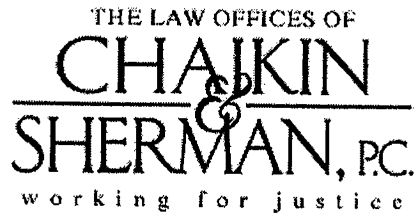

STATEMENT
OF

JOSEPH CAMMARATA, ESQUIRE
PARTNER IN THE
LAW FIRM OF CHAIKIN & SHERMAN, P.C.

BEFORE THE
COUNCIL OF THE DISTRICT OF COLUMBIA
COMMITTEE ON HUMAN SERVICES

MARCH 6, 2006

The Law Building
1232 Seventeenth Street, N.W.
Washington, D.C. 20036
(202) 659-8600

My name is Joseph Cammarata. I am a partner in the law firm of Chaikin & Sherman, P.C. in Washington, D.C.

This submission is provided to give the Council the benefit of my experience and that of my partner, Ira Sherman, representing individuals with developmental disabilities who were wards of the District of Columbia, our perspective with regard to the continuing deficiencies in the care of this protected class of individuals whom the Mayor has aptly characterized as the District's most "vulnerable citizens," and suggestions for systemic changes.

THE TREATMENT OF INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

A. A BRIEF HISTORY.

On December 5, 1999, Katherine Boo, wrote what became a Pulitzer Prize winning series of articles in the *Washington Post* addressing the neglect, abuse, and ultimate death of at least 116 residents of the District's group home system. Coincidentally, one of the "featured" stories was that of Mr. Fred Brandenburg, the brother of our client Ms. Juanita DeButts. The article chronicled the extraordinary deficiency in the care provided to wards of the District of Columbia with developmental disabilities, including Mr. Brandenburg. The article provided numerous examples of the failure of group home caregivers, and the District of Columbia, to care for and protect individuals with whom the District of Columbia has a special relationship.

On December 6, 1999, the law firm of Chaikin & Sherman, P.C. filed a class action, naming Juanita DeButts, the Personal Representative of the Estate of Fred Brandenburg, as a class representative of the families of individuals who died while

residents of what the District of Columbia would ultimately admit was a "broken" group home system.[1] Indeed, the District of Columbia also admitted that the Mental Retardation and Developmental Disabilities Administration ("MRDDA") "system is not a system."[2] Because of the individualized nature of the treatment provided to each member of the group home system, and the resultant harm that befell them, the Court determined that, despite the fact that injury and death was common to all, the individualized nature of their claims precluded the Court from certifying the class.

Nevertheless, litigation was instituted by the law firm on behalf of approximately 15 families. The result was the development of an enormous library of materials relating to the methodology that the District of Columbia employed in its failed attempt to care for the individuals whom the District had agreed to protect. Despite the District of Columbia's fiduciary duty and agreement to provide the highest degree of care for these individuals, the District of Columbia's own investigation of its "system" demonstrated that the system "was fundamentally unable to deliver even the most basic services[ ]"[3] which has "taken a toll on the clients served in the system."[4]

The discovery stage of the litigation resulted in the accumulation of approximately 40,000 pages of documents obtained from the District of Columbia relating to the operation of MRDDA and related agencies.

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[1] See Attachment 1, Opinion and Order in *Evans, et al. v. Williams, et al.*, 139 F. Supp. 2d 79 (D.D.C. 2001), commencing on p.14, which contain Stipulations of Fact entered into by the District of Columbia on December 22, 2000. See Stipulation ("Stip") No. 21.

[2] See Attachment 1, Stip No. 8, which in its entirety reads as follows: "The District government has fundamentally failed its obligation to disabled persons and their families. Painful experience has taught that the District's MRDDA system is not a system. Mayor's Prep. Stmnt. at 3."

[3] See Attachment 1, Stip. No. 17.

[4] See Attachment 1, Stip. No. 7.

