



**REPORT OF THE INVESTIGATION OF
LAKE GROVE AT DURHAM
AND
THE DEPARTMENT OF CHILDREN AND
FAMILIES**

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EXECUTIVE SUMMARY

For several years, the Connecticut Office of the Child Advocate (OCA) and the Office of the Attorney General have collaborated to investigate allegations that the Department of Children and Families (DCF) has failed to adequately protect and care for Connecticut's most vulnerable children. A review of these investigations confirms a chronic pattern of deficiencies in leadership, program planning, service delivery and facility and program oversight at all levels of the DCF. As part of this work, the Child Advocate and the Attorney General have also calculated the immense costs — both in taxpayer dollars and in lost opportunities for generations of children — when the DCF fails to provide appropriate and timely services for children and support for their caregivers. Reports by the Program Review and Investigations Committee of the Connecticut General Assembly and the *Juan F. Court Monitor*¹ reveal similar concerns and evidence of deficiencies. Despite the public findings and specific recommendations for improvement, the DCF continues to demonstrate substantially similar and troubling patterns of response to the needs of Connecticut's children.

This report details the investigation by the Child Advocate and Attorney General of allegations related to program deficiencies at Lake Grove at Durham, a 116-bed institution that was licensed, regulated, and utilized by the DCF to serve children with intellectual disabilities, many of whom also suffered from mental health problems related to the trauma of abuse and neglect. The DCF placed children at Lake Grove because Lake Grove was the only facility in Connecticut to serve children with intellectual disability. The facility was finally closed in September 2007 when DCF stopped sending children there.

The allegations against Lake Grove, and the subsequent findings of this investigation, ranged from health care services that created risks of serious physical harm to the children; the absence of a mental health therapeutic program; practices that ignored regulatory and professional standards of care; disrepair and unsafe conditions; and an inexperienced and poorly supervised staff. In particular, the findings in this report detail the following deficiencies in care and DCF oversight:

1. Lake Grove medical and nursing services violated regulatory and professional standards of care subjecting children to substantial risk of serious injury or death. Nursing care was grossly deficient relying almost exclusively on unsupervised LPNs for all nursing care at Lake Grove, including the administration of medication. Only four LPNs were hired to cover all seven days a week, fifteen hour shifts. Although Lake Grove retained an advanced practice registered nurse for two and one-half years,

¹ (*Juan F. v. O'Neill, et al.*, Civ. No. H-89-859 (AHN) (D. Conn.). A class action filed on behalf of children in foster care claiming the Department of Children and Youth Services (DCF's predecessor) violated the children's rights to protection from abuse and neglect under federal child protection laws and the Constitution. In 1991 the parties negotiated a federal consent decree with a court-appointed independent monitor to oversee system improvements.

- she had no experience with psychiatric care or developmental disabilities. A physician was on site only 1-2 hours per week and most acute care, including diabetes related conditions, was handled in emergency rooms, impeding any continuum or coordination of care and placing children with diabetes at considerable risk. Routine follow-up of crucial testing for effect and negative side effects of medications was largely overlooked and medical records were incomplete and often inaccurate. There was little or no private nurse/child contact, nursing care plans, or individual assessment of needs and expected therapeutic outcomes. Instead of personal attention and contact, the door to the nurse's office was locked and children were required to stand in line in a hallway to receive their medication through a small barred window.
2. Lake Grove's mental health therapeutic program was essentially non-existent despite its license and increased reimbursement rates predicated on the provision of psycho-educational and clinical services for children. A profound absence of consistent clinical expertise and a hierarchy with no professional sense of residential treatment characterized Lake Grove. The few experts who were employed by the facility, a clinical psychologist and a psychiatrist, worked less than ten hours a week to provide care to a population of 116 children. There is no evidence that they directly supervised any clinical staff.
 3. Lake Grove administration and staff lacked the credentials, experience, training and supervision to properly care for children with intellectual disabilities and complex mental health and behavioral conditions. For lengthy periods of time over its twenty-two year operation, no licensed clinical staff was employed at the facility, staff turnover rates were high and salaries were lower than the reimbursements provided Lake Grove by DCF. The number of direct care staff members was seriously deficient, very few had two- or four-year college degrees and most were poorly trained, inexperienced and unprepared. A failure to conduct background checks resulted in the hiring of several staff members with felony records, including sexual assault and substantiated child abuse and neglect. In 2006, of the 200 employees at Lake Grove, 20 had criminal charges filed against them.
 4. The criminal backgrounds, inadequate skill sets, and inappropriate behaviors of too many Lake Grove staff placed children at significant risk for injury and abuse. DCF received 30-40 abuse/neglect complaints annually against Lake Grove staff during Lake Grove's last 10 years of operation, many involving the use of restraints and mistreatment. One child was severely beaten in front of the Lake Grove Dining Hall with no adequate response by Lake Grove staff. Lake Grove maintained a practice of banning children from residential cottages and sending them to the lobby of an old building at Lake Grove as a form of punishment. One banished child was required to live in a laundry room without air conditioning during extreme summer heat, slept on a mattress on the floor, did not attend school and was only allowed brief supervised walks outside.
 5. The physical conditions at Lake Grove were dismal. The physical plant was worn, dirty and far from therapeutic. Floor coverings were worn and dirty, walls had holes and needed to be painted, windows lacked screens, some beds lacked pillows, most lacked bed covers, bathrooms were dank and smelled of urine, bedrooms were small, cell-like and lacked decoration and most rooms had no clothes in them even though

clothing costs were included in the rates paid by DCF. Although the school building was relatively new, clean, with classrooms nicely decorated and a well equipped computer room, nine of the eleven residential “cottages” were barren and despairing, reflecting an organization that was undercapitalized, poorly led and incompetently staffed. The unsanitary, broken, and crowded physical environment at Lake Grove violated public health, structural and therapeutic standards and contributed to harmful and chaotic conditions for the children. DCF inspectors continued to cite the same deficiencies in the physical plant year after year without DCF ever appearing to require correction of those deficiencies or consider the impact of the miserable surroundings on the children’s well being.

6. The DCF was well aware of the problems at Lake Grove, yet failed to initiate timely and decisive action, provide ongoing oversight, child protection and enforce sustained change. Deficient health care at Lake Grove was chronic, persistent and well known to DCF. However, DCF took no effective action to address the lack of access to sufficient medical care or the lack of registered nurse, physician or psychiatrist availability. In fact, some efforts by DCF staff to improve medical care at Lake Grove were rejected by DCF administrators. DCF caseworkers were not engaged with the medical and nursing staff to oversee the children’s care and there appears to have been no integration of medical and nursing goals into the children’s general treatment plan. There is no evidence that DCF followed up on any recommendations that Lake Grove hire and maintain an appropriately educated, licensed and prepared workforce. Nor is there evidence that DCF routinely evaluated staff training and supervision. No DCF monitoring of background checks or review of hiring practices occurred before June 2006. DCF inspectors repeatedly documented and reported deficiencies in the physical plant at Lake Grove, but there is no evidence of an adequate response to those reports by DCF administrators.
7. DCF administrators failed to communicate effectively with each other and throughout the Department.
8. The DCF at all levels failed to recognize and promote health care as an integral component of child welfare. It appears that DCF historically did not view health care as a key component of its child protective services and individuals within DCF who had no health care expertise were making decisions on health care requirements. Those individuals within DCF who had health care expertise were not appropriately utilized by DCF’s administration.
9. The DCF failed to provide appropriate transition planning and oversight for those children who were removed from Lake Grove. Children were moved with little information or planning, creating needless stress and confusion for the children and their families. The transfer of Lake Grove children to other facilities created disruption and transfers of children from those facilities. There appears to have been little follow-up by DCF caseworkers on any of these children, particularly those placed out-of-state.

The DCF enabled Lake Grove to operate under these conditions at an estimated minimum cost of \$135,000 per child annually.

The children at Lake Grove experienced the world in ways very different from their peers without intellectual disabilities. Their intellectual disabilities challenged them to learn,

understand, and respond appropriately to social cues and rules. For some children, exposure to abuse and neglect impacted their emotional health and affected their ability to regulate behaviors. The chaos of daily life at the Lake Grove facility further frustrated their efforts to thrive. The children at Lake Grove needed specialized assessment and treatment to identify and address their needs. Yet, like all children, they also deserved a safe and nurturing environment, an appropriate education, and opportunities to build relationships with caring adults and peers.

Beyond their difficult life experiences and diagnoses, the children at Lake Grove were like all other children. They told us how they would like to decorate their rooms, play basketball and video games, have pets, and visit with family and friends. They spoke about their wish for a place to call home and their longing to explore the world beyond Lake Grove. Many dreamed of attending public school, going to college, and getting a good job.

The Child Advocate and Attorney General recognize the personal and professional commitment of many DCF staff. Yet, at the end of the day, leadership and daily work must be measured by whether children's lives are improved by the State's involvement. At Lake Grove, the DCF placed the well-being of children at great risk. Perhaps most troubling is the cumulative evidence indicating that the DCF was aware of the deficient conditions and systemic concerns at Lake Grove and that these concerns echoed those found in investigations and program reviews of numerous other DCF facilities and programs. Reports on Haddam Hills Academy, Connecticut Juvenile Training School and Riverview Hospital spotlight similar problems at all levels of DCF in the areas of quality assurance and program oversight, internal communication and coordination, and lack of meaningful planning for children with complex needs. The problems at Lake Grove took place at the same time that DCF leadership and staff, many of whom remain in their positions today or who have been promoted, failed to adequately respond to substantially similar co-occurring incidents at other DCF facilities and programs.

Children suffered at Lake Grove at the same time that the DCF was informed about serious abuse and program deficiencies at the Long Lane School, leading to the closure of the only secure girls' facility in Connecticut. Children suffered at Lake Grove at the same time that DCF continued to license Lake Grove's sister facility Haddam Hills Academy, despite substantiated safety and treatment concerns that later required the DCF to revoke that license. Boys suffered at Lake Grove at the same time that significant problems emerged at CJTS. Girls suffered at Lake Grove as two DCF reports were released describing the need for girls' services in Connecticut as "urgent and compelling." Children continued to suffer at Lake Grove after DCF discovered that poorly supervised licensed practical nurses failed to keep the breathing tube clear that would have kept Leeana C. alive in a DCF-licensed group home. Children at Lake Grove who were traumatized by parental abuse suffered at the same time that the Attorney General and Child Advocate issued a report demonstrating significant flaws in DCF processes for investigating allegations of child abuse and neglect. Children with mental health needs suffered at Lake Grove at the same time that the DCF, under pressure from the OCA, investigated and documented serious concerns about Riverview Hospital. Children suffered at Lake Grove even as the DCF's own health care professionals, program review staff, and leadership recorded the persistent absence of appropriate standards of medical and nursing care, therapeutic programming, and a safe and nurturing physical environment at the facility.

Today Lake Grove is empty of children and closed. Yet the failed institution retains its DCF license. The Child Advocate and Attorney General have ongoing, serious concerns about the lack of planning for the transition of children from Lake Grove to appropriate and safe settings that has had a domino effect on the well-being of other Connecticut children. The DCF sent at least ten children from Lake Grove out-of-state as far away as Maine, Illinois, and South Carolina. One child who was sent to an out-of-state residential treatment facility has since attempted suicide. Six months after that incident, DCF officials had not yet visited the child. To accommodate the Lake Grove children, the DCF displaced children from other Connecticut facilities. Particularly troubling has been the removal of an entire unit of nearly twenty girls at High Meadows to accommodate boys removed from Lake Grove. Additionally, a disproportionate number of children at Lake Grove sent out-of-state were girls. At least one girl entered Connecticut's prison for adult women. The treatment and planning for the girls at Lake Grove sheds new light on the DCF's continued failure to implement recommendations from the two DCF reports that described the urgent and compelling need for girls' services. Even the children who returned to community settings from Lake Grove experienced trauma from the sudden and poorly planned removal process that plucked them out of institutional living and dropped them into community settings with little opportunity for the kind of preparatory counseling and skill building needed for successful transition.

At Lake Grove and in the central offices of the Department of Children and Families, the Child Advocate and Attorney General uncovered substantial evidence of the failure of the DCF to provide proper oversight to ensure the safety and care of children with intellectual disabilities. It is critical to note that these investigatory findings were transparent in DCF records. The leadership at DCF was well aware of the deficiencies at Lake Grove and persisted in placing children there.

Now as we report the Lake Grove-DCF findings in 2008 we continue to have significant concerns about the ability of the DCF to ensure appropriate care for children at DCF licensed facilities that DCF managers know are having serious problems. The Department of Children and Families persists in its bad habits of not responding in a manner that would keep the children safe or correct the shameful practices of the institution. The trend of DCF negligence unearthed at Lake Grove persists on a broad scale.

While the DCF has made corrective progress in some areas, the underlying systemic findings and recommendations of the Lake Grove investigation echo those made in previous and current investigations of other DCF-licensed institutions. The following recommendations go beyond Lake Grove to ensure the well-being of all children involved with the Department of Children and Families:

1. The DCF must enforce regulations and nationally recognized professional standards of medical, nursing, and mental health care at all DCF-licensed facilities and programs. The articulation of these standards must be evident in program goals and descriptions, contract language, staff training and supervision, and quality assurance reviews.
2. The DCF must ensure that no residential program will ever be licensed without absolute proof of a functioning, evidence-informed therapeutic program that incorporates a gender-sensitive, trauma-informed, developmentally appropriate design.
3. DCF oversight of state operated facilities serving children must demonstrate independence from DCF functions associated with program development and

administration to ensure that DCF decisions are objective and based solely on the best interests of children.

4. The DCF must clearly define the role of health care professionals as medical, nursing and mental health decision makers and integrate their expertise in every bureau, including quality improvement and child protection services.
5. The DCF must comply with Conn. Gen. Stat. § 17a-61a that mandates DCF achieve accreditation through the Council on Accreditation.
6. The DCF must revamp its management structure and protocols for internal communication to ensure and document timely and accurate information sharing among managers, caseworkers, and providers.
7. The DCF must develop a long term planning unit that operates separately from program administration to understand the needs of children, identify and track trends, and anticipate future needs and reform.
8. The DCF must develop and implement training programs for all DCF personnel and contractors that promote understanding of, and vision for, children with intellectual and developmental disabilities.
9. The DCF must be held accountable for the ongoing care and supports of all former Lake Grove residents and should be required to produce periodic reports of their status.

Despite the DCF decision to cease admissions to Lake Grove, the findings of this investigation still have great relevance. Today, we remain very worried about the well-being of the children who were hastily removed from Lake Grove. We remain worried about the lack of a coordinated system of care for all children, including those with developmental and intellectual disabilities. We remain worried about the pattern of problems emerging at other facilities caring for children in Connecticut and resurfacing at those DCF facilities that have been under investigation in the past. Finally, we worry that the same DCF administrators who hesitated to intervene on behalf of children placed at Lake Grove remain decision makers for the well-being of Connecticut's children.

Time Line: Lake Grove at Durham and the Department of Children and Families

(Please note: This investigation focused on the five-year time period of 2002-2007. Persistent serious concerns about Lake Grove and its operations were noted previous to the period. Only those historical events and concerns that were noted in documents and interviews regarding the investigative time period are here noted below. This is not an exhaustive list and the reader should not conclude that there were no problems at Lake Grove before 1995.)

- July 27, 1985 – Lake Grove Certificate of Incorporation.
- 1995 - Recurring concerns regarding allegations of abuse in use of restraints and injuries to children, staff supervision, clinical treatment.
- July 1997 - DCF makes extensive recommendations for organizational structure, milieu, oversight, supervision, training, and hiring and admissions.
- 1997 - Admissions closed to so-called “sex offender” program due to concerns of safety for the children. Executive and Clinical Directors hired.

- 1998 - Lake Grove sister facility, Haddam Hills, opens with immediate concerns about care and protection of children.
- January 2000 – Recurring concerns regarding use of inappropriate restraints and a negative non-therapeutic culture at Lake Grove.
- 2001 - Haddam Hills is closed following investigative findings of extreme abuse.
- May 2002 - OCA and OAG publish report on investigation of Haddam Hills that exposed extreme abuse and poor DCF oversight.
- December 2002 – Without a job description, Lake Grove hires the first APRN. She has certification in obstetrics and gynecology.
- July 2003 – Child beaten near Lake Grove dining hall. Program Review cites serious deficiencies in emergency response and medical /nursing care.
- August 2003 – DCF administrator’s notes indicate “staff are babysitters...not structured”.
- August 2004 – DCF administrator’s notes indicate Lake Grove has, “Haddam Hills type culture”.
- October 2004 – DCF administrators meeting minutes indicate concerns with inappropriate Lake Grove staff behavior.
- December 2004 – Lake Grove executive director discloses that 20-30% staff need removal due to negative culture and inappropriate restraints.
- 2005 – APRN resigns while under DPH investigation for practicing beyond scope of certification. DPH drops investigation.
- June 2005 - DCF Lake Grove Report completed: per diem rate increased despite deficiencies in therapeutic program, staffing, and medical/nursing care.
- August 2005 – RI OCA makes complaint about lack of supervision and disarray in medical office at Lake Grove; DCF Nurses conduct medical review and find serious deficiencies of care; DCF nurse discovers child restricted to laundry room; OCA and OAG commence investigation.
- October 2005 – DCF Full Program Review Commences; DCF notifies Interstate Compact of concerns about medical care at Lake Grove.
- April 2006 – DCF Commissioner claims DCF was monitoring medical and programmatic issues; Lead DCF investigator re-assigned to investigation at the DCF-operated Riverview Hospital. Lake Grove report never completed.
- May 2006 – DCF review of Lake Grove child care staff training finds little to no formal training.
- December 2006 – DCF nurse investigates health conditions; identifies the same significant deficiencies as in 2005 and worse.
- January 2007 – Licensing violations. Medical review of all children initiated; Admissions closed; Unreported resident child’s arm broken.
- March 2007 –DCF Commissioner asked for resignation; DCF Commissioner testifies Lake Grove will close; Lake Grove plan of action refused for unacceptable description of psychiatric services. Adjustments accepted; Lake Grove bed capacity lowered to 90.
- April 2007 – DCF Chief of Staff and Deputy Director deny plans for facility to close.
- May 8, 2007 - DCF informs Lake Grove they will place no more children and will begin to transfer all Connecticut-placed children out.
- September 15, 2007 Lake Grove, unable to sustain without Connecticut children, is empty and closed.

**KEY INDIVIDUALS RESPONSIBLE FOR OVERSIGHT OF LAKE GROVE
DURING INVESTIGATIVE TIME PERIOD**

Department of Children and Families

Darlene Dunbar, MSW, Commissioner of DCF

Karen Snyder, MA, DCF Chief of Program Operations

Brian Mattiello, MA, DCF Chief of Staff

Heidi Macintosh, MSW, DCF Deputy Commissioner

Peter Mendelson, PhD, DCF Director of the Bureau of Behavioral Health and
Medicine (BBHM) (referred to as Bureau Chief)

Louis Ando, PhD, DCF Chief of Bureau of Continuous Quality Improvement

Karl Kemper, BA, DCF Chief of Bureau of Child Welfare

Arnold Trasente, PhD, DCF Program Review and Evaluation Unit Head

Thomas DeMatteo, JD, DCF Director Division of Administrative Law and Policy

Janet Williams, MD, DCF Medical Director

Victoria Soovajian, MD, DCF Medical Director

Fredericka Wolman, MD, DCF Director of Pediatrics

Katherine Kurlakowsky, PhD, DCF- Lake Grove Liaison

Lake Grove

Michael Suchapar, RN, MA, Executive Director, Lake Grove

REPORT

SCOPE OF THE INVESTIGATION

Document Review: Pursuant to Conn Gen Stat 46a-13k a subpoena was issued to the Department of Children and Families for any and all documents related to activities associated with Lake Grove at Durham. In response to the subpoena, tens of thousands of documents were procured and reviewed. A historical time line was developed and themes of activities related to the care, treatment, planning and oversight of children placed at Lake Grove were identified. Additionally, a sample of LGD resident case records, medical records, and student school records were reviewed in a similar method.

On-Site Program Review: Investigators from the Office of the Child Advocate visited all residential cottages, the school, health center, dining areas, recreation facilities and the administration building on several occasions. Administrators, nurses, teachers, child care workers and residents were interviewed. Additionally, investigators met and took meals with a convenient sample of residents.

Formal Interviews Under Oath: Formal interviews were conducted with current and former employees of Lake Grove and the Department of Children and Families. Subpoenas were issued to compel interview participation in some instances.

INTRODUCTION

A Boy at Lake Grove

B. is a 15 year old boy who likes rap music and camping with his mentor. He likes to go to McDonalds and he likes being able to make choices at meals. Baseball games are fun for B. He knows six Spanish words: Papa, mirar, uno, dos, tres and cuatro.

To impress the other kids, B. tries to act like a hip-hop gangster, but as his caseworker reports, that doesn't really work for B. He knows he is a little overweight and is trying to be more careful about what he eats. He has trouble describing his weaknesses and really cannot describe any of his own strengths. B.'s self esteem is very low. When asked about what he wants to be when he grows up, he first said he wants to be a policeman. But then, in his caseworker's words, "he got more realistic" and said he would be a food line worker. It is not clear what B.'s IQ is because testing over the years has not been consistent, but he is currently documented as having an IQ of 52, well below the threshold for mental retardation. In addition to an intellectual disability, B. also has posttraumatic stress disorder and reactive attachment disorder.

