

**State of New York
Office of the Inspector General**



**A Critical Examination of State Agency
Investigations into Allegations of Abuse
of Jonathan Carey**

EXECUTIVE SUMMARY

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I. Executive Summary

INTRODUCTION

This report presents the findings of a comprehensive examination by the New York State Inspector General of whether state agencies responded appropriately and sufficiently to allegations that Jonathan Carey, an 11-year-old child diagnosed with autism and mental retardation, was abused in 2004 while a resident at the Anderson School in Staatsburg, New York. The Inspector General's Office commenced its investigation of Jonathan's care at the Anderson School in March 2007. The investigation was initiated in response to requests from Governor Eliot Spitzer and State Senate Majority Leader Joseph L. Bruno, as well as Jonathan's parents, Michael and Lisa Carey. Jonathan died under the care of workers at a state-run facility in February 2007. Both workers responsible were prosecuted by the Albany County District Attorney and later convicted.

This report primarily focuses on the investigations of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) in response to the allegations of child abuse at the Anderson School. The actions of the State Police and the Dutchess County District Attorney, the State Education Department, and the Governor's Office in response to these allegations were also reviewed. All responded to complaints by Jonathan's parents that their son had been abused and neglected at the Anderson School, a not-for-profit institution offering services to individuals with developmental disabilities.

The alleged abuse began in September 2004, one year and eight months after Jonathan entered the Anderson School. Although Jonathan had made some progress at the school, he continued to display aggression toward others, and he often would throw himself to the floor or run away from the staff members who were supervising him. Jonathan had begun to remove his clothes at inappropriate times, and he frequently soiled himself. In an attempt to manage some of Jonathan's maladaptive behaviors, the Anderson School implemented a "planned ignore" treatment plan that instructed staff to ignore bad behaviors and reinforce good behaviors. Despite the implementation of the treatment plan intended to address these behaviors, Jonathan's maladaptive behaviors escalated. Sometimes this resulted in staff members "ignoring" Jonathan for most of a day. Ultimately, Jonathan was confined to his room for extended periods while he was acting out. Access to regular meals became contingent on his displaying cooperative behaviors. As a result, Jonathan frequently was not provided regular meals because of his behaviors. During this period, a nurse at the Anderson School documented, "It is becoming more frequent that [Jonathan] will not [get dressed to eat] and longer periods of time are occurring without nourishment." Although provisions were eventually formalized for Jonathan to receive substitute food items when he was not provided his regular meals, it was impossible to determine Jonathan's overall food intake or what food was offered because documentation was poor or missing altogether. Further, the Anderson School did not have this meal plan reviewed by a dietician until 25 days after the plan was implemented.

While in his room, Jonathan was not permitted to have toys, books, or other items he enjoyed. Several weeks after the initial treatment plan was implemented, his window

was covered with frosted paper to prevent him from looking out, and eventually staff members were instructed to limit Jonathan's communication with his parents.

On October 22, 2004, Jonathan's parents removed him from the Anderson School and the next day, brought him to a hospital emergency room for an examination. The Careys alleged that Jonathan had been neglected, and that he was malnourished as a result of the school's practice of limiting his access to meals. They also alleged that Jonathan's treatment plan was modified without their consent, that he had been forced to remain in his bare room for extended periods, and that he was left to lie naked on a urine-soaked bed. Anderson School records indicate that Jonathan sustained multiple bruises during this period, and Jonathan's parents suggested that these were the result of physical abuse. The Careys further alleged that the school had allowed Jonathan to eat dairy products, in violation of his prescribed diet, and that he had missed multiple days of school. As required by law, the emergency room nurse reported the child abuse allegations to the State Central Register of Child Abuse and Maltreatment.

