



**Legislative Hearing Report
Albert J. Solnit Center South and the OCA Review of
Circumstances Leading to the Death of Destiny G.**

September 26, 2018

Introduction

On June 28, 2018, a sixteen (16) year old girl who was a resident at the Albert J. Solnit Center South Campus' Psychiatric Residential Treatment Facility (Solnit S. PRTF) -- a program run by the Department of Children and Families ("DCF") — died by suicide a day before she was scheduled to be discharged to a foster home. Destiny was eight (8) months pregnant at the time of her death. Her unborn child did not survive. Solnit S. PRTF is state-owned and operated and is therefore not required to be licensed. The facility is subject to outside inspection where federal Medicaid law requires investigation of 1) a serious occurrence within the facility, or 2) a once every five year inspection – requirements undertaken in Connecticut by the Department of Public Health (DPH), under contract with Department of Social Services (DSS). For over a decade, the Solnit facilities, previously known as Riverview Hospital for Children and Youth, have been the subject of repeated concerns regarding safety, quality of care, and high cost.

On July 2, 2018, Hartford Courant reporter Josh Kovner, published information that "[t]hree months before a pregnant 16-year-old died in an apparent suicide at [Solnit], public health inspectors [as part of a DPH investigation of serious occurrences] had found that the center had failed to properly supervise two suicidal patients [in March 2018] and was generally placing the residents in 'immediate jeopardy' over gaps in 'medical treatment for injuries,' and the 'education and training' of staff." Mr. Kovner's July 2nd report was the first public mention of the existence of a DPH investigation/s, or that findings had been made that children in the facility were in "immediate jeopardy" of harm. In total, there were six (6) suicide attempts at the Solnit S. PRTF by children between November 14, 2017 and March 22, 2018. In June, Destiny died by suicide at the Solnit S. PRTF, and on July 15, 2018, another youth attempted suicide in the facility.

The dearth of public information prior to the Hartford Courant's July 2, 2018 report regarding DPH's investigative findings about the adequacy of care and the safety of residents at the Solnit S. PRTF occurred despite the involvement of three state agencies: DCF, DPH, and DSS, the pendency of the state's legislative session, and concurrent robust public discussion regarding the adequacy of oversight for state-run facilities and programs.

Consistent with OCA's statutory obligations to review "complaints of persons concerning the actions of any state or municipal agency providing services to children," "review the facilities and procedures of any and all institutions... where a juvenile has been placed by any agency," and "recommend changes in state policies concerning children including changes in the system of providing juvenile justice, child care, foster care, and treatment;"¹ the OCA conducted a review of circumstances leading to Destiny's untimely death in June of this year.

OCA's legislative report does not seek to indict the compassionate and dedicated work of child-serving professionals or investigators at any of the agencies referenced herein, or their collective efforts to serve vulnerable children. Rather, OCA's report was undertaken to respond to serious questions regarding how a state-run program for children became the subject of critical safety findings and how such findings could be made without stakeholders or the public being timely informed. Accordingly, OCA's report examines 1) the circumstances leading to the death of Destiny and her unborn child at the Solnit S. PRTF; 2) the adequacy of the state's framework for ensuring safe and high quality care at Solnit and at other child-serving treatment facilities; and 3) the mechanisms that exist for sharing critical information about the functioning of state-run or state-licensed child-serving treatment programs with stakeholders, consumers, and the public. OCA appreciates the responsiveness of the multiple state agencies whose role and activities are described in this report.

In the wake of Destiny's death, DPH, in partnership with DSS, immediately initiated an investigation of safety and care issues at the facility, conducting in-depth records reviews, unannounced site visits, and meetings with staff and administrators. In July 2018, DPH issued successive findings that children at Solnit S. PRTF were in "immediate jeopardy" of harm due to ongoing deficiencies. On July 27th and August 1, 2018, DPH and DSS told DCF that the Solnit S. PRTF must submit to a directed plan of correction as a condition of continued participation in the Medicaid program. Pursuant to the Directed Plan, DCF would be required to maintain an on-site consultation team, full time, to help implement necessary improvements, which team must report directly to DPH and DSS. DCF has since hired multiple experts to constitute the consulting team and their collective work is underway. On September 11, 2018, DSS issued another letter to DCF outlining a series of grave deficiency findings garnered from additional site visits by DPH in August. The independent consultants continue to work on the ground at Solnit, reporting findings and recommendations to all three agencies.

Findings

The Solnit Facilities

1. Solnit South - inclusive of the hospital and PRTF is an unlicensed, state-run, psychiatric treatment facility for children.

¹ Conn. Gen. Stat. 46a-13k *et seq.*

2. Solnit S. PRTF is situated on the same grounds as Solnit Hospital, previously known as Riverview Hospital, which over the last 12 years has been the subject of repeated concerns about the quality of care and treatment. Multiple public hearings have been held at the legislature regarding the future of Riverview/Solnit.
3. From 2006 to 2008, then Governor M. Jodi Rell directed the facility to be subject to outside monitoring.
4. As recently as 2011, legislators discussed the benefits and consequences of ending DCF management of Solnit and building additional capacity in the private provider community to serve children with complex psychiatric treatment needs.
5. DCF has undertaken multiple facility improvement plans over the years, and in 2012 restructured the Solnit campus to include both in-patient hospital units and the PRTF.
6. As of August 2018, the per diem cost of a bed at Solnit S. PRTF was approximately \$2,900. The PRTF has 24 beds. The entire Solnit South campus, inclusive of the hospital, has 74 beds.

Solnit is a Medicaid-participating Facility and Subject to Specified Oversight/Investigation per Federal Medicaid Law

7. Solnit hospital and PRTFs participate in the federal Medicaid program and as a condition of the state's reimbursement DCF must attest to and DSS, the State Medicaid Agency, must ensure compliance with Medicaid performance requirements.
8. Based on the number of PRTF facilities, every 5 years DSS must ensure inspection all of the state's PRTFs (there have been 5) to audit the facilities' compliance with Medicaid requirements. These audits are conducted by DPH.
9. Neither DPH nor DSS conducts any routine audits or inspections of Solnit as the DCF-run hospital and Solnit S. PRTF are not subject to licensure under Connecticut's system. PRTFs run by private agencies in Connecticut are subject to *DCF* licensure and are inspected quarterly.
10. DPH, functioning as a contractor of DSS, is authorized under federal Medicaid law to investigate serious occurrences at Solnit (and other Medicaid-participating facilities). In this way, DPH and DSS share authority and responsibility to ensure safe and appropriate care at Solnit S.

Nov. 2017 to July 2018—8 Suicidal Incidents at Solnit S. PRTF. Findings Issued that Children at the Facility were in Immediate Jeopardy of Harm. Significant Corrective Action Required.

11. Between November 2017 and July 2018 there were eight (8) serious occurrences at Solnit S. PRTF that involved a suicide attempt (7) or a suicide (1).
12. DPH did not conduct immediate site visit investigations in response to the three suicide attempts at Solnit S. PRTF which occurred in November and December 2017.
13. In the wake of the three 2017 suicide attempts and additional suicide attempts at Solnit S. PRTF in February and March 2018, DPH conducted investigation activities at the facility in February, March and April of 2018, issuing numerous deficiency findings to DCF and a finding that certain deficiencies placed children in "immediate jeopardy" of harm. DPH's findings included concerns that a) certain children were not adequately assessed for safety or risky behavior; b) that the environment of the facility contained ligature and other risks that placed children in jeopardy of self-harm; c) that children were not adequately assessed prior to leaving the facility for community activities, passes, or visits.
14. In interviews with OCA, DPH staff stated that findings of Immediate Jeopardy in a child-serving psychiatric treatment facility, including hospitals and PRTFS, are exceedingly rare.

DPH provided OCA with information regarding only one (1) other such finding in the last 5 years.

