

**Division Circular #15
(N/A)**

**DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES**

EFFECTIVE DATE: February 14, 2006

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(This circular replaces Division Circular 15, "Complaint Investigations in Community Programs issued November 2, 2001)

I. TITLE: **Complaint Investigations in Community Programs**

II. PURPOSE: To establish policies for conducting civil investigations in response to allegations or suspicions of abuse, neglect and exploitation.

III. SCOPE: This circular applies to all Community Services components of the Division, as well as provider agencies, Community Care Residence providers, and all other programs licensed by, regulated by, or under contract with the Division. This circular excludes Developmental Centers, which shall have their own written procedures regarding investigations in accordance with Department of Human Services Administrative Order 1:50.

IV. POLICIES:

- ... All investigations in community programs shall be completed in accordance with this circular.
- ... The Division Director, may make, or cause to be made, such investigations as he/she deems necessary and may require corrective action in accordance with N.J.S.A. 30:1-12.1.

Division Circular # 15 -- Complaint Investigations in Community Programs

- ... Individuals with developmental disabilities receiving services from the Division are entitled to protective services in accordance with N.J.S.A. 30:6D-3b.
- ... It is the responsibility of all employees of the Division, employees of agencies under contract with or licensed by the Division, and Community Care Residence providers to cooperate with an investigation. Failure to cooperate or to knowingly provide false information during an investigation may result in corrective action.
- ... It is the responsibility of all employees of the Division, in accordance with Administrative Order 3:02, to cooperate fully with law enforcement authorities that investigate or prosecute suspected criminal violations.
- ... During the course of an investigation, representatives of the Division, as agents of the Commissioner, have the authority to visit and inspect all regulated and contracted facilities, at any time and as often as may be necessary, as well as the authority to examine all records, books and accounts kept by contracted providers in accordance with N.J.S.A. 30:1-14 and 30:1-15.
- ... Reports of investigations and information gathered during an investigation (including provider agency documents) are not considered to be public information and as such shall be maintained as confidential records. Investigation reports shall not be maintained as part of the client record, but shall be considered agency records as defined in N.J.A.C. 10:41-2 (Division Circular #30).
- ... Components of the Division other than the Special Response Unit shall not conduct investigations of abuse, neglect or exploitation unless otherwise instructed or advised to do so by the Director, Deputy Director, or SRU Chief.
- ... Incidents reported to the Division that have occurred more than two years prior to the date of the initial report will be investigated at the discretion of the SRU Chief.
- ... Incidents reported to the Division that have occurred more than two (2) years prior to the date of the initial report shall be investigated at the discretion of the Chief, Special Response Unit.
- ... Unexpected deaths, injuries and losses must be investigated as possible abuse, neglect or exploitation.

V. GENERAL STANDARDS:

- A. Definitions - for the purpose of this circular, the following terms shall have the meaning defined herein:

Abuse -- refer to Division Circular #14.

Bureau of Guardianship Services (BGS) -- refer to Division Circular #7.

Client Record -- refer to Division Circular #30.

Community Care Residence Provider -- means that person who is licensed and regulated according to N.J.A.C. 10:44B to operate a community residence for individuals with developmental disabilities.

Community Residence for Persons with Head Injuries means a community residential facility licensed pursuant to P.L. 1977 C. 448 (c. 30:11B-1 et seq.) providing food, shelter and personal guidance and/or training under such supervision as required to not more than fifteen (15) persons with head injuries who require assistance, temporarily or permanently, in order to live in the community, and shall include but not be limited to: group homes, halfway houses, supervised apartment living and hostels. Such a residence shall not be considered a health care facility within the meaning of the "Health Care Facilities Planning Act", P.L. 1971, c. 136 (c:26:2H-1 et seq.).

Community Services -- means that component of the Division that provides intake, case management, placement and support services to individuals who reside or work in community settings.

Corrective Action -- means those measures that are intended to reduce the likelihood that the incident will recur or to remediate a deficient condition. Such actions include but are not limited to: removal of an individual receiving services or staff from a program; assignment of additional staff to a residence, installation of additional fire safety devices, staff training; improvements in the physical plant; revision of operating procedures; contractual sanctions; imposition of a negative licensing action (suspension or revocation of a license) submission of a plan of correction; and disciplinary action.