Eleven years ago the DCF found B. being repeatedly sexually abused by one of his parents and a long line of strangers. He was taken into custody and has lived in eleven different places; only two were very brief stays in foster homes, all the rest were residential treatment institutions.

B. was admitted to Lake Grove on his tenth placement just before a DCF nurse consultant discovered for the second time in a little over a year that the care of children at Lake Grove was dangerously deficient. While DCF investigators and hired oversight nurses were being brought in to determine the depths of those deficiencies, B. and his parent complained about the food being bad, the facilities being filthy, and the staff being rude and abusive. One month after being at Lake Grove the boy himself reported having no behavioral plan. Shortly after that he was introduced to his second Lake Grove clinician with whom he needed to form a therapeutic relationship. B. complained to his mother and DCF worker that staff members were hitting other children. B. himself was discovered at one point to have a significant bruise caused by an assault by a staff person. On most of his DCF caseworker's obligatory visits, B., despite his low IQ, would report that he was not doing well at Lake Grove and needed to be some place else.

In September 2007 when the DCF removed all Connecticut children from Lake Grove, they put B. in yet another residential institution, his twelfth. But he appears to be doing better now and reports that he feels safer there than he did at Lake Grove. B. would like to live in a foster home or a group home because he has "lived in residential all his life."

SUMMARY OF EVENTS

In August 2005, officials from the Rhode Island Department of Children, Youth and Families and Rhode Island Juvenile Court alerted Connecticut officials about perceived dangers to children living at the Lake Grove at Durham residential treatment center in Durham, Connecticut. Visiting a child from their state, the Rhode Island officials had observed troubling conditions related to the safety and care of the 116 children with intellectual disabilities placed there. Lake Grove was licensed, regulated and utilized by the Connecticut Department of Children and Families (DCF). Both the Rhode Island officials and the Connecticut Office of the Child Advocate (OCA) notified the DCF through the Abuse and Neglect Hotline. At the same time, the Connecticut Office of the Attorney General (OAG) received a whistleblower complaint about conditions at the facility.

In response to the concerns of both the Rhode Island and Connecticut Child Advocates, DCF immediately deployed nurse consultants to conduct an assessment of the health services at Lake Grove. The DCF nurses substantiated what appeared to be chronic mismanagement of medication administration and storage; generally deficient nursing care; and absent supervision

of licensed practical nurses. Supervision and proper care of the children at Lake Grove also immediately appeared to be inadequate. While conducting the assessment, one DCF nurse encountered a resident who reported being kept in a laundry room under extremely harsh and unsanitary conditions. The DCF nurse confirmed that indeed the child had been isolated to a laundry room with no air conditioning in extreme August heat. The child was given a mattress on the floor, did not attend school, and was only allowed brief supervised walks outside because her assigned staff person could not tolerate the heat in the laundry. Reportedly the child had been “lobbied” out of her residential cottage by staff and other residents. The child was allegedly exhibiting behaviors that both staff and fellow residents were unwilling to tolerate or treat therapeutically. The arrangement was so institutionalized that the accompanying staff person was in possession of a formal protocol designed for maintaining the child in the laundry room. Investigators learned that historically children would be sent to the lobby of an old building at Lake Grove as a form of punishment. The practice of banning children from residential cottages was institutionalized in the coining and use of the expression “lobbied” which implied the child was rejected by the community from his/her living space and banished to a less desirable setting.

Alarmed by the seriousness of the situation at Lake Grove and the evidence that the problems were not acute but deep-rooted, the Connecticut Child Advocate and Attorney General initiated an investigation of the care of children at the facility and its oversight by the DCF.

Lake Grove 1985-2004

The OCA/OAG investigation uncovered a long history of problems at Lake Grove of which the DCF investigators and administrators were cognizant. This investigation was chiefly limited to events of the last five years. However, we discovered documentation, and took testimony from DCF administrators, that confirmed a long awareness of persistent problems at the facility even from its inception in 1985. For example, we estimate there were 30-40 Abuse/Neglect investigations annually during the last ten years of Lake Grove operations. Although the majority of those investigations were not substantiated, the majority did include “Program Concerns,” which are problems that threaten the safety of the children or the integrity of the program.

By 1995, DCF was receiving high numbers of allegations of the following: abuse perpetrated by Lake Grove staff; poor staff supervision; and the absence of clinical treatment. Two years later in 1997, the DCF Program Review and Evaluation Unit (PREU) made extensive recommendations regarding the need for organizational structure, administrative oversight, staff supervision and training, and development of therapeutic programming. Around that same time (1998), allegations of serious abuse and neglect of children at Haddam Hills Academy, owned and operated by the same parent company as Lake Grove, began to surface. In 2001 that sister facility was shut down following confirmation that the owners and operators were allowing brutal treatment of children. A subsequent joint report by the OCA and OAG exposed DCF investigators and administrators to be cognizant of the problems at Haddam Hills without properly intervening to protect the children or to hold the facility accountable. The scrutiny of Lake Grove, the remaining facility owned and operated by that

organization, that would have been expected following such a debacle of care and state oversight, did not materialize. A pattern of crisis in care, DCF investigation, short-term response from the agency, and crisis in care persisted for years. We saw this pattern at other DCF owned or licensed facilities and called attention to it in three reports on the Connecticut Juvenile Training School (2002, 2003, 2004), in addition to the Haddam Hills Report (2002). We also issued a joint report that calculated the immense costs of DCF failing to oversee the delivery of appropriate care or provide adequate community services for children (2003)². These five reports were all issued in the very same time frame during which the DCF was watching Lake Grove perpetuate inadequate and harmful care to children.

In 2003 a child was beaten severely in front of the Lake Grove dining hall. An intensive DCF investigation followed. In addition to the ongoing and well-documented concerns about unsafe facility conditions, inappropriate staff behaviors, and an absence of a therapeutic culture, DCF investigators now identified inability to respond to emergencies and deficient nursing care as serious program concerns at Lake Grove. The very next year, in 2004, a DCF administrator described a “Haddam Hills type culture” at Lake Grove in an email to colleagues. The description could only have referenced the brutal anarchy of the former sister agency, yet little substantial action was taken. Reportedly, not many of the Haddam Hills staff were transferred to Lake Grove at its closing. However, the owners and operators remained the same. Additionally, many of the DCF administrators who oversaw Haddam Hills and failed to intervene on behalf of children placed there were the same overseers and consumers of Lake Grove services. The pattern of inactivity was repeated.

Lake Grove 2005-2007

Instead of taking action to hold Lake Grove administrators accountable and ensure proper care of children, the DCF in fact increased Lake Grove’s per diem rate in 2005. The rate was increased following a broad program review to examine the content of the Lake Grove services and accommodations in order to “re-base” the daily or per diem rate. Despite dismal findings that indicated Lake Grove did not have the ability to meet the needs of children placed there, the DCF re-basing report apparently justified an increased rate just prior to the visit by Rhode Island officials.

Following the Rhode Island complaints in August 2005, the DCF launched yet another broad program review of Lake Grove. That review was never completed or reported because the DCF administrator who launched the review was re-assigned to review the DCF owned and operated Riverview Hospital in early 2006. In yet another parallel of failure, a DCF report issued the following year evidenced such serious concerns about the care and safety of children at Riverview Hospital that Governor Rell assigned a monitor to the facility. But similar deficiencies at Lake Grove persisted and the DCF continued to send children to Lake Grove

² The Cost of Failure, released on March 26, 2003 was a joint report between the OCA and OAG that chronicled the life of a child whose parent sought community-based services for her child. No such services were ever provided and the child was institutionalized in a series of facilities, none of which provided her with services to meet her identified needs. The “cost” to the child was lost years and development while the cost to the state was enormous amounts of money spent on care never provided, not to mention the predicted costs of dependence that the state has perpetuated of the individual upon the state.

until December 2006 when reports of dangerous health care practices caused another investigation by a DCF nurse. Despite the serious deficiencies of care identified in the previous year, and the heightened awareness of potential problems in residential care underscored by the Riverview review, the DCF had only succeeded in assigning a young, newly licensed psychologist to oversee admissions and consult with Lake Grove administration. She did not monitor the health care of the children at Lake Grove and was not aware that the deficiencies identified in August 2005 had not only persisted, but worsened. As will be explained in the narrative below, the DCF failed to ensure proper care and safety of the children at Lake Grove despite full awareness of the problems that persisted. Children continued to be placed there at an estimated cost of \$135,000 annually per child until the spring of 2007 when the DCF began a precipitous removal of Connecticut children. Although the DCF now expressed a lack of confidence in the ability of the facility to provide appropriate and safe care for the children, the agency continued to license Lake Grove, allowing children from other states to be placed there. But without Connecticut's business and financial support the facility could not sustain itself and by September 2007 it was closed.

FACTUAL BACKGROUND

The circumstances of Lake Grove and the role of the Department of Children and Families was complicated by several factors. First, the target population served was children with intellectual disabilities who typically have unique service needs. Serving them and overseeing their care requires an understanding of the children and an appreciation of what appropriate care is. Care for children with developmental disabilities, of which intellectual disabilities is one type, by the DCF has historically been characterized by inappropriate placements, over reliance on restrictive programs, and lack of planning for family and community-based supports. In fact, in 2005 the DCF failure to properly serve the children was memorialized in a transfer of responsibility and budget allocations³ to the Department of Developmental Services (DDS)⁴ for children with mental retardation and mental health conditions whose families were seeking services voluntarily as opposed to through child protection. Second, Lake Grove represented a type of care and treatment that has not been well actualized in the industry as intended. Third, the DCF has complex and competing roles, specifically as consumers of treatment for children and as the overseer and regulator of treatment care providers. This section provides explanation of these factors to assist in understanding what the expectations of Lake Grove should have been in serving children and what the obligations of the DCF were to the children, the facility, and the taxpayers of Connecticut. It will be followed by a summary of investigative findings, conclusions and recommendations.

³ *Interagency Agreement Department of Children and Families and Department of Mental Retardation*, Effective July 1, 2005.

⁴ *DDS, Formerly Department of Mental Retardation (DMR)*.

A. THE CHILDREN AT LAKE GROVE HAD INTELLECTUAL DISABILITIES, A HISTORY OF ABUSE AND NEGLECT AND MEDICAL DISORDERS REQUIRING CLOSE MONITORING AND SPECIALIZED TREATMENT

Lake Grove was a unique and therefore significant institution because of the population of children they admitted. It was considered to be the only residential treatment program available to children with intellectual disabilities in Connecticut. Before reviewing formal descriptions of the children, consider how they saw themselves. Table 1. summarizes a few self-descriptions.⁵

Table 1. A little about the children at Lake Grove:

- *Maurice wants keep going to school to learn more about cooking and work in a restaurant someday.*
- *Robbie thinks he can aspire to work at Wendy's- he thinks it would be really cool to work there or at Friendly's*
- *Vincent is funny and always willing to help. He is really tall and sometimes he is mistaken for staff in his formal ways.*
- *Jason is very careful taking care of his glasses. He is good at math and really likes playing sports.*
- *Susan is artistically inclined and likes to draw when she completes her work. She likes pets and helps in the classroom.*
- *David wants to work with animals. He doesn't think he could be a veterinarian, but he thinks he could help one.*
- *Cheyenne wants to be a midwife; she thinks she would be good helping someone else have a baby.*
- *Donald is shy. He doesn't like to do chores. He likes to play basketball whenever he has the time.*
- *Dennis likes to help with other students on the computer. He does excellent PowerPoint presentations.*
- *Sarah wondered if she would go to a group home or maybe attend a real school*
- *Eric wanted to know where he was going to be "put to live."*

All of the children at Lake Grove had intellectual disabilities either congenitally or as a result of a severe mental illness, chemical imbalances, autism, injuries or maltreatment. The level of intelligence among the residents at Lake Grove, as measured by individual intelligence quotient (IQ) scores varied considerably. There is no consistent number used by States to define the level demarking mental retardation from "normal" intelligence. The State of Connecticut uses an IQ score of 70 or below as one of the eligibility criteria for services through the Department of Developmental Services. Numerically, I.Q. scores among Lake Grove residents ranged from a low of 30 to a high of 87. The average IQ for the residents in Spring 2006 was 55.6, a score that falls within the moderate range of mental retardation. A

⁵ Names have been changed to protect the privacy of the individual children.

low IQ is indicative of more than just intelligence measured by school performance. It also may indicate how a child understands social cues, masters communication skills, follows social rules, and develops and maintains relationships.

A history of abuse and/or neglect was a common characteristic among the children at Lake Grove, as were learning disabilities and some co-occurring complex medical conditions. Some medical conditions were exacerbated by, or simply side effects of, prescribed psychiatric medications. Some of the common medical and psychiatric diagnoses among the children are listed in Table 2. Many of the conditions may be characterized by difficult behaviors. Understanding the underlying cause of behavior is key to determining the best course of treatment and management. For example, behaviors associated with blood sugar emergencies in uncontrolled diabetes, will require substantially different treatment than those caused by mental illness, despite sometimes presenting in similar fashion. Behaviors and conditions associated with incorrect doses of medication can be prevented through close monitoring of treatment. This mix of psychiatric and medical disorders, developmental delays, and experience of abuse and neglect complicated what are typically already challenging needs of the adolescent stage of development. Side effects from the medications predict propensity for developing subsequent additional health conditions without proper care.

One notable group of disorders attributed to the children placed at Lake Grove involved problem sexual behaviors or sexual reactivity. Because Lake Grove claimed to provide specialized treatment, there was a cohort of children with histories of these conditions or behaviors. However, the Lake Grove program description was vague about the types of conditions they provided treatment for and the DCF had no specific protocol for symptomology of children they placed there. Consequently there is no definitive description of the children fitting in this group at Lake Grove. According to the American Academy of Child

Table 2: Identified Diagnoses Among Lake Grove Resident Children⁶

Anxiety Disorder	Dysthymia	Leukemia (History Of)	Psychosis
Asthma	Eating Disorder	Leukopenia	Mild Quadriplegia
Attention Deficit Disorder	Encopresis	Mental Retardation	Reaction Attachment Disorder
Attention Deficit Hyperactivity	Enuresis	Mood Disorder	Schizoaffective Disorder
Autism – Asperger’s	Fatty Liver	Nephropathy	Schizophrenia
Bipolar Disorder	Gastro-Esophageal Reflux	Obesity	Sickle Cell Disease
Bronchopulmonary Dysplasia	Genital Herpes	Obsessive Compulsive Disorder	Seizure Disorder
Cerebral Palsy	Heart Murmur	Perineal lesions	Sexual Reactivity
Cholesterolemia	Hypertension	Pervasive Developmental Disorder	Suicidality
Conduct Disorder	Hyponatremia	Post Traumatic Stress	Sinus Bradycardia
Depression	Hypothyroid	Problem Sexual Behaviors	Spastic Hemiplegia
Diabetes Type I	Kidney dysfunctions	Chronic Otitis	Thrombocytopenia
Diabetes Type II	Lead Poisoning	Pituitary Adenoma	Traumatic Brain Injury

and Adolescent Psychiatry, children who are sexually reactive “display sexually inappropriate behavior in response to sexual abuse or exposure to explicit sexual stimuli”⁷ (p. 58S). Children who have been sexually abused or exposed to deviant sexual experience and violence often demonstrate sexually inappropriate behaviors and early eroticization. They have difficulty

⁶ Extracted from a DCF-generated chart listing all resident children, diagnoses, treatment needs and other identified problems.

⁷ American Academy of Child And Adolescent Psychiatry, (1999). Practical parameters for the assessment and treatment of children and adolescents who are sexually abusive of others. *Journal of the American Academy of Child and Adolescent Psychiatry*, 38(12) Supplement 55S-76S.

knowing the difference between erotic and non-erotic touching. The models of behavior they have been exposed to and to which they look to for formal social rules do not direct them to appropriate behaviors.

Children who have sexually reactive behaviors require a socialization or re-socialization type of therapy that teaches trust, social boundaries, relationship building and healthy relationships. They also must learn accountability for their actions according to their developmental ability. When co-occurring with an intellectual disability, treatment for sexual reactivity requires careful communication and modeling to accommodate learning differences and conceptual obstacles. Early in the history of Lake Grove the program for this group of children was called a “sexual offender” program. Sexual offender is a term that refers to persons convicted of crimes involving sex, including rape, molestation, sexual harassment and pornography production or distribution. That term did not accurately describe the children at Lake Grove who had developmental disabilities and sexually reactive behaviors. Yet the public fears associated with the terminology persisted over the years and we heard the children referred to as “dangerous predators.” We found little evidence of widespread criminal level of sexual behaviors among the children at Lake Grove.

Beyond diagnosis, IQ and other categorizations, the children at Lake Grove were children who liked to decorate their rooms if they had family resources or an attentive DCF caseworker. They liked to play basketball and video games, visit with animals, and receive visits from family and friends. They liked to go home and visit other places in the community. They dreamed of attending public schools or going to college.

Children at Lake Grove were frequently defined by their diagnoses, or more often, their behaviors. These “labels” seemed to predict behavior; placement and discharge options; school settings; and other activities including recreation, religious practice and leisure. DCF officials interviewed for this report and in official documents frequently referred to the children placed at Lake Grove as, “the toughest youngsters in placement,” and, “the most complex.” Minutes from a DCF Service Evaluation and Enhancement Committee (SEEC) meeting indicated that Lake Grove “has a very challenging population.” The then DCF Bureau Chief of Child Welfare (BCW) described the children at Lake Grove as a “population potentially challenging: low IQ, sexually reactive, offending, some with aggression. Put those together and you have difficulty finding foster care.” The Bureau Chief of Continuous Quality Improvement (BCQI) concurred, testifying, “These are difficult kids. There are not a lot of communities with arms open saying, ‘send us your sexually reactive, aggressive, developmentally disabled kids so we can help you take care of them.’”

The then DCF Chief of Staff told us that children with mental retardation are the same population as the children involved in the juvenile justice system, only “with behaviors.” A Lake Grove nurse consultant, in reaction to Lake Grove ultimately closing asked, “What will they do with all the predators?” However, one DCF official expressed the characterization as coming from the system and not the children. He disagreed that the children were the most difficult children to deal with. In an investigative interview he acknowledged that the children had complex issues, low IQs, problem behaviors and medical issues. But he pointed out that the children were, “a product of failings of the Lake Grove program. They (the children) have not developed skills...staff are provoking them. They are distressed.”

The children had unique needs and approached the world in a different way than their “typical” peers. As children with developmental disabilities, they required highly specialized and effective treatment. They required nurturing to grow as all children do; perhaps even more so in order to overcome or better manage their problem behaviors. They required care and respect, just like any child.

B. RESIDENTIAL TREATMENT IS INTENDED TO PROVIDE A SPECIALLY DESIGNED THERAPEUTIC ENVIRONMENT THAT IS SAFE AND PURPOSEFUL WITH CONSISTENT AND PERSISTENT TREATMENT

Residential treatment is one of a continuum of services utilized to treat individuals with chronic conditions, usually when home and community-based treatment has been unsuccessful.⁸ Developed a little over fifty years ago, the hallmark of residential treatment has been the therapeutic milieu. Individuals are admitted to a residential treatment center when their care and treatment needs require consistent and persistent intervention for optimal improvements.

The concept of a “therapeutic milieu” incorporates not only the expertise of the various professional disciplines that lend their skills to the development of a child’s therapeutic treatment program, but also the physical surroundings, daily routine, recreation, schooling, health, clothing, and food prepared for the child.^{9 10} The concept of therapeutic milieu goes beyond the idea of “round-the-clock” or “24/7” supervision. The milieu’s goal is a place where every action towards and in response to a child, and every aspect of the environment is intentional and designed to have a therapeutic effect. Knowledge of a child’s condition and needs are used to develop a comprehensive plan for ensuring a healthy, therapeutic day. All persons who have daily encounters with a resident are trained to interact in a therapeutic way. Thus the team includes teachers, nurses, residence staff, kitchen staff, maintenance and administrative staff. The atmosphere is safe and purposeful and the time spent in residential treatment is optimized for positive results. This of course is a theoretical description of how residential treatment was intended to operate. It was not what we, or even the DCF, observed at Lake Grove as will be described below.

Lake Grove was not entirely unique in its failings to meet the needs of its residents. Little research exists documenting positive outcomes or therapeutic effect in the use of residential treatment as it has evolved. Accusations of “warehousing” children have been made since the early years of the model of care¹¹ and they persist. Recently the model has

⁸ Due to a dearth of foster care resources, children with chronic conditions in the care of the Connecticut child welfare system may be placed in residential treatment when no alternative placements are available.

⁹ Redl, Fritz (1958). *The Meaning of Therapeutic Milieu* in *Walter Reed Army Institute of Research: Symposium on Preventive and Social Psychiatry*. Washington, D.C. United States Government Printing Office, pp 7-15.

¹⁰ Trieschman, A.E., Whitaker, J.K. and Brendtro, L.R.(1969). *The Other 23 Hours: Child Care Work with Emotionally Disturbed Children in a therapeutic milieu*. Aldine De Gruyter, Hawthorne, N.Y.

¹¹ Knitzer, J. (1982). *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*. Washington, DC: Children’s Defense Fund.

come under critical scrutiny by the very professional organizations that promoted it 50 years ago. Alternatives as well as collaborative approaches with community-based providers are now being pursued. Ascribing blame on the dilemma of inadequate home and community-based services and poorly supported foster care placements, Leichtman (2006) suggested that residential treatment is currently viewed as “overused and, at best, as an unfortunate necessity rather than a valuable treatment tool”¹² (p.286). But regardless of the reasons residential treatment has been so heavily relied upon, the oversight by state agencies such as the DCF is designed to be a mechanism of ensuring safety of the children, quality assurance, and accountability for state expenditures on contractual agreements for services.

