1/17/11

To: Members, Wisconsin Senate

From: Lynn Breedlove, Executive Director, Disability Rights Wisconsin

Mike Linton, Governing Board Chair, and Nino Amato, President, Coalition of Wisconsin Aging Groups

Maureen Ryan, Executive Director, WI Coalition of Independent Living Centers

Barb Thoni, President, WI Association of Area Agencies on Aging

Tom Hlavacek, Executive Director, Alzheimer's Association of SE Wisconsin

Molly Cisco, Executive Director, Grassroots Empowerment Project

Kristina Finnel, President, Mental Health of America of Wisconsin

Subject: SB1 – The Abuser Protection Act of 2011

On Friday, January 14, 2010, the Senate Judiciary Committee approved changes in Wisconsin law which, if passed, will make it almost impossible for many victims of abuse in a variety of facilities to ever hold any person or agency accountable for the injuries they have experienced. Tort reform is one thing – protecting abusers from punishment is another.

For the large number of elderly residents of nursing homes or group homes who have any degree of memory loss, for children and adults with intellectual disabilities, and for many people with mental illness, asking the resident to testify about the abuse they experienced is not a realistic option (they may not clearly recall the events or their testimony may not be convincing to the court). The most accurate and compelling evidence of physical or mental abuse they have experienced in a facility would be a) an incident report created by staff of the facility contemporaneous with the incident, as required by federal and or state law; and b) investigative reports generated by the Wisconsin Department of Health Services (DHS). SB 1 explicitly prohibits prosecutors, residents, families, guardians, or advocates from using either of those types of reports in any criminal or civil legal proceeding. This prohibition applies to all state, county, and private long term care, psychiatric, or children's facilities.

In many instances of alleged abuse, there is no police involvement and consequently no police report. There may also be no staff willing to testify regarding the wrongdoing of their co-workers. In other words, if SB1 passes in its current form, in many instances the only evidence that can be introduced is the first hand report of victims with mental impairments, sometimes years after the incident took place. This will generally be insufficient to establish the culpability of an abusive staff person or facility. It is

important to note that in the case of a child who has been abused in a facility, requiring and relying solely on the child's testimony would often be traumatic for the child.

Disability and aging advocates have already begun to refer to SB 1 as the "The Abuser Protection Act of 2011". Agencies that advocate for elderly people and people with disabilities or mental illness regularly receive calls from people (or their families) who have experienced illegal seclusion and restraints, unnecessary injuries, and other forms of abuse and neglect in a variety of facilities. If we believe that people may have a valid claim for damages, we recommend that they retain private counsel. A key reason for this is that people who experience serious injuries may require costly care for many years as a result. If SB1 passes in its current form, abuse victims and their families will soon discover that there may be little if any evidence available to them to make their case and receive the justice and support they deserve.

There is no clear data from DHS to suggest that the level of abuse and neglect in Wisconsin facilities is on the decline. Changing the law to prevent abusers from being held accountable for their activities is not likely to help the situation. In fact, many advocates predict that SB1 will have the opposite effect.

Here are some real Wisconsin examples of wrongful deaths to illustrate our concerns:

1. A group home resident with developmental disabilities died of exposure after wandering away from the group home. The facility insisted that there had been no precautions taken because this was the first time it had happened and there was no history of elopement recorded for this individual. However, the incident reports (accessible under current law) told the true story—there had been multiple incidents of the man wandering, and the facility had done nothing to prevent it. This cover up of gross negligence would not have been exposed if the proposed changes in SB1 were in effect at the time.

2. Angie, a seven year old girl with emotional disabilities, was attending a day treatment program in Rice Lake. Even though she was repeatedly placed in prone restraints (face down) over the course of several months, Angie did not tell her foster mother what was happening to her in the program, but she begged not to have to go there. The final time that staff restrained her, the incident began when Angie blew bubbles in her milk. After she was sent for a time out, and subsequently refused to stop swinging her legs in her chair, she was forced to the floor and put in a prone restraint hold. A large male staffperson lay across her back, and other staff held her limbs. They released her when they thought she had fallen asleep, but she wasn't asleep, she was dead from asphyxiation.

   The facts leading to Angie's death are known because there were reports by facility staff regarding these incidents. Additionally, there was an investigation performed by DHS. Without these reports, there would have been no way to discover the pattern of abuse of this 7 year old girl. There was no other

contemporaneous record made of the events or injury. And, although this case did lead to a criminal investigation and charges, in most cases of abuse and neglect in facilities that care for the elderly or people with disabilities, there is no police investigation to turn to for answers. SB1 would have blocked the disclosure and use in court of both the facility's record of events and the DHS investigation. It would have made it very difficult (perhaps impossible) for the family and prosecutor to get the proof they needed to hold anyone accountable for Angie's death.

3. A 90 year-old nursing home resident with Alzheimer's disease was allowed to starve and dehydrate over a period of less than two months despite being at a known risk for both conditions by the facility. She went from 126 pounds to 110 pounds in 36 days. Her doctor's goal weight for her was 139 pounds. She was consistently drinking far less than her minimum daily fluid requirement as calculated by the nursing home. She died less than two weeks after being hospitalized for malnutrition, dehydration and a urinary tract infection, which turned septic. The DHS report which found deficiencies in the facility's care included interviews with staff that showed awareness of the weight loss and inadequate fluid intake, but a complete failure to take action to stop it. Under this bill these records and interviews would be deemed "irrelevant" and inadmissible in either a civil or criminal action.

We understand the objective of SB1 to achieve "tort reform", but we do not consider it "reform" to shield the abuser from all civil or criminal responsibility and make it impossible for the most vulnerable people in Wisconsin and their families to receive any justice or compensation at all, after a serious tort has been committed against them. For these people, the debate about a cap on non-economic damages will be irrelevant. They will suffer grievous harm and receive no damages at all. This is not only unfair to the person who has been harmed. It is also unfair to the taxpayers of Wisconsin who will "take the tab" (via the Medicaid program) for all of this person's future care resulting from the injury, rather than having the responsible party pay what they owe.

We respectfully ask you to oppose SB1 as it now stands, and amend the bill to correct this problem.

cc: Gov. Scott Walker
DHS Secretary Dennis Smith