Critical Incident Management Unit (CIMU) -- means a unit in DHS that reviews investigation reports submitted by provider agencies.

Deputy Director -- means the Chief Assistant to the Division Director.

Division Component -- means the Regional Assistant Director's office (RAD), regional offices, bureaus, or units of the Division of Developmental Disabilities.

Exploitation -- refer to Division Circular #14.

Follow-Up Action -- means those measures taken in response to an unusual incident report or investigation. Such actions include, but are not limited to: autopsy; clinical treatment interventions; interdisciplinary team review; investigation/further investigation; medical treatment; policy/procedure change; referral to Adult Protective Services, DYFS or the Ombudsman; referral to law enforcement; referral to specific Division components (OLI, SRU, Community Services, or Central Office Administration); those measures as described in the definition of **Corrective Action** in this subsection.

Guardian -- refer to Division Circular #6.

Illegal Contraband -- means prohibited items, the possession of which constitutes a violation of criminal law, such as non-prescription controlled dangerous substances, unregistered or unsecured firearms, and stolen property.

Imminent Peril -- means a situation that could reasonably be expected to cause a serious risk to the health, safety, or welfare of an individual receiving services or of another person in the current living arrangement or day program. Imminent peril does not exist if the Division can provide supports within the living arrangement or day program that eliminate serious risk.

Investigation -- means the systematic inquiry into the factors that contributed to an incident, allegation or complaint. An investigation may range from a brief examination of records and statements to a comprehensive set of interviews and the collection and analysis of all pertinent evidence.

Investigative Conclusion -- means one of the five standard conclusions that may be reached in an investigation report:

1. Unfounded -- no incident occurred or the allegation is found to be inherently improbable or admittedly false; there is no credible evidence that the allegation is true.

2. Unsubstantiated -- there is less than a preponderance of evidence that an allegation is true; there are no related factors that justify reason for concern or follow-up action.
3. Unsubstantiated with Concerns -- there is less than a preponderance of evidence that an allegation is true but other related factors justify reason for concern and follow-up action.
4. Substantiated with Mitigating Factors -- there is a preponderance of evidence that an allegation is true but factors are evident which significantly decrease the culpability of the responsible individual(s).
5. Substantiated -- there is a preponderance of evidence that an allegation is true without mitigating factors.

Law Enforcement Agency -- means an agency responsible for investigating and prosecuting violations of the New Jersey Criminal Code or Federal Criminal Statutes. Such agencies include municipal police departments, state police, county prosecutors, county medical examiners, the N.J. Division of Criminal Justice, and the Federal Bureau of Investigation.

Neglect -- refer to Division Circular #14.

Office of Licensing and Inspections (OLI) -- refer to Division Circular #14.

Plan of Correction -- means the document a provider agency submits in response to the results of a Division investigation that outlines the corrective action to be taken.

Preponderance of Evidence -- means that there is evidence sufficient to generate a belief that the conclusion advanced is likely and more probable than not. It is the greater weight of credible evidence (at least 51%), a tipping of the scales. A preponderance of evidence does not necessarily mean the largest amount of data or the largest number of witnesses. The focus is on the quality of the evidence.

Preservation of Evidence -- means those measures that are intended to ensure that pertinent evidence is secured as soon as possible. Examples include but are not limited to: identifying, securing, and safeguarding physical evidence, such as records, receipts, reports, photographs, audiotapes, videotapes and objects used for physical punishment and restraint; as well as documenting physical injuries through the use of physical examinations, photographs or videotapes.

Protective Services -- means remedial action taken to assure the health, safety, and welfare of individuals receiving services. Examples of protective services include but are not limited to: providing immediate medical attention to address injury, rape, or other health related needs; removing or relocating individuals from situations of imminent peril; removing or relocating staff to eliminate the possibility of further mistreatment of individuals receiving services; the provision of additional or different staff to the residence; as well as contacting law enforcement officials to respond to incidents of a criminal nature.

Provider Agency -- means an organization which is licensed, regulated and/or contracted to operate community residences in accordance with N.J.A.C. 10:44A, 10:47 and/or other community programs.

