



NEWS

From the Office of the New York State Inspector General
Joseph Fisch

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INSPECTOR GENERAL'S REPORT SPARKS CHANGES IN RESIDENTIAL CARE FOR DISABLED CHILDREN

State Inspector General Joseph Fisch today issued a report that makes 20 recommendations for change in state government and criticizes two agencies for neglecting their duties.

The 244-page report examines the response of New York State agencies to allegations of abuse of Jonathan Carey in 2004. It reveals deficiencies in state oversight of Jonathan's care, particularly by the New York State Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC). It finds fault with both CQC and the New York State Office of Mental Retardation and Developmental Disabilities (OMRDD) for providing misleading or inadequate information to the Governor's office and Jonathan Carey's parents. And it recommends a review of the state's Social Services Law related to abuse in institutional settings.

In response, CQC and OMRDD have vowed to improve their approaches to overseeing the care of children with disabilities.

Jonathan Carey was a disabled pre-teen who resided at the Anderson School in Dutchess County from 2003 to 2004. He died in 2007 while in the care of the O.D. Heck Developmental Center in Schenectady County. Two workers were convicted in his death.

"It is difficult to contemplate any tragedy more difficult for parents to endure than the death of a child," Inspector General Joseph Fisch said. "Such pain is more

intolerable when the child, as was the case with Jonathan Carey, suffered at the hands of professionals who were entrusted with Jonathan's care. Jonathan was autistic and developmentally disabled. Such children require more attention, more love, more understanding and more kindness than other youngsters. Parents, and indeed society, have every right to expect and demand such effort in their behalf. They deserve no less."

The Inspector General's probe focused on a complaint that Jonathan Carey was abused at the Anderson School several years prior to his death. Jonathan's parents alleged that his case was improperly investigated by CQC, OMRDD and other government entities. The Inspector General's office reviewed more than 25,000 pages of documents and conducted over 75 interviews.

The report concludes that:

- ❖ CQC conducted a shoddy child abuse investigation, failing to fully address allegations that Jonathan was neglected, inadequately fed and left to lie naked on a urine-soaked bed.
- ❖ CQC issued a report for a second, separate review of the Anderson School's comprehensive treatment of Jonathan without actually examining his care.
- ❖ CQC misrepresented the extent of its work to the state Senate, the Governor, the Inspector General and Michael and Lisa Carey, Jonathan's parents.

In its investigation of OMRDD, the Inspector General found that the agency generally conducted an adequate review and gave follow-up assistance to the Anderson School to correct problems. However, the report also concluded that:

- ❖ OMRDD failed to fully address potential violations by the Anderson School related to the neglect and maltreatment of Jonathan Carey.
- ❖ Safeguards in place for children at state-operated facilities do not apply to disabled residents in private care. These safeguards pertain to restraint, seclusion and restrictive behavioral therapies.
- ❖ OMRDD was deficient in its communications with the Careys and provided inaccurate or misleading information to the Governor.

Fisch noted that on June 2, 2008, Governor David A. Paterson proposed legislation to improve the safety of children in residential programs operated or licensed by the state. The bill defines certain behaviors - such as kicking, biting, or withholding food - as acts of abuse, even if they do not result in an injury to the child. It also expands the application of New York's Statewide Central Register to children in residential programs for the treatment of alcohol or substance abuse.

Fisch praised the Governor's proposal, saying: "It is an important extension of protections for our most vulnerable children. The Governor's proposed legislative reforms and our recommendations give better support and guidelines to the thousands of dedicated caregivers who work tirelessly with children across New York State."

Meanwhile, CQC's new Chief Operating Officer Jane G. Lynch, appointed last month, said she has assigned a "high priority" to improving CQC's oversight. She informed the Inspector General that CQC will:

1. Revise protocols and train employees to ensure that all CQC investigations are actually completed.
2. Establish independent supervisory oversight for each investigation.
3. Conduct adequate site visits.
4. Investigate all State Central Register child abuse allegations that CQC receives, including a broader review of the care of other children in the same program.

In a letter to the Inspector General, Lynch praised the investigation, saying, "I welcome the opportunity... to analyze [CQC] operations and take steps to improve the quality of the oversight and advocacy which it provides New Yorkers with disabilities, their families, advocates and service providers."

OMRDD Commissioner Diana Jones Ritter said the Inspector General's report "indicates that there are still opportunities to improve our approach to investigations and our quality reviews," such as sharing information with families. In addition, Jones Ritter said that OMRDD will:

1. Fully address all potential violations uncovered by an investigation.
2. Conduct a full review of safeguards currently afforded disabled residents in private care to see if they are adequate.

"We are heartened by the positive response to our report by the agencies and entities involved," Inspector General Fisch said. "And we hope that these institutional reforms and those incorporated in the Governor's proposed legislation will prevent such tragedies in the future. The case of Jonathan Carey teaches us that our disabled children deserve a better system."

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