CRITICAL INCIDENT INVESTIGATION FINDINGS & RECOMMENDATIONS

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STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
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INTRODUCTION AND METHODOLOGY

The Office of the Child Advocate (OCA) is issuing this Critical Incident Investigation Findings & Recommendations Report ("Findings Report") to the Department of Children and Families (DCF), the Department of Developmental Services (DDS), the Department of Social Services (DSS), and the Office of the Chief Public Defender (OCPD) in response to an October 2021 critical incident that occurred in a DDS-licensed Community Living Arrangement (CLA) involving a DCF-committed child and a DDS client, which incident led DCF and DDS to make findings of individual and programmatic neglect.

OCA found that a serious incident did occur, and that while the incident was brought to attention of staff at DCF and DDS for safety planning purposes, the matter was not timely reported as a critical incident or report of abuse/neglect. State agency investigations into the incident found that a lack of supervision and programmatic neglect contributed to the incident. However, OCA found a lack of timely follow up by the state agencies to ensure that programmatic concerns and corrective actions were addressed. OCA found that the minor child's state-appointed lawyer (for his child protection case) did not comply with state contractual obligations and performance guidelines.

In accordance with OCA's statutory obligations and authority, OCA undertook a broader review of systemic efforts to prevent critical incidents in DDS-licensed CLAs and effectively address identified programmatic and resource deficiencies. OCA examined findings issued by the Inspector General for the U.S. Department of Health and Human Services (Inspector General) in 2016 which found Connecticut failed to comply with federal Medicaid requirements to ensure the safety of intellectually disabled residents in DDS-licensed settings. OCA also reviewed training requirements and participation for DCF staff regarding ensuring safe care and treatment for developmentally disabled children; and OCA reviewed state performance expectations and oversight for state-appointed lawyers for children. We want to acknowledge the cooperation of the agencies and the community provider with OCA's investigation.

OCA's Methodology for this critical incident review included:

1. Review of DCF and DDS records pertaining to the investigation of an October 2021 critical incident occurring at a DDS-licensed CLA, and all corrective action documents generated in response thereto.
2. Review of DDS regulatory records regarding the CLA, including licensing inspection reports, licensing violations found, agency corrective actions, and records pertaining to enhanced regulatory monitoring of the CLA.

3. Review of provider records regarding the programmatic findings and corrective actions undertaken in response to the October 2021 critical incident.
4. Review of all correspondence between DDS and DCF regarding the October 2021 critical incident.
5. Review of protocols for information-sharing between applicable state and private agencies regarding these critical incident investigations
6. Interviews with administrators/managers from DDS, DCF, and the Community Provider.
7. Interview with the parent/s of the young adult victim.
8. Consultation with individuals who work with individuals who have developmental disabilities.
9. Review of relevant state statutes and regulations regarding the licensing, monitoring, and investigation of CLAs serving children and vulnerable adults.
10. Review of court records pertaining to the child protection proceeding involving the minor child.
11. Attorney billing records related to the state-appointed legal representation of the minor child.
12. Discussion with the OCPD regarding expectations for legal representation of minor children.
13. Review of the U.S. Inspector General for the U.S. Department of Health and Human Services' Report auditing Connecticut compliance with certain Medicaid requirements pertaining to the Home and Community Based Waiver implemented by DDS and DSS.
14. Review of funding and staffing concerns related to licensed CLAs serving individuals with intellectual and developmental disabilities.
15. Provision of draft findings and recommendations to DDS, DSS, DCF, and OCPD.

OCA shared findings and a draft of this Report with all the agencies identified herein, and incorporated responses and feedback received to the final Report. Written agency responses, where offered, are included at the conclusion of the OCA's Brief Findings and Recommendations. DDS and DSS shared steps they are taking to address issues identified in this Report.

I. BACKGROUND

The OCA is an independent government agency that is statutorily authorized to "[r]eview complaints of persons concerning the actions of any state or municipal agency providing services to children and of any entity that provides services to children through funds provided by the state… and investigate those where the Child Advocate determines that a child or family may be in need of assistance … or that a systemic issue in the state's provision of services to children is raised by the complaint."[1] OCA is authorized to "conduct an in-depth investigation and review and issue a report with recommendations on the death or critical incident of a child. The report shall be submitted to the Governor, the General Assembly and the commissioner of any state agency cited in the report and shall be made available to the general public."[2] OCA is further required to "[e]valuate the delivery of

[1] Conn. Gen. Stat. Sec. 46a-13l.

[2] Conn. Gen. Stat. Sec. 46a-13l. Further, "Any state agency cited in a report issued by the Office of the Child Advocate, pursuant to the Child Advocate's responsibilities under this section, shall submit a written response to the report and recommendations made in the report to the Governor and the General Assembly not later than ninety days after receipt of such report and recommendations. The General Assembly shall submit a copy of such response to the Office of the Child Advocate immediately upon receipt." Id.

services to children by state agencies and those entities that provide services to children through funds provided by the state."[3]

DDS licenses hundreds of community settings, called Community Living Arrangements, for persons with intellectual and developmental disabilities who might otherwise depend on institutional care for services. Federal and state dollars support individuals, both adults and sometimes children, in these community settings. Where needed and where a bed is available, DCF (and school districts) will utilize slots in DDS-licensed CLAs for children. Because DCF-involved children have assigned caseworkers, they are not provided with DDS case managers to oversee and support their care in the CLAs. The number of children in state licensed CLAs has been declining during the pendency of this investigation. As of the final drafting of this report there were 5 children under the age of 18 in DDS-licensed CLAs.

In 2016, the Inspector General for the U.S. Department of Health and Human Services found serious safety concerns involving Connecticut's CLAs.[4] Specifically, the Inspector General found that Connecticut failed to comply with Federal Medicaid Waiver and State requirements for reporting, monitoring, and following up on critical incidents involving disabled individuals living in CLAs and that incidents, including deaths, that were suspicious for abuse and neglect were not always investigated. The Inspector General's audit emphasized that individuals with developmental disabilities are at higher risk of abuse and neglect in the community and they may have limited capacity to report concerns or access help. Accordingly, there is an urgent need to effectively monitor the safety of children and adults in licensed settings.[5] The Inspector General issued several corrective recommendations to the Connecticut Department of Social Services (DSS, the state's Medicaid operating agency). DSS and DDS collectively undertook actions to implement the Inspector General's 2016 recommendations and the agencies made several required assurances to the federal government regarding the safety of individuals in the DDS-licensed CLAs. Since 2016 the agencies have made progress towards the implementation of the Inspector General's recommendations and compliance with Medicaid-required safety assurances. To date, however, there is no federal finding that all required assurances or corrective actions have been fully implemented and there is also no public progress monitoring framework at the state level for evaluating the pace and comprehensiveness of these improvements. The state is currently undergoing a follow up audit.

OCA's BRIEF FINDINGS AND RECOMMENDATIONS

[3] Id.

[4] Audit Report of the Office of the Inspector General for the U.S. Department of Health and Human Services, Connecticut Did Not Comply With Federal and State Requirements for Critical Incidents Involving Developmentally Disabled Medicaid Beneficiaries (May 25 2016), found on the web: https://oig.hhs.gov/oas/reports/region1/11400002.asp.

[5] Id. citing to Christy J. Carroll, Efthalia Esser, and Tracey L. Abbott. State of the States on Abuse and Neglect of Individuals with Developmental Disabilities. North Dakota Center for Persons with Disabilities, Minot State University, 2010. Available at http://www.ndcpd.org/assets/abuse--neglect-state-of-the-state-paper.pdf. Accessed on October 18, 2017.

OCA's critical incident and systems investigation found that though systemic efforts have been made by the state to address deficiencies identified in the U.S. Inspector General's 2016 audit, grave concerns persist regarding the adequacy of oversight and allocated resources necessary to support safe and high-quality care for disabled individuals in the community.

Critical incident reviewed by OCA

On October 14, 2021, the OCA received a concern from a first responder regarding an incident between a minor boy and a young adult woman in a DDS-licensed CLA wherein the boy was found attempting sexual intercourse with the young woman. Both the boy and the young woman are developmentally disabled and were unsupervised at the time of the incident. The boy had a known history of sexually reactive behaviors. The DDS-licensed CLA, run by a community-based provider agency,[6] served both minor and adult clients, male and female, with various developmental disabilities. Two of the CLA's residents, including the boy involved in the incident, and a young adult (not connected to the incident), were DCF-involved.[7] DCF was the guardian for the minor boy. OCA found that DCF treatment records did not contain adequate information regarding the child's needs and service plan. OCA found that the provider's attempts to support the young adult victim after the incident were challenged due to the fact it took several days for DCF to identify a new living arrangement for the minor boy.

Although the provider took steps to alert DCF and DDS staff as to what happened, the October 2021 incident and a previous incident involving the same minor child in the CLA were not promptly reported by the CLA as a critical incident or suspicion of child abuse/neglect. OCA found that this CLA was also cited by DDS in late 2021 when inspectors detected a previous critical incident that had occurred two years earlier but had not been reported wherein one of the residents was hospitalized with a serious ingestion injury that occurred due to lack of supervision. OCA found that with regard to both critical incidents and citations, DDS did not adhere to agency requirements for prompt and complete follow-up to ensure that concerns identified by regulators and investigators were timely addressed.

Given the presence of a child and a DCF supervised young adult in the CLA, and pursuant to OCA's statutory authority to investigate complaints that raise a systemic concern in the state's delivery of services to vulnerable children and youth, OCA undertook a broader investigation, examining the State's framework for ensuring the delivery of safe care to individuals with intellectual and developmental disabilities in state licensed CLAs, particularly in the wake of the federal Inspector General's 2016 deficiency findings.

[6] To ensure the privacy of the individuals and staff involved in this critical incident, OCA is not identifying the community provider or CLA.

[7] DCF utilizes DDS CLA slots for children with developmental disabilities, as needed and available.

BRIEF FINDINGS

- DDS and DSS have made efforts to implement the 2016 Inspector General corrective recommendations, updating policies and trainings regarding reporting and follow up to concerns of abuse/neglect and critical incidents; DDS has updated its performance goals and measurements to regularly monitor progress towards Medicaid-required safety assurances.

- DDS and DSS implemented a new software program ("Pulselight") that allows for cross-agency data sharing and permits detection of possibly unreported critical incidents involving DDS clients or individuals residing in DDS licensed settings through analysis of Medicaid treatment claims.

- In 2021, the Pulselight program detected more than 100 critical incidents involving intellectually disabled individuals that had not been timely/reported to the agency. DDS was unable to provide OCA with a breakdown of the nature of the unreported incidents, including how many were investigated by DDS staff and community providers, or how many detected reports led to substantiated neglect findings and corrective actions.

- DDS-licensed CLA inspection histories indicate that unreported incidents continued to be detected following the Inspector General's report. OCA's review of just over 150 providers' licensing histories during a recent five year period revealed 49 providers cited for failing to report harm or failing to have a system for reporting incidents. Only 2 of the 49 providers were revisited by DDS licensing staff within 30 days to verify corrective actions had been implemented. More than half of the 49 providers were not revisited for at least two years.

- OCA reviewed multiple DDS regional Quality Assurance Reports that did not utilize a standardized form, did not contain clear information about safety and quality trends, and did not include adequate information regarding abuse/neglect findings or what corrective actions had been issued and completed

- Limited information about a DDS CLA's licensing history is available on the state's public database and DDS findings of programmatic neglect and corrective actions are not published.

- DDS lacks resources to ensure independent investigation of allegations of abuse and neglect of individuals in licensed CLAs, relying on providers to self-investigate the majority of incidents and report back to DDS.

- There is no public progress monitoring framework for DSS/DDS's response to the U.S. Health and Human Services' Inspector General audit findings.[8] OCA could not find any

[8] DDS and DSS make several assurances to the federal government as part of the state's application for a Medicaid Home and Community Based Waiver. The assurances address safeguards for disabled residents,

public reports on the federal Medicaid, DSS, DDS or Connecticut General Assembly websites that contain details of the agencies' progress towards addressing the federal audit's safety concerns.

- Although DCF was the guardian of the minor child in the CLA critical incident for several years, DCF records do not contain adequate information regarding the educational, treatment, and developmental needs and service delivery to the child.

- Following the 2017 homicide death of a developmentally disabled child involved with DCF, the agency developed a comprehensive training for staff regarding the unique safety and treatment needs of developmentally disabled children. However as of the drafting of this Report, only 10% of caseworkers and supervisors had participated in this training and the training is not mandatory.[9]

- Although DCF is authorized and required to conduct investigations of suspected abuse or neglect of minor children in DDS CLAs, there is no requirement in state law that DCF follow up on concerns the agency identified in child-serving programs that DCF does not license. There is no statutory requirement that DCF publish or otherwise notify parents or guardians when program concerns are identified in settings where their children are placed.

- The minor child's state-appointed lawyer did not adhere to state agency performance guidelines promulgated by the Office of the Chief Public Defender regarding participation in treatment planning and obtaining and reviewing client-specific records. DCF records do not confirm regular notice to the attorney of treatment plan meetings.