C. THE DEPARTMENT OF CHILDREN AND FAMILIES IS OBLIGATED TO ENSURE THAT ALL TREATMENT FACILITIES ARE SAFE AND NURTURING AND PROMOTE POSITIVE PROGRESS FOR THE CHILDREN CARED FOR IN SUCH FACILITIES

The mission of the Department of Children and Families is “to protect children, improve child and family well-being, and support and preserve families.” The agency is the Connecticut state entity mandated to achieve that mission by operating a system of child welfare, juvenile justice, prevention, and mental health services for children. These proscribed roles include actively protecting children, providing prevention and in-home services, taking custody and guardianship of children, placing children in out-of-home placements, licensing and regulating facilities that house and/or provide treatment to children, and even operating facilities and programs that house and provide treatment to children.

The DCF pursues its mission through the direction of established “Guiding Principles” that are founded in the belief that “all children have a basic right to grow up in safe and nurturing environments and to live free from abuse and neglect. All children are entitled to enduring relationships that create a sense of family, stability and belonging.”¹³ To that end, all Connecticut children placed at Lake Grove by the DCF, or with the agency’s assistance, were expected to benefit from appropriate treatment in a safe and nurturing environment with a distinct plan for progression to family-like living as an outcome. The DCF was expected to ensure that the program was safe and nurturing for all children placed at Lake Grove regardless of how or from where they arrived. All children would have a plan of permanency to direct progress back to communities. Each of these responsibilities was assigned to a different bureau within the agency. There are several bureaus that had specific interplay with Lake Grove and the children placed there. The Bureau of Continuous Quality Improvement (BCQI) holds licensing and regulatory responsibilities. The Bureau of Behavioral Health and Medicine (BBHM) oversees the content of therapeutic services. Because the BBHM is the only bureau to employ medical professionals, medical care of the children would be expected to be overseen by that bureau. The Bureau of Child Welfare (BCW) is responsible for overseeing the welfare of the children. The Abuse and Neglect Hotline is housed in that bureau and should be tracking patterns of problematic care. Child welfare caseworkers are the proxy parents for children

¹² Leichtman, M. (2006). Residential treatment of children and adolescents: Past, present, and future. *American Journal of Orthopsychiatry*, 76(3): 285-294.

¹³ Accessed at <http://www.ct.gov/dcf/cwp/view.asp?a=2565&q=314338>, July 13, 2007

placed out of home and are expected to monitor their progress and their access to all necessary services to ensure safety, health, and wellbeing just as any parent would.

It would take an organization with clearly articulated divisions of responsibility and absolutely clear lines of communication to maintain the realm of responsibilities described and assure all children are safe and treated appropriately. In fact, Principal Four of the DCF Guiding Principles speaks specifically to the promotion of effective communication, clear directions, and defined roles and responsibilities in an atmosphere that endorses continuous quality improvement and best practice.¹⁴ The policy implies an obligation of line staff and managers to ensure children's treatment needs are met.

In addition to philosophical principals and bureau responsibilities, the DCF has established specific policy that addresses various circumstances of children. DCF Policy 45-6-1¹⁵ *Appropriate services for children placed in residential facilities* is one policy that directly applied to the children at Lake Grove. It addresses the rights of children to a least restrictive education when they are placed in a residential facility, and in general, the policy states that for any child placed in such a facility DCF, "shall ensure that the child's treatment needs are the highest priority."¹⁶ Furthermore, the DCF *Explanation of medical and health services* policy states that the Department is responsible for "assuring that children in its care and custody receive optimal health care."¹⁷

FINDINGS AND ANALYSIS

LAKE GROVE AND DCF FAILED TO PROPERLY CARE FOR THE CHILDREN PLACED IN THAT FACILITY

There were significant deep-seated problems at Lake Grove and within the Department of Children and Families that had persisted for a long period of time. These included:

- A. a seriously deficient health care program;
- B. the absence of a therapeutic clinical program;
- C. significant facility problems;
- D. significant staffing problems;
- E. The Department of Children and Families was consistently cognizant of the problems but unable or unwilling to take appropriate sustainable corrective action; and
- F. the children at Lake Grove were precipitously moved without sufficient efforts for safe transition.

¹⁴ Accessed at <http://www.ct.gov/dcf/cwp/view.asp?a=2565&q=314338>, July 13, 2007.

¹⁵ Department of Children and Families Mission and Guiding Principles, Accessed at <http://www.ct.gov/dcf/cwp/view.asp?a=2565&q=314338>.

¹⁶ Accessed at <http://www.dir.ct.gov/dcf/Policy/Education45/45-6-1.htm>, July 13, 2007.

¹⁷ Accessed at <http://www.ct.gov/dcf/cwp/view.asp?a=2565&Q=314326>, July 13, 2007.

A summary of each area of concern is provided below with an account of

1. What our investigators found;
2. What the DCF knew and did about the problem; and
3. What the DCF should have done according to practice guidelines, policy, law or children's best interest.

A. HEALTH CARE AT LAKE GROVE WAS SERIOUSLY DEFICIENT

Factors considered in the examination of quality, safe health care services:

1. A safe environment that affords privacy and comfort in which appropriate care can be delivered.
2. Able, properly trained professionals who understand the breadth and limitations of their own professional practice
 - Accessibility
 - Requirements for supervision met
 - Professional standards of care followed
3. Consistency in adequacy of health care and safe practice

What investigators found: The medical care setting was unsuitable

The Lake Grove “Medical Office” was located in the main administration building of the campus. The office was situated in the middle of a long hallway. The majority of interactions between the children and the medical office staff, including medication administration, took place at a small barred window. The windowless entrance door to the office remained locked. To enter the office children had to knock at the door, shout their identity and explain their problem from the hall before a nurse would open the door. Not all children requesting entrance would be admitted. Children who were prescribed medication had to leave their residence building or school, depending upon time of day, walk to the administration building, and stand in line at the barred window to be administered medications in the presence of a group of their peers.

This medical office did not afford an atmosphere of privacy or respect in the delivery of health care. The lack of privacy or individualized attention was counter to a therapeutic milieu. The barred window and barren hallway served to perpetuate the stereotype of institutional existence with little regard for individualized therapy or a safe, comforting environment. The architecture of the area impeded careful assessment of the children for their response to medications, understanding of their use, and their progress towards self-care. The setting also precluded confidentiality of communications between children and nurses.

Children standing in a crowded line for medications were not learning about those medications or how they would be incorporated in a home or community-based routine.

What the DCF knew and actions taken regarding the medical care setting

DCF documents and testimony confirmed agency awareness of poorly delivered health care at Lake Grove. However, there were few references to the conditions of the physical setting where the care was to have taken place. This lapse indicates one of two possibilities: Either DCF officials did not assess physical layout and access to privacy as key components to appropriate health care or they did not notice the dismal condition of the area. The conditions were noticed, however, as evidenced by comments made in an August 2005 meeting that included DCF Bureau Chiefs, administrators, nurses and OCA staff. Several DCF nurses discussed concerns about the physical layout of the Lake Grove medical office. One expressed the opinion that the barred window and the resident children's lack of privacy in contacts with the nursing staff reflected a fear that the Lake Grove nurses held of the children. No one at that meeting disagreed with the nurse's assessment. Regardless of whether the observation was an accurate reflection of the sentiment of Lake Grove nurses or not, it did represent an assessment of imposed distance between the nurses and their patients that impeded therapeutic relationships. In an interview a DCF BCQI administrator told us, "the problem was, rather than visit the cottages, the nurses would bring the cottages to them at their barred window. It had an institutional feel, almost like Nurse Ratched in the movie *One Flew Over the Cuckoo's Nest*. We tried to talk them into moving it [medication administration services] out to the cottages." There was little evidence of any DCF action taken to influence the promotion of privacy in interactions between nurses and children integrated in daily routine.

Some time in mid- to late 2006 the bars in the windows were replaced by Plexiglas and later the space in the hallway was widened. We did not find evidence of whether those changes were influenced by DCF administrators or Lake Grove decision makers. Still, little changed: the distance between the children and the nurses and the lack of privacy persisted. The children continued to wait in line at the window to receive medications, or shouted at the door to gain access to the nurses.

What the DCF should have done about the medical care setting

In order to ensure that children placed at Lake Grove were afforded opportunities for appropriate care, education and skills to optimally self-manage chronic conditions, the DCF should have insisted that there be a proper place and manner for that to occur. The DCF officials should have expected a private office or space for children to meet with nurses that would be conducive to confidential discussions about medication, their purpose and side effects, as they were being administered. Children seeking medical attention should have had a place they could go to where they felt safe and comfortable in addressing their concerns.

The DCF caseworkers who are proxy parents and the DCF inspectors who regulated the facility for compliance with laws and contractual obligations should have noticed that the children were not being cared for in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA mandates confidential, respectful and dignified

care. DCF personnel should be fully cognizant of the standards and regulations of care and the obstacles to those standards and regulations.

What investigators found: Health care professionals, and in turn appropriate health care, were not fully accessible to the children

Lake Grove contracted with a physician who specialized in family practice to be available five hours per week. He was expected to conduct admitting and annual physicals, oversee medications and presumably respond to acute illnesses or injuries for the 116 children¹⁸. By all reports the physician was typically only on campus 1 to 2 hours per week. A psychiatrist was contracted and available just as briefly each week with expectations of prescribing and monitoring psychotropic medications, conducting assessments and participating in treatment plans.

There were few additional means by which resident children could access medical care. In addition to the 1-2 hours per week that the physician was on site at Lake Grove, it was understood that he was also expected to be available by appointment at his medical practice for acute illnesses or injuries. However, Lake Grove nurses interviewed reported that getting an appointment was very difficult and the overwhelming majority of acute incidents were treated through the local hospital emergency department. The Lake Grove-contracted physician was also not a resource to children with chronic conditions that required follow-up. A DCF pediatrician reported that the Lake Grove physician had refused to see children with diabetes. While several children were routinely seen by diabetes clinics at Yale-New Haven Children's Hospital, or in other states, we were told by several sources that children with uncontrolled diabetes were frequently seen in the local emergency department.

Depending upon the time in Lake Grove's history, staffing of the medical office consisted of up to four licensed practical nurses (LPNs) employed at Lake Grove to cover the seven day a week, 15 hour-a-day schedules of the medical office. There were also several Lake Grove nonprofessional staff who had completed DCF training to be certified to administer medication. Only rarely over the years were any of those staff used for such purpose however. Interviews with Lake Grove and DCF administrators suggested that, despite being DCF-certified, there was little confidence in the ability of Lake Grove general staff to administer medication. For the majority of Lake Grove's history, there was no registered nurse (RN) on staff in the medical office.

In December 2002 Lake Grove hired an advanced practice registered nurse (APRN). The APRN was certified as an obstetrics and gynecological nurse practitioner. She told us that at the time of her hiring there was no job description for her position. She was asked to develop one, which she never did because, according to her account, she was "only there for about two and a half years." We discovered an undated Nurse Practitioner job description among DCF Lake Grove documents that indicated responsibility for providing "comprehensive medical and psychiatric care...supervises the Medical Department...provide clients with assessment,

¹⁸ Note on census at Lake Grove: There were 116 licensed beds. The executive director testified that the facility was frequently over census with more children than they were licensed to accommodate. Also, although the average lengths of stay were inordinately long, it should be presumed that some children left and new children were admitted, so there were more than 116 children at any given time who would have needed admission and annual physicals, among other things.

diagnosis, and implementation of treatment goals...” Issues that she recalled identifying early on as being important to her role at Lake Grove were conducting gynecological exams and assessing the children’s diets. Given that the majority of the facility resident children were boys, her specialty was unusual. She had no experience with psychiatric care or children with developmental disabilities. In June 2005 the APRN left Lake Grove precipitously while being investigated by the Department of Public Health (DPH) for practicing beyond her expertise. The DPH referred their investigative findings of practicing “outside the scope of her certification in Women’s Health Care” to the Board of Examiners for Nursing who found “insufficient basis to proceed further” because the APRN had resigned her position at Lake Grove. The case was dismissed.

In early 2006, at the demand of the DCF, Lake Grove hired a registered nurse to supervise the LPNs. In an interview with OCA staff the RN reported having a background in labor and delivery nursing and also teaching in a technical program that trained LPNs. She had not worked with children or psychiatry in the past. She reported relying upon the Lake Grove LPNs to explain the complicated psychotropic medications administered to the children.

Given the limited access to physicians and the absence of a RN with relevant expertise, the oversight and provision of health care for Lake Grove residents largely fell to unsupervised licensed practical nurses or the hospital emergency department. This lack of access translated into considerable neglect of children’s health care on several levels. The reliance upon emergency room services impeded any continuum or coordination of care and placed children with diabetes at considerable risk. Routine follow-up of crucial testing for effect and negative side effects of medications were largely overlooked. Medical records were incomplete and often contained inaccurate reflections of children’s health. Serious and at times life-threatening health conditions were totally overlooked and children were placed at considerable risk of injury.

What the DCF knew and did about the inaccessibility of health care professionals

Our investigators found little documented evidence that the lack of Lake Grove medical physician or psychiatrist time was ever addressed by the DCF. Of all the DCF officials we interviewed who had knowledge of medical resources, no one disputed the inadequacy of physician and psychiatrist availability. However, no one took action to improve access to medical providers. One DCF administrator explained that physician’s salaries were not included in the daily rate contracted and paid for by the state to the facility. Therefore, hours of availability were not routinely addressed or negotiated. There was no evidence that anyone from the DCF examined the availability of other health providers in the community who could have met the children’s care needs through Medicaid or other insurance coverage they may have had. Interestingly, the four DCF-owned and operated facilities where treatment is provided each employ a full time pediatrician, a full time psychiatrist and a full compliment of nursing staff. Those facilities serve generally half the number of resident children. The Bureau Chief of BBHM told us that children were expected to get their health care from their primary care providers outside of the Lake Grove facility. He did not acknowledge, however, that most of the children had been shifted among placements for years and few actually had primary care providers.

Evidence suggested that the problem of shortages of appropriate and accessible nursing staff had been brought to the attention of DCF officials for possibly up to eight years prior. In

July 2003 a child was seriously injured when he was attacked and beaten by a large number of children outside the dining hall. Two DCF bureaus, then called the Bureau of Quality Management and the Bureau of Behavioral Health, Medicine and Education conducted a review of the incident. A number of regulatory violations were identified including inadequate and poorly performing nursing staff. In response to DCF-identified deficiencies, the Lake Grove executive director wrote DCF administrators and reminded them that the facility had made it known three years earlier (2000) that there were fiscal needs for increasing nursing staff and building a medical center. The executive director complained that the DCF had not been forthcoming because of rate negotiations that had been stalled.¹⁹ In what appeared to be a threatening warning, the Lake Grove official wrote, "...the lack of fiscal support from DCF in key areas of our program has and will result in less than optimal program services. This is clearly evidenced by DCF's observations during the review of our medical services". As with the limited access to physician care, there was no evidence that the DCF took any action to address the needs for more nurses and better care coverage until two years later in 2005 when a re-basing report suggested the need for more nurses as part of approving an increased rate of payment for Lake Grove.

In March 2005 DCF nurses identified that the APRN was practicing beyond the scope of her expertise and certification. The DCF nurses reported the APRN to Department of Public Health licensing investigators. As noted above, the APRN left Lake Grove while under investigation. The next time the DCF took any action was following the 2005 nurse investigation when immediate recommendations included the hiring of a registered nurse to supervise the LPNs, but even that recommendation did not fully address the need of inadequate access to proper health care services and ultimately the RN hired had no relevant expertise. Her tenure at Lake Grove was very brief, less than six months.

Only in 2007 when the last investigation of Lake Grove health care provision was completed by DCF was there discussion among DCF administrators about the problem. A DCF pediatrician testified to us about a lack of confidence in the Lake Grove-contracted physician and described concerns about the manifestations of the lack of access to care. Ironically, even within DCF there were obstacles to accessing care for the children. The DCF pediatrician testified upon being informed of the situation at Lake Grove she perceived a need to go the facility and assess the children and situation. But although all of the identified concerns at Lake Grove were of a medical nature, the chief of BBHM refused to allow the pediatrician to get involved. E-mail communications between the pediatrician and the chief of Bureau of Child Welfare (BCW) indicated that the pediatrician was asking for an update of all the children's medical records. The DCF pediatrician stated that physical exams conducted by the Lake Grove physician and any medical reports of follow-up were not reliable. She requested that the DCF Area Office Resource Nurses who are administratively under then BCW be asked to cull records and find prior primary care physicians where possible to bring records up to date and make appointments for examination where possible. The bureau chief of BCW, not a medical professional, objected, as did the bureau chief of BBHM, also not a medical professional, telling the pediatrician to "drop it." It was not until the pediatrician was able to bring the plight of the children to the attention of the DCF commissioner that she was

¹⁹ The DCF froze the per diem rate over allegations of inappropriate rental and service contracts with a Lake Grove parent company

able to visit the facility and begin to coordinate proper health care and attention for the children at Lake Grove.

What the DCF should have done about inaccessibility of health care professionals

Health care should have been a DCF priority in the care, protection and oversight of the children placed at Lake Grove. As described above, this was a population who, by reason of chronic conditions, unhealthy exposures and unique circumstance did not enjoy the health and wellbeing typical of their developmental stage. The majority of the children were also coming from multiple placements including foster care, hospitals, shelters and other institutions. In fact, heightened responsibility would be indicated for many of the children who were in DCF custody because the agency had determined that their parents were not ensuring appropriate care and protection.

The DCF *Explanation of medical and health services* policy states that the Department is responsible for “assuring that children in its care and custody receive optimal health care.”²⁰ The health of children in DCF custody is also addressed in the *Juan F. Consent Decree. Outcome Measure 15: Children’s Needs Met* mandates that “at least 80% of all families and children shall have all their medical, dental, mental health and other service needs provided as specified in the most recently approved clinically appropriate treatment plan.” The case review data for the 1st Quarter of 2008 (January -March 2008) demonstrated that the DCF attained *Needs Met* in only 58.8 percent of the 51-case sample. This was a slight improvement from 4th Quarter of 2007 where they attained only 47.1 percent. The outcome measure has yet to be satisfactorily met in over seventeen years of federal court oversight.

DCF administrators should have acknowledged the fact of inconsistent medical care in the lives of the children and accommodated that shortcoming. Beyond the Consent Decree and DCF policy, federal mandates covering the care of children whose services are reimbursed by Medicaid have very specific early periodic screening, diagnosis and treatment guidelines that must be adhered to and were not at Lake Grove.

In addition to assuring access to care, a standard like that requires a means to evaluate and oversee the delivery of care that children receive. The lack of attention paid to the availability of health care for children placed at Lake Grove suggests that both DCF caseworkers and their administrators were not aware of the policy or they operated on an assumption about Lake Grove rather than on fact. Even if DCF did not have an articulated expectation of access to health care, any parent would be expected to investigate the health care resources available to a child wherever the child lived. Knowledge of the location of medical services should be the first objective to placement criteria. Alternatively, assuming that Lake Grove would assure access to health care without confirming that fact was a complete abandonment of regulatory obligations by the DCF. Not equipping regulatory oversight personnel with the expertise required to examine appropriateness of health care services was a further shortcoming of the DCF.

²⁰ Accessed at <http://www.ct.gov/dcf/cwp/view.asp?a=2565&Q=314326>, July 13, 2007.

The DCF should have known the children and their health needs very well before placing them. The DCF should have been fully cognizant of what type of care, care provider and characteristics of health care support would be required to meet the needs of the children. Finally, the DCF should have known the capacity of Lake Grove to meet those needs. That means the DCF should have had staff and administrators that first identified health care as a priority in the general welfare of children and secondly who had the expertise to determine what appropriate care and access would be. If they identified problems or obstacles to care, DCF staff and administrators should have been empowered to intervene and Lake Grove should have been required to adjust as indicated. DCF administrators also should have looked to other state agencies and resources to enhance the agency's ability to oversee health care and the special needs of institutionalized children. The Department of Public Health should have been engaged in educating DCF inspectors and administrators about professional licensure standards and limitations of practice; the Department of Developmental Services should have been actively engaged in reviewing the quality of care and services to a population with needs for which the DDS has broad expertise and experience.

While funding streams for medical care may vary from funding for residential mental health treatment, that should not have excluded considerations of access to care in the negotiations for service. At the very basic level, DCF caseworkers placing children in any setting should be expected to examine and assure access to appropriate medical care. As massive consumers of institutional care services, the DCF administrators should be doing the same with a broader view to the capacity of local health care systems to absorb large numbers of children, in this case well over 100 children. And as regulators and licensors of institutional services, the DCF should have definitively determined that consistent, appropriate and accessible health care would be available to any and all children placed at Lake Grove.

Finally, the knowledge that appropriate medical and nursing care was not accessible to the children at Lake Grove should have at the very least prompted vigilant oversight of the children's health and medical needs. If the DCF is not going to ensure access to care through contracted providers or community resources then the agency must provide that care and oversight itself.

What investigators found: Licensed practical nurses were not supervised

The limitations of physician and registered nurse availability to provide care to the children was a predictor of problems in the function of the few health care staff that were available. The regulatory requirements for supervision of LPNs by RNs or physicians as described in a previous section were not met at Lake Grove. In addition to the very few hours that a physician was on site at Lake Grove, there were only intermittently employed registered nurses (RNs) on staff for most of the 22 years that the facility had been licensed by the DCF. As the agency Medical Director, the physician was responsible for supervising the nursing staff. In fact, being on campus only one to two hours per week would have made supervision of nurses impossible. There was no documented evidence or testimony that he supervised the operations of the staff or the office.