Regional Administrator -- means an employee of the Division with administrative authority over community programs within a specific geographic region of the State.

Regional Assistant Director (RAD) -- means an employee of the Division with administrative authority over community programs and institutions within a specific geographic region of the State.

Sexual Contact -- as defined in the NJ Criminal Code (NJSA 2C:14-1), means an intentional touching by the victim or actor [perpetrator], either directly or through clothing, of the victim's or actor's intimate parts for the purpose of degrading or humiliating the victim or sexually arousing or sexually gratifying the actor. Sexual contact of the actor with himself must be in view of the victim whom the actor knows to be present.

Sexual Penetration -- as defined in the NJ Criminal Code (NJSA 2C:14-1), means vaginal intercourse, cunnilingus, fellatio or anal intercourse between persons or insertion of the hand, finger or object into the anus or vagina either by the actor [perpetrator] or upon the actor's instruction. The depth of insertion shall not be relevant as to the question of commission of the crime.

Special Response Unit (SRU) -- means that component of the Division responsible for investigating and monitoring unusual incidents, involving allegations of abuse, neglect or exploitation in community programs licensed, contracted or regulated by the Division.

Systemic Issue -- means a pattern of incidents, allegations or practices that are indicative of an operational deficiency within an organization including, but not limited to, licensing, contractual, and/or rights violations.

Unusual Incident -- refer to Division Circular #14.

Unusual Incident Report (UIR) Coordinator -- refer to Division Circular #14.

- B.** An allegation or suspicion of abuse, neglect or exploitation may be reported from any source (anonymous or known). A Division representative or provider agency employee shall then report the allegation or suspicion as an Unusual Incident Report in accordance with Division Circular #14.
- C.** All allegations or suspicions of abuse, neglect or exploitation shall be considered to be unproven unless the matter is substantiated by a preponderance of the evidence following a proper investigation.
- D.** All appropriate and involved contracted providers, Division components, and individuals receiving services or legal guardians shall be notified that an investigation has been initiated unless the Chief, SRU, decides that such notification would compromise the integrity of the investigation.
- E.** Provider agencies shall immediately initiate independent, internal investigations until otherwise instructed by the SRU or a party empowered by statute to investigate (law enforcement, DYFS, Adult Protective Services). However, this does not relieve provider agencies of the responsibility to report incidents under investigation to the Division in accordance with Division Circular #14.

 - 1. Provider agencies shall have internal procedures for conducting investigations that are consistent with the standards and procedures established in this circular. The procedures shall be included in the agency's Policy and Procedure Manual as required at N.J.A.C. 10:44A – 2.2 (b).
 - 2. Provider agencies shall ensure that investigations are conducted by staff who are impartial and not directly involved in the incident under investigation or with the staff to be interviewed. If the provider agency is unable to comply with this requirement, the provider agency shall advise the Chief, SRU immediately.
 - 3. Provider agencies may collaborate with the SRU to conduct investigations.
 - 4. Provider agencies' internal investigation reports shall be forwarded to the SRU and respective Community Services Regional Office.

- F.** The Division Director, Deputy Director and SRU Chief reserve the right to initiate an investigation at any time.
- G.** If a suspected violation of the N.J. Code of Criminal Justice is identified during the course of an administrative investigation, the matter shall be promptly reported to the appropriate law enforcement agency in accordance with Section VI, K. of this Circular. The civil investigation of an incident shall not interfere with the criminal investigation. At the official request of a law enforcement agency, a civil investigation may be suspended. *Referrals to law enforcement agencies are not to be predicated upon a decision to file charges.*
- H.** A request to suspend an investigation received from another agency empowered by statute to investigate abuse, neglect and exploitation, (e.g. N.J. Division of Youth and Family Services, Adult Protective Services, N.J. Office of the Ombudsman) shall be considered on a case by case basis by the SRU Chief and the Executive Director of a provider agency.
- I.** The civil standard of a preponderance of evidence shall be used to determine whether an allegation is substantiated.
- J.** Investigative findings that pertain to the Division shall be forwarded by the SRU Chief to the appropriate administrator and, when applicable, to the Division Director. Such findings shall be considered confidential agency records in accordance with N.J.A.C. 10:41.