- Significant concern persists regarding the adequacy of resources to support non-profit providers' recruitment and retention of staff who care for individuals with disabilities in community settings. Providers throughout the state have reported significant staffing vacancies, and several have publicly reported that funding deficiencies and reimbursement rates for delivered services have profoundly impacted their ability to maintain or offer services for vulnerable consumers. Noting that individuals who provide direct care to vulnerable populations need and deserve reasonable compensation and benefits, these staffing vacancies and challenges are a direct threat to the safety and quality of life of dependent children and adults with intellectual and developmental disabilities. While a recent labor strike was resolved with an increase in support for certain DDS providers, there remains concern as to whether the allocated resources are adequate to address staffing and service availability.

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including assurances for health, safety, and general welfare of individuals with intellectual and developmental disabilities. It is these assurances that the U.S. Inspector General for HHS found Connecticut failed to comply with.

[9] November 9, 2022 email from DCF to OCA.

BRIEF RECOMMENDATIONS

OCA is making several recommendations for the support and protection of vulnerable individuals, including children, who reside in DDS licensed CLAs:

- Amend state law to strengthen the licensing requirements and regulatory oversight for DDS CLAs and require a minimum of one annual unannounced licensing visit and mandatory re-visits when health/safety violations are found (already required for OEC licensed childcare settings).
- Amend state law to require publication of DDS licensing inspection and corrective action documents and provider-responsive plans on the state's E-license database (already required for OEC and DCF licensed childcare settings).
- Amend state law to require inclusion of DDS and DCF investigative program findings and resulting corrective actions in the state's public database/s for state-licensed programs and facilities.
- Amend state law to require that DDS and DCF inform consumers, guardians, and parents, where applicable, when the agency/s make findings of program concerns or programmatic neglect.
- Amend state law to require publication of DSS and DDS quality assurance reports regarding safety and wellbeing for intellectually and developmentally disabled clients.
- Amend state law to require that DDS notify Disability Rights Connecticut (DRCT) of all critical incidents involving disabled individuals in DDS-licensed programs and facilities and provide DRCT with all Medicaid compliance updates and reports regarding the health, safety, and welfare of developmentally disabled consumers.
- Amend state law to require that as part of the approval of the state's application for Medicaid Home and Community Based Waiver services, that the state legislature oversee DSS and DDS's implementation of the federal Inspector General audit findings and relevant Medicaid-required safety and quality of care assurances. Such oversight should include ongoing analysis of staffing attrition and resource allocation and implications for oversight and provision of safe and quality care for children and adults with developmental disabilities in state-licensed settings.
- The state budget should increase resource allocations and reimbursement rates for community providers who deliver essential services to vulnerable populations, including children and adults with intellectual and developmental disabilities and ensure a multi-year strategic plan to address workforce development and service delivery.
- DCF policy or state law should require that all DCF staff, including treatment plan reviewers, receive training regarding the safety and treatment needs of highly vulnerable children, including children with intellectual and developmental disabilities.
- Pursuant to state law amendment or a memorandum of agreement, DDS should ensure that DDS case managers are assigned to any minor child placed in a DDS licensed CLA, whether funded by a school district or DCF to assist with oversight and coordination of direct care and support.
- The state should examine and clarify the concurrent responsibilities of DCF and DDS to serve children with developmental disabilities, including which agency should have primary

responsibility for licensing and oversight of group homes and other contracted services for children with developmental disabilities.

- The state budget should ensure resources adequate to support legal representation for children in child protection proceedings through age 21.
- The legislature should convene a working group to examine the historical and current framework for providing counsel to children in child protection proceedings and make recommendations necessary to ensure quality and consistent legal representation.

AGENCY RESPONSES

Department of Social Services (received by OCA from DSS Commissioner Andrea Barton Reeves)

Thank you for the opportunity to review and respond to the draft report regarding the critical incident that occurred at a DDS Community Living Arrangement in 2016. As your report accurately notes, DSS has a clear responsibility as the state Medicaid Agency related to the health and safety of Medicaid members. To that end, we are revisiting our internal policies related to federal audits, such as this. I have copied my Medicaid Director and Quality Assurance Director on this response to assure you that we are taking this seriously and we are committed to fulfill our role as the state Medicaid Agency.

As you know, there are several services and/or or levels of care that are reimbursed by Medicaid, but managed day to day by another state agency and/or another state agency has licensing responsibilities for these services or level of care. A non-exclusive list of these services include:

- Psychiatric Residential Treatment Facility (PRTF)
- Intermediate Care Facilities (ICFs)
- Group Homes
- Community Living Arrangement (CLAs)

DSS, as the state Medicaid Agency, separate from the roles and responsibilities of the other state agencies who operate or license these facilities, must ensure the health, safety, and payment integrity of these services. Your report identified a vulnerability in our internal process that we are taking action to address. Effective immediately, DSS will have a redundant critical incident response and sustainability plan. There will be a subject matter expert within the Division of Health Services who will be responsible for reviewing and drafting the response that includes a remediation or corrective action plan, if one is warranted. In addition, this person will work in partnership with a staff person in our Quality Assurance (QA) division. The role of the QA staff is to ensure that the response is timely, responsive to the findings, all findings are addressed and that the corrective action plan is implemented and sustained. This process will be a "checks and balances" process where staff from different divisions hold themselves and each other accountable to complete the report and implement the corrective action plan.

We believe this redundant accountability process will ensure that the Department is compliant with our obligation to respond to any audit finding in a timely manner.

Regarding your specific recommendations, the Department respectfully requests that you amend your recommendation that refers to the legislature overseeing DSS and DDS's implementation of the

federal Inspector General audit findings. As worded, we believe this would delay our submission and potential federal revenue for Medicaid waivers, which would have significant financial implications to the state. We request that you amend that recommendation to ensure that DSS comply with the existing waiver requirements contained in "Section G: Participant Safeguards" in all Medicaid waivers. This section speaks to ensuring the health and safety of Medicaid waivers and is already required by CMS.

Thank you for your consideration.

Department of Developmental Services

Thank you for the opportunity to review the draft report.

[With regard to DDS follow up on detected critical incidents] We would clarify to say that we do not specifically "assign" follow up (yet); we inform the [Case Manager], Nurse, Investigator, etc., when we send the notification to the provider, so they can follow up as needed. This is how it is redirected into the reporting flow for the time being.

As a general note in this area, DDS is adding workflow management tools to Pulselight this winter that will integrate tracking of [Detected Critical Incident] status through the review lifecycle into the system.

[DDS can provide c]onfirmation that [the Office of the Inspector General for the U.S. Department of Health and Human Services] has not yet issued their re-audit report.

A point of clarification is that DDS does provide a dashboard of aggregate abuse/neglect investigation information to DRCT monthly.

We have hired three regional directors of quality assurance and one program manager for critical incidents to address many of the issues and recommendations raised in your report. I believe this was in process when last we spoke but had not yet come to fruition. These staff are explicitly focused on some of the areas you highlighted, including standardization of reporting, trend analysis, etc.

Department of Children and Families

We appreciate the opportunity to provide feedback on this draft report. The Department is currently assessing the scope of the child abuse and neglect investigations it conducts in DDS-licensed facilities to determine whether these can or should continue to include program concerns not directly related to the abuse or neglect investigation. In addition, the Department continues to support and offer staff training on meeting the safety and treatment needs of children with developmental disabilities with a focus on providing individualized training for staff when they are serving children with developmental disabilities rather than mandating the training in advance. This allows staff to apply the training in real time with the children and families they are serving, which tends to be a more effective way of delivering this type of specialized training. The Department agrees with the importance of providing timely notice of case plan meetings to attorneys and GALs, and recent enhancements to our automated notification process should continue to improve this practice moving forward.

Office of the Chief Public Defender

The Office of the Chief Public Defender met with OCA and answered questions about the system of legal representation for children in child protection proceedings. Upon review of the draft report, OCPD offered minor revisions and stated that they had no objection to OCA's findings or recommendations.

OCA Note

OCA appreciates the review and responses from the agencies, including the specific steps being taken by DDS and DSS to improve critical incident review and support the safety of disabled residents in community settings. OCA looks forward to continued work with policymakers and state partners on the recommendations contained herein.

II. LEGAL BACKGROUND

State Law Requires DDS Staff and Providers Immediately Report Critical Incidents and Concerns of Abuse and Neglect Involving a Disabled Adult or Child

Connecticut law requires a variety of individuals, including DDS staff, report suspected abuse or neglect of a person with an intellectual disability to DDS for further action and investigation.[10] State law also requires that mandated reporters, which includes many licensed and unlicensed professionals and employees who interact with children, promptly report to DCF or law enforcement a "reasonable suspicion" that a child under the age of eighteen years has been abused or neglected.[11]

State Law Requires That DCF Develop a Treatment Plan for Every Child under the Agency's Supervision

Connecticut general statute requires that DCF must timely create a written "case plan" that addresses the care, treatment, and placement of "every child under the commissioner's supervision."[12] The plan must be reviewed at least every six months and modified as needed. DCF policy provides that a case plan must include: an assessment of the child's strengths and needs, a description of service provisions to address the needs, and a discussion of the monitoring of ongoing progress."[13]

State Law Requires A Lawyer Be Appointed To Represent any Child in a Child Protection Proceeding

State law requires that children in the care and custody of DCF and/or for whom a petition of neglect is filed in the Juvenile Court are "represented by counsel knowledgeable about representing such children."[14] Counsel are appointed by the Office of the Chief Public Defender (OCPD), which is also

[10] Conn. Gen. Stat. Section 46a-11a and 11b. . "Abuse" and "neglect" are defined by statute as (respectively) "the wilful infliction of physical pain or injury or the wilful deprivation by a caregiver of services which are necessary to the person's health or safety;" and "where a person with intellectual disability either is living alone and is not able to obtain the services which are necessary to maintain such person's physical and mental health or is not receiving such necessary services from the caregiver."
[11] Conn. Gen. Stat. Section 17a-101a.
[12] Conn. Gen. Stat. Section 17a-15.
[13] DCF Policy Sec. 20-1.
[14] Conn. Gen. Stat. Section 46b-129a.

statutorily responsible to "establish training, practice and caseload standards for the representation of children and youths."[15] Federal law requires that representatives for children obtain a clear and "first hand" understanding of the needs of the child.[16]

State Law Requires DDS Ensure Adequate Care and Treatment for Individuals in Licensed Group Care

State regulation requires DDS to inspect its licensed homes once every two years.[17] State statute requires that for "community living arrangements," (CLAs), DDS "shall determine a minimum number of licensure-related visits that are unannounced."[18] DDS regulations contain health and safety requirements which are reviewed during licensing visits. Providers are cited for deficiencies and corrective action is required.

- *DDS Licensing Plan of Correction Monitoring*[19]

  DDS's Licensing Unit must review and approve any plan of correction and determine which citations can be verified through documentation and which will "need a site visit to verify that corrections have been made."[20] If the citation and corrective action plan implicate a health or safety issue, DDS policy requires the site be re-visited by the program's contract manager within 30 days.[21]

  DDS regulations also permit the issuance of compliance orders to a provider that include reducing the provider's licensed capacity, requiring the provider to increase staff support and training or accept additional monitoring from DDS.[22] Compliance orders must be implemented within thirty days of issuance, or as specified by the commissioner, unless the licensee requests a hearing.[23]

- *DDS Enhanced Monitoring of Programs*

[15] Conn. Gen. Stat. Section 51-296.
[16] 42 U.S.C. § 5106a(b)(2)(B)(xiii)
[17] Conn. Gen Stat. Section 17a-227-4. (a) Inspections shall be conducted by the department at initial licensure and at intervals of not more than two years.
[18] Conn. Gen. Stat. Section 17a-227(b).
[19] DDS Policy Manual, found at https://portal.ct.gov/-/media/DDS/DDS_Manual/ID_Quality/mortality/PR006LicensingPlanofCorrectionMonitoring.pdf
[20] Id. The Licensing/Certification Unit will then forward a copy of the plan of correction, indicating the citations that require on-site verification, to the assistant regional director for the appropriate division: Public or Private Administration Services.
[21] Id.
[22] Regulation of Connecticut State Agency Section 17-227-7 S
[23] DDS Policy https://portal.ct.gov/-/media/DDS/DDS_Manual/ID_Quality/licensing/CLAlicensinginspections.pdf

DDS may institute "enhanced monitoring," for a provider, which may include frequent site visits, meetings with providers, and documentation requirements deemed necessary by DDS to assess progress of the agency toward meeting identified goals and outcomes. [24]

Federal Law Requires States Assure Delivery of Safe Care to Medicaid Recipients in Community CLAs

Federal Medicaid law requires that states provide assurances to the federal government that individual recipients of Medicaid waiver services are receiving safe and appropriate care. The Medicaid Home and Community Based Services Waiver (HCBS) allows states to provide services to vulnerable persons who otherwise may rely on institutional care, such as elderly individuals or people with intellectual and developmental disabilities.[25] State Medicaid agencies utilizing HCBS waivers make specific assurances to the federal government including that 1) the agency has taken all "necessary safeguards … to protect the health and welfare of the [Medicaid] beneficiaries," 2) that each beneficiary will have a written service plan based on an assessment of the individual's needs, and 3) that each beneficiary is served by a "qualified provider."[26] With regard to the federally required "health and welfare" safeguard states must confirm that they have a "critical event or incident reporting system" and a framework for "responding to critical incidents for developmentally disabled individuals."[27]

States' compliance with these assurances is subject to review by Medicaid regulators and by the U.S. Department of Health and Human Services' Inspector General. The Inspector General has emphasized that "[s]trong oversight of waiver programs is critical to ensuring the quality of care provided to beneficiaries. The beneficiaries served by these programs are among Medicaid's most vulnerable, and the nature of these programs puts beneficiaries at particular risk of receiving inadequate care."[28]

Connecticut DSS complies with the HCBS Medicaid waiver requirements for intellectually disabled individuals through a Memorandum of Understanding with DDS. However, as the state's Medicaid operating agency, DSS maintains ultimate responsibility for ensuring implementation of the Medicaid waiver consistent with federal requirements.