15. DCF responded to DPH's findings with multiple Corrective Actions in the winter and spring of 2018, submitted and approved by DPH—that committed to improved staff training, increased risk assessment and documentation, and review of the facility's off-grounds protocols. There were no investigation site visits to Solnit S. PRTF between April 13, 2018 and Destiny's death on June 28, 2018.

Findings Regarding Destiny's Death

16. After Destiny's death on June 28, 2018, DPH's investigation, conducted in partnership with DSS, found persistent deficiencies that again led to successive findings that children at Solnit S. PRTF were in "immediate jeopardy" and which culminated in a joint determination by DPH and DSS that a Directed Plan of Correction was required, inclusive of a mandatory on-site consulting team.
17. During August and September, 2018, collateral to the imposed condition of a Directed Corrective Action, DPH and DSS continued their respective roles in ensuring the facility's compliance with Medicaid requirements. On September 11, 2018, DSS sent a letter to DCF again outlining multiple identified deficiencies in the care and treatment of children at Solnit, including a finding that the facility failed to report at least one additional serious occurrence to DSS.
18. After OCA's review of circumstances leading to Destiny's death, OCA determined that Destiny minimally participated in individual clinical treatment while at Solnit S PRTF from her admission in February 2018 through her death in June. Despite her persistent refusal to engage in treatment, the resulting lack of documentation regarding her clinical progress, and multiple episodes of concerning behavior by Destiny, including expressions of anger, hopelessness and frustration in the weeks before her death, Destiny was scheduled to be discharged to a foster home on June 29th. OCA finds that Destiny's record lacks adequate documentation as to her readiness to leave the facility. OCA also finds that deficiencies identified with regard to the management of Destiny's care and treatment are similar, and in some cases, identical to deficiencies already identified by DPH in previous investigations and that were subject to corrective action from DCF.
19. The persistence of serious occurrences and repeated findings by DPH of deficiencies in the care and treatment of children at Solnit S. PRTF raise significant concern about the functioning of the facility, and the adequacy and monitoring of the successive corrective action plans.

Lack of Timely Public Disclosure Regarding Immediate Jeopardy Findings at Solnit S.

20. Until Destiny's death was publicly reported by the Hartford Courant, there had been no public disclosure of DPH's immediate jeopardy findings or the corrective actions underway at Solnit S. PRTF, including no disclosure to family members of children in the facility, legislators, or the DCF State Advisory Committee.
21. There is no statutory framework for ongoing inspection and regulation of Solnit to support safe and high quality care and treatment.
22. There is no statutory requirements that key performance and outcome measures regarding child-serving treatment facilities be regularly shared and made available to the public or even direct consumers of the programs.

Recommendations

1. State law should be revised to require that all state-run treatment programs for children be licensed and subject to routine program review and inspection.
2. State law should be amended to ensure an effective and transparent framework of critical performance and outcome measures that address safe and high quality care for children in state-run and state-licensed child-serving treatment and custody programs.
3. State law should be amended to require that such facility performance measures, including information regarding safety, child maltreatment, corrective actions, and treatment outcomes be regularly published and disseminated. A state agency-linked clearinghouse of information should be established that is consumer and family-friendly.
4. State law should require that consumers of state-run or state licensed child-serving treatment programs be immediately informed as to the pendency and general conclusions of regulators' investigations and program reviews.
5. A legislative working group should examine Connecticut's system of shared-accountability (DSS/DPH) for Medicaid-funded programs like Solnit to determine the efficacy of this structure for ensuring safe and high quality care and treatment for vulnerable persons. Such examination should include careful review of accountability frameworks and frameworks for continuous quality improvement used by other jurisdictions, such as Massachusetts.
6. A methodology for comprehensive case review sampling, inclusive of records review and stakeholder interviews, should be developed as part of an effective quality assurance framework for state-operated/state-regulated child-serving treatment programs.
7. Given the recurring controversies surrounding Solnit/Riverview, the high cost of Solnit, and the history of concerns regarding DCF's ability to sustain high quality care in the Solnit facilities, legislators, with the assistance of the working group, should consider the future of Solnit as well as other opportunities to re-balance the division of service delivery to children between state and community providers.

The Office of the Child Advocate

The OCA is an independent oversight agency authorized to: (i) “[r]eview complaints of persons concerning the actions of any state or municipal agency providing services to children . . . through funds provided by the state,” “[e]valuate the delivery of services to children by state agencies and those entities that provide services to children through funds provided by the state” and “[t]ake all possible action including, but not limited to, conducting programs of public education, undertaking legislative advocacy and making proposals for systemic reform and formal legal action, in order to secure and ensure the legal, civil and special rights of children who reside in this state.”² State law provides that “the Child Advocate shall have access to, including the right to inspect and copy, any records necessary to carry out the responsibilities of the Child Advocate . . . [and] may issue a subpoena for the production of such records.”³

² Conn. Gen. Stat. § 46a-13*l*.

³ Conn. Gen. Stat. § 46a-13*m*.

Methodology

In conjunction with the OCA's child fatality investigation into the death of Destiny on June 28, 2018, the OCA examined federal and state law and local practices concerning the regulation of health care organizations and the interplay between federal (CMS) and state (DPH and DSS) authorities with regard to oversight and enforcement. The OCA undertook the following activities in conjunction with this review:

- Review of federal and state law regarding the regulation and licensing of state health care organizations participating in the federal Medicaid Program.
- Review of agency guidance promulgated by the Centers for Medicare & Medicaid Services, which guidance is based on federal law.
- Review of accreditation process and requirements for maintaining accreditation by the Joint Commission.
- Review of clinical and education information for Destiny.
- Review of DPH surveys, findings and DCF corrective actions in 2018.
- Correspondence and discussion with representatives from DCF, DPH and DSS.
- Site visits to Solnit.
- Review of laws/regulations applicable to state health care organizations.
- Review of documents generated by DCF, DPH, and DSS with regard to the investigation of serious occurrences at Solnit, investigation of the facility, findings, corrective actions, and the dissemination of information regarding such events with consumers and the public.
- Review of initial report/s from the Independent Consulting team.
- Discussions and correspondence with the Centers for Medicare & Medicaid Services.
- Discussion with Destiny's relative guardian.

Albert J. Solnit Center South Campus

Albert J. Solnit South ("Solnit S.") is a campus which includes four co-ed hospital units in Middletown and three female Psychiatric Residential Treatment Facility cottages (Solnit S. PRTF) serving children under the age of twenty-one. The Solnit campus is state owned and run by DCF. There is another PRTF for boys in East Windsor, also operated by DCF, and referred to as Solnit North.

Per federal law, a PRTF is "any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21. The facility must be accredited by [the Joint Commission, an outside accreditation body] or any other accrediting organization with comparable standards recognized by the State."⁴

The Solnit South campus was formerly known as the Riverview Hospital for Children and Youth ("Riverview"). Both the in-patient units and the PRTFs participate in the federal Medicaid program

⁴<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/Downloads/WhatIsaPRTF.pdf>

and the state receives partial reimbursement dollars conditioned on meeting Medicaid performance criteria.

Historical Concerns about Safety, Care and Treatment at Riverview Hospital/now part of the Solnit Center

On multiple occasions over the last twelve years, Riverview Hospital/later Solnit had numerous problems identified with its operations. In 2006, a Program Review of Riverview Hospital was conducted by DCF, the OCA, and the *Juan F.* federal court monitor's office, noting stark concerns⁵ including inadequate attention to suicidal children.

Critical incidents on units, such as suicide attempts by children and assaults on staff, are often inadequately processed, or not processed at all with either the children or the staff. Specific to staff, the hospital has implemented and utilized systems ... which involve outside assistance to individual unit staff. This support is useful when available or when staff want it, but the units and the hospital as a system continue to ineffectively process critical incidents on an ongoing basis as a team in order to provide support to both staff and children, and to learn from the incidents in order to provide better patient care.