One LPN held the position of Medical Coordinator for several years with little to no oversight. She supervised the other LPNs, transcribed medical orders, and attended facility treatment meetings. When Lake Grove hired an advanced practice registered nurse (APRN) in

December 2002 she, among other things, would have qualified as a supervisor to the LPNs. However, an undated Nurse Practitioner job description did not include LPN supervision. The APRN reported in interview that she did supervise the LPNs but the Medical Coordinator LPN maintained much of those functions as well. The APRN appeared to be unfamiliar with the regulated scope of practice for LPNs, stating in interview that she “never went through LPN school so I can’t say what they learn.” She further noted that she never reviewed the regulations governing LPN scope of practice while at Lake Grove. Coincidentally, when questioned, the Lake Grove LPN Medical Coordinator reported not being aware of any legal or regulatory restrictions on the scope of her practice, or the requirements for supervision.

Throughout this investigation, it was clear that there was no source of consistent supervision of the Lake Grove LPNs. For long stretches of time the Clinical Director supervised them but the persons holding that position did not possess a professional license appropriate to supervise LPNs according to Connecticut state regulations.²¹

The executive director during the time period of 2001-2005 at Lake Grove was a Registered Nurse. Several DCF documents indicated that DCF officials understood him to be the only RN at the facility. The extent to which he was capable of supervising the LPNs is questionable given his obligation as Executive Director of the entire facility. He provided inconsistent and contradictory testimony at various times acknowledging that he did not provide direct supervision to the LPNs himself, while other times claiming that he did provide this supervision. The Lake Grove APRN testified that it was odd that the executive office would be supervising LPNs because, in her words, “... he did not have a medical background at the same caliber as me.”

The executive director also testified that for a period of time the LPNs were supervised by an outside nurse consultant that Lake Grove had hired to conduct monthly reviews of medication administration documentation. The consultant’s contracts, however did not call for supervision of the LPN staff. The consultant was only on site for monthly visits, precluding her from any opportunity to consistently supervise. Ultimately, she testified that she never supervised the LPNs. An additional claim was evident from several persons’ interviews and DCF documentation revealing that for a period of time the executive director relied upon an RN from a Lake Grove sister facility in New York who was supervising the LPNs at Lake Grove long distance. Supervision in absentia would have been wholly inadequate and illegal if the nurse did not hold a Connecticut license.

It is clear to us from the evidence that the Lake Grove medical office operated for years with a staff of LPNs that simply did not have proper supervision. This is not solely a problem of violation of regulation. The regulation is in place for a reason and that reason is predominantly safety of patient care. As explained in a previous section, LPN practice ability and expertise is extremely limited to carefully directed and supervised tasks. Left unsupervised, LPNs were not able to provide comprehensive care based on a combination of expertise and critical thinking skills. The absence of supervision left children unsafe at Lake Grove.

²¹ Licensed practical nurses may be supervised by Medical Doctors or Registered Nurses. The Clinical Directors were professionals in psychology or counseling. While they may have been suitable for providing supervision of other mental health professionals, they were not suitable for supervising nurses.

What the DCF knew and did about the unsupervised LPNs

The DCF Director of Nursing reported in interview that she had addressed the issue of LPN supervision as early as 2001: “I had a discussion with [the executive director] at the time ... he said he was an RN and he was providing the level of supervision ... I took him for his word.” She was not able to explain how the executive director would have been able to meet his administrative responsibilities to run the entire institution (therapeutic program, residences, school, dining hall, physical plant, etc) and tend to the daily supervision of LPNs caring for 116 children.

Documentation of communications among DCF administrators indicated that the Lake Grove nurse consultant hired to conduct monthly medication administration reviews was supervising the LPNs. Interestingly, DCF documentation consistently referred to the nurse consultant by her title as an elected public official, a position she held in addition to consulting work. As noted above, the consultant refuted the claim that she ever supervised the LPNs. The nurse consultant also testified that when she shared concerns about the unsupervised LPNs with nurses from DCF they told her that supervision was not required under DCF licensing. DCF does not license health care professionals, only the facilities. While there was no documented evidence of that claim, it does appear that DCF central office staff were aware of and discussing the lack of supervision and yet it persisted.

In regards to the claim that a registered nurse in New York was supervising the LPNs at Lake Grove, the DCF Director of Nursing testified that she recalled telling Lake Grove administration that it was not good enough. “It was bizarre,” she reported. Clearly a nurse licensed and practicing in another state was not qualified or available to supervise LPNs in Connecticut. And yet that Director of Nursing took no action to ensure that the LPNs were properly supervised.

We found no evidence that anyone from the DCF ever took action to definitively determine if and by whom the LPNs were supervised and whether that supervision met the regulatory requirement until the Fall of 2005. Only then when the DCF used nurses to investigate the medical care of the children did a recommendation come forth for a registered nurse to be hired immediately to supervise the LPNs.

What the DCF should have done about the unsupervised LPNs

In 1989, the Connecticut State Board of Examiners for Nursing issued a Declaratory Ruling clarifying the interpretation of Conn. Gen. Stat. § 20-87a(c) defining the practice of LPNs as performing selected tasks under the direction of a registered nurse or an advanced practice registered nurse. The direction of the registered nurse should be “immediately available, on site, in health care agencies providing in-patient and outpatient nursing services.” It was apparent to our investigators that the lack of supervision for the Lake Grove LPNs was well known. Failure to act upon that information suggests a total lack of appreciation for the Connecticut state regulations that prescribe these expectations as well as a lack of appreciation for their meaning in terms of safety of children.

The DCF should fully equip the agency’s regulatory inspectors and contract negotiators to be able to judge regulatory compliance. While the details of such regulation may be tedious for all DCF employees to comprehend, those persons who are responsible for oversight of services that include the provision of health care should be so informed. All persons with

expertise and knowledge should also be fully empowered and expected to act upon violations when recognized. The DCF nurses who investigated Lake Grove were able to recognize regulatory violations and safety hazards and to make concrete recommendations for demands upon the institution. But the DCF Director of Nursing, although obviously aware of a problem at Lake Grove, provided no evidence that she intervened to bring Lake Grove into compliance and the children under a safer situation.

Once the DCF did take action in demanding the employment of an RN at Lake Grove, there should have been follow-up. The DCF should have continued surveillance to ensure that the RN hired had the capacity to supervise the LPNs and also that she/he were securely employed. Even after the 2005 investigation there continued to be long periods during which LPNs were not supervised. The Department of Public Health should have been engaged more proactively as a nursing licenser as well as a resource to DCF regulators. The DCF should be engaging with other state agencies to share expertise and strengthen the safety net under children. Ultimately as custodial or statutory parent, regulator and protector, the DCF should have supervised the health care of the children at Lake Grove and the health care providers.

What Investigators Found: Licensed Practical Nurses Failed to Follow Regulatory and Professional Standards of Care

The limitations of access to medical and nursing providers and the lack of supervision of LPNs at Lake Grove essentially assured considerably negligent and substandard health care. The purpose of standards, as with regulations, is to ensure safe, quality care. Without the proper available resources and supervision, the LPNs were not equipped to provide appropriate care to the children at Lake Grove. Our investigators identified three key components of nursing care that Lake Grove failed to deliver: care planning; management of medications and medication administration; and patient education and promotion of self-management of chronic conditions.

Care Planning – There was no evidence that Lake Grove nurses developed nursing care plans or that anything they did for the children was guided by an individual nursing assessment of needs and specific expected therapeutic outcomes. When asked about planning nursing care for the children that the LPNs were responsible for, the Lake Grove APRN who was employed between 2003-2005 replied, “I don’t know if they all had nursing care plans ...There were no goals that I recall.” In an April 2006 interview with us one briefly employed Lake Grove R.N. reported plans to establish a work group with DCF nurses to develop nursing care plans for children in residential facilities. There was no evidence that the work group ever materialized.

Medication Administration – The DCF required Lake Grove to have monthly oversight of medication administration and management. The Lake Grove nurse consultant hired to conduct monthly reviews consistently identified medication errors and incomplete documentation over a period of four years. There was no evidence of any follow-up by DCF to ensure that the problems she identified were addressed. The Lake Grove APRN noted that the nurse consultant never interacted with her, “I always thought it strange that she never came to me if she found problems. Instead she would send a report 3-4 months later...” Ordinarily such a measure would be useful as a means to ensure quality control. However, that kind of delay in follow-up would be too late for correcting immediate errors and ensuring child safety. Also, Lake Grove was unique as a DCF-licensed facility that relied upon LPNs to administer

medications to resident children. The DCF Director of Nursing explained in an interview that their involvement with residential programs is predicated on the use of DCF-certified medication administration staff. Because Lake Grove never used their certified staff to administer medications to the children, the oversight of medication administration was not followed through. Even the medication administration review reports from the Lake Grove nurse consultant did not appear to have a pathway through DCF oversight. If anyone read them, no one ever acted upon them even though they all identified serious medication administration errors.

Three DCF investigations of Lake Grove medical and nursing care were conducted in 2003, 2005, and 2006-7. In each investigation DCF nurse consultants found persistent and enormous gaps in documentation at Lake Grove and related evidence of inappropriate nursing actions (findings from the 2005 investigation are discussed in detail below). Their findings confirmed that DCF oversight had been neglected. They also confirmed that the medication administration reviews conducted by the Lake Grove nurse consultant were never applied to a quality assurance process by the consultant, Lake Grove administrators, or the DCF.

Patient Education – It is difficult to imagine a Lake Grove LPN providing patient education to a child standing in a crowded hallway on the other side of a barred window. There was no evidence that that sort of education was occurring. Nor was there any evidence that the Lake Grove nurses interacted with caregivers of the children or even DCF caseworkers to prepare for discharge. It is unlikely that the LPNs contributed to patient skill development in self-management of chronic conditions; recognizing positive or negative effects of medications; or achieving progress toward community-based living without the benefit of a nursing care plan that outlined specific steps to achieve those goals.

What the DCF knew and did about the performance of the LPNs in regards to regulatory and professional standards of care

According to an undated DCF summary of activities, the DCF review utilized nurses from the DCF Bureaus of Continuous Quality Improvement and Behavioral Health and Medicine. According to their report, *The DCF Review of Lake Grove at Durham*, “medical and nursing systems indicated that the overall systems were significantly deficient, and in particular the basic nursing practices, and were not effectively meeting the needs of the children at the facility.”

The DCF nurses uncovered evidence of medical neglect of a large number of children. This neglect included:

- failure of the facility to provide critical medical follow up for children placed on medications known to have highly toxic side effects;
- failure to pursue medically recommended neurological testing for a child (this child was later discovered to have developed a brain tumor); and
- failure to ensure proper monitoring and care of children with Type 1 (insulin-dependent) diabetes.

Any of these problems, and numerous others that were found during the DCF medical and nursing staff review, could have had devastating, if not life-threatening consequences. The DCF nurses found that none of the children were being monitored consistently. Additionally,

they noted persistent documentation and medication administration errors that could easily have covered up or created serious risk to the children. The DCF nurses summarized specific medication management problems including the following:

- “The Standing Orders²² were not child specific and contained orders that required diagnosing by nurses or medication certified staff that were not licensed to diagnose (sic) i.e. ringworm.
- These orders did not consistently contain specific amounts to use (some had ranges, others had none).
- Treatment orders were combined with medication orders and it was possible that more than one medication could be given at the same time.
- PRN medications did not consistently contain information on the frequency, duration, amounts that could be given and when the notification of the MD would be needed.
- PRN medications on the MARs²³ did not contain times given, reason for giving and the results.
- MARs did not contain all information required to administer the medication.
- The cover staff signature sheet²⁴ lacked signatures for all the nurses and medication certified staff who administered the medications.
- One child’s medication was signed as given for 8 days after it was to be discontinued.
- The monitoring of blood pressures, menstrual cycles and bowel movements were not consistently provided or written on the MARs to enable tracking of the psychotropic medication side effects.
- Several medications were given to the children which were not allowed according to the pediatrician’s orders of medications. There was no evidence that this pediatrician reviewed these medications. (e.g. Children on Lithium and also receiving Motrin pm.²⁵)
- There were approximately 60 blister packs²⁶ of medication that were no longer used and contained hand written notes on them (sic) to re-label this

²² Standing orders – prescriptions for pharmacological or therapeutic interventions for typically benign incidental conditions such as: Tylenol for headache, Benadryl for insect bites, etc.

²³ Medical Administration Records.

²⁴ Staff Signature Sheet – Medication administration is generally documented with a nurse’s initials or signature. Accordingly, there is required a signature sheet with initials, printed name and signature in order to identify clearly who has administered medication.

²⁵ Lithium concentrations/toxicity may be increased by interaction with nonsteroidal anti-inflammatory drugs, such as Motrin.

²⁶ Blister packs – sheets with individually stored pills.

medication for another child. There should be no re-label of medication by agency nurses. Of the 10 reviewed, at least three were outdated.

- The medication refrigerator had a freezer that was full of ice and needed defrosting and contained several staff items.
- This refrigerator contained a thermometer inside that recorded the temperature at 58°. Medications and vaccines that are to be stored in a refrigerator generally need a temperature of 40° or below. There was no record of daily monitoring of the refrigerators (sic) temperature.
- This refrigerator should also have a lock.
- There were 10 controlled substance blister packs that needed to be destroyed.
- One child's blister pack of controlled meds was sent with him on a home visit and had not come back with him. He had not received his medication in 4 days and there was no plan to replace it. There was no incident (report) on file and staff continued to count this controlled medication as if it was still in the box.
- Old controlled drug sheets were not placed into the child's record.
- Several doses of controlled substances were pre-poured. Some were pre-signed, others not signed at all. This led to the pill count not coinciding with the controlled sheet count.”²⁷

The DCF review nurses made several recommendations in their August 11, 2005 report. (Ex. 174, Ex. 228). They outlined a need to improve the management of controlled substances, cross checking and transcribing physician orders, reviewing nursing policy and processes, reviewing documentation of incident reports with restraint reports and reviewing equipment for adequacy. They expressed having serious concerns and recommended close monitoring by DCF until the medication system was “adequate and safe.” They also recommended a thorough review of the children's medical care, **“Due to our major concerns that affect the safety of the children...”** (emphasis in original). Specific recommendations were made towards the Lake Grove nursing department in general, including the immediate removal of a licensed practical nurse from the sole supervisory position and the hiring of a properly credentialed registered nurse manager. The DCF nurses did not address the absence of nursing care plans or implementation of patient education interventions.

Despite the serious findings of the DCF nurses, scrutiny of the operations in the Lake Grove medical office soon faded out. A registered nurse was employed briefly, the DCF nurses were re-assigned elsewhere and the routine at Lake Grove returned to status quo. When a DCF nurse responded to concerns made about nursing care in late 2006 it was to identify all of the very same problems, and some more serious. This time, the DCF initiated monitoring of the Lake Grove nurses. DCF administrators now acknowledged a complete lack of confidence

²⁷ The Controlled Substance Act 1970 mandates accounting of inventory of controlled substances such as narcotics.

in the Lake Grove nurses and therefore contracted with an outside staffing agency for nurses to monitor the Lake Grove nurses. They did not provide care, but just monitored the Lake Grove nurses in the care they provided to the resident children. Even under those conditions the DCF nurse consultant continued to find extreme medication errors and shoddy nursing care. Upon the urging of the Office of the Child Advocate, the DCF filed a complaint with the Department of Public Health (DPH) in regard to the deficient practice of the Lake Grove licensed practical nurses. Cited were the persistent lack of RN supervision, chronic medication errors, systematically poor and absent documentation, and lack of nursing care plans to guide nursing care. The DPH investigators did recognize the deficiencies of the LPNs that their own agency licensed to practice. However, their response to DCF indicated that the problems at Lake Grove were not caused by individual licensed personnel but were rather “systemic problems” and therefore beyond the scope of DPH authority. The children at Lake Grove received wholly inadequate, potentially dangerous health care from licensed practical nurses but the nurses and their licensing agency claimed not to be responsible.

What the DCF should have done about the performance of the LPNs in regards to regulatory and professional standards of care

The August 2005 DCF investigation and medical review conducted in response to the Rhode Island Child Advocate’s complaint underscored the significance of following nursing standards of care. Specifically, the management of medication by properly trained and able nurses and the importance of individualized plans of care were highlighted. Medication management, including the oversight, storage and administration of medication is soundly guided by state and federal regulations. The DCF should have been fully cognizant of those regulations and incorporated that knowledge in contractual negotiations and regular inspections of the facility. Regulations serve as a layer of safety in the delivery of health care by mandating its provision with specific levels of expertise, training and appropriate supervision. In fact, DCF administrators must be familiar with regulatory requirements because the agency does have the expectation that medication administration practices be reviewed monthly. The problem at Lake Grove was that no one reviewed the medication administration reviews. It was not even clear who should have been responsible to do so. The DCF BCQI should have had inspection staff equipped with the knowledge of relevant regulations for management of medications as well as the practice limitations for LPNs. Armed with that expertise, the DCF could have not only recognized a system unable to provide safe care, but also held expectations of appropriate care before children were even placed in the facility.

Additionally, attention to medical or physical care cannot be dismissed or usurped by attention to mental health care. Whether pharmacological interventions compliment or replace other mental health treatments, the physical/medical aspects of those interventions warrant careful care and scrutiny. Individualized care plans that guide the assessment of general physical conditions and the administration of medications must be part of the foundation of care in residential treatment. The 1989 *Connecticut State Board of Examiners for Nursing Memorandum of Decision* set an expectation of strategies of care or use of nursing care plans to guide all nursing actions according to a patient’s needs. Nursing care plans prompt things like standard nursing procedure for administering medications that requires a nurse to assess each child for side effects and effectiveness of the medications. The nurse is also expected to educate the child about the medication they are prescribed by reviewing its name, how and

when to take it, its expected therapeutic effects, what side effects to watch for, and contraindicated foods or activities to avoid while taking the medications. These are the responsibilities of the nurses that nurture the ability of the child and/or family to prepare for return to community living.

Whether medical health care plans are integrated in overall treatment plans or maintained in parallel to them, the DCF must demand that no care or intervention is perpetrated upon a child without well-articulated goals, rationales, expected outcomes and defined evaluative steps. These plans of care must also incorporate patient education and efforts towards the development of self-management skills in anticipation of children returning to community living. Had DCF administrators been aware of the limitations of LPN practice and expertise, they would have anticipated their shortcomings in following these standards of nursing care. Without the registered nurses on the team of providers, there was no able professional to develop plans of care or design patient education. The DCF should have known that. The care and treatment of children with complex conditions and care needs cannot be left to unskilled and unqualified technicians.

What investigators found: Chronic deficient health care and unsafe practices

Deficient health care practices at Lake Grove were chronic, persistent and well known to the DCF. The three nurse-led DCF investigations of medical and nursing care in 2003, 2005 and 2006-7 each identified the same problems and regulatory violations. The deficiencies went beyond the LPNs and their lack of supervision. General practices of care across the Lake Grove grounds left children at risk for developing and existing health conditions.

What DCF knew and did about deficient care and unsafe practices

The injured child at the center of the 2003 DCF medical/nursing investigation at Lake Grove did not receive timely medical attention. The investigation findings of his beating near the cafeteria included a lack of emergency response ability across the facility staff. The local hospital emergency department did not receive complete information from Lake Grove and the Lake Grove medical and nursing staff did not follow instructions from the emergency department physicians. There was no evidence that a certified physician reviewed the child's medications and subsequently the Lake Grove LPNs administered the child's medications improperly. To further complicate the situation, there was no proper area for recuperation and monitoring at Lake Grove. The child was left in a broken bed in his cottage and then moved to a basement area with molds that triggered his asthma. The child's condition deteriorated without the proper attention and he had to return to the hospital. DCF administrators directed Lake Grove administrators to develop a corrective plan to address all of these deficiencies as a condition of maintaining a DCF license.

The Lake Grove executive director responded five days later in a letter to DCF. He claimed to be planning an emergency response protocol and procuring walkie-talkies for staff communication. He indicated that physician and nursing oversight of medication prescription and administration would be reviewed, although he did not provide details or objectives for that review. In that same letter the executive director reminded DCF administrators that the DCF had been warned of the shortages of nursing care at Lake Grove due to insufficient DCF funding. The executive director predicted the deficiencies would persist without the infusion

of more money. Over the years Lake Grove continually requested increased funding for expansion of nursing positions. But one DCF nurse noted that Lake Grove never filled all of the nursing positions the DCF did fund. She did not agree that increasing funding for nurses would solve the problem, as it appeared that Lake Grove was not spending the money they already received for nursing positions on the employment of nurses.

The DCF nurse consultant reported in interview to us that the investigation started in 2003 continued for a year but none of the recommendations or promises for improvements ever came to fruition. In the meantime, despite the executive director's promise of less than optimal services, there were no changes in the number of children placed at Lake Grove. The DCF was told the facility would not meet the children's needs and yet the agency continued to place children there and continued to pay Lake Grove for unsafe health conditions.

A new per diem rate was negotiated in spring 2005 that included appropriations for a substantial increase in child care workers and nurses. Shortly after the new rate was established, the officials from Rhode Island showed up and triggered the next intensive investigation of medical and nursing care at Lake Grove. Nothing had changed. Despite the influx of funding for nursing and child care staff, there was still no registered nurse employed. And despite the alleged ongoing oversight by the DCF, the Lake Grove executive director's threat was carried out and the services were indeed far less than optimal. In fact, they were quite dangerous.