The Inspector General's review covered Jonathan's care at the Anderson School, which began in January 2003 and ended in late October 2004, and the investigative and review activities that followed from late October 2004 through 2006. To address the Careys' allegations, the Inspector General devoted significant resources to this investigation. Beginning in March 2007, attorneys, auditors, and investigators were dedicated to this project for approximately a one-year period. Over 75 interviews were conducted with pertinent staff, executives, and other relevant witnesses and over 25,000 pages of documents were received and analyzed by the Inspector General's Office. The Inspector General's office also devoted over 10 hours of in-person interview time with

Michael and Lisa Carey. Along with the specific allegations, which provided the initial basis for this review, more than 30 investigations of alleged child abuse conducted by CQC were evaluated to examine the adequacy of CQC's interpretation and application of Social Services Law § 412.

STATE AGENCY INVESTIGATIONS

The New York State Office of Mental Retardation and Developmental Disabilities (OMRDD), which certifies the Anderson School, conducted a survey assessing the school's regulatory compliance, while its regional office, the Taconic Developmental Disabilities Services Office (Taconic regional office), conducted an investigation into the abuse allegation. The survey identified regulatory non-compliance related to staff training and implementation of treatment plans. The Taconic regional office identified additional violations at the school, and determined that Jonathan Carey was a victim of neglect and maltreatment, both forms of abuse according to OMRDD regulations. The Anderson School was required to correct deficiencies found in both reports. No action was taken against any staff members as a result of Jonathan's care.

As required by law, the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC), an independent oversight body, investigated the child abuse allegation that was referred to it by the State Central Register for Child Abuse and Maltreatment. Using the standards set forth in the state Social Services Law, CQC found that Jonathan's treatment did not constitute abuse or neglect. However, under the umbrella of a "care and treatment review," CQC criticized the Anderson School for its treatment of Jonathan.

In June 2005, the Dutchess County District Attorney's office reviewed the case for potential criminal charges. A New York State Police investigator assigned to a local child abuse task force investigated the matter under the supervision of the assistant district attorney assigned to the case. The district attorney did not pursue a criminal prosecution and closed the case in April 2006.

In October 2005, the New York State Education Department's Office of Professional Discipline opened an investigation regarding a nurse at the school who was involved in Jonathan's care. In March 2006, the Education Department closed its investigation, citing a lack of cooperation from the Careys. The Careys disputed this claim and at the behest of the Inspector General, the Office of Professional Discipline subsequently re-opened the case. It is still pending as of the issuance of this report.

Although some of the investigations proceeded simultaneously, each agency acted independently in gathering evidence, conducting interviews, and reaching conclusions.

COMPLAINT TO THE INSPECTOR GENERAL

The Careys were dissatisfied with the thoroughness and findings of the various investigations, and claimed that the agencies were engaged in a deliberate and perhaps collaborative attempt to minimize the child abuse incident at the Anderson School. The Careys further alleged that an incorrect application of the state's definition of child abuse by CQC has resulted in the agency's failure to prevent ongoing abuse and neglect at facilities for the disabled throughout the state.

The Careys filed a complaint with the New York State Inspector General, which initiated its own examination of the state agencies over which the Inspector General has jurisdiction. In order to assess whether each investigating agency fulfilled its responsibilities, the Inspector General identified the following questions for this review:

1. Were the investigating agencies' reviews thorough, in light of their mandates?
2. Did the investigating agencies follow their own internal policies and procedures during the conduct of the investigations?
3. Did the investigating agencies meet their obligations to inform the Careys of their findings and to disclose information regarding the investigation as required by law or agency policy?
4. Did the investigating agencies effectively communicate their findings to the Anderson School and take appropriate measures to protect all children residing at the Anderson School?
5. Were there efforts by any of the investigating agencies to conceal or suppress information to cover up child abuse in the Jonathan Carey investigations?
6. Did the investigating agencies, together or separately, attempt to influence the district attorney or the police to prevent them from investigating or prosecuting the case?

In response to the Careys' complaint that CQC, as a general policy, applies the child abuse statutes improperly, this report also examined CQC's interpretation of Social Services Law § 412 through interviews with executive staff, review of procedure manuals, and a review of a sample of child abuse investigations.