VI. PROCEDURES:

A. Determination of Investigative Jurisdiction

1. The SRU Chief shall determine whether the SRU will investigate, review or monitor incidents.
2. For programs licensed under N.J.A.C. 10:44B, Community Care Residences, the SRU shall directly investigate incidents involving abuse, neglect or exploitation.
3. For programs licensed under N.J.A.C. 10:44A, Community Residences for the Developmentally Disabled, provider agencies shall initiate an investigation upon the report of an unusual incident. The Chief, SRU, shall decide whether to investigate, review or monitor the investigation.

- a. The SRU Chief may elect to initiate a parallel investigation involving a provider agency before the completion of that agency's internal investigation.
- b. The SRU may assist and collaborate with an agency's investigation, as needed and available.
4. The SRU shall review agency investigation reports. Upon review of a final investigation report completed by a provider agency, the SRU Chief or designee may elect to initiate a subsequent investigation.
5. Division personnel and provider agency employees shall promptly make referrals to other governmental agencies (e.g. DYFS, Adult Protective Services, Ombudsman) empowered to investigate abuse, neglect and exploitation as needed.
6. When more than one provider is involved in the incident, the Chief, SRU shall coordinate the investigation.

B. Protective Services

1. Community Services or provider agency personnel are responsible for assessing risk to individuals receiving services and implementing protective services immediately following an incident, even if another party assumes jurisdiction for the investigation. Protective service actions must be documented in the client record.
2. The RAD Office, SRU, OLI and/or Regional Office shall review the initial protective services implemented by a provider agency or Community Care Residence provider and may recommend additional protective services.
3. When the party conducting the investigation identifies the need for additional protective services, that party shall be responsible for prompt referral to ensure such services.

C. Preservation of Evidence

1. The party conducting the investigation shall ensure that all pertinent evidence is preserved when possible. The SRU may ask another Division component, a provider agency, or Community Care Residence provider to preserve evidence immediately following an incident.

2. When physical evidence is secured, the party securing the evidence shall be responsible for it and shall provide documentation if the evidence has been altered.

D. Notification of Investigations

1. The party conducting the investigation (e.g. SRU or the provider agency) shall notify appropriate Division components that an investigation has been initiated.
2. The party conducting the investigation shall notify legal guardians of individuals who are alleged or suspected victims of abuse, neglect or exploitation that an investigation has been initiated.
3. The decision to notify an alleged or suspected perpetrator that an investigation has been initiated shall be made on a discretionary basis.
4. The party conducting the investigation shall notify all other appropriate individuals or agencies that an investigation has been initiated.
5. When the SRU initiates an investigation, the SRU shall notify the licensed and/or contracted provider involved.
6. When providing written or verbal notification of an investigation, the general nature of an allegation shall be disclosed. The source of an allegation shall not be divulged.
7. An investigation conducted by the SRU may commence prior to notification of the parties involved when the Division has information that an immediate response is necessary to protect individuals or to secure and preserve evidence.
8. In the event that the scope of an investigation is expanded to include a review of systemic issues, the appropriate provider agency administrators and/or Board of Directors shall be notified in writing except in the limited circumstances where such notification may compromise the integrity of the investigation. There may also be instances when a systemic issue is recognized after the fieldwork is completed and the evidence analyzed. In these instances, the provider agency shall be notified in writing of the systemic issue as soon as possible.

E. Conducting Investigations

1. An investigation shall typically include but is not limited to obtaining medical evaluation(s), as necessary; taking photographs of injuries; securing, reviewing and analyzing evidence such as records, receipts, reports, and relevant objects; inspection of all relevant sites; interviews with anyone who may provide information relevant to the case; and the collection of written statements.
2. The identity of individuals who provide information and wish to remain anonymous shall be protected to the extent possible.
3. The SRU shall advise a provider of services of any necessary corrective action identified during the course of an investigation. Likewise, a provider agency shall advise the Division of any corrective action implemented during the provider agency's internal investigation.
4. The SRU Chief may expand the scope of an investigation in order to investigate additional reports or suspicions of abuse, neglect or exploitation
5. When systemic issues involving a provider agency are identified during the course of a Division investigation, review, or collaboration, the issues shall be referred to the RAD, Regional Office, OLI and/or provider agency for follow-up. All other appropriate Division components shall be notified of such referrals.
6. Information that is confusing or contradictory shall be reconciled to the extent possible in order to reach a definitive conclusion.
7. The party conducting the investigation shall report any additional incidents that emerge during the course of an investigation in accordance with Division Circular #14.