OCA notes that historical lack of adequate funding for community-based services for individuals with intellectual and other developmental disabilities raises concerns as to whether the state is in compliance with access rules for Medicaid-funded home and community-based services.

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[24]https://portal.ct.gov//media/DDS/DDS_Manual/IFPO002TransferPolicy/IGPR003EnhancedMonitoring.pdf.

[25] The Social Security Act (the Act) authorizes the Medicaid Home and Community-Based Services Waiver (HCBS waiver) program (the Act § 1915(c)). "The HCBS waiver authority permits States to waive certain Medicaid requirements to provide a wide range of services to persons who otherwise would receive institutional care." Inspector General Report at 2. (https://the Inspector General.hhs.gov/oei/reports/oei-02-08-00170.pdf).

[26] 42 CFR § 441.302. Other assurances states must make include that each beneficiary must have a written service plan based on an assessment of the individual's needs, and each beneficiary must be served by qualified providers.

[27] Inspector General report at 2.

[28] Id.

III. U.S. INSPECTOR GENERAL FINDS DEFICIENCIES IN CONNECTICUT REGARDING SAFE CARE OF INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

In 2016, the Office of the Inspector General for the U.S. Department of Health and Human Services (Inspector General) completed an audit of Connecticut's compliance with federal Medicaid HCBS waiver requirements regarding the safety of individuals with intellectual disabilities in DDS CLAs. The audit emanated from a Congressional inquiry which followed a report from the Connecticut Office of Protection and Advocacy (now privatized as the non-profit Disability Rights Connecticut). The Office of Protection and Advocacy (OPA) found that dozens of deaths of developmentally disabled individuals in Connecticut between 2004 and 2010 involved suspected abuse and neglect and were not properly investigated by Connecticut officials.[29] The Inspector General's audit examined whether DSS ensured reporting and monitoring of critical incidents involving disabled Medicaid beneficiaries residing in DDS-licensed CLAs from January 2012 through June 2014.[30]

The Inspector General found significant deficiencies in Connecticut's practices, including:[31]

1. CT failed to ensure accurate and reliable reporting of critical incidents by CLA providers;[32]
2. CT failed to record all critical incidents;
3. CT failed to ensure that critical incidents were reported/recorded at the correct severity level; and
4. CT failed to ensure that all incidents were appropriately reviewed and followed up on, including ensuring that incidents suspicious for abuse/neglect were properly investigated.

The Inspector General concluded:

> [DSS] did not comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents [involving DDS clients] because staff at

[29] The Inspector General Report at i. The Abuse Investigation Division at OPA is now housed internally at DDS.

[30] Federal Medicaid regulations defer to state definitions of critical incidents.

DDS defines a critical incident as:

1. Death that resulted from an injury.
2. Severe injury that requires a hospital admission.
3. Vehicle accident causing a severe injury.
4. Missing person who has been reported to the police.
5. Fire caused by the individual that required emergency response or involving a severe injury.
6. Police arrest of the individual.
7. Victim of Aggravated Assault or Forcible Rape.

DDS Procedure No. I.D.PR.009 (revised 2014).

[31] Per a congressional request, the Inspector General extended its audit of Connecticut's compliance with HCBS waiver requirements to Maine and Massachusetts.

[32] The Inspector General found:

> [Connecticut] [g]roup homes did not report to DDS all critical incidents involving developmentally disabled Medicaid beneficiaries. Specifically, of the 310-emergency room visits by 245 developmentally disabled Medicaid beneficiaries, 176 visits met DDS's definition in effect at the time of a critical incident because they included a severe injury However, CLAs did not report 24 (14 percent) of the critical incidents to DDS.

> DDS and CLAs lacked adequate training to correctly identify and report critical incidents and reasonable suspicions of abuse and neglect, DDS staff did not always follow procedures, DDS staff lacked access to Medicaid claims data, and DDS did not establish clear definitions and examples of potential abuse or neglect.

The Inspector General recommended multiple steps to remedy the systems concerns:

> [DSS should] work with DDS to develop and provide training for staff of DDS and CLAs on how to identify and report critical incidents and reasonable suspicions of abuse or neglect, … and work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported.
>
> [DSS should] work with DDS to develop a data-exchange agreement and related analytical procedures to ensure DDS access to the Medicaid claims data contained in Connecticut's Medicaid Management Information System to detect unreported and unrecorded critical incidents, … coordinate with DDS and [Office of Protection and Advocacy] to ensure that any potential cases of abuse or neglect that are identified as a result of new analytical procedures are investigated as needed.[33]

In 2018, the Inspector General issued a joint advisory with the Administration for Community Living, and the U.S. Department of Health and Human Services' Office for Civil Rights outlining best practices for ensuring Medicaid beneficiaries' health and safety in community CLAs.[34]

In communications and meetings with OCA, administrators from DDS and DSS outlined multiple steps the agencies have taken to implement the Inspector General's recommendations, including new policies and trainings for DDS staff and providers and a new software system that allows DDS to access state Medicaid claims to detect potentially unreported critical incidents involving DDS clients. Acknowledging the importance of these improvements, OCA's recent case investigation and subsequent systemic review raised concerns regarding continuing system gaps in ensuring safe and appropriate care of disabled individuals, the lack of a framework for public transparency and accountability regarding system improvement, and whether current resources are adequate to ensure oversight and provision of safe and high-quality care of vulnerable children and adults.

IV. OCA'S INDIVIDUAL CASE FINDINGS

> Individuals involved in the critical incident:
>
> *About the young woman (Jane[35])*
>
> Jane is a young woman with intellectual and other developmental disabilities. She uses a wheelchair for mobility and needs assistance with all tasks of daily living. She is

[33] The Inspector General report at *iii.*

[34] US Department of Health and Human Services Office of the Inspector General, Administration for Community Living, and Office for Civil Rights: Ensuring Beneficiary Health and Safety and Group Homes through State Implementation of Comprehensive Compliance Oversight (January 2018) found on the web at: https://oig.hhs.gov/reports-and-publications/featured-topics/group-homes/group-homes-joint-report.pdf

[35] Pseudonym.

described in DDS records as a happy person who loves to interact with her family and CLA staff, enjoys social activities, including games, helping in the kitchen, and music. She is non-verbal. Jane lived in her CLA for several years prior to the incidents in September and October 2021.

About the boy, (John[36])

John is described in state records as a boy who often presents with a smile. He enjoys going out into the community with staff and is very helpful with chores around the house. John had been committed to DCF custody for several years and had been living in the CLA for almost 4 years prior to the critical incident. John was diagnosed at a young age with Intellectual Disability and Autism. He is described as primarily non-verbal. John was reported to have limited social skills but enjoys helping teachers and other adults in his school building.

October 2021, Critical Incident Occurs—No timely report made by CLA/Provider to DDS or DCF

On October 8, 2021, an incident occurred at a DDS licensed CLA, which incident involved two individual residents of the CLA: a 17-year-old boy, John, committed to DCF, and a young adult woman, Jane, a DDS consumer. While information about the incident was shared by the provider with various individuals at DCF/DDS, the incident was not timely reported as a critical incident or concern of abuse/neglect by the CLA or its community provider agency as required by state law.

A week later, on October 15, 2021, the young woman's family made a formal report to DDS[37] reporting the incident -- a teenage boy in the CLA was found naked on top of their daughter in her bedroom. The young woman's family stated that they were told that this was not the first time the boy had gone into their daughter's room, though no previous incident reports were made to DDS or to the family.

While CLA staff and administrators did not timely report either incident to DDS or DCF as a critical incident/concern of abuse or neglect, staff did call local police on the night of the October 8, 2021, incident and the young woman was transported to the hospital. OCA was later contacted by a first responder alleging concerns about the incident and the supervision of both the boy and young woman, including that there had been multiple incidents involving the boy that had not been properly reported to DDS or DCF. Law enforcement made a timely report to the DCF Careline regarding suspected abuse/neglect by CLA staff, alleging negligent supervision of the minor child.

DDS initially assigned the incident for self-investigation by the Community Provider

Once reported as a critical incident involving suspected abuse/neglect of a DDS client, the case investigation was initially assigned by the DDS regional office to the community provider's internal investigator for self-investigation. After the OCA wrote to DDS leadership of the critical incident, the

[36] Pseudonym.

[37] The young woman's mother reported that she had had conversations with administrators at the Community Provider the week prior about the incident, but after not hearing back… [she] called the complaint into DDS herself.

DDS Deputy Commissioner shifted primary investigative responsibility to DDS's Division of Investigation.[38]

OCA later learned that most investigations of suspected abuse/neglect of an intellectually disabled individual are handled internally by the community provider agencies who self-investigate concerns pursuant to DDS-established standards and report the outcome back to the state. DDS administrators told OCA that they do not have enough staff to independently investigate all claims of abuse and neglect of persons with intellectual disabilities.

DCF commenced a separate investigation into allegations of physical neglect of the minor child by CLA staff. Per the DDS record, these investigations were "coordinated."

CLA/Community Provider Records Document John's Significant Behavioral Support Needs

CLA records dating back several years contain information about John's needs and history of sexually reactive behavior. A behavioral support plan developed by the community provider's assigned behaviorist as early as 2018 included information that John had a history of sexually reactive behavior prior to coming to the CLA, including in his biological family's home and a DCF foster home. His CLA Behavior Plan stated that John's "level of supervision is line of sight while in the residence" and that he "should never be in the home alone with one female staff." CLA staff reported that this information was known to staff shortly after the child's arrival in the home. The provider reported to OCA that they did not have complete information about John's needs prior to his placement.

Multiple Incidents in the CLA Went Unreported in 2021

DDS investigators learned that in August 2021, John was observed "trying to go into another participant's room with only his underwear on. Staff immediately intervened." In September 2021, a CLA record indicates that in the middle of the night John ran into the young woman's room and "attempted to climb in [her] bed." Staff discovered him and redirected him back to his own room. The young woman's parents were not notified.

CLA/Community Provider Lacked Clear Supervision Guidelines

DDS investigators found that John's behaviors escalated and, prior to the September and October 2021 incidents, investigators found that CLA staff were unsure and unsupported in how to respond. Given the lack of clear documentation in John's records, DDS investigators ultimately concluded that it was "not possible to confirm that any action was taken to mitigate John's behavior."

DDS found that due to the provider not having "a clear and consistent definition of the various levels of supervision required for individuals' needs," and inadequate work by the community provider's assigned behaviorist, that John's need for individual supervision was not well defined and that his Behavioral Support Plan did not match supervision expectations.[39]

[38] The re-assignment of the investigation to DDS followed a communication from OCA to DDS leadership alerting them to the critical incident at the CLA.

[39] Multiple CLA staff stated that from 2018 to 2020 John had 1:1 supervision, however sometime in 2020, early 2021, he had a lesser level of supervision (shared staff) due to a "decrease in behavior." Another staff member stated that John's staffing level was changed because "there was no funding for a 1:1." It was unclear to DDS

John Did Not Receive Education/Treatment for His Sexual Health and Behavior

While John's level of supervision changed over the years, there is little documentation in the DDS or DCF records regarding the education and services he received for his sexual health and development during his teenage years.

The CLA's assigned behaviorist reported to DDS investigators that she had been seeking an evaluation for John but had not obtained an appointment for him. DDS investigators noted that the behaviorist had no records or documentation regarding the activities she reportedly undertook on John's behalf. DDS investigators questioned why she had no notes regarding her client or her activities, and her response was, "'I wasn't trained here to do that.'" Her supervisor, the community provider's Director of Behavioral Services, acknowledged that there is no provider expectation that behaviorists maintain client case notes. DDS investigators found that the behaviorist had, in fact, copied previous records on the child from another behaviorist and changed the dates,[40] raising concerns for investigators about the reliability and integrity of the child's support plan.