The 2006 report included extensive recommendations for improvements to Riverview, with rigorous attention paid to 1) suicide prevention; 2) utilization of restraint and seclusion of children; and 3) critical treatment planning issues.

Following the 2006 report, then Governor M. Jodi Rell issued a directive for an independent monitor to conduct ongoing oversight of the hospital and to ensure that critical recommendations arising from the program review were implemented. The monitor was housed at the OCA and she produced quarterly reports. The tenure of the monitor was two years; and at the close of the monitor's work, she concluded that progress was being made towards the corrective goals.

In 2011, Riverview Hospital was again deemed to have serious problems in its operation, and there were legislative discussions and a bill proposal to potentially close the facility.⁶ Commissioner Joette Katz, newly appointed to run DCF, questioned the need for a state-run psychiatric hospital for children:⁷

'Since she became the commissioner a month ago,' said [DCF spokesperson Gary Kleeblatt] of DCF head Joette Katz, 'she has been publically asking the question if the department should be in the business of running institutions. The question of Riverview Hospital needs to occur in that light, that context.'⁸

⁵ See *Riverview Hospital For Children and Youth Program Review*, Dec. 1, 2006

⁶ Senate Bill 198, An Act Concerning Riverview Hospital, found on the web: https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2011&bill_num=198.

⁷ *Official: Closing of Riverview Hospital just 'common sense,'* JASON SIEDZIK, Special to the Press, Published 12:00 am EST, Thursday, February 10, 2011.

⁸ Id.

The proposed bill calling for the development of a plan regarding the future of Riverview and consideration of alternate means to meet children's needs in other settings did not pass. Riverview⁹ remained under DCF, and remained unlicensed and therefore not subject to routine auditing or program review by DPH or DSS.

In 2012, Riverview was officially renamed the Albert J Solnit Children's Center, with a South Campus in Middletown and a North Campus in East Windsor.¹⁰ The re-naming came with a re-design of the facilities to include both the in-patient hospital beds as well as sub-acute hospital beds at both campuses (the PRTFs). The current per diem cost of a bed at Solnit S. PRTF is approximately \$2,900 per day or over \$ 1 million annually, with part of the cost borne by the state and part reimbursed by Medicaid.¹¹

In 2011, DCF responded to concerns about the facilities by convening a working group comprised of mental health experts and policy makers from within and without DCF, including the OCA, to reassess the facilities and offer recommendations for improvement and reform. A final report was released in March, 2012 describing the review and DCF's plan for the future of the facilities: The Albert J. Solnit Children's Center Final Consolidation Report.¹² Central to its facility improvement plan, in 2012, DCF announced ten key action steps to improve quality and safety at the facilities including: 1) An administrative consolidation of Riverview and Connecticut Children's Place into the Solnit Children's Center; 2) Integration of pediatric services across the new Solnit Center and CJTS; 3) Design changes that would create 6 rather than 8 inpatient hospital units and 6 sub-acute units (PRTFs) across the North and South campuses; 4) Improved linkages to DCF area offices; 5) facility oversight by a new DCF Central Office Unit; 6) Continuation as a teaching hospital; 7) Strategic interagency partnerships; 8) Participation in the DCF Training Academy; 9) Facility guidelines on restraint and seclusion; and 10) Application of implementation science and Results-Based Accountability.¹³

DCF has continued to own and operate the Solnit facilities through the present day.

Federal Regulation—Centers for Medicare & Medicaid Services

Though the Solnit PRTFs and the in-patient unit are state-run and unlicensed, both the hospital and the PRTFs participate in the federal Medicaid program, and are therefore subject to certain review under federal law. In order to participate in Medicare and Medicaid programs, facilities must meet specific health and safety standards. The Centers for Medicare and Medicaid Services (CMS) is part of the U.S. Department of Health and Human Services. It provides oversight to all health care

⁹ Since renamed and re-sectioned to include two PRTFs: Solnit North in East Windsor and Solnit South in Middletown on the hospital campus.

¹⁰ Public Act 12-82.

¹¹ Josh Kovner, *After Probe into Pregnant Teen's Suicide, Children's Psychiatric Center to Get Outside Monitoring, Freezes Admissions*, Hartford Courant, Aug. 10, 2018. <http://www.courant.com/news/connecticut/hc-news-solnit-suicide-intense-monitoring-0811-story.html>. A 2015 report from the Auditors of Public Accounts shows that the per diem cost of a bed at Solnit South at 2013 was \$2,423. The state is reimbursed a percentage of this cost via Medicaid dollars.

¹² OCA could not find this report on the DCF or CT.Gov website.

¹³ *Albert J. Solnit Children's Center Update: Discussion with the Connecticut Behavioral Health Partnership*, Jan. 18, 2012, found on the web: <http://www.ctnonprofits.org/ctnonprofits/sites/default/files/fckeditor/file/policy/private/Jon/SolnitCenterPresentation.pdf>.

organizations, including psychiatric hospitals and PRTFs that participate in Medicare and Medicaid programs. In Connecticut, DSS administers all Medicaid funding for the state.

To be certified as a Medicaid-participating program, states must have a mechanism for certification, and where prescribed, investigation of programs to assess compliance with Medicaid Conditions of Participation. Federal law provides that “inspection” is done on behalf of CMS by State Survey Agencies. In Connecticut, the State Survey Agency is DPH, and DPH works under contract with DSS, and in consultation with CMS, to ensure these responsibilities are fulfilled.

DPH reported to OCA that, pursuant to federal regulation, it has only conducted a routine audit/inspection of child-serving PRTFs in Connecticut once every five years.¹⁴ It does not conduct any other routine inspections or program reviews. DPH is, however, authorized under federal law to investigate a Medicaid-participating facility upon receipt of a serious occurrence notification that implicates the facility’s applicable Medicaid Condition/s of Participation.

Medicaid Condition of Participation for PRTFs (like Solnit S. PRTF)

Depending on the nature of the Medicaid-participating facility, there are different or fewer regulatory Conditions of Participation (CoP). The PRTF, which is a sub-acute level of care from an in-patient hospital unit, is subject to one (1) CoP related to the Use of Restraint and Seclusion. Federal regulation outlines that as part of the CoP, PRTFs must adequately protect residents, have appropriate orders and monitoring practices, parental notification procedures, appropriate medical treatment after an emergency safety intervention, adequate facility reporting procedures, and adequate education and training for staff so that they can identify resident behaviors, events, and environmental factors that may trigger emergency safety situations.¹⁵

Notification of Serious Occurrences by Facility to DPH/DSS

Solnit S. PRTF must give immediate notice to DSS and the State-designated Protection and Advocacy system¹⁶ of a serious occurrence in the facility.¹⁷ All notifications of Serious Occurrences are sent by DSS to DPH’s facility licensing and investigation division. If the serious occurrence falls under DPH’s authority to review the CoP for the facility, then DPH will investigate the occurrence, identify deficiencies, and require Corrective Action as needed.

¹⁴ The Medicaid requirement is that “survey agencies are required to validate the attestation statements for a 20 percent of all PRTFs in their state on an annual basis. Validation requires that the Survey Agency review attestation letters, conduct on-site review of PRTFs based on criteria established in 42 CFR 441.151 through 441.156, and determine compliance with federal standards and regulations.”

¹⁵ CFR 483.356 through 483.376.

¹⁶ OCA is copied on notifications from DCF of all significant events, serious occurrences, and critical and fatal injuries to children under DCF’s supervision, in DCF’s custody, or called into DCF as suspicious for abuse and neglect. There are several hundred such notifications every year received by OCA.

¹⁷ 42 CFR § 483.374(b)/ Reporting of serious occurrences.

Per federal regulation¹⁸ a “serious occurrence” includes a resident’s death, a “serious injury”¹⁹ to a resident, and a resident’s suicide attempt.