F. Investigative Interviews

1. Division personnel, provider agency employees and Community Care Residence providers are required to cooperate with the scheduling and conducting of investigative interviews. Individuals providing information may be required to participate in more than one interview.

2. Interviews may be conducted with any individual who may provide information relevant to the investigation, including but not limited to individuals receiving services, provider agency employees, Community Care Residence providers, Division personnel, legal guardians, family members, school personnel, and medical service providers.
3. Site selection and scheduling of interviews will be arranged by the investigator and the interviewee in a manner that does not compromise the integrity of the interview or impede the investigation.
4. In most cases, only the investigator(s) and the interviewee shall attend an interview. However, a union representative or attorney representing the interviewee may attend an interview upon the interviewee's request as long as his/her attendance does not unreasonably delay the interview or impede the investigation. Other individuals may attend an interview at the discretion of the investigating party.
5. A legal guardian shall be permitted to attend the investigative interview of the person they represent as long as his/her attendance does not unreasonably delay the interview or impede the investigation.
6. The legal guardian of an individual receiving services shall be notified of a pending interview when the individual receiving services is the alleged perpetrator. The legal guardian's participation in the interview may not unreasonably delay the interview or impede the investigation.
7. Alleged or suspected perpetrators and their union representatives and attorneys shall be advised of the allegation(s) in question prior to the completion of the interview.
8. All individuals who attend investigative interviews shall be advised of the confidentiality of information regarding individuals receiving services in accordance with N.J.S.A. 30:4-24.3 and as defined in N.J.A.C. 10:41-2 (Division Circular #30).

G. Investigation Reports

1. Staff assigned to conduct an investigation shall develop a report.

2. An investigation report shall include but is not limited to the following elements:
 - a. Identifying information (such as alleged victim, alleged perpetrator, provider, residence, legal guardians, and community services personnel)
 - b. Description of the allegation (of abuse, neglect or exploitation) or suspicion (such as an unexplained injury or property loss)
 - c. Findings (a review of the evidence, such as summary of witness statements, a list of pertinent documentation, a description of physical evidence, and an analysis of contributing factors)
 - d. Conclusions (as described in V.A. of this circular)
 - e. Recommendations (such as for corrective action)
 - f. Attachments (such as written statements, medical reports, or log entries, as needed)
3. The standard of preponderance of evidence shall be used to determine whether an allegation is substantiated.
4. An Investigation Report shall not include an in-depth presentation of systemic or operational issues revealed during the investigation of abuse, neglect or exploitation. Provider agency or Division systemic issues shall be addressed in separate reports, as needed and forwarded to the appropriate Division component(s) and provider agency.

H. Dissemination & Review of the Results of Investigations

1. When a provider agency conducts an investigation, it shall submit a written report to the SRU and the respective Community Services Regional Office that includes the elements of an investigation report as described in Section G. of this circular. Most importantly, the report must indicate a specific conclusion, action taken, the author of the report with his/her signature, and the date that the report was signed.
 - a. The SRU shall be responsible for reviewing all investigations conducted by provider agencies to determine if further action

is necessary. Supporting documents shall be made available to the SRU upon request.

- b. The SRU will notify a provider agency when the SRU concurs with the conclusion of that agency's investigation.
 - c. The SRU may disagree with the final conclusion of a provider agency's investigation. If, after further discussion, investigation and review, agreement cannot be reached, the SRU may document a different conclusion. Provider agencies will be notified of such actions by the SRU and advised of the reasons a different conclusion was reached.
2. When the SRU conducts an investigation, the results shall be disseminated as follows:
- a. The SRU investigator shall complete a Follow-Up Report documenting the results of the SRU investigation.
 - b. The SRU shall forward an investigation report to OLI and the Regional Office when abuse, neglect or exploitation has been substantiated.
 - c. Written correspondence containing the conclusions and recommendations resulting from an investigation will be provided to the appropriate provider agency and/or Community Care Residence provider.
 - d. The Deputy Director shall receive an executive summary of an investigation when determined necessary by the SRU Chief.
 - e. Division components, provider agencies and Community Care Residence providers shall receive notification of referrals to investigative or regulatory agencies outside of the Division when such notification will not impede or interfere with the investigation process.
 - f. Division investigation reports concerning a provider agency may be obtained by that agency through an attorney issued subpoena.
 - g. Division investigation reports shall only be released to other interested parties in accordance with N.J.S.A. 30:4-24.3 upon written request and administrative approval.