The provider's Director of Behavioral Services stated that he too consulted on John's case multiple times after the September 2021 incident, though he also had no notes or documentation regarding this consultation. He stated that he sent the behaviorist and CLA program director a message in September asking if John "**needed an increase in his level of supervision**," but that he received no response. He stated that he did not follow up to ensure that the level of supervision was addressed but that he had assumed it would be. He had also suggested, in writing, to CLA staff that John may need to be moved to another CLA given him "ramping up sexually." Only after the second incident in October 2021, did he learn that "**nothing had been done.**"

DDS records reflect investigators' dismay at the absence of documentation and case notes regarding John. Investigators noted that the child's assigned behaviorist was responsible for 10 CLAs and 60 developmentally disabled clients. Her supervisor was "ultimately responsible for all individuals" served by the community agency. DDS concluded that "without documentation, it is not possible to accurately recall all details necessary of the multiple individuals' needs." The failure to maintain a "standard system to document all issues regarding participants" was found by DDS investigators to be a serious program deficiency.[41] Upon review of OCA's draft findings, the community provider emphasized the need for adequate resources to support high quality service delivery and supervision.

DCF's case plan records for John (DCF case plans are updated every six months per state and federal requirements) reflect a dearth of information regarding John's intensive behavioral support and

staff investigating the October 2021 incident why the staff supervision was titrated down as documents throughout 2020 indicated that John still struggled with sexually reactive and impulsive behaviors and that it was often difficult for staff to re-direct him. His 2021 Behavior Support Plan, a CLA document, continued to list John as having periodic aggression, impulsivity, and inappropriate boundaries and sexual interactions.

[40] OCA obtained the behaviorist's personnel record from DCF, where she previously worked for over 10 years. This record indicated that the behaviorist was involuntarily separated from employment at DCF due to concerns about her work. While an agreement was made at the time that the employee would not be fired, she applied for and was denied state unemployment benefits due to the Department of Labor's finding that she was, for all practical purposes, terminated for cause by DCF.

[41] OCA queries whether this should be or was a contract expectation and how DDS fiscal managers review such expectations in their compliance audits.

treatment needs prior to October 2021. There is no documentation in the treatment records that a plan for John's basic sexual health and adolescent development were independently developed and discussed with the CLA and school staff. The records repeatedly document that DDS CLA staff were "working with John on establishing boundaries and personal space," and that John was redirected by having "alone time in his room" and "verbally processing" with staff.[42] His DCF treatment plan review from March 2021 does state that John receives "comprehensive services" in his CLA, including "behavioral health management and medication management, 24-hour supervision, life skills, recreational activities," and that he had maintained "stability" in recent months. The DCF plan reviewer emphasized that DCF case managers should "ensure reports from the CLA are provided and documented" in the case record. There is no follow up in the DCF treatment plan regarding an earlier recommendation for John to get involved with a "social skills group and other activities that focus on children with autism." The section of John's DCF treatment plan dedicated to adolescent supports for children aged 13 and over reads identically from one plan to the next over multiple years.

Overall, DCF treatment plan records contain few specifics regarding John's behavioral support needs and the assessments and interventions brought to bear to ensure his healthy development.

DDS and DCF investigators both found that on the night of October 8, 2021, no staff were supervising John or the young woman.

Both DCF and DDS investigators found that there was no 1:1 supervision for either client on the night of October 8, 2021, and that in fact, staff had no line of sight for John at the time of the incident. It was not until a staff member physically opened the young woman's bedroom door that John was found naked on top of her.

As one staff member later reported to DDS:

> In my opinion I feel that we as an agency failed both John and Jane. Had he still had 1:1 staffing this incident would not have occurred because he would not have been left alone.

DDS Substantiated the CLA for Programmatic Neglect—Issued Recommendations and Expectations for Improvement

DDS substantiated the CLA/community provider for programmatic neglect. The behaviorist, her supervisor, and the CLA program director were all individually substantiated for neglect. DDS investigators issued several recommendations for program improvements to address individual and systemic concerns, including:

1. Provider will create and implement a format used to determine the Level of Supervision for each individual that includes clear definitions to ensure consistency throughout the agency and

[42] A DCF treatment plan document from 2019 states that there is a behavior support plan for John to have "line of sight [supervision]" in the CLA, and that he cannot be alone with female staff. An updated treatment plan in 2020 again states that CLA staff were "working with John on establishing boundaries and personal space." A final treatment plan before the October 2021 critical incident states that John "had a positive year from a behavior perspective … [and] attained the goal of engaging in targeting behaviors less than an average of 5 times per month," and had "adjusted to the structure of the CLA." Targeted behaviors were not defined.

all applicable staff will be trained on the new format, the definitions, and requirements within 30 days.
2. All relevant staff in Community Programs will document all correspondence involved in an Individual's care in the electronic health record. Provider will ensure all TEAM members have been trained on the procedure within 30 days.
3. All Behavior Support Plans, and other relevant documentation, created by John's assigned BEHAVIORIST must be independently reviewed for accuracy and appropriateness.
4. All staff substantiated for neglect will be disciplined per agency policy and procedure for their part in failing to ensure proper care, coverage, and vigilance for both John and the young woman.
5. The CLA will ensure that a DDS incident report form will be completed for all required events and guardians will be notified of all events.

DCF Substantiated Individual Staff for Neglect of the Minor Child—Documented Program Concerns

Concurrently, DCF investigators substantiated multiple staff at the CLA for neglect. DCF investigators found that "[t]here was inadequate supervision given John's age and cognitive ability, staff were aware of John's sexual behaviors. Both staff were eating dinner with no line of sight of bedrooms, leaving John alone for approximately 30 minutes, providing him an opportunity to enter Jane's bedroom and attempt to sexually assault her." Similar to DDS, DCF also identified "program concerns:"[43]

1. There needs to be a written policy manual at the CLA readily available for staff with definitions as to what general supervision, Line of Sight, 1:1 and continuous supervision is.
2. There is insufficient documentation pertaining to John's Behavior Support Plan by the Community Provider and his Supervision Guidelines
3. There was inconsistency with CLA staff knowing John's supervision.
4. CLA staff failed to notify the legal guardian and DCF Careline when John entered M's room the first time. CLA staff failed to communicate with the school regarding K's sexual behaviors at the CLA.

There is no documentation in the DCF record as to how these program concerns would be disseminated and addressed and by which agency.

Parents Received Scant Information from Agencies

[43] There is no state law governing either DDS or DCF's practice regarding the identification of program concerns, or in DDS's case, programmatic neglect. Each agency has developed either a policy or a practice of having investigators document programmatic concerns that investigators find affect children or residents' safety and wellbeing. Program concerns typically speak to staffing, supervision, infrastructure, or training. DDS policy authorizes investigators to substantiate a provider for programmatic neglect. DCF's practice is to allow investigators discretion in documenting program concerns notwithstanding any determination to substantiate or unsubstantiate the underlying finding of individual abuse/neglect. OCA explores this issue in more depth in Part II of this Report.

OCA found that the young woman's parents were not informed about safety incidents as they occurred and were not briefed on DDS or DCF's investigation and program concerns/findings.

Community Provider Reports Receiving Scant Information from Either DCF or DDS

The Community Provider whose CLA was implicated in the critical incident reported to OCA that it did not receive timely or complete information from either DCF or DDS. The provider did not receive a copy of DCF's completed investigation until after OCA inquired several months later. The provider also stated that it did not receive a completed DDS investigation and was denied information regarding staff statements to DDS investigators. The provider expressed concerns as to how long it took to find a separate placement for John after the incident and noted that John and Mary were maintained for more than a week in separate areas of the group home.

Inadequate Licensing Oversight for this CLA by DDS and A Previous Unreported Critical Incident in 2019.

At the conclusion of the DDS and DCF concurrent investigations regarding the October 2021 incident, OCA requested from DDS all documented regulatory and investigative activities as well as any corrective actions and documented oversight during the past three years. OCA sought to review how regulatory and/or investigative findings, including programmatic findings and recommendations, are timely implemented and supervised by DDS.

DDS's record contained a copy of its 2021-22 investigation and the required corrective actions as well as a concurrent licensing inspection report/violations, and a list of required corrective actions. However, despite DDS policy and state assurances (embedded in the state's HCBS Medicaid waiver) that DDS staff conduct prompt revisits to verify corrective actions, the file provided to OCA contained no such documentation.[44]

OCA followed up with DDS to see whether other responsive documents existed. In August 2022, ten months after the critical incident, DDS provided OCA a revised copy of its investigation report, which was supplemented to include handwritten dates next to various corrective action items, ranging from shortly after the October 2021 incident to July 2022, purportedly marking completion of various activities. DDS told OCA that these dates were filled in by the community provider following OCA's request for additional information. The DDS file still did not contain any supporting documentation from the provider or DDS, such as a follow up visit by DDS licensing, contract management or investigative staff to verify that concerns had been sustainably remedied as required by agency policy and federal Medicaid law.

OCA also learned that the same CLA was cited by DDS licensing staff in November 2021 for an unreported critical event that occurred two years prior and had resulted in a life-threatening incident

[44] The file included a copy of the DDS investigation findings and recommendations, and an explicit direction that the DDS recommendation boxes be "checked" by the provider if they were completed and that the date of completion should be included. On the documents that DDS gave OCA, these boxes were blank. The DDS investigation record provided to OCA also included a section to be completed by the community provider that indicates that the provider either "approve[s] the investigation report," or "disagree[s] with the findings for the following reasons," and the form states that the provider should explain how individual employees identified in the investigation report were addressed and disciplined. Again, the file provided to OCA by DDS was blank in all areas and the section remained unsigned.

and hospitalization of a resident. Upon detection by DDS licensing staff after the 2022 incident, the CLA was cited for multiple regulatory violations, including concerns about documentation, failure to report the incident as required, and a lack of supervision for the client that resulted in the dangerous ingestion and aspirational pneumonia. Although the DDS licensing staff required additional corrective actions from the provider, the record given to OCA contained no documentation of DDS regulatory follow up. Additionally, despite the licensing staff's directive that the incident be belatedly investigated by DDS staff, DDS was unable to produce a record indicating that the incident had in fact been investigated.[45] Upon inquiry from OCA, DDS responded that when it conducted a subsequent licensing revisit in November 2022—12 months later— "DDS cited the provider for not following the Plan of Correction for this incident."

In discussion with OCA, DDS central office administrators were not able to explain the reasons for the lack of documentation in the provider's record, stating that many follow up activities are delegated to the DDS regional offices. One DDS administrator acknowledged that it was concerning how long it took DDS to put together responsive documentation for the OCA, and s/he stated that resource pressures and staff constraints in the DDS regional offices have likely impacted the agency's ability to follow up with its contracted providers and CLA staff as frequently as they may have done in the past.

John did not have a DDS-assigned case manager.

When a child is placed in a DDS licensed setting by DCF, the child is typically not provided a DDS case manager. Providers have spoken to OCA about the need for youth to be assigned case managers to ensure that direct care and service planning is well coordinated and overseen by individuals knowledgeable about DDS services and the needs of children and adults with disabilities. DDS administrators separately stated to OCA that the agency's case managers play a vital day-to-day quality assurance role in ensuring safe and appropriate care.

State Records Reflect that John was Regularly Visited (Virtually and in-Person) by his State Appointed Lawyer, but do not Reflect That the Lawyer Participated in DCF Treatment Plan Meetings or Requested Records from DCF or DDS

Like other children under DCF supervision/guardianship, John was assigned a lawyer to represent him and advocate for him. Lawyers for children and indigent parents are appointed by the Office of the Chief Public Defender (OCPD). Federal law requires that states ensure children in child protection proceedings are represented by an individual who may be a lawyer and who obtains a "first-hand, clear understanding of the situation and needs of the child."[46] State law codifies this provision by requiring the appointment of "counsel knowledgeable about representing such children," and who shall be "granted immediate access to (i) records relating to the child, including, but not limited to, Department of Social Services records and medical, mental health and substance abuse treatment, law enforcement

[45] Administrators also noted that Covid-19 resulted in restrictions on home visits to DDS licensed community providers. OCA finds however, that the regulatory and investigative records maintained by DDS with regard to this CLA reflect limited to no documented follow up on the safety and wellbeing of residents, whether conducted virtually or through records review between December 2019 (the date of the inspection) and October 2021, the date of the incident that is the subject of this review.

[46] Child Abuse Prevention and Treatment Act, 42 U.S.C. 5106a(b)(2)(B)(xiii).

and educational records without the necessity of securing further releases, and (ii) the child, for the purpose of consulting with the child privately."[47]

The OCPD Performance Guidelines for Counsel for Children, referenced in the state contracts for assigned counsel, provide that lawyers will obtain records, consult with service providers, visit often with the child, and assess whether the child is receiving the supports and services they need.[48] The Guidelines advise lawyers for children to "interview the caregiver and other family members or staff in any placement," "independently consult with service providers to assess the child's progress and well-being and to determine if additional services are needed," and regularly "obtain records from the child's medical, educational, and childcare providers to assess the development and well-being of the child client."[49] OCPD contracts for pre-service and in-service training of lawyers representing children, covering a range of topics pertinent to the representation of children and adult clients.