For the 2005 medical/nursing review the DCF nurse consultants developed a database of all Lake Grove resident children outlining medical needs and deficiencies in their care. There were substantial and sometimes dangerous deficiencies noted. Of significant concern to our investigators was the fact that the DCF nurses had identified 68% of the residents with general medical conditions that could have been relevant to the understanding and/or management of the child's mental health or developmental disorder. No evidence was found in any treatment plans reviewed or interviews with health care staff at Lake Grove that a child's general medical condition was emphasized as an important component of the overall treatment plan. Conditions identified by DCF nurse consultants are listed in Table 1.

The DCF nurses shared their findings about the children with the DCF Medical Director. An internal DCF e-mail from the DCF Risk Management director indicated that the medical director, at the time the only pediatrician in the DCF central office, was concerned that the children at Lake Grove were "inherently unsafe." The physician called for 24-hour monitoring. The Risk Management director, not a health care professional, indicated to the recipients of the e-mail that she had assured the medical director a plan was in place and the suggested 24-hour monitoring was unnecessary. We interviewed many of the recipients of the e-mail. None of them was able to justify dismissing the physician's concerns or even describe what the plan in place was. In fact interviews with two DCF physicians identified a culture within the DCF, specifically the Bureau of Behavioral Health and Medicine, that typically dismissed medical expertise even with respect to medical issues. This was evident in the absence of medical professionals in health-related decision making processes at the DCF. One DCF administrator noted that, "There was an issue of credibility for [the medical director]. She didn't have the same level of respect..."

After the August 2005 scrutiny of medical records at Lake Grove, the lead DCF nurse consultant on the review returned to other responsibilities within the DCF. She did not recall returning to Lake Grove more than once or twice after the Fall of 2005. Her understanding was that DCF nurses in the BBHM, those responsible for training unlicensed staff to administer medications, would have been charged with any follow up. However the DCF Director of Nursing who oversees the medication administration program could only recall that she assisted the nurse consultant with a medical record review in August 2005. She did not recall following up on any of the findings. She reported having the impression that the nurse consultant issued a report but was not aware of any follow up.

In October 2005 only at the urging of the Office of the Child Advocate, the DCF notified other states about concerns at Lake Grove. The Bureau of Adoption and Interstate Compact Services issued a notice to all states with interstate compact agreements for placing children at Lake Grove. The notice outlined the DCF response to concerns that the Lake Grove medical department “was in a state of disarray and that children were not being properly supervised.” It further stated that “DCF did determine that the medical department had a number of problems including, but not limited to: poor documentation, lack of follow up medical testing for children on certain medications, and lack of follow up with children complaining of injuries or illness.”

Although the DCF went to these lengths to warn other states, the agency still did not put in place any kind of correction or oversight to protect the children. In fact, there was a great deal of confusion concerning which DCF bureau was responsible for oversight between the DCF Bureau of Behavioral Health Management (BBHM) and the DCF Bureau of Continuous Quality Improvement (BCQI). The bureau chief of BBHM insisted to us that medical care oversight fell to the BCQI - this, in spite of the fact that BCQI employed no nurses or physicians at the time. He told us he would be “shocked if there was any disagreement about that responsibility.” Shortly after that initial medical review in the Fall of 2005, the BBHM bureau chief assigned a BBHM psychologist to Lake Grove as his only on-site overseer. Her responsibilities, according to him, were to oversee the admissions process, stop the flow of children with complex medical conditions from being admitted; and consult on the clinical program. Screening out candidates with complicating medical conditions would prevent admissions of children whose needs could not be met by Lake Grove health care staff. This plan did not take into consideration addressing the medical needs for those children who were already at Lake Grove.

Few DCF officials expressed concerns about the BBHM psychologist’s lack of medical expertise to do medical screenings. By most accounts she was effective with screening candidates for admission to Lake Grove. Over time, and without any written communication to DCF staff, DCF employees on all levels came to view her as being not only a liaison between DCF and Lake Grove, but also as the DCF’s on-site oversight for all aspects of Lake Grove services and facilities. A Deputy Commissioner told us she would be surprised to learn that the BBHM psychologist “was not involved in all components of services at Lake Grove.” The DCF Chief of Program Operations, told us that the BBHM psychologist, “was there as a behavioral health staff member to assist the organization in improving overall operations and delivery of services to children ... she was not there just for the behavioral

health program of the facility ... I was assured, yes,” that she was visiting, “all of the campus, units, school and etcetera.” This was all contrary to the BBHM bureau chief’s claim that BBHM only had responsibility for monitoring individual children and that the DCF BCQI had responsibility for monitoring the overall program at Lake Grove.

The third and last medical/nursing investigation at Lake Grove occurred nearly a year and a half after the August 2005 review. A new DCF nurse consultant responded to concerns about a child with dangerous blood glucose levels at Lake Grove. A December 2006 E-mail from her to BCQI administrators indicated that in one day she had discovered a child receiving an overdose of two flu shots because the LPN discovered the first was expired after administering it; that a child had received another child’s medication because she had gotten “out of line for the med window” and that another child had a precipitous blood glucose level of 496²⁸. Blood glucose levels that high are extremely dangerous and can even result in coma from cerebral edema and death if not treated. The DCF nurse consultant also discovered that Lake Grove did not file a DCF Abuse and Neglect Hotline report for the incident.

Marking that third wave in major DCF reviews of the medical and nursing care at Lake Grove, an undated 2006 “preliminary report” described visits to Lake Grove on 12/20, 12/21, and 12/27/06 (there is no evidence either from documents reviewed or testimony given, that a final report was ever produced). The outlined concerns were stunningly similar to, if not the same and in some cases worse than the problems that were identified one and a half years earlier in August 2005 and three years earlier in 2003. Noting that the “Facility does not seem to be able to consistently meet department expectations for provision of children’s health care,” the nurse made the following observations:

- There were considerable deficiencies to policies and procedures for response to emergency situations such as access to Epi-pens, asthma inhalers or emergency First Aid.
- Monthly medication administration reviews were inconsistent and incomplete with little reporting and follow-up to serious medication errors.
- Medication administration was poorly documented and in many cases incorrectly so, including missing physician orders and signatures.
- Orders were missing when medications were administered.
- Children were not being monitored for side effects of psychotropic drugs.
- Nursing care plans or guides were not developed upon which to base nursing actions and follow-up.
- Nurses were seeing children for follow-up according to critical incident protocol (restraints, injuries) but they were not assessing the children for injury properly and not documenting why they were seen.

²⁸ A normal blood glucose level is lower than 100 when fasting and less than 180 after meals.

- Blood work was being ordered by LPNs rather than physicians who were licensed to do so.
- Dietary consults were not completed; physical examination forms were not complete.
- Axis III medical diagnoses were not being incorporated into overall treatment plans.
- Dental care was entirely deficient.
- Documentation was so poor and disorganized that a separate list indicating who had received flu shots was misplaced and no one could confirm who had them or who needed them (living in a densely populated congregate setting placed the children at very high risk for communicable diseases).
- Diagnoses were inconsistently documented.

The DCF nurse consultant also noted that documentation of incident reporting by Lake Grove was problematic. According to her report, Lake Grove staff was directed by supervisors to re-write incident reports, and Hotline reports were not being consistently made by Lake Grove. Little had improved and much had worsened since the first DCF nurse consultant assessed the Lake Grove situation for DCF in July 2003.

During an interview with us, the former DCF Medical Director explained her view that medical professionals in the DCF hierarchy were frequently left out of the discussion about Lake Grove, even though the primary concerns over the previous several years were serious medical care deficiencies. According to the medical director, “The agency [DCF] is not oriented to look at things in a health-related manner ... they don’t think about medical issues. It is not part of what they look at and is not part of the equation.” The commissioner of the time confirmed this perception explaining that the Department was only slowly transitioning from a perspective of strictly child protective services that apparently did not historically encompass the health care of the child.

One of the DCF nurses who investigated health care practices at Lake Grove blamed the lack of DCF policies regarding standards of care for the lapse in oversight and attention to the children’s health care. “If you don’t have policies or expectations of what standards are or should be,” she stated, “you can’t expect good care ... I have actually found that some of these kids will get better care in other states because the levels of care and scrutiny in other states and standards are better.” A BCQI administrator explained to us in an interview that regulations were being developed. A DCF pediatrician also testified that she was developing a protocol for assuring appropriate health care of children in DCF care. However, she also testified that people without medical expertise were making the final decisions about her proposals.

What DCF should have done about deficient health care and unsafe practices.

When it was discovered that Lake Grove had no ability to respond to medical emergencies the DCF should have taken immediate action to ensure the safety of all children. Although the facility provided a plan to improve nursing care and emergency response, there is no evidence, and there was testimony to the contrary, that those plans were implemented. When it was discovered that Lake Grove LPNs had made errors in medication administration the DCF should have first evaluated the level of supervision the LPNs were receiving and corrected any violation of the regulations. In absence of appropriate supervision, the DCF should have provided immediate on-sight supervision and monitoring until the deficiency could be corrected permanently. Additionally, the DCF should have repeatedly reported the violations and errors to the Department of Public Health where LPNs are licensed and through which their practice is regulated.

Threats made by the Lake Grove executive director for continued and worsening care without increased financial support should have been taken very seriously for the danger they represented. No provider of services for children should be excused for not meeting safe, therapeutic standards of care due to a lack of proper resources. Instead, constant and vigilant oversight should recognize resource limitations with immediacy and claims of shortages examined post haste. If in fact shortages exist then solutions should be sought or alternatives found for care and placement of the children. The DCF should have interrupted the admissions of children and even withdrawn children from Lake Grove until a point where the facility could properly manage their care needs, if at all. Technical assistance in the form of multidisciplinary professionals could have been mobilized to assist in developing and sustaining proper care. Once stability and proper care standards were met at Lake Grove the DCF should have maintained constant and vigilant surveillance of all care provision, including medical and nursing care to ensure permanent service improvement and safety of the children.

As licensed professionals, the Lake Grove nursing staff should have performed duties within the scope of their practice outlined by Connecticut law. Nurses have just as much a duty to report and remedy inappropriate assignments for which they are not qualified, as they have to provide proper care in appropriate assignments. The administration at Lake Grove should have provided proper supervision of the nurses according to Connecticut law. The DCF as regulator and licensing agent should have ensured that Lake Grove, with whom they had a contract and to whom they paid massive amounts of tax dollars, was operating properly within the laws and regulations of this state.

As the overseer and regulator of the services provided at Lake Grove, the DCF failed to assure quality, safe health care for children placed at Lake Grove. As the consumer of services on behalf of children the DCF was negligent and wasteful with tax dollars. As the statutory parent or custodian of the majority of Connecticut children placed at Lake Grove the DCF failed to assure that the children at Lake Grove received proper medical care. A biological parent who fails to access proper medical care for a child could well be charged by DCF with medical neglect of the child. What then if DCF as parent fails to ensure that a child receives proper care? The DCF should have applied the same standards of child welfare to their own caseworkers and administrators that is applied to the public. In fact, any time the DCF removes a child from their own family's home the standard should be held higher to counter the impact of that separation. The State of Connecticut must do better than a neglectful parent.

The then bureau chief of Child Welfare insisted to us that caseworkers were not qualified to monitor the medical care of children assigned to them and given his reluctance to allow DCF health professionals to intervene, there is a palpable risk that all Connecticut children in residential placements are at risk for neglect. Furthermore, he indicated to us a larger problem. When discussing the deficiencies of medical care, the then bureau chief noted, "Lake Grove is not the only program that has problems with medication administration. Lake Grove is just the most egregious." Immediate action must be undertaken to ensure the health and safety of all children in DCF care and DCF-licensed or operated institutions.

When DCF administrators sent nurses to Lake Grove to review medical and nursing practices they uncovered significant and well-articulated information. For the most part the nurses proved themselves to have good assessment skills of both the children's needs and the ability of Lake Grove systems to respond to them. The nurses also appear to have been knowledgeable of practice standards and the laws that regulate the manner in which licensed professionals practice. Despite this excellent resource, DCF administrators chose to ignore the information that the nurses were bringing forth. The decision to neglect response and follow-up to the nurses' findings proved to be a colossal waste of Department resources and a brazen dismissal of identified dangers to the children. That the agency believed a relatively inexperienced psychologist on a solo assignment was equipped to conduct medical screenings of admissions and oversee the delivery of health care at Lake Grove was simply irresponsible. Professionals with the proper expertise of both pediatric health care and regulatory standards would have recognized the deficiencies at Lake Grove before entire years passed. More than one person would have ensured broad assessments of what was occurring at the institution. The DCF should be using informed professionals to oversee and investigate the health services provided for children in any state care. DCF caseworkers as well, must be held to the same standard that any parent would be in the pursuit of medical care and oversight for their children. The health of children and the care they receive to maintain or recuperate health must be acknowledged for the priority of child welfare it is.

Finally, an agency with any degree of obligation to the care and protection of children must have solid policy to guide the practice of meeting those obligations. Without explicit policy there is nothing to guide practice and nothing to measure performance against. The DCF must formulate appropriate policy to guide the oversight of children's health care and all levels of DCF employees should be immediately trained and empowered to oversee the care of the children for whom they are responsible.

B. THERE WAS NO THERAPEUTIC PROGRAM AT LAKE GROVE

Lake Grove at Durham was established as an independent not-for-profit organization with claims of providing residential, psycho-educational and clinical services for children with cognitive delays and problematic behaviors ages 10-21. The Certificate of Incorporation, dated June 27, 1985 identified as the purpose of the organization: "to develop and operate a facility dedicated, but not limited to, promoting the general welfare of handicapped adults and children". In 2005, at a time when increased reimbursement rates were being negotiated with DCF, Lake Grove submitted program descriptions to DCF. These

program descriptions identified three separate programs for children sent to Lake Grove. The brief program descriptions were:

- Gateways - “Residents in the Gateways Program have been identified by educational or social service agencies as emotionally or socially maladjusted, and/or mentally retarded. They are in need of a structured, therapeutic setting with 24-hour supervision and special education. Residents in this program often have a history of pervasive developmental disorders, psychiatric issues, learning disabilities, substance abuse, truancy, or other behavioral conduct issues.”
- New Dawn - “The New Dawn program services children developmentally disabled who are handicapped by compounded disabilities. These handicaps may include mental retardation, language delays and severe social impairment, among others. The primary goal of the program is to integrate learned skills into a functional whole. To achieve this, the community is an important part of the New Dawn’s student’s day. Math and reading skills in that they relate to practical banking, mailing letters, shopping, cooking, and successfully navigating within the community are critical elements of the New Dawn program. As the students exhibit a wide range of functioning levels, the program is tailored to accommodate specific goals for each child.”
- Journey - “The Journey program is designed for male adolescents with emotionally (sic) and a history of acting out behaviors. These residents are very similar to the Gateway’s residents in terms of their emotional problems. However, they are also in treatment for impulsive reactivity/acting out behavior. Support and training is provided by an intense ratio of trained staff in a highly structured treatment program in which clients experience progression from an out of control life style to one in which they demonstrate control over their impulses.”

We found substantial evidence that DCF officials had determined there to be no actual therapeutic programming at Lake Grove. In addition to lacking a defined therapeutic mental health program, Lake Grove lacked the infrastructure to support a clinical program.

Missing factors in clinical infrastructure at Lake Grove:

1. No clearly defined treatment program
2. Clinical structure was not suitably staffed
 - improperly staffed clinical structure
 - understaffed clinical structure
 - no clinical coordination across campus

What investigators found: There were no clearly defined or implemented therapeutic mental health programs at Lake Grove

The program descriptions quoted above lacked a comprehensive treatment philosophy or description of treatment culture. The description of the Gateways program did not express any goals or means of treatment. It simply described the types of children targeted. The New Dawn description did include some explanation of how skills might be developed for what could be assumed to be community living beyond treatment. Still there is little explanation of the program or means of treatment. Finally, the Journey program description also seemed to be limited to describing the types of children targeted. The only goal expressed in that description referenced a change in “lifestyle” which seems to discount the complexity of developmental disabilities or mental health conditions and corresponding treatment. Also, the Journey program was consistently and exclusively described by both Lake Grove and DCF officials as serving children with problematic sexual behaviors, which was not included in the program description.

Lake Grove was offering services without specific programmatic descriptions or clear explanations of what the goals of the programs were. These vague program descriptions covered up the reality that Lake Grove had no coherent or effective treatment program at all. Nevertheless, the DCF continued to place children, make payments to and this facility.

What DCF knew and did about the lack of a therapeutic program at Lake Grove

According to a DCF BCQI administrator, Lake Grove “treatment services were minimal at best.” This conclusive sentiment was echoed by other DCF officials and became evident to us during on-site observations. According to the 2005 DCF-generated evaluative report produced as part of the review to determine increased reimbursement rates for Lake Grove services (re-basing report), there was no real delineation of therapeutic process between programs. Further, the Lake Grove staff, the report noted, did not know or agree upon what the therapeutic culture was. Of the Lake Grove affiliated individuals that DCF staff interviewed only one part-time consulting clinical psychologist even appeared capable of being “able to articulate clinical models”. One of the DCF investigators for the re-basing report told us that the Lake Grove executive director did not understand the need for program models or a conceptual framework, underscoring the dearth of clinical vision for the program or the care of the children. A BCQI administrator testified to us that, “the program was generic custodial care.” In other words, the children were being warehoused.

The DCF re-basing report described functional behavioral analyses of children at Lake Grove as rudimentary and only conducted on the children with the most problematic behaviors. A “level system” used to reward and punish children for their behaviors (higher levels achieved for good behavior would typically be associated with certain privileges), was described as “imprecise and more arbitrary than is desired.” Finally, where it would be assumed that without appropriate behavioral plans there was more reliance upon psychotropic drugs to control behaviors, the DCF investigators expressed concern that the Lake Grove psychiatrist was only available for a few hours per week to oversee the use of those drugs and

many of those hours were often on Sundays and in the evening when the clinical team was not there.

There was ample evidence that DCF managers were well-informed about the lack of therapeutic programming provided by Lake Grove. Yet the DCF continued to send children to Lake Grove with very complex needs and continued to spend state tax dollars to pay for it. The re-basing report that identified such a colossal failure of service provision resulted in the base rate increasing to \$236.27 per day per child. That translated to over \$86,000 dollars per year per child, before all the additional payments made to the facility. Additionally, the education daily rate was \$262.15, which brought the total annual cost of Lake Grove to almost \$135,000 per year per child²⁹. DCF managers knew that for this \$135,000 per year (plus all of the other incidental expenses associated with bond funding and dedication of DCF resources) the children would not be getting proper treatment and the taxpayers not receiving good value for their money. As a DCF BCQI administrator testified, “In general, in Connecticut anyway, I don’t know how well we have done with this population of kids ... A lot of placements have been made without thought in regards to fit...”

There was broad agreement among DCF officials that the clinical program at Lake Grove was either deficient or absent. However, there was no evidence that any such concerns had been raised to the level of the DCF taking action with respect to that issue. No DCF official interviewed for this investigation could recall any program improvements being implemented following the 2005 re-basing report. On the individual child level, a search of thousands of documents produced only one record of a caseworker expressing concerns to the DCF Central Office about a child who was not receiving the treatment for which she was placed at Lake Grove. In 2001 the caseworker filed an *Urgent/Managerial Case Practice Issue Report* asking for an investigation of contractual violation related to the fact that the child was not receiving the specified treatment. Both DCF Licensing and PREU declined to investigate indicating that neither investigated contractual issues. They did indicate, however, that they would look at the services provided to the child. Unfortunately, the child became pregnant and was discharged from Lake Grove before the requested therapy could be initiated. When questioned about this response, a PREU administrator explained that he probably had staff follow up on the complaint but in fact no one investigates contractual complaints and his unit had no obligation to do so. The DCF administration was aware of and had documented the absence of a therapeutic program at Lake Grove yet they continued to send children with great needs to that facility.

What DCF should have done about the lack of a therapeutic program at Lake Grove

Without clinical models or clear program descriptions, it is unlikely that any provider can deliver effective treatment to any patient regardless of needs. It makes very little sense to place a child in an institution for therapy when it is well known that therapy is not available. When the DCF re-basing report was completed, DCF administrators should have been alerted

²⁹ Assuming a school year of 185 days, the educational rate was \$48,497.75 annually added to 365 days of Lake Grove care at \$86,238.55 annually for total cost per child of \$134,736.05 taxpayer dollars. The finest boarding schools with state-of-the-art campuses, highly respected educational programs, individualized tutoring, a full compliment of health care staff, athletics and arts programs cost an average of \$40-45,000 per year.

to the fact that the therapeutic program was non-existent. The rate of payment should never have been increased unless or until actual services, beyond custodial care, were assured to be provided. The DCF also should have addressed Lake Grove's failure to meet contractual agreements and acceptance of payments without provision of service. The DCF had a contract with Lake Grove for provision of therapeutic mental health services, among other things, that should have been enforced. By committing so many state tax dollars to a private provider, the DCF had a distinct obligation to make sure that services were rendered appropriately. As the child welfare agency, the DCF had a distinct obligation to ensure the children placed at Lake Grove were safe, cared for properly and received the treatment for which they were placed.