3. The investigating party, whether a provider agency or the SRU, shall provide a written summary of the conclusions of the investigation to legal guardians of individuals receiving services who are substantiated or alleged victims of abuse, neglect or exploitation of investigative results. The provider agency shall not send the written summary of the conclusions to the legal guardian until the SRU has reviewed and approved their investigation.
4. Investigative results shall be communicated to individuals receiving services who are substantiated or alleged victims of abuse, neglect or exploitation and who have been assessed as able to act as their own guardians. The SRU, the provider agency, or the Regional Office can carry out this notification. The manner in which these results are communicated is discretionary.
5. The decision to inform complainants of the conclusions of an investigation shall be made on a discretionary basis.
6. Any investigative document (including but not limited to reports, summaries, and systemic findings) and all information gathered during an investigation shall be confidential and maintained as agency records according to N.J.A.C. 10:41-2 (Division Circular #30) and as defined in Section IV "Policies" of this circular. These documents shall not be disclosed to the public or to the press either directly or as part of any otherwise public record. Steps shall be taken to limit access to investigative documents solely to personnel who require the information for administrative purposes, service provision, and/or to implement corrective action. Investigative documents shall be maintained separately from the client record.

I. Corrective Action & Other Follow-Up

1. Following an SRU investigation involving a Community Care Residence provider:
 - a. The SRU will notify the Community Care Residence provider/alleged perpetrator, in writing, of recommendations made for corrective action and/or further review.
 - b. The SRU will refer such recommendations regarding Community Care Residence providers to OLI and/or the Regional Office as needed and appropriate.

- c. OLI shall ensure that licensing sanctions are implemented regarding Community Care Residence providers as needed and appropriate. The Regional Office and/or OLI shall ensure that all other corrective actions are implemented as needed and appropriate
2. Following an SRU investigation or review involving a provider agency:
 - a. The SRU will notify the provider agency in writing of its investigation findings and conclusions and any related concerns.
 - b. The SRU will provide to Developmental Disabilities Licensing, DDD- Office of Quality Improvement, and applicable DDD Regional Administrator a copy of its investigation report and associated letters.
 - c. The provider agency shall forward a copy of Plan Correction to the Office of Quality Improvement and to the applicable Regional Administrator.
 - d. The Office of Quality Improvement shall inform the applicable Regional Administrator of which SRU completed investigations it is following up on.
 - e. The Office of Quality Improvement shall assess the provider agency's response to the SRU Investigation and refer its findings to Developmental Disabilities licensing and the Office of Contracting if additional follow up is warranted.
 - f. The Office of Quality Improvement shall review all cases that are closed, substantiated, by the Critical Incident Management Unit and determine the need for further follow up with provider agencies.
 - g. The Office of Quality Improvement shall elicit additional information from agencies on cases closed, substantiated, under CIMU jurisdiction to confirm appropriate follow up actions have been taken.
 - h. The Office of Quality Improvement shall inform the applicable Regional Administrator of which CIMU closed cases it is following up on.

3. Following an SRU investigation or review, concerns regarding a Division component shall be conveyed to the appropriate Division administrator and/or the Deputy Director as deemed necessary by the SRU Chief.

J. Closing Unusual Incidents

1. When the SRU assumes responsibility for investigating, reviewing or monitoring an incident involving an allegation of abuse, neglect or exploitation, the SRU shall close that incident using the Departmental Incident Follow-Up Report.
2. All other incidents that do not fall under the purview of the SRU shall be closed by the applicable Division component using the Departmental Incident Follow-Up Report.
3. The party conducting the investigation shall consider new evidence. When the evidence gives rise to new issues or calls into question the prior conclusions, the investigation may be reopened. The results of the initial investigation may be revised or supplemented if appropriate.
4. All formal responses to investigative results shall become part of the permanent record, in accordance with N.J.A.C. 10:41-2 (Division Circular #30). All parties who received the original report shall receive a copy of any formal response.
5. When a referral is made to an authority outside of the Division, as set forth in section VI.A. of this circular, the referring party shall request a written response to the referral.