The OCPD monitors lawyers' performance in part through an internal review of billing codes. Lawyers have been paid a combination of flat fee (most recently $500 per case for the life of the case) and hourly billing ($65 per hour during the period relevant to this review)[50] for a set number of activities such as visits with the child client, participation in children's treatment plan meetings, and trial time.

A review of billing records sought by the OCA indicates that John's lawyer conducted several virtual and in-person visits with him in 2020 and 2021. The records do not reflect that John's lawyer billed for participation in any of John's DCF treatment plan review meetings during this period. DCF records do not indicate that the lawyer was provided notice of treatment plan meetings, though all DCF involved clients have these meetings every six months. John's lawyer did not request records from DCF or DDS while representing John. Given John's disability and communication impairment, his attorney's lack of participation in case planning and failure to obtain records may run afoul of ethical obligations contained in the Rules of Professional Responsibility, particularly those that require lawyers to provide "competent representation"[51] and take "protective action" on behalf of a client with diminished capacity when necessary to prevent harm to the client.[52]

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[47] Connecticut General Statute Section 46b-129a.

[48] OCPD Performance Guidelines for Lawyers https://portal.ct.gov/-/media/OCPD/Forms/Assigned-Counsel/CT_Performance_Standards_For_Counsel_In_Child_Protection_Matters_-Rev_1-2017.pdf

[49] Id.

[50] The June 2023 state budget provides additional resources to the OCPD to support increased rates for assigned counsel, including counsel for children. New contracts issued for the 2023-24 fiscal year have higher rates for assigned counsel.

[51] Rule 1.1 of the Connecticut Rules of Professional Conduct provide that "a lawyer shall provide competent representation to a client. Competent representation requires the legal knowledge, skill, thoroughness, and preparation reasonably necessary for the representation." The Commentary to Rule 1.1 provides, in part, "Competent handling of a particular matter includes inquiry into and analysis of the factual and legal elements of the problem, and use of methods and procedures meeting the standards of competent practitioners. It also includes adequate preparation."

[52] Rule 1.14 of the Connecticut Rules of Professional Responsibility provides, in part: "Client with Impaired Capacity (Amended June 26, 2006, to take effect Jan. 1, 2007; amended June 30, 2008, to take effect Jan. 1, 2009.) (a) When a client's capacity to make or communicate adequately considered decisions in connection with a representation is impaired, whether because of minority, mental impairment or for some other reason, the lawyer shall, as far as reasonably possible, maintain a normal client-lawyer relationship with the client. (b) When

From a systems perspective, while lack of adequate payment does not relieve any lawyer from their ethical obligations, OCA notes that compensation for lawyers representing children in these cases has been stagnant, and the fee schedule heretofore in use has not allowed lawyers to bill for several expectations codified in state law or contained in the OCPD Performance Guidelines, including acquiring and reviewing records, consulting with treatment providers, calling state or local agency providers, or convening with providers or case managers to address unexpected issues or concerns. These activities are particularly critical for children who have complex treatment and developmental needs, and/or children who cannot effectively communicate. John's case, like many other children who remain in DCF care without achieving "permanency" (i.e.., reunification with a parent/family member, or adoption) went on for several years without an adequate reimbursement structure for ensuring ongoing quality representation. The OCPD has sought significant additional funding from the state to support recruitment and retention of lawyers for children in child protection proceedings, citing the challenges in maintaining an adequate system of legal service delivery for this highly vulnerable population of children. The recently approved state budget increases funding for OCPD "assigned counsel" to address this concern. It will be important for policy makers to ensure that children have well trained and effective counsel to represent them in these sensitive proceedings.

OCPD administrators reported to OCA that they conduct regular audits to assess assigned counsel's compliance with certain Performance Guidelines, particularly visits with children.[53] OCPD also conducts informal observations of contract attorneys' in-court performance, where possible. If observations raise concerns or if attorneys are not billing for activities in which they should be engaging, like visiting clients, OCPD staff meet with lawyers who are not meeting standards, and may put them on an improvement plan, or in some cases, will terminate or not renew a contract.

OCPD reported to OCA that it does not have an adequate number of assigned counsel for children, as recruitment and retention of lawyers has become increasingly difficult due to the compensation structure in place prior to the newly passed budget. Additionally, there are no current caseload standards. OCPD does not have the ability to track when cases close, as that occurs through the court process. Given the nature of independent contractor work, OCPD also does not have information about the amount of non-contract legal work an assigned counsel must also be handling, creating additional difficulties in setting caseload/workload standards of expectations. OCPD hopes that recent and additional infusions of resources into this system will improve recruitment and retention of counsel for children and support consistent quality legal representation.

V. SYSTEM FINDINGS—DDS OVERSIGHT OF COMMUNITY LIVING ARRANGEMENTS

the lawyer reasonably believes that the client is unable to make or communicate adequately considered decisions, is likely to suffer substantial physical, financial or other harm unless action is taken and cannot adequately act in the client's own interest, the lawyer may take reasonably necessary protective action, including consulting with individuals or entities that have the ability to take action to protect the client and, in appropriate cases, seeking the appointment of a legal representative."

[53] Audits involve a review of billing information but do not include any qualitative file review. This kind of review would not provide OCPD with information regarding non-billable activities, like contacting the child's pediatrician, talking to the child's school, or requesting and reviewing DCF or other relevant records.

Given the findings above and the 2016 U.S. Inspector General report, OCA undertook a systemic review to examine aspects of the state's current framework for supporting and overseeing safe care in DDS CLAs, including how DDS and DSS implemented the Inspector General's corrective recommendations. Because the CLA here included two DCF-involved residents, one minor child and one young adult, OCA also examined how DCF staff are trained to assess the safety and care of developmentally disabled children in group settings, whether DCF or DDS licensed.

DSS and DDS Have Made Progress on Inspector General Recommendations, but Unreported Critical Incidents and Follow-up Remain a Concern

OCA requested information from DDS regarding its responsive activities over the last several years to the 2016 Inspector General audit. DDS previously reported to OCA[54] that it had taken multiple steps to follow up on the federal audit recommendations:

> DDS updated Abuse and Neglect procedures, revised Abuse and Neglect trainings, and tightened provider requirements around Abuse and Neglect curricula and training requirements. Part of this work was to more specifically address examples of abuse/neglect to ensure that staff are appropriately identifying instances and understanding how/when to report them.
>
> DDS also revised our Abuse and Neglect Curriculum for DDS Qualified Providers. The curriculum is updated regularly to report up-to-date statistics and examples for discussion. The Critical Incident area describes examples of what is considered a critical example, who & how to immediately report and how to fill out the form properly. All new Qualified Providers must submit all core training curricula, including Abuse, Neglect Prevention training to the DDS Operations Center [for approval]…. DDS recently implemented a review process in which qualified providers are required to attest to and provide documentation of completing the training requirements for all staff. Specific to the training regarding abuse and neglect reporting prevention, the policy requires this training to be completed within six months of hire and annually thereafter. As part of the annual quality review with regional resource administration, the qualified provider must attest to all staff completing such trainings within the timeframes allotted.

DDS and DSS described for OCA the implementation of the State's new Pulselight program, software that allows DDS to utilize the state's Medicaid claims database to discern potentially unreported critical incidents involving DDS clients that resulted in a Medicaid claim for treatment. DDS reported that it assigns follow up to each detected report, whether by a DDS-nurse consultant or a DDS case manager. Where the incident involves an assault, sexual assault, fracture, or head injury, the incident report is also assigned to a DDS abuse/neglect investigator for follow up.[55]

[54] In the context of an OCA fatality investigation involving a DCF client living in a foster home previously licensed by DDS.

[55] Correspondence from DDS Chief of Staff, Sept. 30, 2022, on file with OCA.

DDS reported to OCA that between February and December 2021, Pulselight detected between **10 and 12 potentially unreported critical incidents every month**.[56] Though DDS stated that approximately 30 percent of these incidents were determined to be routine or expected medical care for the individual, DDS was unable to provide a breakdown of the unreported critical incidents—e.g., how many were injuries, accidents, etc.[57] For context, DDS data also indicates that there were a total of 301 critical incidents reported or detected in 2021—indicating that up to a third were not timely reported. Additionally, DDS reported to OCA that it issued more than 100 regulatory citations for "failure to report" an incident (both critical and non-critical) over a recent 3 year period (2019 and 2022).

DDS's May 2021 progress report to the Inspector General stated that "the DDS Director of investigations and the [Abuse Investigation Division] Lead investigator participate in a monthly Statewide Critical Incident Review Committee that analyzes Medicaid medical claims data through Pulselight to determine if further investigation is warranted."[58] DDS wrote that its "Director of Investigations and Regional Lead investigators review all critical incidents to determine if there is potential abuse and neglect which then warrants further investigation."[59] However, DDS was not able to confirm for OCA how many of the Pulselight detected incidents in 2021 were followed up on by abuse/neglect investigators. DDS was also not able to say how many of the detected incidents led to regulatory or investigative findings of neglect, nor was DDS able to report to OCA how many incidents from 2021 resulted in a corrective action for a community provider.

DDS explained that the purpose of the Pulselight software, still in a development phase, is to catch unreported incidents and "direct them back to the reporting flow." Yet it is unclear how DDS and DSS audit the impact of the Pulselight program without a centralized analysis of the trends and nature of incidents that are both reported and unreported, and without clear information as to what regulatory and investigative findings, as well as corrective actions, ensued.

DDS and DSS also reported to OCA that a new audit by the federal Inspector General is underway, with an anticipated completion date in 2023.

Resources Constrain Agency's Ability to Investigate and Regulate Providers Where Concerns Have Been Alleged or Identified

Multiple DDS administrators reported to OCA that due to resource limitations, the agency relies on community providers to not only report incidents that are suspicious of abuse or neglect but to also self-investigate such allegations, even where the matter may include a critical incident.[60] In 2021 there were 405 investigations into abuse/neglect completed by DDS and there were 1,726 investigations

[56] DDS stated that some incidents may have been properly reported by a community provider but were not captured as "matched" by Pulselight due to the incident having been reported late, or an incident report not having been filed or correctly submitted.
[57] Earlier data requested by OCA was not yet available at the time of this draft report.
[58] May 2021 DDS Progress Report to OIG, "DDS OIG Audit Recommendations Update," provided by DDS to OCA. On file with OCA.
[59] Id. at 3.
[60] The critical incident from October 2021 was initially assigned by DDS to the community provider for self-investigation.

completed by private providers (and reviewed by DDS staff). These investigations led to 1,819 substantiations of neglect.

Concerns Regarding Adequacy of Licensing and Regulatory Oversight of CLAs

State regulation requires that DDS conduct one licensing visit every two years. State statute requires that for "community living arrangements," the DDS commissioner "shall determine a minimum number of licensure visits that are unannounced."[61] However, DDS administrators told OCA that in practice, regular licensing visits are typically announced. The default practice of conducting announced licensing visits every two years differs from the more frequent inspection practices of the Office of Early Childhood and DCF.[62]

Additionally, DDS rarely conducts a prompt licensing re-visit after regulatory violations are found, even where serious deficiencies are noted. Multiple DDS administrators reported to OCA that timely revisits are not routinely conducted due to resource constraints. OCA was told that given these constraints DDS regulators use discretion to determine whether to conduct a revisit to a particular CLA. OCA was told that regulators subject approximately a 20 percent sample of the state licensed CLAs across the state to a "revisit" during each two-year license period. It was not clear what criteria are used to support and guide the exercise of this discretion.

To further assess this issue, OCA reviewed the licensing inspection histories of approximately 150 DDS licensed CLAs[63] across the state on the state's E-License database for the 5-year period following the U.S. Inspector General audit (2017 to 2022), approximately a 20 percent sample. OCA examined the frequency of inspections, the frequency of significant regulatory citations, and the percentage of cited homes that were promptly re-visited to verify a change in condition and completion of corrective actions. The state's E-License database—a public-facing clearinghouse of various professionals and facilities licensed by the state-- includes the regulatory citation but does not include any underlying facts or the specifics of directed corrective actions. Therefore, OCA looked for whether a CLA was issued citation/s for "failure to report harm" or failure to have a "system" for reporting incidents for investigation.[64]

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[61] Connecticut General Statute Section 17a-227(b).

[62] This policy differs from the practices of the Office of Early Childhood and the Department of Children and Families. The OEC is statutorily required to conduct a minimum of one unannounced licensing and inspection visit every year,[62] and DCF conducts at least four program visits every year, though they are not full licensing inspections.[62] Notably, in 2013 Connecticut was the subject of serious findings by federal auditors[62] for failure to adequately monitor and ensure safe environments in state-licensed child care programs, regulated by the Department of Public Health during the review period. Legislators and the newly created Office of Early Childhood made numerous systemic changes to improve oversight, transparency, and accountability for state-licensed childcare programs.

[63] OCA reviewed licensing histories found in alphabetic order on the E-License database.