This report describes the incidents leading to the Careys' allegation of abuse at the Anderson School. Although the Inspector General did not make findings regarding Jonathan's standard of care, to understand the context of the state investigations into this matter, the Inspector General consulted experts regarding treatment of children with

developmental disabilities. The experts were critical of Jonathan's care at the Anderson School, but this report will not revisit the initial clinical judgments or make a finding of child abuse. Those determinations are appropriately left to the agencies with relevant expertise that are charged with that responsibility. This report also will not address the circumstances surrounding Jonathan's death, as the Albany County District Attorney had begun its prosecution at the time this investigation was initiated.

The Inspector General's mandate is to receive and investigate complaints concerning allegations of corruption, fraud, criminal activity, conflicts of interest, or abuse in any agencies under its jurisdiction. Accordingly, this investigation is limited to the actions of the oversight agencies in response to the Careys' complaints. Although the actions of the Dutchess County District Attorney and the State Education Department are discussed briefly herein, the Inspector General makes no findings regarding these agencies, as they are not subject to the Inspector General's jurisdiction.

FINDINGS OF THE INSPECTOR GENERAL

This investigation found deficiencies related to each investigation or review discussed in this report, with the most significant deficiencies related to CQC's child abuse investigation and purported care and treatment review. However, the Inspector General did not find any evidence indicating that any agencies uncovered evidence of child abuse at the Anderson School that they deliberately tried to minimize, either separately or in collaboration. Nor did this investigation identify any evidence that the Dutchess County District Attorney had been pressured by any state agency or employee to discontinue its investigation or to decline to prosecute the case.

The Taconic Regional Office's Investigation

As noted above, the Taconic regional office of OMRDD conducted an investigation into the allegations of abuse of Jonathan Carey at the Anderson School. Although this report notes a few criticisms, the Inspector General found that the Taconic regional office's investigation was comprehensive and competently executed. The Taconic investigation involved over two dozen interviews and multiple site visits, and the resulting report addressed every allegation raised by the Careys.

The Taconic regional office's report found that the Anderson School's practice of isolating Jonathan and withholding meals constituted "mistreatment" and "neglect," both forms of abuse under OMRDD regulations. It also confirmed that Jonathan's parents were not involved in, and possibly actively excluded from, the development of Jonathan's plan of care; Jonathan did miss several days of school; the school intended to suspend the Careys' contact with their son for a period without first discussing this with them; a staff member's allegation of abuse involving Jonathan was not properly reported; and, at times, staff did not adhere to his prescribed diet. The Taconic regional office's report did not substantiate allegations that Jonathan was allowed to lie in urine for extended periods or that his bruises were the result of physical abuse. With regard to the bruises, the report concluded that they were likely the result of Jonathan's own aggressive behaviors or staff interventions to curb those behaviors. On December 20, 2004, the Taconic regional office reported its findings to the Anderson School and recommended immediate action by the school to correct the identified deficiencies.

The Inspector General's review found only minor deficiencies in the Taconic regional office's investigation. Initially, the Taconic regional office directed the

Anderson School to investigate on its own, even though school management officials were named in the allegations and the school's Executive Director had informed the Taconic regional office Director that he perceived a conflict of interest. Additionally, Taconic investigators failed to interview two school employees who could have provided relevant information.

Based on a review of the same evidence available to the Taconic regional office, the Inspector General questions one finding of the office's report that Jonathan was not left or forced to lie naked, or in urine, for any extended period of time.

In addition, there were a few minor omissions in the Taconic regional office's letter to the Anderson School after the completion of its investigation.

Finally, the Taconic regional office's letter of its findings to the Careys was only a brief summary of its investigation, which omitted several important findings. While the Taconic regional office has the discretion to disclose what information it deems relevant and appropriate in a letter of findings to the parents, a complete disclosure would have been more prudent.

Despite these minor deficiencies, the Inspector General found that the Taconic regional office conducted a thorough and appropriate investigation.