K. Reporting Incidents to Law Enforcement Agencies

1. All parties licensed by or under contract with the Division or employed by the Division have a responsibility to report incidents of a potential criminal nature to law enforcement authorities. The guidelines below are intended to assist provider agency employees, Community Care Residence providers, and Division personnel in making judgements regarding when to report such incidents to the police. The decisions to report a potential crime to law enforcement authorities can occur before, during or after an investigation. However, there must not be undue delay in making such a report. *NOTE: These guidelines are not intended to serve as a substitute for the requirements to report crimes under New Jersey Statute.*

2. The following incident types, depending on the circumstances, include those that may involve potential crimes:
 - Unexpected, sudden or unusual deaths.
 - Sexual abuse
 - Physical abuse
 - Neglect
 - Exploitation
 - Unexplained losses of money or property
 - Unexplained injuries
 - Illegal Contraband

3. The following are some of the criminal statutes (N.J. Criminal Code) that can be applied by law enforcement authorities to crimes committed by caregivers against adults with developmental disabilities that correspond to categories of abuse, neglect and exploitation:
 - 2C:12-1a Simple assault
 - 2C:12-1b Aggravated assault
 - 2C:12-2 Recklessly endangering another person
 - 2C:12-3 Terroristic Threats
 - 2C:14-2 Sexual Assault
 - 2C:14-3 Criminal Sexual Contact
 - 2C:14-4 Lewdness
 - 2C:20 et. seq. Theft
 - 2C:24-7 Endangering the welfare of an incompetent person
 - 2C:24-8 Abandonment, neglect of elderly person, disabled adult
 - 2C:44-3 Hate/Bias Crimes (penalty enhancement)

4. In accordance with N.J.S.A. 52:17B-89 (Report of death; violation), any person who may become aware of any death by criminal violence or by accident or suicide or in any suspicious or unusual manner, shall report such death to the office of county medical examiner, the office of State Medical Examiner, or to the police department of the municipality in which such person died. Any person who shall willfully neglect or refuse to report such death, or who, without an order from the office of county medical examiner or the office of State Medical Examiner, shall willfully touch, remove or disturb the body of any such person, or touch, remove or disturb the clothing upon or near such body, is a disorderly person. (L.1967, c. 234, s. 12, eff. Jan. 1, 1968.).

5. The following incident types must be reported to local law enforcement authorities immediately by provider agencies, Community Care Residence providers, and Division employees:

- a. **Unexpected, unusual or sudden deaths** in accordance with N.J.S.A. 52:17B-89 as described in subsection VI., K., 4. of this circular.
- b. **Sexual abuse** of an individual receiving services by a caregiver/employee when there is corroborating or credible evidence that the act may have occurred. A credible allegation or an unexplained injury consistent with possible sexual abuse/assault is enough to make a report to law enforcement immediately. Sexual acts between a caregiver/employee and individual receiving services are not to be considered consensual. Both sexual contact and sexual penetration are crimes (refer to the Definitions section of this circular).
- c. **Physical abuse or neglect** of an individual receiving services by an employee/caregiver when there is an injury consistent with abuse or neglect and corroborating or credible evidence that the act may have occurred. A credible allegation and the presence of an injury consistent with abuse or neglect are enough to make a report to law enforcement. Injuries consistent with abuse and neglect include (but are not limited to) the following:
 - bodily injuries resulting in gastrointestinal symptoms or genitourinary symptoms
 - bruises or burns on the genital area.
 - bruising in distinct shapes
 - choking injury leaving marks
 - cigarette burns
 - extensive burns
 - fractures of the skull, long bones, ribs, spine, or pelvis
 - head injuries, such as concussion
 - injuries causing large or multiple hematomas
 - injuries or medical conditions requiring hospitalization
 - injuries to the eye
 - malnutrition/dehydration/unexplained excessive weight loss
 - missing teeth
 - puncture wounds
 - significant overdose/underdose of prescribed medication
 - suspicious scars
 - visible or bleeding wounds to the mouth
 - welts
 - wounds requiring extensive suturing
- d. **Financial exploitation** of an individual receiving services by an employee/caregiver when the person suspected or accused admits taking