Investigation

For purposes of a facility investigation, DPH acts as agent of CMS, and per contract with DSS, looks at issues related to restraint and seclusion, inclusive of staff training, facility environment, and safe care for children.

Enforcement

If during its investigation, DPH identifies concerns and potential or actual federal regulatory violations in the facility, DPH, in consultation and partnership with DSS and federal CMS authorities, will discuss findings and corrective actions that will be required.

Following an investigation conducted by DPH, the facility will receive, if applicable, a “Statement of Deficiencies,” and the facility must submit a Corrective Action Plan or risk termination from the state’s Medicaid Program.

Immediate Jeopardy

The most serious deficiencies/violations lead to findings of “Immediate Jeopardy,” which is defined as: “[a] situation in which the provider’s noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.”²⁰

In interviews with OCA, DPH stated that findings of Immediate Jeopardy in a child-serving psychiatric treatment facility, including hospitals and PRTFS, are exceedingly rare. DPH provided OCA with information regarding only 1 other such finding in the last 5 years.

Medicaid Guidelines for Investigating Concerns of Immediate Jeopardy

The Medicaid State Operating Manual provides extensive guidelines for State Medicaid Agencies (DSS) and State Survey Agencies (DPH) regarding the investigation of circumstances which may or do represent concerns of Immediate Jeopardy.²¹ The Guidelines address the scope and methodology of the investigation, record keeping, and questions that must be answered by the investigation team, including:

1. How serious is the potential/actual harm?
2. Has [the harm] happened to other individuals? If yes, how many? Are there others to whom this is likely to occur?

¹⁸ 42 CFR § 483.352.

¹⁹ “Serious injury” as “any significant impairment of the physical condition of the resident as determined by qualified medical personnel. This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.” Id.

²⁰ See 42 CFR Part 489.3.

²¹ CMS/Medicaid State Operating Manual, Appendix Q. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf

3. Was the Immediate Jeopardy preventable? Is there a system in place to prevent further occurrences? Is this a repeat deficient practice?

Public Disclosure of Critical Findings Regarding Safety and Quality of Care in Child-Serving Treatment Facilities

Limited Information Published about Licensed Child-Serving Treatment Facilities

Most child-serving treatment programs in the state are licensed by DCF. Though Connecticut law provides that all records related to a child protection activities or children in DCF care are confidential, the same law provides that upon written request, limited information regarding a DCF-licensed facility will be disclosed.²² However, there is no statutory requirement that comprehensive and individualized performance information regarding licensed child-serving treatment facilities be shared with the public. This means that information regarding a licensed facility's record of safety, maltreatment, efficacy of treatment, or discharge outcomes are not routinely published for consumers and stakeholders.

There is no specific statutory requirement that DCF, DPH or DSS regularly publish information as to the existence of investigations, program reviews, or corrective actions regarding state-run, child-serving facilities.²³ A review of DSS', DPH' or DCF's websites does not bring up investigation or corrective action information about the Solnit S. PRTF.

For comparison purposes, information regarding a day care's inspection, license and corrective action history, with reference to relevant agency regulations (regulatory agency is the Office of Early Childhood) is available on the state's database for licensed programs. This database does not include information, however, about *DCF*-licensed programs.

DCF-run Facilities Required to Report to the DCF State Advisory Committee

There is a requirement in state law that children's facilities under DCF jurisdiction (which would include Solnit and the now-closed CJTS) are required to annually report performance information to the DCF State Advisory Committee (SAC).²⁴ **However, a review of the SAC website does not reveal or list any DCF facility reports.**²⁵

DCF Did Not Disclose Information Regarding the Immediate Jeopardy Findings at Solnit Prior to Destiny's Death

²² Conn. Gen. Stat. 17a-28(e) requires disclosure upon written request of the name of the license, the date and status of the license, whether an investigation or review is pending, and whether DCF has taken a licensing action

²³ The family of a child who is the victim of maltreatment will receive information related to the existence of the DCF investigation and subsequent findings by DCF. There is some aggregate "report card" information about residential treatment (this does not include DCF *run* programs, however) that looks at indicators such as restraint and seclusion, repeat admission, exit to higher level of care. But these reports are not broken down by facility. They are available on the DCF website here: <https://portal.ct.gov/DCF/RBA/Home#ReportCards>.

²⁴ Conn. Gen. Stat. 17a-32a. There is significant information posted by DCF regarding the efficacy of community-based service models and in-home service models.

²⁵ <https://portal.ct.gov/DCF/State-Advisory-Council/Home>

As part of this review OCA sought to understand more about how, to whom, and when DCF disclosed the DPH deficiency findings regarding Solnit S PRTF. Accordingly, OCA requested the following information from DCF --

We are requesting information regarding what entities or stakeholders outside of DSS or DPH were notified (and when such entities or stakeholders were notified) of DPH inspection findings and DCF corrective actions related to Solnit South within the past 18 months including, but not limited to, parents/guardians, relevant advisory committees, public/elected officials.

DCF did not produce documentation indicating that any parent/guardian, advisory committee or legislative official was notified of the deficiency findings, including Immediate Jeopardy Findings, or Corrective Actions regarding Solnit S. PRTF, prior to Destiny's death in June, 2018.

DCF did not produce information that it notified its State Advisory Committee of the deficiency findings regarding Solnit.²⁶ DCF also provided no information that the deficiency findings regarding Solnit or the need for Corrective Action were provided to other relevant councils and committees, including the state's Behavioral Health Partnership Oversight Council,²⁷ or the DCF Regional Advisory Councils.

The lack of disclosure regarding DPH's findings about child safety in a DCF-run facility resounds against the backdrop of recent and robust public discussion about the adequacy of the current oversight/regulatory framework for state-run institutions and programs. During the 2018 legislative session there was significant discussion in the Connecticut General Assembly's Public Health Committee regarding the oversight/regulatory framework of the adult-serving state-run psychiatric hospital (CVH) with specific focus on the forensic division. There was also a bill proposal for a legislatively appointed DCF Oversight Committee—duties of which would have included monitoring and evaluating DCF policies and practices related to child and youth safety and well-being, and submitting policy and legislative recommendations to DCF and the legislature. This proposal was passed by the Senate and House but was vetoed at the close of the session.

There is an urgent need to create a transparent and accountable framework for child-serving treatment facilities, licensed by DCF or run by DCF (or other state agencies) to ensure safe and high quality care for vulnerable children.

Serious Occurrences at Solnit South PRTF from January 2017- July 2018

²⁶ Conn. Gen. Stat. 17a-4. Provides that the role of the SAC includes making recommendations to DCF which will “improve services for children and youths, including behavioral health services ... interpret to the community at large the policies, duties and programs of the department ... issue any reports it deems necessary to the Governor and [DCF] ... [and] independently monitor [DCF]’s progress in achieving its goals as expressed in [the agency’s] strategic plan.” DCF’s website hosts the SAC information. There is no meeting information posted since 2017. <https://portal.ct.gov/DCF/State-Advisory-Council/Home>

²⁷ Conn. Gen. Stat. 17a-22i. Duties of the Council include: “review of periodic reports on program activities, finances and outcomes ... on achievement of service delivery system goals” which goals include review of emergency department overcrowding and reducing admissions and lengths of stay in hospitals and residential treatment facilities.

OCA examined serious occurrences at Solnit S PRTF from January 2017 through July, 2018 that involved suicide attempts or suicide. OCA found 8 reported serious occurrences between November 2017 and July 2018: **7 suicide attempts and 1 suicide.**²⁸ OCA examined activities from DPH, DSS and DCF in response to these serious occurrences.

