

Don't Be the Next Penn State

Good intentions only go so far: protect your clients and agency with these precautionary measures and responses

by Kathryn M. Vanden Berk

I have been following the media coverage of the recent problems at Penn State through a legal lens. While we all can breathe a sigh of relief that our organization is not the one on the front pages, we should take a moment to review how to prevent similar events from happening, as well as steps to take if anything comparable were to occur.

Let's look specifically at the issue of sexual misconduct by staff. It's a tough subject to deal with, but one that arises too often in the context of caring for children.

Necessary Precautions

First, the everyday precautions required by licensing agencies and ordinary risk prevention programs cannot be overstated:

- Hire carefully.
- Require background checks and personal references for any new staff member who will have direct contact with children. If a job applicant cannot give you a valid, living person as a reference, don't hire him or her.
- Inform all staff about sexual misconduct policies, whistleblower protections, and mandatory reporting procedures required both within the agency and by external agencies.
- Ensure that your policies and practices are designed to minimize sexual exploitation. I've provided a sample policy, which can be accessed through the online version of this article at alliance1.org/ magazine. (See the sidebar on page 24 for additional examples from the Council on Accreditation.)

- Be vigilant and take every allegation of sexual misconduct very seriously.

Critical Responses

Any report that involves a client and a staff member should trigger, at a bare minimum, these steps:

Step 1: Initial Report. Instruct employees to report any abuse allegation to a supervisor, who can assist with routing the allegation through your internal incident reporting system. Also keep in mind any external reporting requirements, as the employee who receives the initial allegation most likely is a mandated reporter under your state's mandated reporting act.¹

Step 2: Immediate Response. Assign a clinical staff member to review the facts surrounding the allegation and decide whether immediate physical or psychological needs must be addressed clinically. If the allegation involves a staff member, that person must be separated from the client during the investigation, either by transfer to another unit or suspension.

Step 3: Internal Review and Assessment. The incident should be evaluated to identify if there were any lapses in agency policies; whether proper response and documentation was followed; and if the agency should evaluate the need

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COA Standards Provide Guidance

Alliance Severson Center provides support in developing and adapting policies

Several Council on Accreditation standards, adopted by many members of the Alliance for Children and Families, also cover the subject of risk management and reporting:

- Risk Prevention Management covers the reporting of “critical incidents”;
- Ethical Practice Standard addresses professional standards, including reporting procedures, policies for protecting those who report suspected misconduct, and whistleblower policies; and
- Behavioral Support and Management spells out the need to comply with federal, state, and local regulations.

The Alliance Severson Center can provide more information about these standards, as well as supply example policies used by Alliance members.

Learn more at alliance1.org/severson/about.

for changes in policies and procedures, or provide additional staff training. This evaluation should be followed by a complete report to the board of directors and, as needed, government agencies and accreditation bodies.

Step 4: Board Action. Fully inform the board of the details of the allegation, the steps taken, and any additional steps that might be needed due to the nature of the allegation. If the incident is likely to be reported in the media, appoint a spokesperson for the agency and develop a strategy of disclosure, as necessary, for informing the public that the incident has been properly responded to.

Transparency is key when reporting any potential abuse situation. Be forthcoming with information so there can be no claim of concealment.

Determining the Root Causes

In considering the Penn State situation or any case of misconduct involving children, it’s helpful, at a later date, to consider the root causes that left the organization open to conduct and events which threatened its reputation.

For this exercise, I recommend The Joint Commission’s policy for “Sentinel Events” and the “Framework for a Root Cause Analysis and Action Plan in Response to a Sentinel Event.”² A sentinel event is described as “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.”

When a sentinel event occurs, the “Root Cause Analysis” provides a “what,” “where,” “when,” and “why” investigatory framework that looks below the surface and tries to determine the true reasons for an event that involves significant risk exposures.³ The “Root Cause Analysis” is the kind of in-depth review that must take place when your reputation is on the line, the issues are complex, and emotions run high.

Related to the Penn State situation, legal blogs have focused on the potential for liability⁴ and suggest that several factors may have allowed a sexual predator to continue interacting with young victims, including:

- board being too big, too busy, or too lackadaisical;
- board-staff relationships being too cozy;

- concern for reputation overwhelming concern for the safety of children; and
- breakdown of reporting processes or the lack of whistleblower policies.

Whatever the ultimate cause, the reality is that Penn State will be burdened for years with lawsuits, loss of alumni support, and other disintegrations. With appropriate planning and determination to protect your clients, as well as your agency, you can avoid this disastrous and wholly avoidable result. ■

ENDNOTES:

1. Information about state statutes for mandated reporting is available from the Child Welfare Information Gateway at childwelfare.gov/responding/mandated.cfm.
2. The Joint Commission is primarily involved with the accreditation of hospitals and other health care organizations. It accredits more than 19,000 health care organizations and programs in the United States.
3. Access the “Root Cause Analysis” at jointcommission.org/Framework_for_Conducting_a_Root_Cause_Analysis_and_Action_Plan.
4. At the time of writing, a litigation firm based in Washington, D.C., was reportedly working with experts to evaluate possible common law tort violations by Penn State, such as assault and battery, failure to report a crime, conspiracy, negligent concealment, and failure to supervise employees.



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