money or property from an individual for his/her own use; when money or property belonging to an individual is missing and the employee/caregiver responsible has suddenly resigned or abandoned their position; and in any other case when it is immediately clear that an individual has had their money/property stolen or improperly used by an employee/caregiver. Losses of money or property valued at \$100 or more must be reported. This category also includes large-scale fraud committed against a group of individual receiving services. *NOTE: This category excludes conflicts between individuals receiving services and representative payees of benefits.*

- e. **Illegal contraband** discovered in any residence or program licensed by or under contract with the Division and suspected to belong to an employee/caregiver. This includes (but is not limited to) illegal drugs and unregistered firearms.
 - f. **Child abuse** -- credible allegations or suspicions that an individual receiving services has sexually assaulted a child (minor), has had sexual contact with a child, or has physically assaulted a child.
 - g. **Any situation in which an individual receiving services requests assistance to contact the police** unless there is no doubt that the individual is fabricating an allegation or acting-out as a result of a psychiatric disorder.
6. The following incident types must be reported to local law enforcement authorities if, after an initial fact-finding inquiry (not to exceed 48 hours), there is credible evidence that a criminal act may have occurred, the possibility remains that a crime may have been committed, or there is no alternative explanation for the incident, allegation or injury. *Up to forty-eight hours may be taken to conduct an initial fact-finding inquiry only when there is doubt that the incident has occurred as initially reported due to an apparent lack of supporting (corroborating) evidence:*
- a. Allegations or suspicions of sexual abuse of an individual receiving services when there is no corroborating evidence that the act may have occurred. Determinations must be made quickly to avoid the potential loss of crucial evidence.
 - b. Allegations of physical abuse (employee/caregiver to individual receiving services) when there is no other corroborating evidence, such as an injury consistent with abuse or an eyewitness.

- c. Unexplained injuries of a serious nature with no associated allegation. This includes (but is not limited to) the list of injuries consistent with abuse as defined in sub-section K.5.c. of this circular addendum.
- d. Allegations or suspicions of theft and/or the financial exploitation of an individual receiving services when it is possible that the money or property has simply been misplaced.
- e. Incidents of abuse, neglect or exploitation in which it is alleged or suspected that the perpetrator acted with a purpose to intimidate an individual or group of individuals because of race, color, gender, disability, religion, sexual orientation or ethnicity (Hate or Bias crimes).
- f. Unexplained missing prescription medications when there is a pattern or a substantial amount involved. This includes (but is not limited to) narcotics, stimulants, depressants, anticonvulsant and psychotropic medications.
- g. Allegations or suspicions that an individual receiving services has sexually assaulted a child, has had sexual contact with a child, or has physically assaulted a child only when there is no supporting/corroborating evidence or the initial allegation is not credible.
- h. The discovery of apparently illegal contraband in any residence or program licensed, contracted or regulated by the Division when it is possible that the owner is an individual receiving services.
- i. Allegations or suspicions of sexual assault or physical assault when both alleged perpetrator and alleged victim are individuals receiving services and the victim has been admitted to a hospital for injuries. *NOTE:* Any incident in which an individual receiving services is the alleged perpetrator should include a consideration of situational factors, such as mental/psychiatric state, level of cognitive functioning, credibility, severity of act, clinical history, etc., for both the alleged victim and perpetrator.
- j. Allegations made by an individual receiving services or legal guardian that the individual has been the victim of a crime and assistance is requested to a contact a law enforcement agency.
- k. Any other alleged or suspected criminal act involving a caregiver and/or individual receiving services.

Division Circular # 15 -- Complaint Investigations in Community Programs

7. Representatives of provider agencies, Community Care Residence providers, and Division employees may consult with the SRU when it is unclear whether an incident should be reported to a law enforcement agency.

Carol Grant
Director

File Name: DC15