As part of this review, OCA also examined more than 60 additional incidents at Solnit S PRTF that were coded internally as “DCF Significant Events,” and that involved a variety of concerning resident activity such as AWOLs, AWOLs with some attempt to self-harm, peer-to-peer altercation, and accidental injury. There are some incidents that involved the AWOL of a resident from the PRTF along with the resident’s attempt to self-harm that were not coded as a Serious Occurrence and therefore were not reported to DPH.²⁹ Some of the incidents may fall into a gray area in terms of reporting, based on the facility’s assessment of whether the child was significantly harmed or had an actual intent/plan to die. The most recent letter from DSS to DCF, dated September 11, 2018, included a finding that Solnit did not transmit notification of at least one incident of self-inflicted serious injury, which injury was subject to serious occurrence notification.

7 Suicide Attempts and 1 Suicide at the Solnit-S PRTF Nov. 2017- July 2018.

1. November 16, 2017—Serious Occurrence: Suicide Attempt

Youth attempted to hang herself using a sweater attached to the hinge of the closet door in her bedroom. She reported the incident on her own, saying that she stopped when she began to feel physical distress. The youth was seen by her attending psychiatrist and placed on watch precautions, which per DCF’s record resulted in the locking of her closet door, eliminating potential ligature points, and restricting her access to potentially dangerous items.

2. November 29, 2017 – Serious Occurrence: Suicide Attempt

Youth stated she wanted to be hospitalized, and she did not respond to verbal support from staff. She ran from the unit, expressed suicidal intent and her desire to jump off a nearby bridge into a river. She had to be restrained on the bridge to keep her from jumping off. Police assisted with her return to the campus and she was hospitalized on the in-patient unit.

3. December 25, 2017 – Serious Occurrence: Suicide Attempt

Youth was on a day pass from the facility. Another youth called the facility to state that youth # 1 wanted to hurt herself and others. When staff connected with youth #1’s guardian, staff was informed that the youth had already attempted to hang herself, was found unresponsive and was currently being transported by Life Star to a local hospital.

4. February 2, 2018 – Serious Occurrence: Suicide Attempt

Youth engaged in self-injurious behavior, including banging her head. When staff checked on youth in her room, she was found lying in her bed with a sheet tied around her neck. Staff was

²⁸ There were other reported serious occurrences that involved accidental injury and injuries incurred as a result of a fight between peers.

²⁹ Example: October 31, 2017—Significant Event (DCF). Youth stated that she didn’t want to be here anymore, and walked off the unit without permission; staff followed. Youth made statements of wanting to jump off the bridge. DMHAS police responded and detained her; youth was returned to the unit. After a nurse and doctor assessed the child as high risk, youth was sent to CCMC by ambulance, for psychiatric evaluation.

able to remove the sheet but also found a hair band around the child's neck which they also removed. The child was assessed and transferred to the Solnit in-patient hospital unit.

5. **March 11, 2018 – Serious Occurrence: Suicide Attempt**

Staff went into a youth's room at dinner time; youth had been sleeping during previous checks. When youth was awakened for dinner, she was found lying in a large amount of vomit. Upon waking, she was disoriented, unable to report what happened. Youth later reported that she consumed 144 pills of Benadryl and the empty packs were found in her backpack. She stated that she wanted to kill herself then reported that she digested sleeping/anti-histamine pills as a suicide pass. Youth was transported to a local hospital.

6. **March 21, 2018 – Serious Occurrence: Suicide Attempt**

Staff heard a bang from youth's bedroom. Upon entering the youth's room, staff observed her face to be discolored and she had multiple scarves tied around her neck. Youth was assessed by medical and psychiatric staff and hospitalized. (A Solnit staff member reported to the OCA that if staff had not heard the noise from the youth's bedroom, they were fearful the youth would have died.

7. **June 28, 2018 – Serious Occurrence: Suicide**

Destiny was found hanging in her room. She was transported to a local hospital and died from her injuries.

8. **July 15, 2018 – Serious Occurrence: Suicide Attempt**

Youth was reportedly upset, retreated to her room with staff following. When she entered her bedroom she got in bed and put the covers up. When staff lifted the blanket they saw something in her hand and around her neck. Staff was able to get youth up and remove item from her neck, but youth sought out a piece of jewelry and tried to cut her wrist. She was restrained, assessed, and transferred to the in-patient unit.

DPH, DSS, and DCF Activities Conducted in Response to Serious Occurrences at Solnit

November 2017 - January 2018

While serious occurrence notifications of the three suicide attempts at Solnit S. PRTF in November and December were immediately transmitted by DCF, DPH did not conduct an onsite survey/investigation of the incidents until its February site visits (see below). DPH reported to OCA that its facility investigators folded in at least two of the suicide attempts into the February survey of Solnit S. The February survey does not expressly reference either of those occurrences.

Solnit leadership and managers on their own conducted an internal review of serious occurrences and "high end youth" at the Solnit S. PRTF, and facility notes and correspondence from January 2017 shared by DCF with OCA indicate that Solnit administrators expected an imminent investigative

response from DPH.³⁰ DCF records also indicate that Solnit leadership directed the following corrective actions internally:

1. Additional suicide prevention training for staff.
2. Steps to ensure that facility “visitation procedures” were reviewed, and all clinicians were directed to ensure that an assessment of a resident’s readiness to participate in unsupervised passes and a safety plan for the pass would be documented in the resident’s record.
3. A review would be conducted of the facility’s tools used to assess residents for discharge.

It is unclear why DPH investigators did not conduct an immediate review of the November and December suicide attempts. The CMS State Operations Manual for PRTFs provides that any investigation of allegations which “may represent an immediate jeopardy situation” must be conducted “within 2 working days of complaint receipt” and that for “non-immediate jeopardy situations, the State Medicaid Agency in conjunction with the Survey Agency will establish a mechanism by which to prioritize the nature of complaints.” OCA has not been able to confirm whether DPH or DSS interpret the applicable regulations and guidance as having required an immediate on-site investigation of the three suicide attempts in late 2017. In response to questions from OCA, DPH stated that there is no “prescribed” timeframe for initiating and completing a review or issuing findings.³¹ In correspondence with CMS officials, OCA received information that “[u]sually after receiving a serious occurrence report ... [the state survey agency] will conduct an unannounced survey of the facility,”³² and that the survey agencies follow CMS guidelines for addressing concerns of Immediate Jeopardy.

Subsequent suicide/suicide attempt notifications received by DPH were immediately investigated in March, June and July of 2018.

February 2018 Investigation by DPH—Deficiency Findings

DPH’s Facility Licensing & Investigations Division conducted multiple unannounced site visits³³ at the Solnit S. PRTF in February: 2/1, 2/6, 2/23, 2/26, to assess the facility’s compliance with its CoP, presumably after DPH received the November and December serious occurrence notifications. There was an additional suicide attempt in the facility on February 2nd. Though the DPH report does not specifically reference or analyze any of these four suicide attempts, both DPH and DCF indicated that specific youth incidents were the trigger for DPH’s February investigation. DPH identified the following deficiencies:

- a. Use of Restraint and Seclusion³⁴— DPH found that based on documentation, interviews and site visits, the facility failed “to ensure that the environment was free from ligature risks to secure a safe environment.”
- b. Education and Training³⁵ -- DPH found that the facility was not in compliance with this requirement due to the same evident safety risks in the environment.

³⁰ An email from DSS to DCF, dated January 5th, 2018, indicates that the DPH Facility investigations Division was seeking additional information regarding the December 25th 2018 suicide attempt of a resident on pass from Solnit. PRTF administrator responded that the facility had been sending updates herself to DPH investigators.

³¹ Email between DPH Branch Chief for Healthcare Quality and Safety.

³² Email to OCA from CMS headquarters, dated Sept. 24th, 2018.

³³ All DPH site visits in response to concerns are required to be unannounced by CMS.

³⁴ CFR 483.354.

³⁵ CFR 483.376.