The OMRDD Central Office's Survey

Although its regional office was conducting an investigation into the primary complaint of abuse of Jonathan Carey, OMRDD Central Office's Division of Quality Assurance conducted a survey that reviewed Jonathan's care as part of a broader examination of systemic issues and regulatory compliance at the Anderson School. The

regulatory violations identified in the survey were set forth in a November 2004 Statement of Deficiencies and sent to the Anderson School. OMRDD officials explained that the Statement of Deficiencies typically would cite only one instance of a violation identified by surveyors as an illustrative example, even though the surveyors may have identified multiple instances of the same violation.

The Inspector General found that OMRDD Central Office's survey of the Anderson School was adequate and its follow-up assistance was extensive. From late 2004 and continuing into early 2007, OMRDD Central Office staff maintained a regular presence at the Anderson School, providing technical assistance to improve behavioral intervention, consumer rights, incident management, dietary services, and coordination of services. OMRDD Central Office staff conducted at least 17 separate site visits to the school between November 2004 and January 2007, a 27-month span. The evidence does not indicate that OMRDD "purposefully minimized" its findings or attempted to "cover up" any findings of child abuse involving Jonathan Carey, as alleged.

In its survey, OMRDD correctly identified serious problems at the Anderson School, with particular focus on its use of techniques like planned ignoring in its behavior plans, developing a behavior plan that prohibited family visits and limited telephone contact to Jonathan from his parents, as well as the improper withholding of meals for behavior modification, the lack of staff training, and the failure to provide the family the opportunity to participate in treatment plans or to object to treatment. However, the Inspector General found some oversights in its review methodology. The Inspector General also identified regulatory violations related to Jonathan's care that were not addressed.

In conducting its survey, OMRDD failed to obtain information collected by the Taconic regional office or to learn of its findings. As a result, the Statement of Deficiencies was incomplete and, in places, inconsistent with the findings of the Taconic regional office's investigation. OMRDD officials, including the Commissioner at the time, conceded that this lack of coordination was a problem.

OMRDD Central Office also did not interview Jonathan's parents and did not seek to examine an Anderson School logbook in the Careys' possession that they claimed held evidence of abuse against Jonathan.

While OMRDD cited several regulatory violations by the Anderson School regarding Jonathan's care, it obtained evidence of other violations, some very serious in nature, that were not included in the Statement of Deficiencies. Notably, OMRDD failed to mention potential violations of regulations prohibiting seclusion, unauthorized time-out, or neglect, all of which are forms of abuse under OMRDD regulations.

OMRDD Central Office accepted a Plan of Corrective Action from the Anderson School in response to the Statement of Deficiencies, even though the school's Plan of Corrective Action contained erroneous or dubious information that should have been rejected.

OMRDD also provided inaccurate and misleading information regarding their investigative efforts to the Governor's Office when asked to respond to the Careys' complaint to Governor George Pataki.

Finally, the Inspector General learned that there are inconsistent regulatory safeguards for OMRDD consumers receiving services in some private settings when

compared to consumers in state-operated programs. Draft OMRDD regulations dating back to at least 1994 provide additional clarification and guidance on the practice of behavior modification, including the issues of restraint, seclusion, restrictive behavior modification techniques, and time-out. All of these policies would have guided the Anderson School's treatment of Jonathan. Although the draft regulations were never promulgated, OMRDD issued them as policies applicable to state-operated facilities. However, private providers like the Anderson School are not required to abide by them. This results in consumers receiving different protections and guidance solely due to whether they are placed in state-operated or voluntary programs.

CQC's Investigations

The Inspector General found that CQC conducted a cursory investigation of the child abuse complaint that did not address all of the allegations presented to it. In addition, the agency issued findings under the umbrella of a separate care and treatment review, even though no such review was conducted. When criticized for the shortcomings of its investigation of the Careys' allegations, CQC repeatedly overstated the extent of its investigative activities to several parties, including the Careys, the New York State Senate, the office of Governor Pataki, and the Inspector General. Also, deficiencies in documentation of investigative activities revealed a lack of supervision within the agency.