What investigators found: The Lake Grove clinical structure was not suitably staffed

There were major deficiencies in the qualifications and assignment of responsibilities among Lake Grove clinical staff. In November 2005 a report sent to DCF from the Lake Grove executive director listed 11 employed clinicians and their credentials. Four individuals had master degrees in fields that are not licensed by the State of Connecticut. One had a degree in Criminal Justice that is an unrelated field and offers no supervised clinical experience as part of its curriculum. At the same time that the list of names and degrees were forwarded to DCF, a PREU administrator reported to his Lake Grove investigative team that none of the clinicians employed by Lake Grove were licensed.

There are two important implications that follow from having no licensed clinical staff employed: (1) the clinicians at Lake Grove either lacked the requisite professional expertise and experience required to take the licensing exam, did not take it, or failed to pass it, and (2) without a clinician who is licensed or supervised by a licensed clinician an agency cannot submit bills for therapy to third-party payers, most specifically, Medicaid.³⁰ The lack of staff with appropriate professional credentials also meant that the children were not being treated by professionals with the ability to do so.

In addition to clinical staff there were two part time consultants at Lake Grove who played key roles in the treatment of the resident children. A clinical psychologist was engaged for 12 hours per week. His work was predominantly taken up by psychological assessments of children with a history of being sexually reactive. On occasion he was asked to serve as an acting clinical director and also to provide training and consultation to staff as time permitted. Despite having taken those roles, his assessment of the clinical staff was dismal. According to the DCF re-basing report, the consulting psychologist reported that, although he was a member of the clinical department and on paper reported to the clinical director, the reality was that he reported directly to the executive director.

The second consultant was the psychiatrist described in a previous section. The psychiatrist was primarily responsible for prescribing psychotropic medication, monitoring the results of those prescriptions, attending children's treatment conferences and providing consultation to the clinicians. The consultation agreement between Lake Grove and the

³⁰ Billing Medicaid for services provided without proper supervisions by licensed professionals is a serious offense. We did not find any evidence that the DCF investigated the billing practices of Lake Grove, even though they were aware there were no licensed personnel.

psychiatrist stipulated that he would provide a minimum of five contact hours per week. According to testimony, the most he was ever scheduled was 12 hours per week but during the three years of rate negotiations his hours were limited to six per week. Both former Lake Grove staff and DCF officials deemed these scheduled hours as inadequate to meet those expectations.

Over 90 percent of the 116 children in residence were being administered psychotropic medication; over 80 of the children were taking two or more. Despite the all too obvious difference between the need for increased psychiatric consultation, and the administration's decision to reduce the psychiatrist's consulting hours, Lake Grove focused its request for more staffing on nursing positions in negotiations with DCF between 2002 and 2005. The psychiatrist scheduled himself to be on campus in the late afternoon, working sometimes until 10:00 PM reviewing charts and prescribing medications. He seldom was available to assess children directly and was generally unavailable during normal working hours to consult with Lake Grove clinical staff.

A similar pattern existed for the position of Clinical Director. For short periods of time a qualified, licensed person filled the role. At other times persons in that role were not qualified to supervise the clinical staff, nor were there other full time persons employed by Lake Grove qualified to do so. At times Lake Grove claimed that the part time consulting psychologist was supervising clinical staff or even that the part time psychiatrist was doing so. However, our investigation did not reveal any evidence that those persons were directly supervising any clinical staff. While the Lake Grove executive director held a master's degree in counseling he was only licensed as a registered nurse. Thus there was no permanent presence within the administration of Lake Grove that represented clinical knowledge or even child development expertise.

What the DCF knew and did about the unsuitably staffed clinical structure

We found no evidence that DCF personnel ever made any attempt to demand improved access to a psychiatrist, psychologist or qualified clinicians. As noted in the previous section, the 2005 DCF re-basing report described in detail the lack of a therapeutic program at Lake Grove and the inability of staff and administrators to articulate a program. We found no evidence of the DCF demanding proof of a proper program until 2007.

What the DCF should have done about the unsuitably staffed clinical structure

Just as with the recognition of lack of therapeutic programming, the DCF should have recognized the impact on the program that unsuitable clinicians would have. Similar to the violation of regulations governing restrictions on the practice of licensed practical nurses, DCF should have cited Lake Grove for operating a program without sufficient expertise or credentialed staff. As would-be consumers of children's mental health services, the DCF had an obligation to make sure the children were not only treated properly but free from the harm of misinformed providers. And more importantly, the DCF had an obligation to recognize the potential for fraud upon third party payers, including the federal government, in the billing for services by unqualified, unsupervised personnel.

DCF inspectors should be equipped with knowledge of necessary clinical hierarchies and reimbursement regulations. They should also be empowered to identify breaches in professional and regulated practices and interrupt children's placements when services are not available.

What investigators found: The clinical structure was chronically understaffed

Even if the Lake Grove clinical staff had the appropriate qualifications for provision of mental health services, sufficiency of their numbers was a chronic problem (Ex. 389) At a capacity of 116 children, with the eleven clinicians Lake Grove was expected to employ by DCF contract, there would have been a ratio of 1:11. That ratio is well within national standards. Unfortunately, since inception there were clinical positions that were persistently vacant. This often meant that children were not seen on a regular basis or were seen by clinicians with whom they had no relationship (Ex. 154).

What DCF knew and did about the understaffed clinical structure

DCF investigators conducting the 2005 rate re-basing review reported that the clinician to child ratio they identified of 1:12.8 was adequate. The DCF investigators did not, however, make note of the fact that there was high turnover of clinical staff, persistently unfilled positions, and therefore higher ratios of children to clinicians.

At different times during the 22 years that Lake Grove was in operation, the entire clinical staff consistently turned over in a short period of time. Reasons for the high turnover varied. The DCF BBHM bureau chief explained in our interview that turnover is expected as new clinicians traditionally gain experience working in residential treatment while they study for professional and licensing exams and then move on to better positions. Several DCF officials suggested that the turnover was reflective of low salaries. While three DCF officials, including the BBHM psychologist assigned to Lake Grove, noted that low pay was a factor, they also noted that Lake Grove was paying salaries to clinicians at a significantly lower rate than the facility was paid by DCF. The state reimbursement rate allotted an annual salary of \$47,000 while Lake Grove clinicians were actually only paid annual salaries closer to \$30,000. A former Lake Grove clinical director suggested that the clinical staff did not feel appreciated or respected by the Lake Grove administration. As noted above, although Lake Grove purported to provide clinical psychological treatment as their chief purpose, they had virtually no psychological expertise in their administration and reportedly a very poor relationship with what clinical staff they employed.

What DCF should have done about the understaffed clinical structure

The DCF failed to follow through on two specific issues with regard to Lake Grove clinical staff numbers. First, a review of the clinician-patient ratio should never have been calculated with unfilled positions. It would have been very easy to review employment records to recognize the persistent gaps in staffing. What should be versus what is has no credible meaning in evaluating the delivery of services. The DCF should have demanded that an adequate number of qualified clinicians be employed. Absent enough clinicians, the DCF

should have stopped placing children and removed any children who were not actually being accommodated as reasonable treatment plans would indicate.

Second, the DCF was paying Lake Grove a rate that incorporated a specific salary for the clinicians. DCF officials were aware that clinicians were not being paid at the level of salary that DCF was reimbursing. An accounting of the unused funds should have been demanded immediately and the expenditure of state funds scrutinized.

What investigators found: There was no coordination across programming and disciplines at Lake Grove

A lack of coordinated programming between clinical, residential, educational, recreational, and health services (the milieu) had profoundly negative impact on coordination of individual treatment plans. Without interdisciplinary cooperation and follow-up for each child, their treatment programs, if they existed, could not have been implemented in such a way that treatment goals and objectives could be reinforced and attained in daily living.

What DCF knew and did about the lack of coordination of care at Lake Grove

A lack of coordination between services at Lake Grove was noted in several reports by DCF investigators. This was especially noticeable in the absence of medical and nursing goals integrated into the general treatment plan as described in a previous section of this report. A former Lake Grove clinical director gave an example of the difficulty experienced between the clinical, educational, and residential departments. She testified that the clinical department had initiated a pilot program in two residential cottages that stressed positive reinforcement and rewards for children. Results from this pilot program showed improved behavior management among the children and a reduced number of physical restraints used in the residential cottages. Before this pilot program could be implemented across the Lake Grove campus, the education director and executive director objected to the program. Apparently they did not understand the therapeutic milieu or the value of positive reinforcement versus negative. Reportedly the educational director claimed that the, “kids were getting away with things,” and they needed consequences. So the executive director, who had no clinical expertise, rejected the positive reinforcement program. The former clinical director said conditions deteriorated and morale among clinicians dropped as they worried about increasing restrictions on the children.

Ultimately, the lack of appreciation for therapeutic milieu, as identified in the 2005 DCF re-basing report, resulted in an inability for Lake Grove staff to engage in cross-disciplinary coordinated treatment for the children. The DCF documented the lack of milieu in that report but notes from DCF meetings and statements made in interviews suggested that DCF officials were aware of the lack of coordinated programming tied together in a therapeutic milieu but never took action to address that deficiency.

We have previously described a lack of evidence that DCF caseworkers were engaged with the medical and nursing staff to oversee the children’s care. We also noted frequent absences of DCF caseworkers at treatment team meetings. Even after the DCF determined to remove all of the Connecticut children from the facility DCF caseworkers were conspicuously

and frequently absent from planning meetings for treatment and discharge or transfer to other facilities. Without this kind of engagement, the DCF was not able to ensure coordination of care. Even the DCF BBHM psychologist who was assigned to Lake Grove did not engage with the health care, residential or educational staff, although she did attend treatment team meetings in the final days of the facility. We could only conclude that the DCF did not have an expectation of coordination of care within the milieu at Lake Grove.

What DCF should have done about the lack of coordination of care at Lake Grove

Outcome Measure 3 of the Juan F. federal consent decree addresses treatment plans. The expectation is expressed, “In at least 90% of the cases...clinically appropriate individualized family and child specific treatment plans shall be developed in conjunction with parents, children, providers and others involved with the case...” The measure refers to the overall child welfare treatment plan but certainly reflects and incorporates the expectation that a child’s care will be developed and coordinated by and among all parties involved in that care and provision of service. The DCF should have pursued this outcome measure at Lake Grove and the fact that the agency did not suggests noncompliance with the consent decree.

As parents, consumers, regulators and protectors of children, the DCF should have been more engaged in the care and treatment of children at Lake Grove across all aspects of their days. DCF caseworkers should have been attending and taking a leadership role in treatment team meetings and they should have been demanding the involvement of all Lake Grove specialty areas. When DCF reviewed the program at Lake Grove there should have been attention to the degree to which coordination among disciplines was occurring and expectations expressed that they would all be engaged. Coordination among Lake Grove disciplines should have also integrated the children’s families or caregivers and/or the persons to whom the children would be discharged in order to prepare the child and caregivers for successful discharge out of the institutional setting.

C. THE DCF IDENTIFIED CHRONIC PROBLEMS WITH THE LAKE GROVE PHYSICAL PLANT THAT WERE NEVER CORRECTED

What investigators found: Lake Grove had persistent problems with the habitability and therapeutic atmosphere of the physical plant

The programmatic issues of health care and mental health therapeutic clinical services described previously were compounded by numerous facility problems including problems with the physical plant, interiors, furnishings, and the general environment. Evidence confirmed that DCF personnel were aware of numerous and persistent facilities issues but unable to correct the problems.

Lake Grove at Durham was situated on a 55-acre lot in rural Durham, Connecticut that was privately owned and leased from a Lake Grove parent organization. The grounds were relatively neat. There were no gardens or borders, but the lawns were kept mowed. From the roadway, the campus buildings appeared to be well maintained. The campus consisted of an administration building, a school building, a dining hall with kitchen, a gymnasium, 11 residential buildings, a swimming pool, a mixed-use building with laundry and cafeteria, and

farm buildings. At the time of our site visits in 2005-2007 the licensed capacity of the agency was 116 beds, making it the largest DCF licensed residential facility in the State of Connecticut. The Lake Grove executive director told us that the facility was generally full and frequently over the 116-child licensed capacity without the knowledge of the DCF.

With an eye to evidence of a therapeutic milieu, we visited buildings and grounds to experience the atmosphere of the facility. The interior of the administration building was worn but clean. Administrative offices were nondescript with old furnishings. At the other end of the building, away from the administrative offices, was the nursing and doctor's (medical) office that was accessed through a locked door or barred window as previously described. The basement of the administrative building contained a series of offices and a sitting area. The school building was one of the newest buildings on the campus. Classrooms were nicely decorated; a computer room was well-equipped with new computers, and the building was clean. The gymnasium was a simple structure with a basketball court. Farm animals were kept in a cluster of barns and sheds with small paddocks.

Of the 11 residential buildings referred to as "cottages", there were eight dormitory-like split-level buildings, and three converted raised ranch houses. Five buildings were assigned for girls. From 8 to 10 girls lived in each of the cottages. In April 2006 adjustments were made to cottage assignments following chronic incidents of exacerbation of negative behaviors in cottages housing close to 20 girls. The population in one of the girl's units was split and reduced to house 6-9 girls in two cottages. No similar downsizing occurred for the boys. They were housed in six units accommodating from 10 to 17 youngsters. Each cottage, in addition to bedrooms, had public sitting areas, laundry, bathrooms, storage, and offices for cottage staff. There were also kitchens in which the disrepair of cabinets, stoves and refrigerators suggested little use (children ate in the dining hall).

Attempts to create an attractive home-like atmosphere in the cottages varied significantly. In general, the more children in each cottage, the less homelike and attractive the living units were. The variability in the attractiveness and home-like atmosphere of the cottages appeared reflective of individual characteristics of assigned supervisors. One raised ranch house had decorations, a fish tank and a well-stocked snack shelf in the supervisor's office. Visitors could imagine children returning from school and relaxing together with an afternoon snack in that cottage, like one might expect any child living at home would do. That cottage was unique — reflecting the personal involvement of the cottage supervisor.

Upon approaching and entering the other residential cottages, the first impression of a well cared for facility was dispelled. With few exceptions, most of the cottages were very poorly resourced with little support for cleaning and upkeep. Common areas were not attractively decorated nor maintained. They generally contained old, worn furniture in need of repair. Floor coverings were dirty and worn. On a repeat visit we noted that carpeting was being replaced in one cottage. Walls needed to be painted and lacked decorations. Windows were missing screens and in general the buildings' appearances were not homelike. Passageways to bedrooms were narrow. Seating in the hallway for staff providing direct supervision hampered the thruway. In these areas the atmosphere could be crowded, noisy, and chaotic.

Appearances became even worse in the children's assigned bedrooms. Many mattresses were lumpy and in need of replacement. Few rooms were decorated, which a Lake Grove

Resident Director explained reflected either a child's available family resources or characteristics of the child's DCF caseworker. (Some DCF caseworkers were reportedly very involved and sensitive to the needs of assigned children while others were conspicuously absent in the daily life and living needs of their charges.) The same Resident Director explained one room with virtually no personalized decorations, as that of a child with such a low IQ that the child would not notice personalized decorations. Closets were lacking doors or any coverings. Some beds lacked pillows, most beds lacked bed covers. There were holes in walls, and graffiti existed in abundance. Some beds were old, steel frame beds with sharp corners and others were made of wood.

In the two cottages associated with the program for boys with sexually reactive behaviors, the rooms were all individual, very small, cell-like, and poorly kept. On one visit we observed that a boy's bed was soaked in water because a window had been left open during a morning rainstorm. If there were housekeeping standards promulgated by the Lake Grove administration, they were not in evidence. Bathrooms were dank and smelled of urine. Many of the Lake Grove resident children appeared to have no identity expressed in their rooms. In addition to identifying props, decorations in a child's room are sources of comfort and coping for one who has been removed or is without biological or significant caring adults and family. Very few children had family photographs or letters from family members posted on their bedroom walls — exhibiting their only connections to special people in their lives. In contrast, the barrenness of some rooms might even have had significantly negative effects on children.

Included in the daily rate paid to Lake Grove by DCF is money for clothing. In many of the children's rooms there were almost no clothes in the closets and few in dresser drawers. In some bedrooms there was an abundance of clothing. Staff when questioned noted that some of the children's families provided clothing for them. If there was a system in place to ensure that all children were adequately clothed, it was not evident. We also found no evidence that any DCF caseworker or licensing inspector ever brought forward concerns about the lack of clothing supplied to the children.

The public sitting areas in each cottage doubled as group meeting rooms. There were no areas where children could retreat for quiet and comfort as in a healing milieu. There appeared to be little opportunity to experience or learn to respect furnishings or decorative items that typically contribute to the comfort of a home.

With the exception of the newer school building there was no sense of a therapeutic atmosphere or milieu in the majority of the facility buildings. Unless the Lake Grove intention was to promote a milieu of barrenness and despair, the physical surroundings in all but two of the cottages were reflective of an organization that was undercapitalized, poorly led and incompetently staffed.

What DCF knew and did about the problems with the physical plant

DCF authorities had known for years that the living facilities at Lake Grove at Durham were not providing the home-like, attractive environments that the children are entitled to under the DCF guiding principles and policy. Report after report cited the lack of compliance with DCF and Department of Public Health regulations. Many of the DCF reports triggered corrective action plans from Lake Grove. But the inspections that followed typically identified the same and frequently worse conditions. Corrections were not consistently implemented by

Lake Grove or maintained but apparently monitoring of those corrections by the DCF did not occur either. While there would at times be some limited improvements, there was never a complete overhaul of the buildings to bring Lake Grove into full compliance with regulations or even to keep the facilities clean and comfortable for the children. DCF officials we interviewed uniformly concluded that Lake Grove was never able to sustain any improvements regarding the condition of the physical plant. The confusion about the role of the BBHM psychologist at the facility underscores a lack of appreciation by DCF for the concept and importance of therapeutic milieu. She and the BBHM bureau chief clearly did not recognize that the residential cottages, cafeteria, medical office, school, and every other inch of Lake Grove comprised what should have been a therapeutic environment. Despite consistently documented deficiencies of the physical plant at Lake Grove, the DCF failed to take any action that resulted in sustained improvements.

As the licensing and regulatory agency for Lake Grove, the DCF was responsible for periodic inspections of the facility to ensure that legal and contractual expectations were being met and that the children were living in an appropriate environment. The DCF had in fact inspected the Lake Grove facilities regularly. Given that this investigation found the facility lacking, we examined evidence of DCF assessments. The time line below illustrates DCF's observations concerning the persistent absence of a safe and appropriate environment at Lake Grove.

- In July 2001, the annual water quality inspection of the Lake Grove facility was conducted by the Department of Public Health. Nineteen deficiencies were noted in the children's living areas and included structural problems in the cottages in need of repair and equipment in need of replacement (e.g. broken or inoperable doorsills, refrigerator, furniture, toilet, and window screens).
- In May 2002, a team of DCF licensing inspectors conducted a licensing inspection. The team found a total of 35 problems in the cottage facilities. These problems ranged from holes in the walls, peeling paint and broken doors in bedrooms to missing screens on windows, furniture in need of replacement, rooms in need of painting, carpets in need of replacement, missing light fixtures and non-functioning toilets. There was no evidence of follow-up by DCF personnel.
- In October 2003, a DCF licensing inspection of the physical plant identified over 100 deficiencies. Structural repairs cited in all of the previous reports persisted. Many areas were in need of basic cleaning. Throughout the cottages there was broken bedroom furniture; walls, woodwork and doors in need of paint and repair; carpeting in need of replacement; missing drain covers in bathrooms; sagging or missing bathroom ceiling tile; and graffiti.
- In March 2004, another DCF inspection of the physical plant reported 38 items in need of attention. Clearly some progress had been made in the 6 months since the previous inspection, but many items noted as out of compliance were the same items identified in earlier inspection reports going back three years.

- In August 2004, DCF licensing inspection significant deficiencies were identified in six cottage living areas. Eight cottages were found to be out of compliance in regards the physical conditions of the bedrooms. Holes in bedroom walls, blinds missing from windows, pillow cases missing from beds, worn and peeling paint, dirty worn carpets and graffiti were some of the conditions noted by the inspectors. Bathroom problems were identified in four of the cottages (toilet stall doors broken, drains missing, painting and cleaning needed in all four bathrooms). Inspectors also noted problems in the bathroom facilities in the gymnasium and the main cafeteria.
- In August 2005, all of the cottages were to have been reviewed by DCF as part of a major program review. DCF investigator notes described a residential building lacking in child specific decorations, carpets that were old, worn and unclean, a basement littered with old laundry equipment, boxes and loose debris. The basement was wet and smelled of mildew, a smell that coincided with the smell in an upstairs bathroom.

The DCF licensing inspectors appear to have performed their jobs and documented what they observed in their reports. However, the licensing inspectors' jobs were primarily to evaluate the Lake Grove facilities rather than the effect of the facilities on children. We found no evidence of any protocol for DCF administrators to respond to the identification of such deficiencies.

Both Lake Grove and DCF personnel interviewed for this investigation indicated they had concerns about the physical environment of the children's living quarters. One BCQI administrator reasoned that similar conditions existed throughout Connecticut residential treatment centers due to the financial constraints the organizations experience. The evidence suggests that managers at DCF did not follow up on the many DCF reports of facilities problems at Lake Grove. There was no evidence that the reports were ever examined in the context of their effect on the children living in those substandard conditions, in many cases for years. We found no formal complaints made by DCF caseworkers or administrators in regards to the physical environment, lack of therapeutic milieu and the effect on the resident children. However, all DCF officials interviewed about this issue expressed agreement that the environment at Lake Grove was dismal.³¹ There was no other evidence in interviews or document reviews that suggested an appreciation for or effort to provide the children with a therapeutic physical environment. Where facility and surroundings were meant to be designed as comforting, safe feeling and developmentally appropriate to provide a therapeutic effect on the children, Lake Grove provided a sense of negligence.