DSS as the State Medicaid Agency informed DCF of the deficiencies and directed DCF to submit a plan of corrective action to DPH, which would be reviewed for adequacy and checked by re-visit to ensure compliance. DCF submitted a Corrective Action, which was approved by DPH.

Compared to later survey reports by DPH in March and July, the February report was brief, did not reference the accumulation of 4 suicide attempts since November, and did not make any findings of Immediate Jeopardy.

March 2018 Investigation by DPH, with DSS—Immediate Jeopardy Finding

In response to the two more suicide attempts by girls at the Solnit S. PRTF in March, DPH's Facility Licensing & Investigations Division, this time "in partnership with DSS"³⁶ conducted multiple unannounced site visits to assess the facility's compliance with the code of federal regulations for PRTFs. DPH and DSS's visits and DPH's investigation "**identified the most serious deficiencies [at Solnit S. PRTF] to constitute immediate jeopardy to health and safety.**" Specifically, investigators found the following deficiencies/violations:

DPH found:

- The facility failed to provide the appropriate level of supervision which resulted in a resident who had a significant suicide history and recent suicidal ideation consuming an excessive number of medication (obtained during a staff-supervised community pass) in a suicide attempt while in the facility.
- Failed to transfer a resident who had made a suicide attempt to an acute care setting.
- Failed to follow facility policy requiring a physician order prior to approval of a resident attending an off-ground activity.
- Failed to follow facility policy to assess all youth for safety prior to youth leaving on an off-grounds activity.

OCA finds that the DCF internal corrective action measures outlined in January 2018 were meant to address aspects of the deficiencies now identified by DPH in March 2018.

April 6, 2018 -- Letter from DSS to DCF-- Corrective Action Needed to Address Immediate Jeopardy

The DSS letter advised DCF that it had 10 days to submit the required Corrective Action Plan, that the facility would be reviewed again in a follow-up visit, and that the Corrective Action must address, in part, "What measures will be put into place or systemic changes made to ensure that the deficient practice does not recur," and "to ensure the solutions are permanent," and that "corrections are achieved and sustained."

DCF's plan of correction contained numerous action steps, including:

1. Additional training for supervisory staff regarding medical assessment procedures.
2. Additional training for all staff on youth care, suicide prevention, management of risk, and other updates to staff/facility protocols.
3. Creation of an interdisciplinary committee focused on suicide prevention.
4. A senior leadership review of all youth currently in care to ensure that those with histories of suicidal ideation/gestures/attempts had targeted treatment interventions in their treatment plans.

³⁶ April 6, 2018 letter from DSS Medicaid Director Kate McEvoy to DCF, on file with OCA.

5. A restructuring of staff resources.

The finding of immediate jeopardy was removed by DPH on April 13, 2018.

April 13, 2018 through June 28, 2018, Destiny's Death

No site visits conducted by DPH. In response to OCA questions regarding whether DPH is authorized to conduct additional site visits to monitor compliance with the facility's corrective action plan, DPH provided a copy of the Medicaid State Operating Manual, but did not clarify its interpretation of applicable provisions.

June 29, 2018 DPH/DSS Site Visit to Solnit—Immediate Jeopardy Finding

Following Destiny's death on June 28th, 2018, DPH, in partnership with DSS, immediately conducted an unannounced site visit at the Solnit S. PRTF. Additional site visits ensued. By July 2nd, 2018, DPH had identified deficiencies leading to another finding of "Immediate Jeopardy."

July 10, 2018—Letter from DSS to DCF Regarding the New Immediate Jeopardy Finding

On July 10th, DSS sent a letter to DCF stating that the June 29th site visit revealed that Solnit S. PRTF "failed to ensure that the facility was free of ligature risks in an environment that cares for residents with behavioral diagnoses and that emergency equipment was readily accessible in the event of a medical emergency." The letter stated that as a result of the investigation, investigators found:

"The most serious deficiencies ... to constitute immediate jeopardy to health and safety."

As with previous letters to DCF, DSS stated that a Corrective Action Plan must be submitted to DPH within 10 days and that the Plan must address individual and systemic concerns, and how to ensure durability and sustainability of improvements.

July 13, 2018 -- DCF Submits Corrective Action Plan

DCF's Corrective Action Plan was submitted to DPH, and focused, in part, on:

1. Increasing staffing levels for the PRTF;
2. Addressing environmental hazards and risks;
3. Enhancing/increasing training for staff;
4. Requiring a nursing assessment for each youth on each shift;
5. Ensuring additional emergency medical equipment for each unit and cottage at the Solnit in-patient unit and the PRTF.

July 18, 2018 -- DPH Investigation Post Destiny's Death Continues -- Another Immediate Jeopardy Finding is Made

On July 16th, 2018, DPH completed an investigation report, and on July 18th, 2018, DSS sent a letter to DCF notifying it of another "immediate jeopardy" finding. The DPH report included reference to investigators' review of multiple youth's clinical records and another suicide attempt on July 15th. DPH found:

1. Based on staff interviews and review of records associated with youth who had histories of suicidal ideation and self-harm behaviors, the Solnit S. PRTF "failed to ensure that assessments were conducted timely when a change in condition/behaviors were noted and/or failed to provide the appropriate level of observation/supervision and/or failed to initiate the

emergency medical system timely and/or conduct environmental assessments and/or when such change was noted resulting in the finding of immediate jeopardy.”

2. With regard to Destiny, DPH found that in the month prior to her death, facility records documented “multiple incidents of anxiety, threatening behaviors that included acts of violence, irritability, multiple refusals to speak with clinician, and verbal expressions of hopelessness...” Though the record reflected Destiny’s reservations about her discharge to a foster home in the days prior to her suicide, DPH found that “the clinical record failed to identify that such reservations were explored further.”
3. DPH reviewed the record of another youth who engaged in suicidal behavior, finding that “[a]lthough the [unit] staff identified concerns regarding a change in Resident’s behavior, the clinical record lacked documentation of an [nursing] assessment and/or the implementation of additional interventions to ensure resident safety once suspicious behaviors were noted.”
4. DPH reviewed the record of a third youth who deliberately cut herself in the facility, finding that “the facility failed to explain discrepancies in documentation related to the type of object Resident utilized to injure self and/or failed to complete inspections of resident possessions to ensure a safe environment.”

OCA finds that the deficiencies identified by DPH in its July 16th report are similar to issues identified or addressed in previous reports and corrective action plans. The timeline and recurrent nature of similar deficiencies related to safe environment, treatment planning, and suicide prevention, raise stark questions regarding the adequacy, implementation and sustainability of corrective action plans. A July 2nd, 2018 Hartford Courant article about events at Solnit S. quotes a spokesperson for DPH who acknowledged the previous findings of immediate jeopardy in March and who stated that the designation “had been lifted in the spring, and that Solnit [S. PRTF] was back in compliance before [Destiny’s] death.”³⁷

July 19, 2018 – DCF Seeks Independent Review of Safety Concerns at Solnit.

One day following DSS’ letter to DCF regarding the new finding of Immediate Jeopardy at Solnit S. PRTF, DCF determined that “fresh eyes” would be helpful to ensure that DCF was “doing everything possible to secure a safe environment.”³⁸

July 27, 2018—DPH Recommends a Directed Corrective Action Plan (CFR 488.424)

As a result of its investigative findings, DPH sent a letter to DCF articulating its recommendation to DSS, as the State Medicaid agency, that DCF be subject to a “Directed Plan of Correction.” The DPH communication outlined the mandatory provisions of the proposed Directed Plan of Correction, which provisions included:

1. Retention of an “independent health care/behavioral health consultant, pre-approved by DPH and DSS... [which consultant] shall have knowledge, education and experience” regarding Medicaid requirements for PRTFs.
2. The independent consultant (IC) must provide services to Solnit S. for a minimum of 40 hours per week.
3. The IC must “assess, monitor, and evaluate the coordination of resident care and services ... and make recommendations for improvement.”

