement.

The primary purpose of conducting investigations is to insure the well-being of clients receiving treatment from a mental health provider. One of the more critical intended outcomes, as noted on page 6 of this Manual, is to “assist in preventing recurrence of similar incidents, to reduce risk and to improve the quality of care through analysis of facts, processes and circumstances that contribute to the situation...”

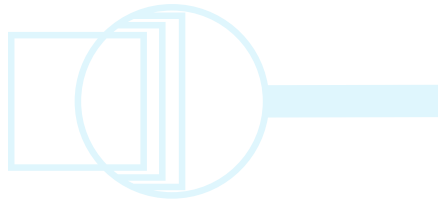
For investigations to serve this purpose and achieve this outcome, the investigation process must be but one part of an array of clinical risk management and quality management efforts focused on the identification of areas of risk and the improvement of processes and outcomes of care.

OMH facilities have been required to prepare a clinical risk management plan and to create clinical risk management teams with the following responsibilities:

### Incident Management

In the area of incident management, the Clinical Risk Management team would:

- ◆ look at safety reports, morning rounds reports, and change of shift reports to assure events are followed up through incident reporting;
- ◆ assume responsibility for all levels of incident investigation and review;
- ◆ conduct all special investigations in a timely, objective and thorough manner;
- ◆ track implementation of preventive measures and plans of corrective action;



- ◆ assist the Incident Review Committee in its review of incidents to ensure that they are appropriately classified, documented and investigated;
- ◆ ensure that all incidents receive accurate classification and severity ratings and that significant developments and trends receive appropriate attention;
- ◆ prepare monthly reports on all incident types, to identify and analyze trends as well as deviations related to incidents occurring at the hospital.

### Identification and Monitoring of High Risk Clients

Closely related to incident management functions is the monitoring of high risk clients. Clinical Risk Management staff are well equipped to develop rosters of such clients, based on review of the incident, restraint/seclusion, case review and other clinical risk management data bases, to facilitate review of patients' care, noting interventions already utilized, and to project options for the future.

### Technical Assistance

In addition to improving the quality, integrity, and responsiveness of investigations, a dedicated Clinical Risk Management team can produce a number of additional benefits. Such teams can play a role in a variety of clinical risk management related functions thereby integrating these functions and making them more efficient. Among the responsibilities such a team could assume are the following:

- ◆ develop materials and provide training for staff and recipients in clinical risk management areas such as clients' rights versus privileges, incident prevention, etc.;
- ◆ serve as a technical resource for staff regarding a variety of clinical risk management related issues, e.g. a Clinical Risk Management Question Line.

## Other Clinical Risk Management Functions

- ◆ coordinate the facility-wide Patient Safety Program;
- ◆ oversee, participate in and/or coordinate, as appropriate other clinical risk management related functions which are perceived as helpful/supportive by staff, such as the facility's Traumatic Events Response Team, the facility's response to Sentinel Events (overseeing the teams assembled to conduct root cause analysis), performance improvement teams and projects, including the implementation process; facility responses to CQC inquiries, etc.;
- ◆ assume clinical risk management related functions that may currently be handled by others, thereby improving the clinical risk management function and freeing other staff for other duties, e.g., serving as primary facility liaison with law enforcement agencies on incidents which may be reportable as crimes, information gathering for lawsuits, managing confidentiality issues, handling information management and data analysis, coordinating case review functions, conducting medical record reviews, coordinating and monitoring the facility's grievance/suggestion system, etc.