Coincidental to the litigation initiated by Chaikin & Sherman, P.C. was the ongoing litigation in *Joy Evans, et al. v. Anthony A. Williams, et al.,* which was filed in Federal Court as a result of the abuses suffered by residents of the District of Columbia's group home system, who had previously resided in the District of Columbia's institution known as Forest Haven. The *Evans* litigation has been on going for approximately 30 years and has provided a wealth of knowledge regarding literally decades of effort by the judicial system to "encourage" the District of Columbia to fulfill its fiduciary duty to individuals with developmental disabilities whom it had agreed to protect from neglect and abuse. The history of the *Evans* litigation, and the Court Orders resulting from it, reveal a dismal picture. Perhaps, the best way to summarize the admitted failure by the District of Columbia to provide a system to care for developmentally disabled individuals residing in its group homes are the 129 Stipulations of Fact entered into, more than five years ago on December 22, 2000, as a partial resolution of the matters then pending before the Court in *Evans*. This set of admissions by the District of Columbia is attached, commencing on page 14, within Attachment No. 1. It is important to note that each Stipulation references the document from which it was obtained, each of which is a document developed at the request, and on behalf of, either the Executive or Legislative Branch of the District of Columbia. These admitted Statements of Fact were part of the blueprint "for the development of permanent and independent mechanisms to safeguard the rights of [the *Evans*] class members, and for the phased withdrawal of judicial oversight of the District of Columbia's mental retardation system as compliance with the Court's Orders is achieved."[5]

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[5] See Attachment 1, p. 3.

Further examples of the contents of the 129 Stipulations include:

a. Mistakes in the District's system of support for individuals with developmental disabilities cover 20 years of neglect and mismanagement.[6]

b. The District government has fundamentally failed its obligation to disabled persons and their families.[7]

c. The entire mental retardation and developmental disabilities service delivery system is incapable of providing quality service.[8]

d. The District's system is highly dysfunctional and unable to execute its mission at its most basic level through its current structure and procedures.[9]

e. The entire District service delivery system must be redefined and rebuilt.[10]

f. MRDDA does not and cannot meet its stated mission which is to serve individuals with mental retardation and other developmental disabilities.[11]

g. The need for reform in the District's system ranges from the broadest to the smallest of issues and simply 'tinkering around the edges' will not solve the systemic problems in the system.[12]

h. MRDDA employees have not been provided adequate training for the jobs that they do.[13]

i. The management and oversight of both District employees and private sector providers has been inadequate.[14]

j. MRDDA employees have not had adequate supervision.[15]

k. There are inadequate methods for background checks on providers and the employees of providers in the District's system.[16]

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[6] See Attachment 1, Stip. 2.
[7] See Attachment 1, Stip. 8.
[8] See Attachment 1, Stip. 20.
[9] See Attachment 1, Stip. 22.
[10] See Attachment 1, Stip. 25.
[11] See Attachment 1, Stip. 28.
[12] See Attachment 1, Stip. 26.
[13] See Attachment 1, Stip. 40
[14] See Attachment 1, Stip. 66.
[15] See Attachment 1, Stip. 83.
[16] See Attachment 1, Stip. 86.

Despite the development of a blueprint to conclude the *Evans* litigation, and the placement of a permanent plaque outside of the office of the Director of the Department of Health and Human Services which memorializes the lives of the individuals who died unnecessarily in the District's group home system (which was placed as part of the settlement of a case filed by the law firm of Chaikin & Sherman, P.C.), revelations of recent deaths within the District of Columbia's group home system, and litigation recently concluded by Chaikin & Sherman, P.C., demonstrate that what we hoped would be the final chapter turned out to be part of a continuing saga.

B. PROBLEM AREAS IN THE GROUP HOME SYSTEM REQUIRING FURTHER INVESTIGATION.

Throughout the course of the litigation, our investigation into each of the cases, our overview of the system itself, and our continuing interest in this area, we have identified certain areas that continue to prove problematic and require investigation, oversight, and remedial action to correct those problems, and protect the vulnerable wards of the District of Columbia. Those areas include the following: (1) the appropriateness of the residential placement of individuals and the timeliness of transfers; (2) the failure to have a set of requirements for staff, which include adequate background checks, and training; (3) the failure to consistently have accurate records concerning medicine administration, doctor's appointments, required follow-up medical care, and monitoring of personal hygiene; (4) inadequate supervision; (5) the lack of enforcement action taken against providers and staff; and (6) the lack of and/or involvement of advocates for the District's wards. Each is discussed in turn.