³⁷ Josh Kovner, Hartford Courant, *3 Months Before Pregnant Teen’s Death, DCF Center Had Been Found To Place Patients In ‘Immediate Jeopardy,’* July 2, 2018.

³⁸ Josh Kovner, Hartford Courant, *DCF Commissioner Orders Outside Review of Solnit Center Following Pregnant Teen’s Suicide,* July 19, 2018.

4. The IC must review clinical records, incident reports, and all facility policies and procedures related to care and services.
5. The IC must conduct an environmental risk assessment of the facility within 14 days (of a contract), with recommendations for improvement.
6. Within 21 days (of a contract) the IC must submit a report to DSS and DPH regarding its assessments and recommendations.
7. Mandatory utilization of nurse supervisors on every shift.
8. The development of a Quality Assurance Performance Improvement Program.

August 1, 2018—Letter from DSS to DCF Supplementing the Directed Plan of Correction

On August 1st, DSS sent a letter to DCF stating that it had adopted the DPH recommendation for a Directed Plan of Correction for Solnit S. PRTF. DSS noted that several provisions of the directed Plan of Correction involved improvements to clinical services, and DSS was not able to determine if the firm selected by DCF had the requisite expertise. Therefore, DSS stated that it and DPH would approve DCF's firm with the provision that there be an additional arrangement or DCF contract with a consultant who has "specific expertise necessary to address the clinical concerns," identified by DPH and DSS.

DCF subsequently sought additional clinical consultation to work with the contracted firm selected, Barrins & Associates.

August – September 11, 2018. Investigation by DPH—Deficiency Findings

DPH continued assessment of conditions at the Solnit PRTF and conducted a site visit on August 18h, 2018 to assess conditions and "the Immediate Jeopardy to Health and Safety that was identified on July 16th, 2018."³⁹ The DPH report was completed August 28th and a letter outlining the new deficiency findings was sent by DSS to the Solnit Superintendent on September 11th. The 44 page DPH report itemized concerns derived from a series of clinical records and interviews with facility staff. DPH made the following findings:

1. The facility did not meet federal requirements regarding adequate individual plans of care for all youth and ensuring safe discharge plans;
2. The facility failed to report a serious occurrence (self-inflicted lacerations to a youth's arm).
3. The facility failed to ensure a clean, safe and sanitary environment and failure to ensure all necessary equipment was ready for use during a medical emergency.

DPH continues to actively review DCF's compliance with the Directed Plan of Correction and the facility's compliance with Medicaid Condition/s of Participation for PRTFs. The Independent Consulting team has submitted multiple reports as of September 21st, 2018.

Destiny

Destiny's very early life included her exposure to trauma. Guardianship of Destiny was granted to a relative when she was two years old. In September 2016, Destiny was hospitalized for a suicide attempt after she took an overdose of Tylenol. Destiny was placed in DCF's custody in October 2016. The

³⁹ Letter from the DSS Medicaid Director to Solnit Superintendent, dated September 11th, 2018.

record indicates that Destiny's guardian was doing the best she could, but was struggling to address Destiny's substantial mental health treatment needs. Once in DCF care, Destiny continued to struggle and engaged in many high risk behaviors. Destiny moved through a variety of DCF-licensed placements, including a temporary therapeutic group home (SFTT), foster home, and multiple stays in short-term congregate care (STAR homes).

Destiny ran very frequently from DCF placements, sometimes for days at a time. There was significant concerns outlined in her record that while AWOL she engaged in very high-risk, unsafe behaviors in the community.

In June 2017, the STAR group home that Destiny was living in expressed significant concern to DCF that staff did not "feel they could offer anything additional to help stabilize Destiny as she has continued to refuse services." The program staff stated that Destiny had already been in their program for almost 200 days and they recommended a "higher level of care for her." Destiny's relative expressed concerns that Destiny's needs were not being adequately addressed in state custody.

After August 2017, the DCF and community provider records continued to reflect numerous concerns about Destiny engaging in high-risk behavior and abusing substances. DCF facilitated multiple referrals for Destiny to residential care, but records indicate that Destiny did not cooperate with placement interviews and continued to AWOL regularly.

In December, 2017, Destiny was informed by her DCF social worker that she would likely be referred to a hospital setting. Destiny was upset about this prospect and said that DCF was "making her life worse." The DCF record states the following:

"She was depressed being in DCF care and [said] that she didn't have the balls to kill herself, but if someone was to put a gun to her head at least she would be with her grandfather who loved her... Destiny denied wanting to harm herself ... however, she stated that she [was] not afraid to die because everyone dies."

The record indicates that Destiny was struggling with depression and suicidal ideation at that time, making statements that she "wished she was dead," and that "she doesn't want to be here." As a result of the hopeless statements she made, Destiny was brought to a local hospital where she was deemed to meet in-patient level of care. Solnit agreed to take her, but they reportedly had a multi-week waiting list. She was therefore transferred to a local inpatient adolescent unit. She stayed there for one week and was discharged back to the STAR home where she continued to AWOL until her admission to Solnit S. PRTF on February 6, 2018.

Destiny's Admission to Solnit S. PRTF

Destiny's Solnit record indicates that upon admission she was considered "low risk for suicidal attempts, self-injurious behavior or assaults." Destiny was known to be 12 weeks pregnant at the time of her admission. Despite the admission assessment of Destiny as being low risk for suicide, the admission records also reflect Destiny's recent hospitalization for suicidal ideation and Destiny's statement that she within the past few months she experienced depression and acknowledged feeling that "she did not mind if she died if it was her time."

The admission assessment references a reported family history of suicide attempts and notes Destiny's higher risk for suicidality and depression given this history. She was identified as having many

strengths: she was artistic, liked music and singing. She stated she liked to build things and do arts and crafts. Destiny stated that she wanted to engage in treatment at Solnit to offer herself and her child a better life.

Destiny's Treatment Plan/Goals

Destiny was expected to attend school at the Solnit School; participate in group activities on the unit or in the facility; meet with a clinician/psychologist twice per week; and meet with a psychiatrist twice per month.

- Education. Destiny's education record indicates that she was often absent from the Solnit school program. Her progress report from June 2018 included multiple notes from teachers that Destiny did not demonstrate progress or demonstrated limited progress in various educational areas due to "chronic attendance issues." One exception was that Destiny demonstrated satisfactory progress with reading.
- Group Activities. The record reflects that Destiny demonstrated some willingness to engage in group activities and she showed a preference for "rehab therapy assessment" activities, such as woodworking, games, music, and art work.
- Clinical Treatment. Destiny's clinician was to meet with her twice per week to work on "interpersonal effectiveness, distress tolerance, and emotional regulation skills." Between February and April 2018 most interactions between Destiny and her clinician were due to the clinician's supervision of Destiny's calls to her family, with some noted level of engagement between Destiny and her clinician. Clinical notes indicate that Destiny had "mixed feelings" regarding her pregnancy. She continued to express her desire to live with a family member and her frustration that being in DCF care was ruining her life.

Beginning in late-April 2018, Destiny began to refuse engagement with her clinician.

From April 24th, 2018 through her death in the end of June, there is no further documentation of an individual clinical session for Destiny. Progress notes became sparser or were not entered in May and June.

- Psychiatric Treatment. Destiny was to meet with the psychiatrist twice per month to assess her mental status and monitor the efficacy of her treatment.

Records indicate Destiny refused to meet individually for sessions with the psychiatrist on March 12, March 29, April 10, April 30, (mid-May no record), May 21.

A psychiatric progress note in May indicated that Destiny was "not cooperative in engaging in individualized meeting."

June 5: the psychiatric note indicated that Destiny talked about her "gender reveal" party, and she was told of the pending transfer of her case management to a new psychiatrist. Destiny stated she had no concerns. The note acknowledged occurrences of oppositional behavior by Destiny towards staff and recent sanctions for that behavior.