As required by Social Services Law, CQC investigated the allegations regarding Jonathan Carey's abuse which was referred to it by the State Central Register of Child Abuse and Maltreatment. In contrast to the comprehensive review of the Taconic regional office of OMRDD, CQC made only one site visit to the Anderson School and

conducted only four interviews. Three of these interviews were with the targets of the child abuse investigation. Only one non-target witness was interviewed, and the notes from this interview were difficult for the CQC investigator to interpret and explain to the Inspector General. In violation of CQC policy, the investigator failed to document her activities of her one site visit to the school or her initial telephone discussion with Michael Carey. The investigator also failed to review all relevant documents, including a logbook in the possession of Michael and Lisa Carey that they claimed contained evidence of abuse against Jonathan. CQC was made aware of the logbook on multiple occasions.

The investigation focused solely on whether Jonathan's meals were withheld inappropriately, on the related behavior plans, and on whether, as a result, Jonathan was physically injured or placed at risk of physical injury. None of the Careys' other allegations regarding bruising, missed school, isolation, limited communication with their son, the stark conditions in his bedroom, or unsanitary practices were investigated by CQC. CQC did not obtain investigative results from the Taconic regional office, nor did it obtain the results of the OMRDD Central Office's survey, documents that CQC is legally entitled to and routinely requests in its investigations. These documents could have assisted CQC in determining whether all of the Careys' complaints had been identified, addressed, and corrected.

Likewise, CQC did not adequately attempt to determine whether Jonathan experienced serious emotional injury, or was at risk of serious emotional injury, as set forth in the Social Services Law definitions of "abuse" and "neglect." Although CQC identified some concerns that it planned on addressing "under separate cover," it

determined that Jonathan's treatment did not constitute abuse or neglect as those terms are defined in the Social Services Law.¹

Two months after the conclusion of the child abuse investigation, CQC opened a care and treatment review, and the investigator issued findings of that review on the same day. Letters of findings were sent to the Anderson School and subsequently to the Careys. CQC informed the Careys that "in an attempt to manage [Jonathan's] periodic refusal to put on clothes and come to the table and eat, staff did withhold his regular meal and offer a basic nutritional substitute as part of his behavior plan."

CQC also criticized the Anderson School for:

- Poorly developed and implemented behavior plans
- Failure to provide staff direction on what to do if Jonathan refused to dress and come to meals
- Insufficient documentation by staff
- Failure to include the Careys in Jonathan's treatment team meetings or obtain their approval for aspects of his behavior plan

The investigator informed the Inspector General that, although she did not conduct a care and treatment review, she presented problems discovered during her child abuse investigation as if they were discovered during a care and treatment review. She stated that she did this so that the findings would be publicly available, since all records related to child abuse investigations are confidential. An actual care and treatment review would have been a full examination of Jonathan's care, including examination of relevant records for the previous six months. The child abuse investigation, and therefore

¹ This finding is not necessarily in conflict with the finding of the Taconic regional office of OMRDD that Jonathan had been a victim of maltreatment and neglect pursuant to OMRDD regulations. The standards set forth in the Social Services Law are more stringent than those in the OMRDD regulations.

the purported care and treatment findings, focused primarily on the withholding of meals and related behavior plans.

When questioned or criticized regarding its actions, CQC executives repeatedly insisted that the agency had conducted two comprehensive reviews of Jonathan's care, even contradicting the investigator who acknowledged that she did not do a care and treatment review. CQC made misleading claims about the care and treatment review to the Careys, the state Senate, and to the Inspector General. In addition, CQC provided other misleading or inaccurate information to the Governor's Office in a written response to a complaint by the Careys.

In examining CQC's application of the Social Services Law definitions of abuse and neglect, the Inspector General examined all 32 child abuse investigations opened in January 2007. Based on this review and interviews with CQC officials, the Inspector General found that CQC rarely substantiates cases based on actual serious emotional injury and virtually never substantiates cases based on risk of serious emotional injury, two components of child abuse investigations that CQC is charged with evaluating in reaching its determinations. In the Jonathan Carey case, CQC did not thoroughly investigate whether Jonathan sustained, or was placed at a risk of, serious emotional injury by the treatment he received at the Anderson School.