1. Residential Placement and Transfers.

At the outset, individuals with developmental disabilities need to be placed properly and in the event that there is reason to believe the placement is no longer appropriate, a transfer, on an emergency basis if necessary, must be implemented. The Honorable Robert R. Rigsby, then Acting Corporation Counsel, testified on December 20, 1999 before this Committee that the District of Columbia has the ability to effectuate an emergency transfer. His testimony, in part, was as follows:

> In addition, emergency transfers are authorized, under the statute, without court approval in an emergency situation when the life of the resident is in danger. See D.C. Code § 6-1929(c).

The dismal failure of the District of Columbia to fulfill this obligation, and implement residential transfers is demonstrated by the following two examples:

1. John (fictitious name) was placed in a group home because he was cognitively profoundly retarded, and was able to perform only at the level of a six to eight month old child. John also had other congenital conditions which caused the potential for target behaviors (*e.g.,* self-injurious behavior and pica [swallowing inedible objects]). For 33 years John's medical condition and target behaviors were appropriately managed and controlled. However, thereafter John's target behaviors increased dramatically. The group home administrators agreed they could no longer care for John and requested a meeting with District of Columbia officials. The committee responsible for John's habilitation, which included John's District of Columbia case manager, unanimously concluded John needed to be transferred emergently because John was "at risk of immediate harm." In accordance with its obligation, the District of Columbia

agreed to effectuate the transfer. Despite repeated pleas by group home personnel, the District of Columbia failed to fulfill its promise and John died approximately 40 days after the agreement to transfer him.

2. In a striking similar situation, approximately two years later and with a different group home, the group home and the District of Columbia agreed that Robert (fictitious name) was not appropriately placed in that group home and that he needed an immediate transfer. As a sad demonstration that there were no improvements in the District of Columbia's system to care for the developmentally disabled it promised to protect, Robert died approximately 33 days after the District of Columbia case manager acknowledged that the group home could not meet Robert's habilitative needs.

2. Staff Training and Background Checks.

The most striking example of the District of Columbia's need to have an effective pre- and post-employment background check of individuals hired to care for its wards occurred in a case in which Frank (fictitious name) was burned on his back approximately 20 times with either a cigarette or cigarette lighter. The discovery process in that case revealed that the caregiver in the group home last to be with Frank before the burns were discovered was convicted of multiple felonious crimes of violence before he was hired by the group home.

At the deposition of this "caregiver," conducted at a State Prison because of his conviction for drug distribution which occurred while he was caring for Frank, this "caregiver" on the one hand denied that burning was the type of violent act he was capable of doing, and on the other hand accused others at the group home of being the

perpetrators. The results of the depositions of the other alleged perpetrators will be discussed in Section 4 below.

This instance reflects the failure of the District of Columbia to have adequate requirements for conducting background checks and recertification of a group home's selection of their employees.

This also demonstrates that there is inadequate enforcement of the requirement that staff report abuse which they believe to have occurred.

3. Adequacy of Recordkeeping.

Group home providers are required to record information concerning a group home resident on a daily basis. The direct care staff responsible for these entries act merely as scribes and not evaluators of the observed behavior (*e.g.,* frequency of bowel movements, self-injurious behavior, or other activities or lack thereof). We have found that there are inadequate guidelines communicated to the direct care staff regarding the content of the entry, the significance of the reported observation, and the need to seek supervisory assistance when a question arises regarding the health or welfare of a resident. District of Columbia officials do not review the documents either for completeness, or more importantly to assure that areas of concern have been addressed.

We have also observed that when group home managers learn of upcoming reviews by the District of Columbia, there is often an eleventh hour effort to "update" records of residents.

4. Inadequate Supervision.

During discovery conducted in the case previously referred to involving Frank, we engaged in a search to identify the employee of the group home who burned our client. We conducted numerous depositions of staff, each of whom alleged that an employee, other than themselves, was the perpetrator. Each supported their allegation by specific references to misconduct (*e.g.*, observed physical abuse upon our client or another resident). The most profoundly disturbing sworn testimony reported that a co-resident at the group home at which Frank resided was forced to become what amounted to a sex slave of a group home employee. Essentially the testimony was that this employee specially clothed, fed, and cared for a particular resident with whom he allegedly had an open relationship that included sexual intercourse which was evidenced by conditions consistent with that behavior and observed by the individual providing the testimony, *e.g.*, soiled bed sheets.