[64] Connecticut State Agencies Regulation Section 17a-227-15. Special protections

(a) Human Rights

Policies and procedures shall be in place which:

(1) ensure that each individual, parent, legal guardian or advocate is fully informed of the individual's rights and of all rules and regulations governing individual conduct and responsibilities;

(2) assure confidential treatment of all information concerning individuals;

OCA's review of the 150 licensing visit histories corresponding to CLAs throughout the state found:

- Approximately 1/3 of the sampled CLAs (n=49)were cited for violation of Regulation 17a-227-15(a)4b or 15(a)4d during the period of review, indicating either a failure to report harm or the failure to have a system for reporting incidents;
- Following the citation, 2/49 CLAs were revisited by DDS licensing staff within 30 days;
- 7/49 CLAs were revisited by DDS licensing staff within 12 months;
- More than half of the CLAs, 29/49 were not revisited by DDS licensing staff for at least 2 years.

The above data reflects that 95% of CLAs in the sample that were found to have violated state regulations regarding "having a system for reporting alleged violations," and/or "ensuring that all incidents, injuries, restraints, serious accidents and deaths are reported in a timely fashion" were not revisited by licensing staff within 30 days to ensure corrective actions had been implemented. Less than 20% of the homes were revisited within 12 months.

OCA requested more detailed licensing information from DDS on a small sample of CLAs that appeared to have very serious and lengthy histories of regulatory violations to learn more about the facts surrounding the violations and DDS's follow-up regulatory actions. OCA's review of the records confirmed that the homes were cited for serious safety concerns, were not timely revisited by licensing staff, and were cited for failure to implement required corrective actions—issues that should have been timely detected and remedied.

CLA 1

- September 2018. Licensing visit. Record references an investigation that substantiated neglect for Individual 1. Licensing staff directed the provider to retrain staff, review the individual's care plan, and discipline staff.
- September 2019. Licensing visit. Citation issued. "**Documentation of evidence was lacking from the record to verify that the [previous] recommendations were implemented**." Several other regulatory violations noted.
- September 2021. First return licensing visit.

CLA 2

(3) provide for the safekeeping and accountability of individuals' personal property;

(4) comply with Sec. 17a-238 CGS and the regulations promulgated thereunder, concerning the rights of individuals under the supervision of the commissioner of mental retardation and which:

(A) prohibit mistreatment, neglect or abuse of individuals;

(B) include a system for reporting alleged violations, carrying out investigations in accordance with Sections 17a-101, 17a-430 and 46a-11 CGS, and instituting appropriate sanctions if the allegation is substantiated;

(C) are formulated with individual participation where appropriate; and

(D) ensure that all incidents, injuries, restraints, serious accidents and deaths are reported in a timely fashion.

- May 2017. Licensing visit. **Citation issued for failure to implement a previous Plan of Correction**. Unannounced visit due to concerns. Citation issued for multiple medication errors and failure to report the medication errors as required by DDS Policies on incident reporting. Additional violations for medication errors, health plan deficiencies, failure to obtain a wheelchair for a client, and failure to monitor an individual's vital signs as required.
- June 2018. Licensing revisit. CLA **cited for failure to implement previous Plan of Correction**. Concern regarding residents not being able to participate in community activities due to presence of "temporary staff." Concerns regarding commingling of individual and agency funds and failure to account for expenditure of clients' money. Concern that Plan of Correction previously issued was not implemented.
- June 2019. Licensing revisit. Multiple violations noted.
- June 2021. Licensing revisit. Multiple violations noted.

CLA 3

- 2017. License visit. Citation for violation of mandated reporting. "In review of documentation, evidence of completion of DDS critical incident forms for emergency room visits on [multiple occasions] were lacking." Several other citations issued for lack of documentation regarding review of behavior modifying medications/restraints/aversive procedures; lack of documentation regarding behavior support plan/s; medication administration issues. Failure to document that previous programmatic recommendations arising from sexual abuse/physical abuse of individual were actually implemented. **New corrective action required**.
- September 2018. Licensing visit. **Citation for failure to implement previous Plan of Correction**. Cited for violation of Conn. State Agencies Reg. Section 17a-227-15(a)(4)d for failure to create a report regarding individual's fractured finger. Cited for violation of 15a-4d for failure to report Emergency Department visit for another individual who had an "unwitnessed fall" despite requirement for 1:1 supervision. Licensing staff reported incident for abuse/neglect investigation. Multiple other citations for medication administration concerns and lack of nursing reviews.
- October 2019. Licensing visit. Citation for violation of 15a-4d. "In review of documentation, substantiated neglect occurred on February 17, 2019, for Individual 2. This inspector requested documentation regarding the recommendations and follow-up from this investigation; however, the requested information was not received. As a result **evidence was lacking to verify the implementation of any programmatic recommendations for the outcome of this investigation**… Going forward follow up for recommendations will be kept with investigation reports. In addition, Agency investigator will keep an electronic file with documentation that all recommendations are completed within thirty days of investigation completions."
- November 2021. Next visit by licensing. M**ultiple citations issued regarding failure to implement required training**; lack of documentation to verify monthly monitoring of "aversive procedures;" inadequate provision of medical services.

CLA 4

- September 2017. Licensing visit. Multiple regulatory citations for failure to have an individual care plan in case of emergency; failure to have policies and procedures to ensure behavior management techniques which include the use of aversive procedures and/or restraint are developed, reviewed, and approved by program review and human rights committee; failure to have behavioral support plan for individual.
- September 2018. Licensing visit. Minor violations.
- October 2019. Licensing visit. Multiple citations for being "years out of date" with training for "resident routines, basic behavior, and emergency procedures." Abuse/neglect training not current. Multiple citations regarding individual plans of service and supports; citations for failure to ensure monthly review of aversive procedures occurred; citations for medical care concerns and related documentation.
- October 2021. Next licensing visit. Citations for failure to ensure furniture is safe and in good repair. Furniture "presented with broken arms, broken springs for seating, and ripped cushions." Violations for ensuring staff training up to date, including health and behavioral needs, resident routines, emergency procedures, first aid, abuse/neglect prevention training, planning and provision of services, behavioral emergency techniques, CPR. Violation of Regulation 15a4d. "**Documentation was lacking to verify that required follow up occurred following two substantiated abuse/neglect investigations as they were unavailable for review."** Failure to secure approval of restraints, and restraint lasted for 90 minutes. Violation of requirement that aversive procedures be reviewed monthly. Violations for failure to implement a client's service plan and for failure to follow up on client's fall after individual "had been found on the bedroom floor."

CLA 5

- April 2017. Licensing visit. Multiple citations regarding inadequate physical infrastructure, emergency planning, and medication consents; failure to ensure appropriate procedure and approval for behavior plan and aversives; failing to create an individual support plan: no baseline data, no identified goals and objectives, no functional assessment, failure to ensure community integration; inadequate medical and dental follow up care.
- August 2018. Licensing visit. "Revisit to ensure the Plan of Correction from the Standard Inspection conducted on April 2017 was conducted. **The Plan of Correction was not implemented.**"
- February 2019. Licensing visit. Citations regarding physical infrastructure, emergency planning, staff training; violation of Regulation 15a-4d for failure to report and ensure adequate follow up for individual with foot injury.
- April 2021. Licensing visit. Citations for inadequate physical infrastructure (same issue as in February 2019). Continued violations regarding emergency planning, fire drills, staff training; violations for overall plans of service, reviews of behavior progress, medication administration concerns, medical follow up, and lack of financial audits.
- October 2022. Licensing revisit. **Citations for failure to implement Plan of Correction** with regard to behavior plans, emergency planning, training, and financial audits.

A review of licensing actions above confirms lack of prompt revisits to verify corrective actions are actually implemented, and persistent findings regarding corrective actions not being demonstratively implemented, to the potential or actual detriment of DDS clients. These concerns are identical to the individual case findings made by OCA in Section IV.

Data provided to OCA by DDS indicates that few serious licensing actions issued in recent years. Despite the 100 citations issued by DDS for failure to report incidents/injuries/abuse or neglect during a recent three-year period, DDS issued just 15 one-year licenses (as opposed to the typical two-year license) and had not revoked a single license during the previous three year period.[65] DDS told OCA in mid-2022 that it had only two programs (out of approximately 800) on "enhanced monitoring." Based on OCA's review of more than 150 regulatory histories and conversation with DDS managers, OCA attributes the dearth of licensing actions and oversight visits to resource constraints.

Regional Quality Assurance Reports Lack Meaningful and Uniform Information

As DDS reported to OCA and the federal government that quality management and follow up to critical incidents and other programmatic concerns is done at the regional level and documented through Annual Quality Assurance Reports, OCA reviewed three such reports for the provider whose CLA was the subject of the October 2021 critical incident detailed in this report. OCA found that the Quality Assurance Reports did not use a standardized form, did not contain clear information about safety and quality trends, and did not include adequate information regarding abuse/neglect findings or what corrective actions had been issued and completed. For example, one report noted that there were 14 investigations during the previous year, 8 not yet complete, and that there were 301 **"open recommendations for this review period."** However, there was no information in the Report regarding the nature of abuse/neglect findings, systemic concerns, what the outstanding or implemented recommendations for corrective action and program improvement were, or what follow up was taking place. In sum, the regional reports reviewed by OCA did not depict a clear or reliable methodology to ensure the quality and safety of care. There may well be rigorous review and discussion between regional DDS staff and providers, however these reports did not detail such efforts, nor are the reports publicly available.

DDS and DSS Federal Medicaid Waiver Application Contains Several Assurances Regarding Individual Safety of Beneficiaries in Licensed Community Settings

OCA reviewed the state's 2021 submission to the federal government modifying Connecticut's Home and Community Based Waiver application for persons with Intellectual and Developmental Disabilities. The DSS/DDS application states that substantiated cases of abuse and neglect and resulting corrective actions are closely monitored, and that a "**standard tracking system is used to track responses to the recommendations ... Monthly reports on recommendations tracking are generated and reviewed by regional staff**."[66] The state's Medicaid application further states:

[65] A one-year license imposes more licensing visits (unannounced) and may include additional resource management visits to ensure correction action implementation.
[66] Connecticut's Medicaid Home and Community Based Services Waiver Application.

> The [DDS] Protection and Advocacy Abuse Investigation Division is charged with the responsibility of oversight for Abuse/Neglect for individuals between the ages of 18 and 59, DCF has responsibility for children under the age of 18 and DSS (the State Medicaid Agency) has responsibility for people age 60 and over. DDS has joint responsibility for Abuse/Neglect reporting as well as Critical Incident Reporting, Investigation and Follow-up. The Office of Protection and Advocacy also monitors the submission of abuse and neglect reporting, investigations and reports. Critical Incidents are reported using the DDS Incident Reporting Procedure and are stored in the DDS Incident Reporting data system. Critical incident oversight is managed at many different levels. Critical incident reporting is tracked in a database. Each specific incident has to have a follow-up plan that should start with the participant's support team. Data is reviewed quarterly by each Region. Central office quality management staff follow-up on critical incidents during the course of their quality reviews. Regional staff meet every six months with qualified providers and critical incident data and follow-up is reviewed.

OCA reviewed all progress reports between Connecticut DDS/DSS and the federal government regarding the outstanding Inspector General audit recommendations from 2016 and findings from CMS regarding the state's compliance with HCBS waiver assurances for persons with intellectual disabilities. Documents provided to OCA indicate that Connecticut has not yet demonstrated actual compliance with HCBS assurance requirements or fully addressed all of the Inspector General audit findings. As stated earlier, an Inspector General re-audit is underway.

OCA's review of DDS performance measures regarding the HCBS safety assurances for 2022 and 2023 indicate that progress has been made as to training requirements and completion of investigations. However, gaps remain with regard to the "Number and percent of Critical incidents where there was follow up by the region per DDS Policy," with 2022 and part of 2023 data reviewed by OCA indicating a compliance rate of 65%.

While OCA credits the steps taken by DSS and DDS to implement the Inspector General's corrective actions, the information developed by OCA during this investigation raises several questions and outstanding concerns, including:

1. The persistent concerns regarding timely reporting of critical incidents and suspicions of abuse/neglect involving disabled individuals;
2. The adequacy of resources at the state agency/s to ensure independent investigation of incidents of harm to disabled individuals;
3. The adequacy of the regulatory/oversight structure and resources to ensure programmatic concerns are timely corrected;
4. The framework for public transparency and accountability for state agency findings of abuse, neglect, and program concerns in state-licensed CLAs.

Given the vulnerability of the DDS clientele living in state-licensed homes, it is imperative that the state assure it has a comprehensive and reliable system to promote the health, safety and general welfare of these individuals.