June 19: Destiny was transferred to a new psychiatrist. There is no record that Destiny met with the newly assigned psychiatrist prior to her death on June 28.

There were a number of entries in Destiny's Solnit record from May and June, 2018 regarding her concerning behavior on the unit, with descriptions of her behavior as "defiant," "threatening," and "rude." A nursing note on June 7th stated that Destiny "presented significant safety risk to herself and staff members," in that she threatened multiple staff members while working in the kitchen. Also in June Destiny was mandated to complete multiple restorative "action plans," to address her oppositional behavior on the unit.

A nursing note from June 15th states that Destiny was refusing to eat that day, and that Destiny said the following:

"I'm tired of people telling me that it will be ok. I'm tired of trying. Nothing works out, it only gets worse."

Nursing notes record that Destiny "was given encouragement, but she walked away. [Unit Supervisor] was notified of the conversation." There is no documentation in the record of follow-up to these statements by her assigned clinician or psychiatrist.

Nursing notes from June 18th and June 20th indicate that Destiny went on passes/ visits with a prospective foster family, and that Destiny stated the visits went well. However, the note from Destiny's assigned clinician dated June 21st stated that Destiny "refused to meet with the clinician" to discuss the foster home visit/s, and she refused to attend her "care planning meeting." A note in the record also indicates that Destiny shared with "nursing staff some reservations she was having about" being discharged to a foster home.

In the last week of her life, Destiny's record reflects her continued struggles on the unit, including an incident on June 22nd, 2018 where she engaged in threatening verbal behavior (to others), including stating that she would "hurt or kill someone that gets in her way," and that "she didn't care if she was pregnant." Also on June 22nd, 2018, the Solnit record indicates that Destiny's clinician sent her a typed letter. The letter acknowledged that Destiny was "not speaking" to the clinician, but that a foster home overnight pass had been scheduled for the upcoming week. The clinician advised Destiny that the psychiatrist would need to talk to her prior to going on the pass. The clinician described this meeting as "standard procedure." The letter further stated-

[The psychiatrist] just needs to know that you are committed to being safe on the pass and using a safety plan if you need to. I'm pretty sure [psychiatrist] will not write the pass without talking to you – it may not need to be a long conversation but it has to happen.

There is no documentation in the record that the psychiatric assessment took place. On June 23rd, the record describes Destiny as spending the day in her room, presenting as "rude and irritable." There is no documentation in Destiny's clinical record on June 24th, 25th or 26th.

On Monday, June 25th, the clinician responded to an inquiry from Destiny's DCF caseworker by emailing her information about Destiny's foster home visit:

"Overnight is tonight ... After that we can see if Destiny feels ready for discharge on Friday or would want to visit more – to give her some sense of control over the transition."

Destiny left Solnit for the overnight with the foster home. There is no record that the assigned clinician or psychiatrist assessed Destiny upon her return to Solnit on June 26th. A June 27th email sent by the assigned clinician to the DCF area office stated that “Destiny returned to Solnit last night in positive spirits [and] she is wanting to leave on Friday as planned. [The clinician] spoke with foster mother who also reported that the overnight went well.”

As part of this review OCA met with the Village for Children and Families, the agency who was supporting the therapeutic foster home that Destiny was being placed with. In response to questions about what clinical records or summaries the agency received to support the foster home match, the Village staff reported that they received a therapeutic foster care referral packet which contained some but not detailed or comprehensive information about Destiny’s clinical profile. The Village stated they did not receive any documentation from Solnit regarding Destiny’s progress in treatment nor was the Village aware of a pattern of any depressive behavior on Destiny’s part.

On Wednesday June 27th, Destiny left Solnit for a doctor’s appointment and was described in a unit nursing note as having a “bright affect upon return.”⁴⁰

Through email to the Solnit clinician in the days prior to Destiny’s anticipated discharge, Destiny’s DCF caseworker expressed some concern about the lack of educational plan in place for Destiny who had stated reluctance to attend school for personal reasons. The caseworker stated that “we need to have a plan for Destiny as I don’t want her just sitting around the house doing nothing or looking for boys.” The caseworker also inquired with the Solnit clinician as to whether a referral had been made for Destiny to receive out-patient therapy upon discharge, with the clinician responding “no,” given Destiny’s lack of engagement and the support services that she thought would already be in place through the foster care agency. On Wednesday, June 27th, two days before Destiny’s discharge date, the clinician emailed the DCF casework team to outline questions and issues presented by the foster mother, including whether there was a plan in place for how to manage or supervise Destiny’s contact with various relatives, and whether or not a concrete school plan was in place.

The email exchanges reveal a concerning lack of comprehensive discharge planning for Destiny, and raise questions as to how a discharge date was confirmed with key aspects of Destiny’s case plan unresolved or not fully discussed with the foster family. It is also unclear as to why Solnit was set to discharge Destiny despite her history of high risk behaviors, her significant unmet treatment needs, and the persistent nature of her alternately angry and hopeless expressions.

⁴⁰ The DCF caseworker responded to this advisement by stating some level of concern about the lack of educational plan in place for Destiny who had stated reluctance to attend school for personal reasons. The caseworker stated that “we need to have a plan for Destiny as I don’t want her just sitting around the house doing nothing or looking for boys.” In response to additional inquiry from the caseworker regarding whether a referral has been made by the Solnit team for Destiny to receive out-patient therapy, the clinician responded “no,” given Destiny’s lack of engagement and the support services associated with the foster care agency.

On Thursday, June 28th, the clinician left another typed letter for Destiny reminding Destiny that her DCF case worker was coming to pick her up for her discharge the next day. The clinician signed off the letter by stating she hoped “all the best for [Destiny] and for [her] baby girl to be.”

On June 28th, Destiny died by suicide.

In a meeting between OCA staff and Solnit administration in August, participants agreed that upon review, Destiny had not engaged meaningfully in treatment while at Solnit. Solnit administrators stated that Destiny’s case should have bubbled up for an intensive case review conducted by a multi-disciplinary treatment team, but unfortunately it did not. Solnit administrators reported that they were working on a root-cause analysis with regard to Destiny’s suicide so that they could fully understand what occurred and what changes the facility needs to make going forward.

OCA Findings Regarding Destiny’s Death

OCA’s findings regarding Destiny’s death are similar to those made by DPH in its July 16th, 2018 report,⁴¹ including:

1. Failure to conduct regular risk assessments despite Destiny’s despondent or threatening behavior;
2. Failure to address Destiny’s ambivalence or concerns about her discharge;
3. Failure to provide timely and adequate emergency medical response when Destiny was discovered asphyxiating in her room.

OCA also finds the following:

1. Failure to modify Destiny’s treatment plan when she ceased to engage at all with her assigned clinician or psychiatrist in April 2018, two months prior to her discharge.
2. Failure to re-evaluate the appropriateness of Destiny’s discharge given her lack of documented progress in treatment, and her recurrent depressive or threatening/angry behavior.
3. Failure to plan appropriately for discharge, including a lack of adequate or timely attention to family visits, need for individual therapy in the community, the development of an educational plan, and the sharing of critical information with the foster care agency.

With regard to previous findings from DPH in response to other serious occurrences at Solnit S. PRTE, OCA finds that the deficiencies identified with regard to Destiny’s care and treatment are similar to findings already made by DPH during previous investigations, and that were supposed to be addressed through agency corrective action. This conclusion raises marked concern regarding the efficacy, implementation and adequacy or availability of oversight regarding the Corrective Actions approved by DSS and DPH in the months prior to Destiny’s suicide.

⁴¹ DPH conducted an additional site visit and survey at Solnit S. PRTE in August, 2018. Its survey reports and deficiency findings, conveyed by DSS to DCF on September 11th, 2018 reflect additional review of Destiny’s records and similar factual findings to those made by OCA and outlined in this report.