This case dramatically demonstrates the failure of the District of Columbia to have adequate mechanisms in place to detect even the most egregious misconduct.

5. Lack of Enforcement Action.

In each of the approximately 15 cases litigated by Chaikin & Sherman, P.C. the District of Columbia's own investigation compiled a list of deficiencies in the care provided by the group home to the individual the District of Columbia promised to care for and protect. Nevertheless, the District of Columbia failed to pursue any administrative action against any contractor and conducted the litigation as if its letter of deficiency and the 129 Stipulations admitting wrongdoing in the *Evans* case did not exist.

The failure of the District of Columbia to have the intellectual integrity to pursue administrative remedies against a contractor they found to be careless, and/or to participate in the litigation as an advocate for their injured ward, is a significant contributing factor to the ongoing failure of MRDDA to change the habits of its staff and those of its contractors. It resulted in a continuation of the abuses it acknowledged it first became aware of in February 1999[17] and in a waste of government resources.

6. Advocates for Wards.

The group home system requires that each resident have an advocate to assure that the home to which they are assigned is free of abuse and neglect. Although there is a budget for this purpose, all wards either do not have an advocate or to the extent they are assigned our experience is that they are totally ineffective. Not a single advocate for any of our clients advocated to protect our clients from abuse or neglect, before or after the initial injury resulting in litigation.

C. Recommendations for Change.

1. The owners and operators of group homes must themselves be qualified to engage in this activity rather than merely being shareholders of corporations with names that communicate caring.

2. Owners of group homes must be required to engage in intensive training intended to assure the implementation of the District of Columbia's system for administrating the group homes.

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[17] See Attachment 1, Stip. No. 13.

3. In the event of a failure to fulfill the requirements of the group home system, there must be a contractually agreed upon reliable methodology to implement sanctions for non-compliance. We propose the sanctions include "debarment," which is the complete elimination of the ability of the contractor to conduct any business with the District of Columbia, rather than just the elimination of the contract to operate the one group home at issue.

4. Development of a system of personal accountability for all employees within the District of Columbia group home system to assure that they fulfill continuing education requirements as well as demonstrate that they are completing the job requirements in a professional manner with full understanding of their fiduciary duty to the individual. Similarly, each contractor should be required to provide, no less than on a quarterly basis, reports relating to individual hires certifying, among other things, the continuing qualifications of each individual to perform the task to which they have been hired to perform. Further, documentation of background checks should include a search of any jurisdiction in which the applicant has resided, worked, or had a drivers' license.

5. Incentives should be established to encourage individuals employed within the group home system, whether by the District of Columbia or contractors, to report failures of co-workers to fulfill their fiduciary duty to the wards of the District of Columbia.

6. The Qualified Mental Retardation Professional ("QMRP") should be required to provide monthly reports on each resident analyzing the significance of the entries in the daily logs. That report should be submitted to the individual assigned by the contractor to supervise the group home as well as to the District of Columbia's

assigned case manager for that individual. These two individuals must be required to review the report and consult within a specified time, and either indicate by their signature that no action need be taken, or address concerns with their respective supervisors. This recommendation presumes direct personal contact with the assigned individual on a monthly basis.

7. Any inference of the existence of neglect or abuse on an individual or group home basis must be recorded, and reported to the QMPR, case manager and the advocate. The subsequent discovery of an unreported abusive situation should result in disciplinary action against the QMRP and the case manager.

8. Advocates assigned to each resident of a group home, must agree to spend a minimum number of hours per month with the ward in the residence and in the day program, both to get to know the individual as well as to observe the individual in each program in which the individual participates. The advocate must be required to submit, under oath, a report based on his monthly observations to various supervisory personnel within the group home and the District of Columbia monitoring system. In the event there are any concerns noted by the advocate which remain unaddressed for an unreasonable period of time, the advocate must be obligated to petition the Court for relief and be held personally responsible for the failure to do so.

9. The failure to make appropriate residential transfers in accordance with Judge Rigsby's testimony should result in disciplinary action against those involved in the transfer process.