Community Providers Must Have Adequate Resources To Provide Needed Staff And Supports To Vulnerable Clients

The state relies almost entirely on a network of community-based nonprofit providers to deliver essential services, including group home care, to individuals with disabilities. The adequacy of resources, including staffing and state funding, necessary to enable the providers to deliver these services has been a persistent public concern. As the state workforce has shrunk[67] state consultants recommended strengthening the capacity of nonprofit community-based providers to deliver care to vulnerable populations.[68] Individuals who work in caregiving roles need and deserve reasonable compensation, workforce supports, and quality of life. Too many human service and direct care professionals earn little more than minimum wage, and for some of the hardest work with the most vulnerable of populations, resulting in growing vacancies in the workforce and providers that struggle to maintain minimal staffing levels for their clients. As recently as the 2023 legislative session, multiple non-profit leaders testified regarding unprecedented staffing vacancies, and not being able to deliver services to individuals and families due to lack of resources.[69] The lack of appropriate resources for providers delivering essential services to vulnerable populations is not acceptable or sustainable. A recent settlement with the union for several group home providers resulted in an increase in compensation, but it remains unclear what the systemic impact of this settlement will be.

OCA emphasizes that the provision of safe and appropriate care to vulnerable individuals with disabilities requires an effective state oversight framework as well as adequate resources for community providers. Deficiencies in either category place at risk individuals who are dependent on the state for their safety and wellbeing.

VI. SYSTEM FINDINGS: DCF

DCF Record Contains Inadequate Documentation of Follow up to Investigation Findings

DCF is required to investigate allegations of abuse and neglect and make a finding as to whether an individual will be substantiated for maltreatment. At the conclusion of DCF's investigation of the October 2021 critical incident at the DDS-licensed CLA, DCF substantiated multiple staff members for neglect. DCF investigators also documented "program concerns" regarding the provider's staffing policies and supervision. As stated in Section IV, DCF did not timely notify the CLA provider agency of the investigation findings and program concerns. OCA met with DCF regulators and investigation managers, who acknowledged forgetting to send the community provider a completed copy of the DCF investigation record. The managers also confirmed that DCF does not typically follow up on program concerns made regarding a facility that it does not license (this includes schools and community provider programs licensed by other agencies). There is also no statutory requirement to ensure that consumers or the public are alerted to DCF's program findings.[70]

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[67] Connecticut Department of Administrative Services' Workforce Reports June through August 2022.

[68] *Connecticut Creates Report, Opportunities for the Government of Connecticut to improve service quality, delivery, and equity for residents and businesses, mitigate retirement risks, and reduce costs.* (2021) https://portal.ct.gov/-/media/Office-of-the-Governor/News/2021/20210331-CREATES-final-report.pdf.

[69] Testimony to the Connecticut General Assembly on House Bill 5001, found on the web at https://www.cga.ct.gov/aspx/CGADisplayTestimonies/CGADisplayTestimony.aspx?bill=HB-05001&doc_year=2023

[70] OCA has made this finding before. See Hartford Public Schools' Report, wherein OCA found that though DCF area office social work staff had conducted numerous investigations into concerns of abuse and neglect

DDS and DCF's Completed Findings and Recommendations Were Not Shared with DCF Social Work Staff for Either DCF-involved Youth in the CLA

DCF regional social work staff for both DCF-involved youth in the CLA told OCA that they did not receive a briefing regarding the DCF or DDS incident investigation in October-November 2021. John's social work team said that they had a conversation with DCF investigators about the October incident and program concerns but that they did not receive the final report and did not receive any report from DDS. The social work team for a second DCF-involved youth in the CLA, James,[71] who is also intellectually disabled and non-verbal, reported to OCA that nobody from the CLA informed them of what had been transpiring, and they did not receive anything from the DDS or DCF Special Investigation Divisions regarding program concerns at the CLA. One of the DCF social workers stated that they were very concerned about not receiving this information as James is "non-verbal and if anything has happened to him, he would not be able to report or tell what has been done to him or anyone else."

DCF regulatory and special investigations staff told OCA that there is no specific requirement to discuss information from the DCF special investigation team with the DCF case workers and therefore there was no formal briefing for John or James' social worker or supervisor.

DCF's Training for Staff Regarding Meeting the Safety and Treatment Needs of Children with Developmental Disabilities Should be Mandatory

It is imperative that DCF social work staff have training to understand the vulnerabilities of children with disabilities, including that children with disabilities are more likely to be abused by their caregivers and more likely to have unmet treatment needs than children without disabilities. In OCA's 2017 report regarding the death by homicide of Matthew Tirado, a 17-year boy with developmental disabilities who was the subject of an open DCF case, OCA recommended that DCF improve staff training and treatment planning protocols for children with disabilities. OCA recommended in Matthew's report:

> Children with multiple disabilities, intellectual disabilities, communication disorders, and Autism Spectrum Disorders, are more vulnerable to abuse and neglect and are often less able or even unable to advocate for themselves or even tell someone what is happening to them. Our safety net for these children across systems must be improved.
>
> Child welfare agency workers will need specific training regarding working with families and providers who have children or are serving children with disabilities, including 1) the unique vulnerability of children with disabilities to abuse and neglect; 2) signs of abuse and neglect for children with disabilities; 3) assessment and investigation practices for children who may have limited or no capacity for communication; 4) guidance regarding purposeful visits to children with disabilities; 5) guidance regarding utilization of internal and external consultation resources to assist with serving and protecting such

of students over a 5-year period, which investigations frequently included "program concerns" that impacted children's safety or wellbeing, there was no documentary evidence of follow up between DCF and the public school district regarding such concerns, and no framework for transparency with parents.

[71] Pseudonym.

children; and 6) guidance regarding community resources that assist with case planning and service delivery for children with developmental disabilities.

OCA credits DCF's efforts following the publication of OCA's report regarding *Matthew Tirado* and the agency's development of a new training curriculum for social work staff. OCA reviewed the training curriculum and found that it contains comprehensive information regarding the vulnerability and treatment needs of children with developmental disabilities. Over the last three years, however, only a small number of DCF staff have participated in this training. OCA notes that while there are annual training hours requirements for DCF staff, not all trainings are mandatory. It will be essential to ensure that trainings regarding safety planning and service delivery for vulnerable populations are mandatory and such expectations enforced for social work staff and case plan reviewers.

There Is No State Law Requirement or Agency Practice to Ensure That Programmatic Neglect Findings and Corrective Actions Are Shared With the Public or Consumers

Under state law, records pertaining to licensing visits, and applicable corrective actions are public documents (state law recently changed to require DCF to share such information as well).[72] DCF and DDS *investigation* records are not public. Accordingly, neither DCF nor DDS publishes or otherwise publicly disseminates information when they make *programmatic* neglect findings or related programmatic concerns, despite these concerns typically involving regulatory matters such as inadequate supervision, training, or program infrastructure. Because the system findings and recommendations are created by agency investigators (as opposed to licensing staff*),* the agencies may consider such information as falling under confidentiality rules pertaining to findings of abuse or neglect. This should be re-examined and restructured under state law. While confidentiality for individual victims is important, public policy should require disclosure of programmatic concerns, recommendations, and corrective actions.

VII. RECOMMENDATIONS

1. State Law Should Require That DDS Conduct A Minimum Of One Unannounced Licensing Inspection Every Year And Timely Revisits To Ensure Applicable Corrective Actions Are Taken

OCA recommends a statutory change to require annual, unannounced, licensing visits by DDS regulatory staff and a requirement that programs be timely revisited where violations are found that impact the safety of residents. This will likely require additional staffing and resources be appropriated to DDS for this purpose.[73] The "sampling" of homes that DDS subjects to re-visits during the two-year period, a reported twenty percent of licensed homes, is insufficient to ensure quality and safety for vulnerable clients. OCA's review of information available in the state's E-License database quickly revealed that there are many DDS-licensed homes that have been cited for long lists of regulatory violations and that were not re-visited timely by DDS regulators. DDS administrators agreed with

[72] Changes were made in state law in 2019 to require DCF publish licensing and corrective action information. These statutory changes emanated from an OCA investigative report regarding the death of a child in a DCF run treatment facility.

[73] Amend C.G.S. § 17a-227. See for comparison, Conn. Gen. Stat. Sec. 19a-80, which requires OEC to conduct an annual unannounced licensing investigation or inspection visit each year.

OCA that strengthening of the agency's quality assurance resources was needed and would be addressed.

2. The State's E-License Database Should Include Inspection Documents, the Factual Basis For Regulatory Violation Citations, and the Corrective Actions Submitted by DDS Licensed Community Living Arrangements

OCA found that the state's E-License database includes only a list of dates that a facility inspection was made and a list of what regulatory violations were found, with no factual explanations, no inspection documents and no corrective action documents available.[74]

OCA recommends that all state agency databases of information (211/OEC, DCF's database of licensed providers) regarding publicly funded, operated and licensed facilities be linked, and that the public be able to access the inspection/licensing and corrective action information relevant to any and all publicly-funded, state-licensed program.

3. DDS Should Notify Consumers and Parents/Guardians of the Results of a Licensing Inspection and Any Corrective Action Required.

State law[75] should be amended to require that DDS develop a process for promptly notifying consumers and, where applicable, the guardians or conservators of consumers receiving services at licensed facilities and community living arrangements of a) the results of any licensing inspection of the licensed facility or community living arrangement; b) any action taken relating to the provider's license or any directed corrective action; and c) any corrective actions taken by DDS or the contracted provider following such actions or sanctions.

4. The State Should Ensure Publication of DDS and DCF'S Program Concern Findings and Require Regulatory Follow Up.

OCA recommends that the legislature explicitly require that programmatic deficiencies found by state investigators at DDS and DCF be published in the agency's public-facing databases. OCA also recommends that corrective action be required of the regulating agency whenever programmatic deficiencies are identified, and that the agencies distribute findings and applicable corrective action requirements directly to consumers and parents/guardians of affected individuals. OCA found that both DDS and DCF investigation divisions, either per explicit agency policy or per agency practice, identify and record program concerns or programmatic neglect findings when investigating allegations of abuse and neglect of children or adults. This means that the investigators not only address what happened to an individual child or adult but may also document whether there were underlying systemic deficiencies, including staffing and supervision or treatment plan concerns, that contributed

[74] OEC has rectified this deficiency by partnering with the state's 211 database to create, consistent with federal law requirements for that agency, a consumer-friendly database that includes ample information regarding licensing visits, inspection findings, regulatory violations, and corrective actions. Most (though not all) applicable documents can be opened by the public. Pursuant to other recent changes in state law, DCF now has constructed a public-facing database that includes licensing/inspection information and corrective action documents. DCF is also obligated to inform consumers of a program whenever the agency takes an action regarding a provider's license, such as placing a holding on admissions due to concerns of health or safety.

[75] C.G.S. § 17a-227.

to an unsafe environment. However, neither agency's findings of programmatic concerns are made public. Programmatic concerns are frequently regulatory in nature and should be recorded and published as such to ensure transparency and accountability for correction.

5. DDS Should Report Publicly Regarding Various Measures Related to Safety and Wellbeing of Consumers

DDS should publish annually the aggregate number of deaths and serious injuries for each provider category and licensing status and instances of substantiated abuse or neglect, including whether the finding related to a determination of programmatic or individual neglect, that occur in licensed settings each year, and the number of corrective action plans verified to have been implemented within 90 days, and the number of corrective action plans that were not successfully completed within 90 days.

DDS and DSS should coordinate to ensure prominent publication on their agency websites of information detailing the state's compliance with Medicaid Home and Community Based Waiver required assurances regarding the safety and wellbeing of consumers and the provision of qualified care to consumers. Such information should include all compliance findings made by federal regulators, including the Inspector General for the United States Department of Health and Human Services and the Centers for Medicaid and Medicare Services, all related progress reports submitted by the State of Connecticut, and all state-based performance measures and methodologies undertaken to ensure the health, safety, and wellbeing of consumers and Waiver recipients.

Connecticut General Statute Section 17a-211 should be amended to require that DDS annually report regarding improvements to its information management and technology framework and its efficacy in ensuring centralized and reliable information regarding the Department's provision of supports and services and the agency's licensing, investigation, and case management work ensuring the safety and wellbeing of consumers and provision of care by qualified providers. DDS should identify in detail any outstanding needs for ensuring an effective informational management system, including systems for data-sharing between the Departments of Social Services and Children and Families.

6. The Legislature Should Provide An Oversight Framework To Ensure DDS And DSS Adhere to State And Federal Safety Obligations for Medicaid Beneficiaries in State-Licensed Settings

The Connecticut General Assembly should annually review the efforts made by DDS and DSS to ensure the safety, wellbeing and provision of qualified care to Medicaid waiver recipients and any progress made towards federally-identified compliance concerns, and the agencies' coordinated or joint analysis of the resources employed and needed to ensure the safety, well-being and provision of qualified care to DDS consumers and Medicaid waiver recipients, including those resources needed by contracted providers to ensure recruitment and retention of qualified staff and adequate resources to safely meet the daily needs of consumers. DDS should provide information regarding provider waitlists, staff vacancies, starting salaries for provider staff, and reimbursement increases needed to support recruitment and retention of adequate and highly qualified staff to serve DDS consumers and maintain appropriate living arrangements for consumers.

