After Scathing Federal Report, State Pledges Changes To Protect Developmentally Disabled

Abuse and neglect are cited as factors in the deaths of dozens of devlopmentally disabled in state care since reforms were instituted a decade ago. Here are some of the lives affected. Read more of the Courant's investigation.

By **Josh Kovner · Contact Reporter**

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HARTFORD — The state says it has developed a strategy to better protect people with developmental disabilities, including computerizing injury reports, increasing staff training and monitoring the medical diagnosis and treatment of clients – actions officials hope will radically improve the detection of possible abuse and neglect.

The plan to repair Connecticut's tattered safety net is in response to a scathing federal audit last week that revealed some group homes failed to report injuries or mischaracterized their severity, and that

the Department of Developmental Services routinely missed "critical incidents" that warranted abuse or neglect investigations. Also, some hospitals failed to report injuries that should have raised a suspicion of abuse, the audit found.

But some experts in disability services expressed doubt that DDS could continue to police itself or provide the amount of ongoing injury-recognition training necessary to overcome the problems cited by the audit. An expert also said that Connecticut's state-run institutions continue to divert money and time away from the agency's mission of safeguarding clients.

The U.S. Department of Health and Human Services began its investigation in 2013 at the request of U.S. Sen. Chris Murphy, after The Courant exposed the preventable deaths of 76 people with developmental disabilities in state care. The report released last week focused on reporting and detecting injuries, rather than preventing abuse, although officials said they have updated a registry to better assure that workers who were found to have abused clients are never hired again.

DDS Deputy Commissioner Jordan Scheff said Friday that a key reason for the system failures was the inability of the agency to see the Medicaid bills and treatment records of injured clients.

As a result, DDS was missing some severe injuries that were detected by X-rays and other tests at hospitals, but had been initially reported as relatively minor by the group home.

For example, a resident could be seen limping by group-home staff members and be taken to a hospital emergency room for what is reported as an unknown injury. If an X-ray later revealed a fractured tibia, the initial report would not be updated, nor would a new report be generated that reflects the more serious injury and the elevated concern that would accompany that finding.

"This is where our system has broken down," Scheff said. "The coding of an injury by a doctor – something we don't have the ability to see – may be different from the original assessment by the direct-care staff at the group home."

In fact, the first thing the federal investigators did was look at the Medicaid records of several hundred clients treated at hospitals, and then looked backward to see how those injuries were initially reported and responded to.

Scheff said DDS is now working with the Department of Social Services, the state's Medicaid administrator, to be able to see all the Medicaid claims, bills and treatment records of DDS clients who are taken to a hospital. He said officials are trying to overcome legal and privacy issues that had blocked access to the Medicaid records. He said the same problem exists in other states.

Scheff said he was hopeful the department would gain routine access to Medicaid treatment records for DDS clients by the end of the year.

Meanwhile, Scheff said DDS is working to improve an antiquated, paper-based, injury-reporting system that makes it difficult for the department to recognize injury trends and patterns.

Scheff said that while the audit focused on private providers who contract with DDS, mistakes and omissions also occur in state-run facilities. He said that despite the findings, most of the public and private workers perform their jobs well. He said clients and their families can still trust the safeguards that are in place in the community, but advocates said families are upset and scared by the breakdowns in injury reporting and response.

Investigators with the inspector general's office at HHS finished their probe in September 2015, gave DDS a draft report in October, noted the department's responses in November and finished the final report last week. The Courant obtained the audit Tuesday. The audit focuses on 2012 through mid-2014.

Chris McClure, a spokesman for Gov. Dannel P. Malloy, said the audit "is alarming and unacceptable and that's why DDS has worked, and will continue to work, across agencies to improve their processes and institute quality controls. The health and safety of residents is among our primary concerns."

One expert interviewed last week expressed doubts that DDS was capable of policing itself, and carrying out the dual role of providing services and oversight. Another expert said that DDS has not demonstrated the ability over the last several years to provide the training and technical assistance to private group homes, and the level of monitoring needed to guard against abuse and neglect of its clients.

A third expert said that Connecticut's state-run institutions continue to drain money and distract DDS from what should be its main mission of protecting clients in community residences, where the vast majority of its people live.

"We're pouring money into a system that has an interest in protecting itself," said lawyer David Shaw of Bloomfield, who has filed landmark lawsuits that have forced reforms of Connecticut's disabilities system over the last 30 years, including the closing of Mansfield Training School.

"There needs to be a regular systemic review by an independent group that identifies problems and makes them public in reports to the legislature," Shaw said. "We can't make reforms if the public only finds out about problems every three or four years when a major crisis is revealed."

Allan I. Bergman, a national consultant on services to people with developmental disabilities, noted that DDS directly provided injury- and abuse-recognition training to only a fraction of the group homes.

"You cannot assure quality without ongoing training and technical assistance and monitoring," said Bergman, who has done extensive consulting work in Connecticut. "If I haven't been trained and re-trained, and if the injury-reporting material isn't user friendly, then there's going to be compliance problems."

Scheff said the department will expand training for DDS workers and the private contractors.

Nancy Ray, who has led court-ordered reforms in Tennessee and Ohio, and was a monitor in the Mansfield Training School case, said states that have closed all or most of their institutions have freed up substantial amounts of money and time to create safeguards for clients living in the community.

Ray said it is possible for a developmental disabilities department to effectively police itself, but only if its investigative unit is insulated from the portion of the department that delivers services.

Scheff said that's the case in Connecticut, where the director of the investigation division, Kendres Lally, reports directly to Commissioner Morna Murray. Many of the department's dozen investigators are former police detectives, and no one in the division is beholden "to any particular outcomes," Scheff said.

But Scheff acknowledged that there is a high rate of suspected abuse and neglect of clients in state care, as there is nationally.

In fiscal year 2013, the investigation division probed 1,504 allegations of abuse or neglect and substantiated the mistreatment in 684 cases. In fiscal 2014, there were 1,514 allegations and substantiations in 660 cases. In fiscal year 2015, the number of allegations rose to 1,870, and abuse or neglect was confirmed in 799 cases.

Sanctions against workers and managers ranged from written warnings to terminations, to referrals for criminal prosecution. Anyone found to have mistreated a DDS client is placed on the department's abuse registry.

Two years ago, there was a backlog of 214 cases in which the names of abusers had not been entered on the registry. Scheff said the backlog has been cleared and the registry is up to date. Group homes check the list each time a person is considered for employment, and all current workers are checked against the registry twice a year, Scheff said.

As of Friday, there were 496 people on the abuse registry.