What DCF should have done about the problems of the physical plant

³¹ The only exception noted to the tolerance of dismal surroundings was the one Lake Grove cottage supervisor who described his significant personal attention to developing a comfortable atmosphere in the raised ranch that he oversaw for girl residents. The cottage and the girls' rooms in that cottage were well cared for and attractively decorated. He did not express any knowledge of the concept of therapeutic milieu and had no background in psychology or child development. However, he did seem to recognize the benefit of a pleasant surrounding.

As noted previously in this report, residential treatment for children, particularly children who have experienced neglect and abuse, requires that every component of their daily living needs to be considered in the formation of a therapeutic milieu. Physical environment is particularly critical for children in institutional care who lack the softness of intimate relationships (a mother's hug, a sibling's grasp). Institutional settings and social mores prohibit the tactile comforts found in family living so must be replicated with soft environmental props. The physical condition of the residential units where the children spent the majority of their time was reflective of a lack of respect and dignity for the children. There appeared to be a total disregard for the usefulness of therapeutic milieu and an overall lack of quality care rendered the children.

Children should not have been placed in an institution that was so poorly kept. If the DCF believed that the deficiencies could be improved upon, there should have been strict monitoring and clear expectations of improvements until they were completed and permanent. If improvements were necessary across the campus of the institution then children's admissions should have been delayed and resident children shifted to safe, appropriate environments as each building was renovated. All of the improvements that should have been demanded should also have been guided by therapeutic expertise in developmentally and therapeutically appropriate environmental details.

DCF administrators and caseworkers should have been trained and informed about the concept of therapeutic milieu. Any DCF official who visits children in institutional care should have the skills to assess the appropriateness of the environment. When found inappropriate, DCF officials should have a protocol for bringing such a deficiency to the attention of administrators who can demand correction. The milieu is the treatment. If the milieu is lacking, the treatment will not be fully effective and the reason for the child's placement mute. Absent identification of the problem or demands for correction, the DCF is condoning the deficient environment and signaling satisfaction with unsatisfactory care. The DCF should have had examination of therapeutic environment as priority for any and all visitors to Lake Grove. Finally, technical assistance in the form of guidance and educational programs regarding therapeutic milieu should have been offered to Lake Grove staff and administrators so that they would have the capacity to understand and achieve the appropriate environment for their residents.

D. SERIOUS DIRECT CARE STAFFING PROBLEMS AT LAKE GROVE WERE NOT ADDRESSED

The eleven cottages that comprised the residential living facilities for the 116 boys and girls at Lake Grove were staffed by a cadre of child care workers supervised by program managers. Program managers were supervised by the residential director who reported to the executive director. There were persistent concerns expressed and documented by DCF officials and supported by numerous Abuse and Neglect Hotline Reports that indicated there were significant problems with staffing on several levels.

Significant problems with direct care staffing on several levels:

1. Inadequate numbers of direct care staff at Lake Grove
2. Insufficient education and preparation of staff to care for the children
3. Insufficient training and supervision of direct care staff
4. Poor oversight and scrutiny of staff backgrounds, particularly criminal behaviors and abuse or neglect of children
5. A pervasive negative staff culture counter to a therapeutic milieu
6. Poor control and management of Lake Grove direct care staff

What investigators found: An inadequate number of direct care staff

We found ample evidence indicating that since the DCF first licensed Lake Grove in 1985 as a residential treatment center the institution did not employ an adequate number of child care staff to ensure the safety of the children. Despite the evidence, there was no indication that either the DCF or Lake Grove ever sought to address the issue until recommendations were made in the 2005 re-basing report to increase the number of child care staff.

What DCF knew and did about the inadequacy of numbers of staff

In a report to the DCF dated July 7, 2004 the Lake Grove executive director listed a total of 51 direct care staff employed by Lake Grove. In the winter of 2005 the number of direct care staff was increased to 62.5, although we found no evidence of indication for that increase. No documents were found in review of DCF records that addressed the numbers or ratios of staff to children at the institution or requests from the institution to increase the staffing. Following the DCF 2005 program review for re-basing the reimbursement rate, the DCF recommended increasing the authorized number of positions substantially. The net result was an increase to 126 direct care worker positions at Lake Grove, more than doubling previous number of staff. There was no documented explanation for the substantial increase or whether the numbers previously were considered problematic.

What DCF should have done about the inadequacy of numbers of staff

As part of standard review and oversight of licensed residential treatment centers the DCF should have incorporated minimum standards for staff-to-child ratios. We found little evidence that the DCF attended to this issue in any way. Lake Grove was not accredited by the leading accrediting organization in the United States for agencies serving children and families, the Council on Accreditation (COA).³² But even without accreditation, applying the Council on Accreditation's standards to licensed residential treatment centers could ensure a minimum quality of care. In the case of child care worker to child ratios, the minimum

³² Council on Accreditation Standards. Accessed at <http://www.coastandards.org>.

expectation of the COA is one awake adult worker to every five residents.³³ Checking staffing positions and staff-to-child ratios is a task that should have been incorporated into general inspections or reviews of the institution by DCF, the regulating agency. Without attention to staffing positions there is no way that the agency could determine if the basic infrastructure of safety existed.

What investigators found: Insufficient education and preparation of staff

The children who were placed at Lake Grove had complex conditions and needs warranting careful attention and interaction in order to achieve therapeutic outcomes. We found no evidence of the issue of preparation to provide direct care being a concern of the DCF.

What DCF knew and did about the inadequacies of education and preparation

In a July 2004 Lake Grove report to the DCF the educational backgrounds of the 51 staff members of the time were listed. Only seven had college baccalaureate degrees and one held an associates degree. A second level of child care worker included in the group were five program instructors who were assigned overall responsibility for the children in a cottage and whom assumed responsibility for all associated administrative work. None of the program instructors were college graduates. Although not noted in the report, it was assumed that the child care workers without college degrees were high school graduates. There was no evidence that the DCF ever reviewed the educational needs and preparation of direct care staff with the Lake Grove administration. There was a great deal of documented evidence and DCF interview reports that indicated concerns about how the direct care staff were trained, supervised, and how they interacted with the children. The issue of their preparation for the job never appeared to be examined.

What DCF should have done about the education and preparation of staff

The levels of education of those staff members who interact most directly and most often with the children throughout their days in residential care are critical to the quality of those interactions. They are also significant in that the COA requires that the majority of persons serving as child care workers in residential treatment programs be college graduates or extensively experienced and trained. The standards reflect the level of ability best fit to meet the needs of children with conditions so complex they require residential treatment. In 2005 the Connecticut General Assembly passed legislation, now codified as Conn. Gen. Stat. §17a-61a, mandating that DCF be accredited. But the DCF has yet to comply with the law. The challenges of working with children with complex conditions in a residential therapeutic milieu demands recruitment of the best educated and experienced individuals possible, regardless of whether the facilities are accredited, as Lake Grove was not.

³³ Council on Accreditation, (2008). RTX 16.04 Resident Care and Supervision. Downloaded from: http://www.coastandards.org/standards.php?navView=private&core_id=1032

The concept of therapeutic milieu can be difficult to grasp when dealing with difficult client behaviors. Effective child care staff must have the ability to separate outward behavior from underlying cause and recognize the necessity for therapeutic intervention versus punishment. They must also be able to appreciate the purpose of therapeutic milieu and promote healing and self care abilities. Establishing relationships with healthy boundaries, nurturing growth and development and enhancing self-esteem are “tasks” for all residential treatment staff in the milieu. Therefore, ensuring the hiring of qualified staff and supporting them with training and supervision are critical components of the facility’s ability to function. When a child is in distress and acting out, all staff must have hardy coping skills and critical thinking ability in order to assess a situation for what it is and not what it appears to be.

At the time of this investigation there were 17 not-for-profit residential treatment centers in Connecticut. Many of those agencies were accredited by the Council on Accreditation and thus, according to the accrediting agency, met the standard that required them to employ college graduates and/or persons with exceptional experience. If those other agencies in Connecticut could do it, Lake Grove should have follow suit. The DCF should have overseen those efforts. We found no evidence that the DCF ever engaged in guiding Lake Grove towards hiring and maintaining an appropriately prepared direct care work force.

What investigators found: Inadequate training and supervision of staff

Although we found evidence that DCF officials had concerns about the adequacy of training and supervision of direct care staff, we found little indication that the DCF made specific demands for improvement of training and supervision.

What DCF knew and did about the inadequacies of training and supervision

Over 50 percent of the child care staff at Lake Grove were employed less than two years. While there was a training program for newly hired staff, it consisted primarily of an orientation to the agency; an introduction to the characteristics of children in their care; and state mandated therapeutic crisis intervention training (use of restraints). In notes from a May 2006 DCF review of Lake Grove staff orientation and training, DCF investigators reported that “All staff report having little to no formal training ... or on the job training.” A program instructor was quoted in the report as saying “after Orientation Training, they [direct care staff] were put right on the line, did not shadow anyone or do a practicum and basically learned on the job ‘under fire.’”

Former Lake Grove staff and DCF officials reported to us that a number of child care workers were considered competent employees. However, many of the same individuals noted an inexperience and lack of training apparent among child care workers. Perhaps most telling, in September 2004 the Lake Grove executive director shared with DCF program review and licensing officials that, “20% - 30% of [his] staff should be removed and replaced by more effective individuals.”

What DCF should have done about the training and supervision of staff

Utilization of insufficient, under-educated, under-trained and poorly supervised staff to care for children with complex conditions creates significant risks going well beyond the risk of ineffective treatment. There are also serious risks of injury to both resident children and staff.

We can say with certainty that the DCF was aware of insufficient training and supervision by 2006. We did not, however, find evidence that the DCF routinely evaluated staff training programs and supervision in regular reviews of the institution. The DCF should have included full assessments of staff supports and training as soon as the institution requested a license. Careful scrutiny of these programs should have increased following the debacle at Haddam Hills. The chief problem at the sister institution was an unsupervised and properly trained staff. The DCF should have been alert to the possibility such deficiencies would be likely at Lake Grove.

What investigators found: Insufficient oversight and scrutiny of staff backgrounds, particularly criminal behavior and abuse and neglect of children

The current set of DCF child caring regulations does not specifically call for a police background check on employees of residential facilities. In 1999 a DCF memo was issued communicating DCF's interpretation that facilities must conduct a police and DCF background check in order to comply with State of Connecticut regulation 17a-145-63 which requires providers to take the steps necessary to provide for the safety of children.

It appeared there was little attention paid to the criminal backgrounds of individuals hired to provide direct care to the children at Lake Grove. As we reviewed hundreds of Abuse and Neglect Hotline reports involving allegations against Lake Grove staff we recognized the risk of violence against children perpetrated by individuals who may already have had histories of violent behavior and poor coping abilities.

What DCF knew and did about staff criminal and child abuse backgrounds

In 2001, a DCF investigation of an abuse/neglect referral identified a Lake Grove staff person with a record of Sexual Assault 1 with unlawful restraint and Sexual Assault 3 with a firearm. Another child care worker, in addition to felony convictions, was also substantiated for physically abusing and neglecting her two biological sons. Lake Grove had conducted no background checks on this person at the time of her initial employment in 1998 or her re-employment in 2002. In 2004, the Lake Grove executive director requested clarification from the DCF PREU regarding the hiring of persons for whom DCF had substantiated as having neglected a child. The response from the DCF was that it was "the department's intention to exclude neglect from this mandatory section of the residential contract language."

In June 2006, the DCF BCQI asked Lake Grove administrators for a review of criminal records among staff persons. Of the 200 total employees at that time, twenty among direct care staff had criminal charges filed against them. Eight of those individuals were charged with crimes against persons and six served prison sentences for crimes against persons, including sexual assault and assault of a police officer. In a memo to the DCF Commissioner at the time,

the Bureau Chief of BCQI summarized state regulations regarding hiring persons with criminal backgrounds. “Finally,” he wrote, “RTCs³⁴ are prohibited from hiring anyone who has been convicted of an assault or crime against another person.” That memo was in response to a whistleblower report regarding a childcare worker with a criminal background. As follow up, the DCF psychologist assigned to monitor Lake Grove admissions appeared to recognize the potential for a larger problem. She noted in a memo to DCF managers, “I met with [the executive director] on Friday of last week to discuss my concerns about this particular staff member, but also the larger issue of whether or not Lake Grove employs others with similar arrest/conviction histories.” According to voluminous documents reviewed, this was the first time that DCF had taken an interest in the backgrounds of who was caring for the children the agency was placing at Lake Grove. No DCF monitoring of background checks or review of hiring practices appears to have occurred prior to that point.

What DCF should have done about staff background checks

The DCF should have clear policies about the extent and frequency of background checks of persons employed by DCF-licensed institutions. In addition to the policies, DCF administrators and investigators should be ensuring compliance with frequent reviews of employee records, background checks and subsequent actions taken. As the licensing and regulating agency, the DCF cannot rely upon licensed institutions to regulate themselves. Background checks should also be repeated periodically in order to capture any subsequent criminal behavior that may have repercussions in the work place, putting children at risk. In regards to abuse/neglect histories, individuals employed to care for vulnerable children should be held to the same or higher standards as a biological parent would be subject to.

What investigators found: Pervasive negative staff culture counter to therapeutic milieu

Of those staff members Lake Grove employed, many were able, committed employees. However, there were a number of employees at Lake Grove who were simply not suitable for a facility caring for children. The incident described earlier of the child who was “lobbied” out of her residential cottage by staff and other residents is an example of an inappropriate intervention for which a small number of staff were responsible. However, the enormity of the negative implications of a child being rejected from her place of therapeutic safety suggests a complicity of the entire Lake Grove staff; the fact that it happened in the first place set the tone. Children living at Lake Grove witnessing that practice would have lived with the threat of also being rejected by the community they expected to be therapeutic. Children were sent to Lake Grove to learn trust and relationship building, with the expectation of safety and supervision. Instead they lived in an atmosphere of potential rejection for reasons well beyond their control.

What DCF knew and did about the pervasive negative staff culture

In 2004 DCF administrators began to take notice and document concerns about the culture at Lake Grove perpetrated by the direct care staff.

³⁴ RTC - residential treatment center.

- August 2004 - A memorandum from the BCQI bureau chief noted that, “There is...a residual ‘Haddam Hills’ type culture and there are a number of staff who have not adopted a more collaborative, treatment focused method of operation.”
- October 2004 - The DCF Service Evaluation and Enhancement Committee (SEEC) met and discussed problems of Lake Grove staff. Minutes from the meeting noted, “There are high incidents of inappropriate staff behavior. DCF is working with them around their systems and QA activities for identifying the staff and the problems of inappropriate behavior.”
- July 2005 - SEEC meeting minutes noted, “DCF met with Lake Grove’s administrative team last year and brought to their attention a sub-culture that existed among some of the staff members who were inappropriate in how they engaged the residents.”
- Concern about staff sub-culture was echoed in a memo from DCF PREU questioning whether culture could be an underlying cause for the high incidence of Abuse/Neglect Hotline referrals and subsequent investigations. The author wrote, “The referrals and investigations during the early 2005 time frame, raises some questions about the staff culture...”
- August 2005 - Handwritten notes from meetings with DCF administrators seemed to acknowledge problematic impact on the children as the author wrote, “...injuries during restraint, staff instigating kid...” and further on noting, “Staff resistant to change – QA division made up of long-term employees who adhere to old ways.”
- August 2005 - Memo to the DCF PREU the bureau chief of BCQI wrote, “One approach to this issue [inappropriate behavior of a Lake Grove child care worker] is to make it a QA and Personnel systems issue and to discuss with [the executive director] how Lake Grove deals with repeatedly ineffective staff.”
- December 2005 - Making the connection between the serious staff problems and its impact on the overall program, a DCF PREU administrator wrote to his colleagues about early findings from the August 2005-initiated program review. He wrote, “Out of that more focused review it became apparent that there were other system deficits and the most significant ones were in the Lake Grove residential milieu.”

DCF administrators had concerns about ineffective staff at Lake Grove for years. The facility had been licensed for 20 years; it would seem that by 2005 the DCF administrators would be familiar with the way the facility operated. Rather than reminding Lake Grove administrators of their obligation to care for children and keep them safe, therefore overseeing staff accordingly, the DCF administrator appeared to be at a loss for how to approach what would ultimately be a child protection concern.

Although it is clear that by 2004-2005 DCF administrators were beginning to recognize a problem with the staff culture at Lake Grove, there was little evidence of defined interventions or demands directed toward the institution. We found no record of staff trainings’, in-services or other educational programs. There was also no record of any specific recommendations regarding the guidance or termination of any staff perpetrators. Also lacking

were any accounts of DCF caseworkers reporting to administrators concerns about the negative culture or the impact on individual children. Returning to the example of the child who had been “lobbied” from her resident cottage to the floor of a laundry room, we found evidence that the child had been treated similarly several times. We found no evidence of the child’s caseworker following up or making complaints about the care and treatment of the child before the nurse consultant found her.

What DCF should have done about the pervasive negative staff culture

Beyond being the licensing-regulating agency, the children’s mental health agency, the family prevention agency and the juvenile justice agency, the DCF is most critically the child protection agency. These are roles for which obligations should be very clear. Demanding from residential providers a staff with the capacity to provide a therapeutic milieu is an action that ensures delivery of contractual agreements for service as well as safety of children. Because there was no clearly articulated therapeutic mental health program however, and because the DCF did not attend to examining therapeutic milieu, there was no framework within which to measure the performance of the direct care staff.

The DCF should have had a mechanism for evaluating the delivery of appropriate services that included first and foremost a clearly articulated therapeutic program, a well planned therapeutic milieu and a staff able to support that milieu with sufficient expertise, training and supervision. DCF licensing investigators were not expected to review such programmatic details during their periodic visits. The Bureau of Behavioral Health and Medicine did not do periodic reviews of the program, they only responded to individual problems. When the BBHM had a representative on site at Lake Grove, she failed to even assess the general milieu of the institution. Without those broad assessments, there would be no framework by which to hold accountable the direct care staff. The DCF bureaus should have been working together to ensure comprehensive understanding of what was going on at Lake Grove. At the very least, the child protection agency should have responded to the multiple reports of staff violence and inappropriate behaviors that placed the children at risk.

What investigators found: Poor control and management of the Lake Grove direct care staff

It appeared as though little action was taken to ensure the safety of children at Lake Grove through the maintenance of a well-managed staff. We found that DCF officials had concerns about the staff at Lake Grove but did little to either assist the Lake Grove administration to achieve a well-managed staff or show that the expectation existed.

What DCF knew and did about poor control and management of Lake Grove staff

Six months after the Rhode Island officials complained that a child had unsupervised access to areas of the facility that posed significant risk, February 2006 DCF SEEC meeting minutes indicated that, “a youth gained access to cleaning products through an unlocked bathroom and allegedly drank the cleaning products.” DCF Hotline reports corroborated what the DCF administrators discussed in their meeting. Again nine months after that first incident another child drank from a bottle of Spic and Span left unattended in a classroom. Fortunately, neither child was harmed but the incidents clearly demonstrated that Lake Grove continued to fail to properly supervise staff and child residents.

Interviews with DCF officials and review of DCF documents revealed that the issue of the staff shortcomings at Lake Grove was common knowledge at DCF and had been so since at least 1995. Attention to staffing issues was generally triggered by a recurring high incidence of allegations of abuse and injury related to physical restraint of child residents at Lake Grove. Also since 1995 there were widespread concerns in regards to the effectiveness of staff supervision of children and “concerns regarding both the quality and consistency of the clinical/treatment services for children.”

In 1997 the DCF PREU did actually make extensive recommendations in regards to the administrative oversight of all Lake Grove departments. They included procedures for staff hiring, training and supervision. Again, however, there was no evidence that the Lake Grove administration followed any of the recommendations. Late in Fall 2004 a participant’s notes from a DCF administration meeting observed that the Lake Grove executive director was finally recognizing and lamenting staff problems. It appears that the executive director was asking DCF for assistance and promising change:

- “He [the executive director] asked those present at the meeting “how do we hire employees we can trust and screen out marginal employees”?”
- Announced a decision to establish staff competencies.
- Stated that he would work with the Lake Grove employee union to put employees on performance plans.
- Stated that he would work on developing “tools for competencies.”

There was no evidence, however, that the DCF followed up to ensure staff competencies, performance plans, or “tools for competencies” developed at Lake Grove.

What the DCF should have done about control and management of the Lake Grove staff

The unrelenting descriptions of the children as being “difficult to care for” due to their problem behaviors may have obscured the fact that the children were not receiving treatment at Lake Grove. The children’s behaviors, in fact, may have been exacerbated or intensified due to the therapeutic incompetence of the program, environment, and the staff. The absence of coordination in treatment delivery; the persistence of needs not being met; the wholesale lack of progress among the children; and the children’s long lengths of stay should have triggered scrutiny of who the staff were and what they were doing. The DCF should have examined staff training and supervision to determine whether capacity to provide a therapeutic milieu and reinforcement of clinical and pharmacological interventions even existed.

Several factors suggested a lack of ability to control and manage the direct care staff at Lake Grove: persistently poor progress among the children; persistent high rate of abuse/neglect reports involving injuries during restraints and staff mistreatment of residents; and the executive director’s own pleas to DCF for guidance in how to hire and manage staff. At each juncture the DCF should have responded with immediate intervention to ensure control of a therapeutic environment. Technical assistance, in-service training, review of employee background checks and credentials, and on-site monitoring are all actions the DCF should have engaged in until there was evidence that problems were resolved and better practice was stable. Further, if DCF administrators believed the executive director of the

institution to lack the necessary skills to run Lake Grove, they should have continuously brought these concerns to the Lake Grove Board of Directors and insisted improvements. Barring such improvements, the DCF should have stopped placing children at Lake Grove and removed those who were there.