This report references the federal audit findings by the U.S. Department of Health and Human Services Office of the Inspector General (the Inspector General), which found that the state "did not

comply with Federal Medicaid waiver and State requirements for reporting and monitoring critical incidents [involving DDS clients]." The Inspector General made several recommendations to the DSS and DDS, including that DSS work with DDS to "develop and provide training for staff of DDS and CLAs on how to identify and report critical incidents and reasonable suspicions of abuse or neglect, … and work with DDS to update DDS policies and procedures to clearly define and provide examples of potential abuse or neglect that must be reported," and that DSS provide DDS access to Medicaid claims information to help the agencies detect potentially unreported critical incidents involving disabled clients. It is imperative that progress towards the federally issued corrective actions be regularly reviewed by the relevant legislative committees- Public Health, Human Services, and Appropriations.

7. DDS Should Share Abuse/Neglect and Critical Incident Information with Disability Rights Connecticut and, Where Applicable, the Office of the Child Advocate

DDS should provide written notice to Disability Rights Connecticut within 72 hours of a new report of suspected abuse or neglect, or a critical incident as defined by DDS policy. Where the consumer who is the alleged victim of abuse, neglect, or a critical incident is a minor, or is under the supervision of DCF, then DDS should also provide the written notification to the Office of the Child Advocate. DDS should provide, within 45 days of the conclusion of any investigation of abuse, neglect, or critical injury, a summary of corrective actions taken by DDS and its contracted providers, and the dates of revisits conducted to verify implementation of corrective actions.

OCA also recommends that DDS ensure notification of any reports and subsequent individual/programmatic findings to the DCF caseworker whenever applicable.

8. DCF Treatment Planning For Children With Developmental Disabilities— Additional Training Needed

As OCA wrote in our report regarding the homicide death of 17 year old Matthew Tirado from child abuse, "Children with multiple disabilities are more vulnerable to abuse and neglect and often less able or even unable to advocate for themselves or even tell someone what is happening to them. Our safety net for these children across systems must be improved."[76] After Matthew's death, OCA recommended that "Child welfare agency workers [receive] specific training regarding working with families who have children with developmental or multiple disabilities" and that DCF develop "protocols for investigation and case planning that are specific to the specialized needs of children with disabilities, including children with intellectual and developmental disabilities."[77]

As stated above, DCF developed comprehensive training regarding the needs of children with developmental disabilities. However, a relatively small percentage of staff have participated in the training, and participation is not mandatory. It is important that all DCF staff, including the supervisory chain of command and case reviewers, receive regular pre-service and in-service training regarding working with various vulnerable populations, such as children with developmental

[76] Matthew Tirado Report at 67. Found on the OCA website at: https://portal.ct.gov/-/media/OCA/MTfinal12122017pdf.pdf

[77] Id. at 68.

disabilities, including how to monitor the safety and wellbeing of the child if placed in out-of-home care.

9. All Children Receiving Services in DDS licensed CLAs Should Have a DDS Case Manager Assigned to Them

OCA was informed during the course of this investigation that DCF or school-district placed children in DDS-licensed settings are not assigned a DDS case manager to assist with coordination of care and implementation of appropriate services. Multiple providers identified the DDS case manager as a key player in ensuring safe and quality care for disabled individuals. DDS administration separately identified case managers as essential staff for assisting with quality assurance and oversight of care in licensed settings. OCA recommends that all children eligible for DDS services and placed in DDS licensed settings be assigned a DDS case manager to assist with care coordination and to help provide oversight of their care/treatment plans.

10. Lawyers for Children Should Receive Pre-Service and In-Service Training Regarding Representing Children with Developmental Disabilities

As OCA wrote in our report regarding Matthew Tirado, "[l]awyers and other professionals working with children will benefit from additional guidance and training regarding representing children with diminished capacity, including children with complex disabilities. Young children and children with disabilities are highly vulnerable and dependent on state actors, and above all else, their legal counsel, to offer guidance and protection."[78]

Following OCA's report, the OCPD implemented pre-service training regarding representing children with developmental disabilities for lawyers representing children. The OCPD and the Judicial Branch also invited the OCA to develop and facilitate in-service training for lawyers and juvenile court judges.

The OCA recommends that in-service training for both lawyers representing children and juvenile court judges frequently include attention to issues affecting children with developmental disabilities.

11. **Reliable Notification to Lawyers and GALs of DCF Case Plan Meetings Needed**

OCA found that in this review and another recent critical incident review, DCF did not provide the lawyer/GAL for the child consistent written notice of administrative meetings concerning the child, including permanency planning meetings and federally/state required Administrative Case Reviews. Lawyers' participation in these case planning meetings is important to ensure the child is safe, and getting their needs met.

OCA recommends an automated and electronic notification process to attorneys and Guardians Ad Litem for DCF client-centered administrative meetings, with quarterly or bi-yearly reports to the OCPD confirming notice to attorneys of Administrative Case Reviews. DCF permanency plan motions/accompanying studies provided to the Juvenile Court should include information regarding dates of ACRs and permanency planning meetings, any identified case plan concerns, and attach a copy of the notice to the attorney/GAL.

[78] Id. at 72.

12. The OCPD Should Strengthen Legal Representation of Children

OCA discussed issues contained in this Report on multiple occasions with administrators from the Office of the Chief Public Defender, and the OCPD shared information and records necessary for this review.

Counsel for children in child protection proceedings are assigned by the Office of the Chief Public Defender of the Division of Public Defender Services (OCPD).[79] While OCPD does have a small number of employees who represent parents or children in a limited number of child welfare cases, most parents and children are represented by private attorneys under individual contract with the OCPD.

As outlined above, OCA found that while K's lawyer visited with him, the lawyer obtained no records regarding the child's care and treatment during the review period. Given K's disability, he was entirely dependent on his lawyer to obtain independent information and ensure that state and local agencies were meeting his needs.

As one author writes:

> The CAPTA requirement reflects the view that children have interests that may differ from the interests of their parents and the state. The idea is that even though the state has brought the action to protect the child, the voice and needs of the child may get lost in the fray of the arguments and allegations between [the parties] … the child needs an advocate should the state fail to deliver on necessary services and actions due to fiscal constraints and organizational failures.[80]

Federal law requires that representatives for children "obtain firsthand, a clear understanding of the situation and needs of the child."[81] In Connecticut, the primary role of counsel for the child is to "advocate for the child in accordance with the Rules of Professional Conduct, except that if the child is incapable of expressing the child's wishes to the child's counsel because of age or other incapacity, the counsel for the child shall advocate for the best interests of the child."[82] Where the Court finds that the child "cannot adequately act in his or her own best interests and the child's wishes, as determine by counsel, if followed, could lead to substantial physical, financial or other harm to the child unless protective action is taken, counsel may request, and the court may order that a separate guardian ad litem be assigned for the child . . .."[83] Pursuant to Connecticut law, the Guardian ad Litem (GAL), is to "perform an independent investigation of the case and may present at any hearing

[79] The OCPD provides for the representation of indigent adults in criminal matters, representation of children in juvenile delinquency matters, and representation of children and parents in child welfare maters. For criminal and delinquency matters, OCPD has employees who represent individuals for whom the court has appointed counsel. In addition, OCPD manages contracts with independent counsel for matters in which the OCPD may have a conflict.

[80] Pitchal, 2006; Taylor, 2009.

[81] 42 U.S.C. § 5106a(b)(2)(B)(xiii).

[82] Connecticut General Statute Section 46b-129a(2)(C).

[83] Connecticut General Statute Section 46b-129a(2)(D).

information pertinent to the court's determination of the best interests of the child." When a GAL is appointed, the Court should set out the scope of duties of the GAL in the specific case.[84]

State law requires that OCPD "establish training, practice and caseload standards for the representation of children and youths."[85] As outlined in this Report, the OCPD has adopted Performance Guidelines for Counsel in Child Protection Matters, and the OCPD provides or contracts for regular pre-service and in-service training for assigned counsel.

Due to the independent contractor system, however, there are no current caseload standards for assigned counsel for children. OCPD does not have the ability to track when cases close, as that occurs through the court process. Given the nature of independent contractor work, OCPD also does not have information about the amount of non-contract legal work an assigned counsel must also be handling, creating additional difficulties in setting caseload/workload standards of expectations. OCPD reported to OCA that they do not have an adequate number of assigned counsel for children, as recruitment and retention of lawyers has become increasingly difficult due to the historical compensation structure in place prior to the newly passed budget. Adequate compensation, administrative support, and other case supports, along with enhanced quality assurance mechanisms are needed to strengthen representation for children in juvenile court proceedings.

From a systems perspective, while lack of adequate payment does not relieve any lawyer from their ethical obligations, compensation for lawyers representing children in these cases has historically been low and stagnant, and the fee schedule heretofore in use has not allowed lawyers to bill for several expectations codified in federal and state law or contained in the OCPD Performance Guidelines, including acquiring and reviewing records, consulting with treatment providers, calling state or local agency providers, or convening with providers or case managers to address unexpected issues or concerns. These activities are particularly critical for children who have complex treatment and developmental needs, and/or children who cannot effectively communicate because of minority, like Liam. The OCPD sought and recently received additional funding from the state to support recruitment and retention of lawyers for children in child protection proceedings, citing the challenges in maintaining an adequate system of legal services for this highly vulnerable population of children. The recently approved state budget increases funding for OCPD "assigned counsel" to address this concern. It will be important for policy makers to ensure that children have well trained and effective counsel to represent them in these sensitive proceedings.

With regard to oversight of the quality of lawyering, the system's reliance on independent contractors throughout the state creates challenges for ensuring the adequacy of representation for children. OCPD administrators reported to OCA that they conduct regular billing audits to review assigned

[84] "The duties of the guardian ad litem, however, are contextually specific to the case at hand, and the scope of those duties should be set by the trial court judge and communicated to the guardian ad litem. Because those duties may subsume those traditionally performed by counsel when counsel is the child's sole representative; see Connecticut General Statutes § 46b-54 (c); counsel's duties must be similarly articulated by the court." *In re: Tayquon H.*, 76 Conn.App. 693, 708 (Conn.App. 2003).

[85] Connecticut General Statute Section 51-296.

counsel's compliance with certain Performance Guidelines, including visits with children.[86] OCPD also conducts informal observations of contract attorneys' in-court performance, where possible. If observations raise concerns or if attorneys are not billing for activities in which they should be engaging, like visiting clients, OCPD staff meet with lawyers who are not meeting standards, and may put them on an improvement plan, or in some cases, will terminate or not renew a contract. Given that requesting records and independently assessing a child's case are not billable activities, they are not subject to audit review by OCPD. Additionally, as independent contractors, assigned counsel are not subject to supervision or qualitative file review by OCPD. It should be noted the tension between holding lawyers accountable to the standards and retaining enough assigned counsel to handle the workflow, an increasing challenge in recent years as attrition rates have accelerated, and according to OCPD, several experienced juvenile court attorneys ended their contracts.

Recommendations to improve the quality of lawyering for children

1. While the state agency guidelines and statutory expectations for lawyers who represent children are laudable, resources must support the realization of those requirements. Resources could include federal Title IV-E revenue received by the state and an hourly rate for lawyers that matches the performance guidelines and contractual expectations. Importantly, the recent state budget includes increases for assigned counsel for children, requested by the OCPD.
2. In addition to higher hourly and case rates, OCPD should also explore additional quality assurance measures that may be built into contracts to ensure adequate legal representation is provided to children.
3. OCPD may consider expanding categories for which assigned counsel may bill hourly, to include obtaining and reviewing records and communicating with service providers. It may also be prudent to permit billing for paralegal and/or social workers for tasks like record review and other fact-gathering activities such as meetings with service providers.
4. OCPD should consider additional administrative and practice supports that can be afforded to assigned counsel, including providing access to agency-based investigators, social workers, and other support staff.
5. OCPD should review and strengthen the performance guidelines for appointed Guardians Ad Litem to clarify expectations for these representatives of children.
6. State law should be amended to ensure that during child protection hearings, that the Court canvas the lawyer for the child to ensure that the child has been seen and that the lawyer has independently gathered information necessary to advancement of the client's interests. OCA notes that children are legal parties to these proceedings, as are their parents. Adult parties are often present during hearings, and they are canvassed by the Court at various stages of the case to ensure that they have an opportunity to confer with counsel and that they understand the nature of the proceedings. Children are typically not in the court room, and there is no parallel procedure to ensure the due process/statutory right to counsel for the child.
7. The legislature should create a working group to review the delivery of legal services to children in child protection proceedings and make necessary recommendations to support high quality representation for children.

[86] Audits involve a review of billing information but do not include any qualitative file review. This kind of review would not provide OCPD with information regarding non-billable activities, like contacting the child's pediatrician, talking to the child's school, or requesting and reviewing DCF or other relevant records.

VIII. CONCLUSION

OCA's review of the individual critical incident and ensuing systemic investigation found serious deficiencies in the resources and oversight structure for the safety and care of individuals with developmental and intellectual disabilities in DDS-licensed Community Living Arrangements. Significant work needs to be done to strengthen this system, enhance resources for providers to support high quality care for dependent clients, improve the quality of lawyering for children in child protection proceedings, and ensure transparency and accountability for publicly-funded systems that serve highly vulnerable populations.