Another complaint in the Inspector General's sample of child abuse cases from January 2007 arguably could have been substantiated based on the risk of serious emotional injury standard, but it appears that CQC did not adequately explore this possibility. Yet another case reviewed suggested that CQC incorrectly unfounded a case involving a risk of physical injury.

Statements from CQC executives and case examples suggest that CQC is overly conservative in recommending that cases be substantiated. Further, a comparison of CQC indication rates with the institutional abuse data of the New York State Office of Children and Family Services reveal that the latter has an indication rate more than three times higher, on average, than that of CQC.

Although this investigation found deficiencies with CQC's application of the definitions of child abuse and neglect in the Social Services Law, the Inspector General acknowledges that the definitions themselves may make it difficult for CQC to find abuse in some instances. Specifically, current institutional child abuse laws center around serious injury or the risk of such that must be satisfied to indicate (substantiate) a case of child abuse, regardless of the degree and/or nature of the inappropriate conduct of the employee. Current CQC officials noted the limitations of the Social Services Law. Additionally, a former CQC official interviewed stated that given the vulnerability of this population, unacceptable staff behavior should not be tolerated regardless of the seriousness of the injury to the child. Therefore, he suggested that the standard be re-examined to focus solely on the actions or behaviors of the employee, rather than the extent of injury or impact to the child.

Finally, CQC policies for designating a child as "institutionally neglected" appear to be at odds with the plain language of the enacting law and its sponsors' legislative intent. This has led to findings of institutional neglect where there were none, and findings of "unfounded" that may have been better classified as institutional neglect.

Office of Governor Pataki

Following OMRDD and CQC's reviews, the Careys complained in a letter to Governor George Pataki that the two agencies minimized and covered up their findings of child abuse. The Governor's Office then tasked the agencies involved with providing a joint written response to the complaints delineated in the Careys' letter. Subsequently, a meeting was held, which was attended by representatives of Governor Pataki, the aforementioned agencies, and the Careys. A second meeting was held between the Careys and the two agency heads.

Dissatisfied with the Governor's response, the Careys complained to the Inspector General of collusion between the Governor's Office and the investigative bodies. Given the governor's role as chief executive of the State of New York, it is within his discretion to request agencies to respond to complaints in this manner. Neither the joint response nor the meetings were inappropriate, and there was no evidence that Governor Pataki's office attempted to minimize any findings of child abuse involving Jonathan Carey at the Anderson School or to cover up the agencies' investigative failures. Rather, the Inspector General found evidence to suggest that Governor Pataki's office attempted to address the Careys' complaints efficiently and to foster open discussion about their concerns.

Dutchess County District Attorney and the New York State Police

The Dutchess County District Attorney's office in conjunction with an investigator from the State Police reviewed the abuse allegations regarding Jonathan Carey and, after an investigation, declined to prosecute. In their complaint to the Inspector General, the Careys alleged that the district attorney had agreed to prosecute the case, but subsequently closed the investigation as a result of political pressure from the

investigating agencies or the Governor. The Inspector General found no evidence that the State Police or the assistant district attorney was pressured to discontinue the investigation or prosecution of the case.

RECOMMENDATIONS

The Inspector General has provided copies of this report to the relevant state agencies. In addition, copies have been provided to the Albany, Schenectady, and Dutchess County district attorneys' offices for information and review.

Taconic Developmental Disabilities Services Office

1. The Inspector General recommends that the Taconic regional office of OMRDD, or any regional office, take primary responsibility for an investigation regarding a child's care at a facility within its jurisdiction whenever the facility discloses a conflict of interest or an appearance of such a conflict that would interfere with an internal investigation.
2. The Inspector General recommends that the Taconic regional office take steps to ensure full cooperation of employees in state-certified facilities with OMRDD investigations, as required by law. These steps could include notification of the facility's Executive Director or Board of Directors of an employee's failure to comply with this obligation, as well as a referral of the matter to OMRDD Central Office to review the provider's certification to operate in New York.

