CRITICAL INCIDENT INVESTIGATION FINDINGS & RECOMMENDATIONS

EXECUTIVE SUMMARY

NOVEMBER 2023

STATE OF CONNECTICUT
OFFICE OF THE CHILD ADVOCATE
165 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
www.ct.gov/oca

Sarah Healy Eagan, J.D.
Child Advocate

INTRODUCTION AND METHODOLOGY

The Office of the Child Advocate (OCA) is issuing this Critical Incident Investigation Findings & Recommendations Report ("Findings Report") in response to an October 2021 critical incident that occurred in a Department of Developmental Services (DDS)-licensed Community Living Arrangement (CLA) involving a Department of Children and Families (DCF)-committed youth and a DDS client, wherein the youth was found attempting to compel sexual intercourse with a young woman. Both the youth and the young woman are intellectually and developmentally disabled. The incident led DCF and DDS to make findings of individual and programmatic neglect.

OCA's investigation found that a serious incident did occur, and that previous incidents had occurred and gone unreported in the CLA. OCA found that while the October 2021 incident was brought to attention of staff at DCF and DDS for safety planning purposes, the matter was not timely reported by the provider as a critical incident or report of abuse/neglect. OCA found a lack of timely follow up by the state agencies to ensure that identified programmatic concerns and required corrective actions were addressed. OCA found that the minor child's state-appointed lawyer overall did not comply with state contractual obligations and performance guidelines for representing child clients, which includes gathering records to inform advocacy for the care and treatment of the child.

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 programmatic and resource deficiencies. OCA examined findings issued in 2016 by the Inspector General for the U.S. Department of Health and Human Services (Inspector General) 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. OCA reviewed state performance expectations and oversight for state-appointed lawyers for children.

OCA found that while efforts have been made to support the care of developmentally disabled children and adults in state-licensed settings, grave concerns persist regarding resources and oversight to ensure safe and high quality care for these individuals. Significant concern also remains regarding the adequacy of resources to support non-profit providers' recruitment and retention of staff who care for individuals with disabilities in community settings.

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. DDS, DSS, and OCPD shared steps they are or

have been taking to address systemic issues identified in this Report, which steps are summarized at the conclusion of this Executive Summary.

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]

DDS licenses hundreds of community settings, called Community Living Arrangements or CLAs, 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.[2] 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.[3] The Inspector General issued several corrective recommendations directed to DSS as the state Medicaid agency and funder of the CLAs. DSS and DDS collectively undertook actions to implement the Inspector General's recommendations and the agencies made several required assurances to the federal government regarding the safety of individuals in the 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

---

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

[2] 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.

[3] 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.

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

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,[4] 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.[5] 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

[4] To ensure the privacy of the individuals and staff involved in this critical incident, OCA is not identifying the community provider or CLA.
[5] DCF utilizes DDS CLA slots for children with developmental disabilities, as needed and available.

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.

ADDITIONAL 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 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 also 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 by licensing staff 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.[6] OCA could not find any 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.[7]

- 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

---

[6] 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, 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.

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

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.

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 (SUMMARY)

DSS is establishing a redundant critical incident response and sustainability plan which will include 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 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;

DDS stated that it is continuing to enhance critical incident detection and tracking, and that the agency hired three regional directors of quality assurance and a program manager for critical incident review to address issues and recommendations raised in this report.

DCF stated that it 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. 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.

OCPD referenced new resources that it sought and will continue to seek to enhance recruitment and retention of lawyers for children and support quality oversight for the system of legal representation.