Office of Mental Retardation and Developmental Disabilities

1. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to fully incorporate all regulatory violations into a Statements of Deficiencies.
2. The Inspector General recommends that OMRDD Central Office ensure compliance with its policy directing surveyors to examine all available information, including pertinent documents and witness interviews.
3. In instances when a survey related to a separate investigation by one of OMRDD's regional offices is conducted, the Inspector General recommends that OMRDD Central Office coordinate such efforts and obtain the investigative findings of the regional office.
4. In light of Jonathan's Law which provides families with greater access to certain investigatory records, the Inspector General encourages OMRDD to re-evaluate the language used in its Statements of Deficiencies to determine whether the document should indicate when many instances occurred, even if only one instance of a violation is being cited.
5. The Inspector General reminds OMRDD Central Office of its ethical and legal responsibility to provide thoroughly accurate information to the Governor's Office. OMRDD should take measures to ensure compliance with the fulfillment of such responsibility.
6. The Inspector General recommends that OMRDD review the conduct of those responsible for providing a response to Governor Pataki's office that did not accurately reflect OMRDD's actions in this matter.

7. There is no justification for a child placed in a private, state-certified facility to be afforded less protection from abuse than a child in a state-run facility. The Inspector General encourages OMRDD to re-examine draft regulations on behavior management (14 NYCRR § 633.16) to ensure consistent safety and oversight protections for all consumers statewide.
8. The Inspector General recommends that OMRDD explicitly recommend agencies under its jurisdiction to review an employee's conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

Commission on Quality of Care and Advocacy for Persons with Disabilities

1. This investigation revealed that CQC officials made inaccurate and misleading statements to Governor Pataki's office, the Inspector General, the State Senate, and the Careys. The Inspector General recommends that the Governor's Office review the conduct of CQC, and its leadership, with respect to the findings of this report.
2. The Inspector General recommends that CQC review the conduct of staff members assigned to investigate and oversee the Jonathan Carey investigation, and take appropriate action, given the significant and numerous deficiencies cited in this report.
3. The Inspector General recommends that CQC review its investigative policies and procedures to ensure that cases are investigated thoroughly, actions are documented appropriately, relevant evidence is obtained, and case files are completed.

4. The Inspector General recommends that CQC ensure that its child abuse investigations are not simply repackaged when it is necessary to also conduct a broader and separate care and treatment review to evaluate the overall quality of care for individuals with disabilities.
5. The Inspector General recommends that CQC utilize all aspects of the Social Services statute, including the risk of physical and emotional injury, when assessing allegations of child abuse for the State Central Register for Child Abuse and Maltreatment.
6. The Inspector General recommends that CQC, as an independent oversight agency, obtain and review the investigative findings of the investigatory bodies that it oversees when CQC is also investigating the same matter to ensure that full and appropriate inquiries were conducted.
7. The Inspector General reminds CQC of its ethical and legal responsibility to provide thoroughly accurate information to the Governor's Office. CQC should take measures to ensure compliance with the fulfillment of such responsibility.
8. The Inspector General recommends that CQC re-evaluate its policies regarding Social Services Law § 412(10), "Institutionally neglected child in residential care," to ensure that the law is applied in accordance with its plain language and its legislative intent to identify systemic problems at regulated institutions and ensure that the appropriate agency is aware of and addresses the problem.
9. The Inspector General recommends that CQC explicitly recommend agencies under its jurisdiction to review an employee's conduct and take appropriate disciplinary action, when circumstances warrant such a recommendation.

Legislative Recommendation

The Inspector General recommends that the New York State Legislature review current Social Services statutes that are used to uncover abuse or neglect of a child in an institutional setting, including Social Services Law §412, to determine if they are adequate.