E. THE DCF ENGAGED IN WASTEFUL, DUPLICITOUS PERFORMANCE

Operations at the DCF can only be characterized as dysfunctional, poorly organized and uncommunicative. There appears to have been a high tolerance for poor performance both within the agency and with providers. We found six areas of deficiency in DCF performance as related to Lake Grove.

Six Areas of Deficiency in DCF Performance:

1. Child protection and oversight failed to ensure safety of the children at all times
2. Program assessments and reports, when completed, were never utilized or compared
3. Program ownership was an obstacle to program oversight
4. There were poor communications among DCF bureaus
5. Quality assurance and improvement activities were ineffective and poorly orchestrated
6. The commissioner's cabinet staff were insubordinate of her intentions

What investigators found: Basic tenets of child protection and oversight of the children's care failed to be implemented and preserved at Lake Grove

Lake Grove at Durham enjoyed one of the largest compilations of DCF abuse and neglect allegations to the Hotline we have examined among DCF-licensed facilities. We were equally impressed with the number of incidents of restraints of children, including those resulting in injury. Lake Grove had a fairly sophisticated ability to collect data about restraints and injuries in April 2006 when we visited, but we found little evidence that the facility or the DCF utilized any of that data to improve the care of the children. The discovery of a child living in a hot laundry room and evidence of an institutionalized practice of rejecting children from their residential cottages strengthened the conclusion that there was little active oversight or protection of those children. The lack of follow-up on the health care of individual children as well as that following large reviews of health care services was medical neglect with no protection or oversight to have prevented it.

What the DCF knew about the failed protection and oversight of children at Lake Grove

Because the DCF is the agency to receive and respond to allegations of neglect and abuse, at least one bureau in the agency was aware of the sheer numbers of reports. Additionally, we also found evidence in meeting notes and e-mail communications that other

DCF administrators were aware of extensive Hotline activities concerning Lake Grove. Although it appeared that DCF officials might have discussed concerns about the numbers of allegations made on behalf of children at Lake Grove with Lake Grove officials, we found no evidence of actual systematic investigations designed to identify factors affecting the number of events and allegations. Hotline referrals were responded to individually and not in aggregate as a symptom of systemic dysfunction.

How reports were made was also problematic at Lake Grove. Although educators and direct care workers are considered by the State of Connecticut to be mandated reporters,³⁵ the practice at Lake Grove was to require the clinicians to make the telephone call to the DCF Hot Line in instances when the possibility of abusive or neglectful incidents occurred on campus. There were also several instances in which critical incidents were discovered not to have been reported at all. In December 2006 when the DCF was just entering into the third and final extensive review of the Lake Grove health services, and when the facility was already under scrutiny for serious programmatic concerns, the DCF nurse consultant discovered a child with a broken arm. The arm had been broken in an aggressive staff restraint and the event, as many before it, went unreported.

What the DCF should have done to ensure the children at Lake Grove were safely protected and their care overseen

The DCF had several responsibilities in the case of Lake Grove. First and foremost there was a responsibility to assure the children were safe and cared for properly. That includes not only within immediate interactions with the children but also in the context of state and federal regulations that oversee the operations of such institutions. There were several sources of information that should have informed the DCF of the children's unsafe predicament at Lake Grove, but none better than the volume of Abuse and Neglect Hotline reports. The DCF should have monitored that activity carefully and sought to understand the underlying cause of so many complaints and injuries. As noted in an earlier section, the majority of Hotline investigation reports, including those that did not substantiate the allegations, identified serious program concerns with Lake Grove. There should have been a systematic follow-up to all program concerns as an integral part in child protection and oversight at Lake Grove.

All of the employees at Lake Grove were mandated reporters and the DCF should have ensured that they complied as such. The practice of limiting reports to the Hotline to clinicians violated the mandate. This practice employed the clinicians as a type of screening device and created an obstacle to accuracy of reporting through distancing of witness reports to second and third parties. Mandated reporting should have been a standard component of employee training, and it appears to some degree it may have been. But the DCF should have overseen the content of any training programs and tested the knowledge and understanding of staff on a regular basis to ensure that all Lake Grove staff knew their responsibilities and, more importantly, knew what abuse and neglect were so they could adjust their practices accordingly.

³⁵ Pursuant to Conn Stat §17a-101 through 17a-103a, those professionals who, because their work involves regular contact with children, are mandated by law to report suspected child abuse and neglect.

What investigators found: Assessments and reports were done and never utilized

Throughout the history of Lake Grove at Durham there were persistent concerns among DCF authorities that were highlighted, discussed, documented and never fully resolved. Nothing learned from one crisis was ever carried over and applied to assessment of the next.

What DCF knew and did with information they collected about Lake Grove

Despite ongoing concerns about the institution, it was not until 2003 that a comprehensive review of Lake Grove was conducted (following the beating of a child near the dining hall) but since then two more followed, in 2004-5 (the re-basing review) and again in 2005 (following the Rhode Island Child Advocate's complaint). Each review represented great cost in time, staffing and resources invested by the DCF. Yet none of the reviews resulted in major change at Lake Grove, and more shockingly, each of the earlier efforts was ignored by the next. Likewise, investigations specific to medical and nursing practice were conducted three times, in 2003, 2005 and 2006-7, and each disregarded the previous in follow-up and comparisons of outcomes.

Each of the reviews identified the same problems at Lake Grove: most notably clinical program deficiencies, unsupervised LPNs and deficient medical/nursing practices, and problematic staff culture. What was observed to be occurring in each review was not new, just persistent.

What DCF should have done when the need to review the program arose

The DCF should have returned to previous reviews of the Lake Grove programs, supplemented them with new findings and measured improvements or deterioration. Instead, DCF administrators chose to start over from scratch each time. The investigator who conducted the 2004-5 re-basing report told us she went to the bureau chief of BBHM in the Fall of 2005 and reminded him that the re-basing report was available, but she felt he ignored what should have been a useful reference. In August 2005 no one at DCF returned to the original reviews. Instead officials in a different bureau, the BCQI, initiated a new program review. Nothing was communicated between the bureaus. This is the simplest basis of oversight and evaluation: to document evidence, compare new evidence to old, and determine improvements or failure to improve. The factual, historical perspective would have provided a clearer picture of the persistence of problems at Lake Grove and the inability of the institution to resolve those problems. It would also have underscored the efforts of DCF over time and signaled a point of futility in expecting improvements at the institution. To paraphrase the DCF commissioner of the time speaking to a different failure of the agency, program performance comparisons would have "connected the dots" and revealed the persistent problems of the entire program. Further, better use of existing information would have optimized expenditure of resources at the DCF. Attention to the cost associated with each review would have precluded the wholesale waste of state resources.

What investigators found: “Program ownership” was an obstacle to progress

Bickering and turf battles between the Bureau of Behavioral Health and Medicine and Continuous Quality Improvement impeded the DCF’s ability to properly regulate Lake Grove service delivery.

What DCF knew and did about the perceptions of “program ownership”

During the administration of the last commissioner, the BBHM began to define themselves as “program owners” of facilities serving children placed by DCF, including residential treatment centers. This was done without BBHM or anyone else at DCF ever establishing any formal policy or protocol for facility operations. Few DCF administrators could agree on the meaning of “program ownership.” The commissioner had never heard of the term. The bureau chief of BBHM appeared to use it to define his bureau’s “turf” and the bureau chief of BCQI seemed to perceive it as an obstacle to taking action. A BCQI administrator told us in interview that his unit learned about the change, “by stepping on people’s toes ... hearing things in meetings...” He recalled that after Haddam Hills, the DCF Licensing Unit and PREU were empowered to be more independent in providing oversight of DCF-licensed facilities. However, with the passage of time, a tension developed within DCF between the dual roles of the need to utilize programs by placing children in them, while also retaining responsibility for providing regulatory oversight for those same programs. According to the BCQI administrator, there “was blurring between boundary of utilization and oversight. There was regression away from clear boundaries and utilization interfered with oversight.” There was in fact great tension between the roles of DCF the consumer and DCF the regulator. A DCF nurse consultant described ongoing discussions about the risks of closing Lake Grove, “...the consensus was they [Lake Grove] provided a unique service for unique clientele.” She noted that DCF officials said on, “more than one occasion they just need to shut this program down, yet recognized in the next breath we have no where else to send those kids.”

With the bulk of authority perceived to be in BBHM as the “program owner”, and by all accounts that was the case, there was no guarantee DCF could effectively provide regulatory oversight. Even the commissioner, a social worker, was historically focused on what programs were available for placing children in DCF care — the Bureau of Child Welfare needed “beds” for children. Compromising the number of available beds by demanding quality services around those beds was not a well-supported risk. In the case of Lake Grove in late 2005, a BCQI administrator told us, “To be frank I was feeling frustration and lack of clarity about who was doing what.” The bickering over “program ownership” was interfering with the child welfare agency’s focus on the children.

The commissioner appears to have been unaware of this bureaucratic in-fighting. She told us she believed her administration was operating as a team. She was not aware of the expression “program ownership.” In fact, she stated that no one person or bureau could “own the whole outcome,” but insisted all had to be at the table to take part in the process and share the responsibility. However, in her administration, a DCF BCQI administrator testified, the culture at DCF was, “not one of collaboration. Some could speak to concerns or issues and not get recognition.” He noted that the DCF Central Office could almost be characterized by an

“internal caste system” where the long-time relationship between the BBHM bureau chief and the Chief of Program Operations³⁶ was the center of power. Even the two deputy commissioners were “nice but not empowered, not able to negotiate the bureaucracy.” “This has been a frustrating time in the Department,” one BCQI administrator noted, “for those of us who have wanted to establish well-delineated programs of oversight and empower regulatory oversight. A system of who has power is debilitating.”

What DCF should have done about the tension caused by “program ownership”

The DCF should have and must have clear delineations of responsibility between and among the bureaus. Constant communication and inter-bureau, inter-disciplinary team work could have recognized the obstacles to oversight and the failure of the DCF to meet mandates of child protection, facilitation of access to appropriate mental health services, and regulation of a DCF-licensed institution.

Given the long history of failure to successfully regulate while consuming services, DCF administrators should have sought to separate those responsibilities or at the very least carefully scrutinized how they were carried out.

What investigators found: There were serious limitations of communication between bureaus

Cooperation between DCF bureaus would require well-formed pathways for communication and good working relationships among administrators. However, at the DCF there was little communication between bureaus and relationships between and among administrators were variously described on a range from good to hostile.

What DCF knew and did regarding limitations of communication between bureaus

The commissioner at the time testified that communication and full participation were manifest in periodic meetings that brought the various bureaus and managers together. She expressed the belief that the Service Evaluation and Enhancement Committee (SEEC) was the key avenue for information sharing and problem solving with respect to providers and facilities serving children in Connecticut. She indicated it was her expectation that all of her bureau chiefs attended that meeting and that SEEC was the chief source for all subsequent information disseminated throughout the bureaus and area offices to the rank and file. In discussions with the then Bureau Chief for BCW, he insisted that he only obtained information about issues regarding facilities or residential treatment centers from SEEC meetings. However, meeting minutes and reports from those who had attended regularly indicated that the BCW bureau chief was rarely in attendance at SEEC meetings. When pressed to clarify how he kept informed at DCF, the then chief who is now the DCF Chief of Staff explained, “[the chief of BCQI] and I smoke. A couple of times a day we are chatting in the back of the building.” In

³⁶ The title Chief of Program Operations was equivalent on the DCF organizational chart to the role of a Deputy Commissioner.

fact, he came to understand the BBHM psychologist's role at Lake Grove because, "[she] smokes too."

With the exception of SEEC meeting minutes, we found a dearth of documentation of any decisions, assignments, expected practices or communications about roles and responsibilities. Despite descriptions and references to frequent gatherings of committees, work groups and investigative bodies, there was no documentation of the findings, decisions, or assignments from those meetings other than the hand-written personal notes of individuals. The BCW chief testified that he distributed information about concerns at Lake Grove through an e-mail list to the Area Offices. He assured us that everyone who needed to be alerted to concerns about Lake Grove was so alerted. In the tens of thousands of documents that we reviewed from the DCF, we did not find any such e-mails from the Bureau Chief to Area Office directors. The absence of such documents suggests one of three possible things: 1) the bureau chief did not comply with the subpoena we issued for any and all documents related to Lake Grove; 2) he did not preserve, either electronically or in hard copy his directed actions communicated to the Area Offices; or 3) he did not communicate any directions to Area Offices regarding concerns at Lake Grove. Regardless of the reason, there is no way to account for the Bureau Chief's actions without documentation, and the lack of documentation reflects his apparent reluctance to formalize and memorialize communications with the rest of the agency.

What DCF should have done about lines of communication in the agency

With a budget of nearly 800 million dollars at the time, it seems reasonable to expect better communication from agency officials than what transpires at a smoking area in the back of the building at 505 Hudson Street. The flow of information to the BCW chief is important because that position is the sole source of information to the Area Offices and ultimately the **caseworkers** responsible for individual children. When there are concerns about quality of service or safety of children in an institution, caseworkers have to know about those concerns in order to ensure safety of the children assigned to them. Communications between the bureau chiefs, committees and the Area Offices should have been documented and maintained. Likewise, meetings should have been memorialized in order to ensure communication about findings, assignments and tasks taken on. This would have created pathways for follow-up and oversight. The DCF has no way of knowing what was accomplished without evidence of what was expected and from whom.

What investigators found: The DCF did not conduct effective quality improvement or quality assurance with Lake Grove

The persistence of poor and absent care in all areas at Lake Grove was a testament to the fact that the DCF did not conduct proper quality improvement or assurance in their oversight or technical assistance to the institution.

What DCF knew and did regarding quality improvement and assurance

Despite the lackluster findings of the 2005 rebasing review, the DCF increased the Lake Grove reimbursement rate. The BCQI bureau chief told us in an interview that, "When we looked at Lake Grove, we knew what we expected and what we were getting. We went the

American way. We threw some money at it.” We found no evidence of discussion within any level of DCF management about quality of service in the context of contractual obligations, much less violation of health care and education regulations. As one DCF BCQI administrator testified with regard to the use of unsupervised LPNs and unqualified clinicians, “we trusted what providers told us.” The Chief of Program Operations told us that DCF relies upon providers, their qualifications, and expertise to assist with decisions about a child’s care. “The facility itself has a license and responsibility to ensure quality care,” she said. In particular, the children with developmental disabilities and complex medical conditions, the Chief of Program Operations pointed out, “they need greater oversight ... and we felt their needs were being overseen by the providers.” In essence the DCF, the regulator, left it up to Lake Grove, the regulated, to oversee itself.

Perhaps the problem was the inability of DCF to effectively oversee Lake Grove. One deputy commissioner testified about a lack of ability within the Department to even conduct quality improvement. “We have recruited staff without skills for quality improvement. They came with a lack of skills but we promoted them and we have to be accountable for that.” Whether the Department had the expertise or not to conduct quality improvement and quality assurance with contracting agencies such as Lake Grove, the tension over ownership of the program remained an obstacle. The BCQI administrators essentially stepped back on the assumption that the BBHM administrators were managing problems at Lake Grove, the mismatch of responsibilities of the two bureaus notwithstanding.

What DCF should have done regarding quality improvement and assurance

In order to meet those responsibilities the DCF should have employed professionals with the appropriate expertise to develop quality assurance and improvement programs, to monitor them and to evaluate outcomes. Neither quality improvement nor quality assurance are compatible with crisis management. Instead of responding to problems that arose at Lake Grove with demands that were soon forgotten and assigned staff soon re-assigned elsewhere, the DCF should have conducted comprehensive reviews that were used to develop specific immediate and ongoing QI/QA programs.

What investigators found: DCF administrators ignored the commissioner’s intentions to close Lake Grove and made decisions that could have put children at risk

Once the DCF commissioner concluded that Lake Grove was no longer an appropriate placement for children, her administrators delayed and at times seemed to deny that the facility would be closed. In fact, ultimately the DCF did not close the facility and would have continued to license it to serve other state’s children despite the determination that services provided there were unsafe and deficient.

What DCF knew and did about the commissioner’s intentions and the care of children from out-of-state

In the Spring of 2006 the DCF administration seemed to finally see the big picture of what the track record had been for Lake Grove over the past 20 years. The Lake Grove

executive director resigned suddenly and according to testimony from several DCF administrators, there was a consensus of even less leadership ability within the facility. The DCF commissioner noted the history of a cycle of concerns arising, actions taken, problems being addressed and then re-occurring all over again. She indicated that while DCF was well aware of the problems over time and they were well documented, it was “not put together until December 2006.” At that time the commissioner described the situation as “system conversion for a facility in need of closure.” The questions she and her team asked, she reported, were whether or not the model of care at Lake Grove was matching the mission of the DCF and the needs of the children. According to her the answer was no on several levels: the DCF was moving away from large congregate settings, staff were not well served in such a situation and within it events were exaggerated and exacerbated that did not need to occur at all. It was her expectation that a process was underway to get the children’s records in order, locate alternative placements for them, work with the facility in regards to settling employment contracts with the large staff and first and foremost, work with the state Office of Policy and Management to determine the best way to move forward. That interview occurred on March 20, 2007 and not a month later her chief of staff, chief of program operations and a deputy commissioner, the commissioner’s closest administrators, each insisted to us that the commissioner never intended for Lake Grove to be closed.

In fact, the DCF took action to limit the license issued to Lake Grove at Durham residential treatment program in January and March 2007. The limitations imposed included closing new admissions to the facility until a plan of action to remedy repeated failures of compliance with DCF regulations. Lake Grove submitted a plan of action on March 19th and on March 23rd the BCQI bureau chief wrote back to Lake Grove’s new chief administrator explaining that the plan was not acceptable because, most notably, the plan describing psychiatric services was unacceptable. Nearly twenty years after the facility was first licensed, the BCQI chief requested a comprehensive description of services, including who would provide them, how they would be provided, how often, how they would be measured and what the intended outcomes of treatment would be.

On March 26th the BCQI chief wrote again to Lake Grove and acknowledged a revised plan the facility had produced three days earlier that the DCF found acceptable. Six days after the DCF commissioner told us Lake Grove would be closed the licensing action was raised and admissions would be resumed pending provision and implementation of a plan for delivery of psychiatric services, and cooperation with ongoing monitoring. The licensed bed capacity was decreased from 116 to 90 beds. On April 17th a child’s arm was broken when a staff person restrained him. The incident went unreported to the DCF. Once discovered, the BCQI chief wrote to Lake Grove on April 20th warning of possible legal action. On May 8, 2007 the DCF notified Lake Grove administration that they no longer intended to place children at the facility and planned to remove all Connecticut children by September 15, 2007. Ultimately, Lake Grove could not operate with a significantly reduced population of resident children.

Although the DCF commissioner expressed intent to close the facility in March 2007, it was not until early September that Lake Grove was empty and closed for lack of business. The DCF did not ever rescind Lake Grove’s license. Rather, DCF just determined not to use it any longer. The DCF BBHM bureau chief told us in an interview that although Lake Grove did not meet a standard for Connecticut children, the DCF had no obligation to judge the standard of care provided to children from other states. The BCQI chief expressed strong disagreement

with the interpretation of the chief from BBHM regarding DCF responsibility to children placed in Connecticut from other states. His belief, he testified, was that DCF “would break the law if we didn’t make sure that *all* kids are safe in mental health services in Connecticut.” There was significant internal disagreement at DCF with his interpretation of the responsibility of DCF as both the regulating agency and the child protection agency. As a consumer of services, DCF cast a vote of no confidence in Lake Grove. As a regulator of services, DCF cast a vote of little confidence in Lake Grove. As the protector of all children in the state regardless of their origin, the DCF ignored its responsibility and placed children from other states at risk of negligent if not worse care. Nevertheless, with the drop in census Lake Grove closed and all children were removed.

What the DCF should have done about the commissioner’s intent to close Lake Grove

The disconnect between the commissioner’s intentions to close the facility and the actions taken by DCF administrators underscores the lack of leadership and respect for leadership at the agency. It also unearths a wide gap of interpretations of safety for children and DCF responsibilities between and among administrators.

The DCF commissioner should have led a team of professionals who together assessed the appropriateness of continuing to send children to Lake Grove and investing state funds in the facility. Together they should have made solid decisions about how to proceed. Questions about the obligations of the Department to children from other states should have been answered. The fact that some highly placed DCF administrators believed it was acceptable to license a facility to serve children from other states after it had been determined the care at the facility was deficient is troubling. These views should have been examined carefully and the obligations of the agency reviewed to ensure that every member of DCF leadership was properly informed.

F. THE DCF FAILED TO PLAN OR OVERSEE THE CHILDREN’S TRANSITION FROM LAKE GROVE

The sudden and precipitous removal of children from Lake Grove perpetuated and underscored the agency’s lack of planning to meet the needs of children with developmental disabilities. We noted two specific areas of concern:

1. Poor planning for the children at Lake Grove with domino effect upon other children
2. Contrary to Connecticut law and DCF policy, there was no adequate follow-up with the children who were moved from Lake Grove

What investigators found: Transition – poor planning and domino effect

The transition of children out of Lake Grove was characterized by poor planning that negatively impacted the children and produced a problematic domino effect among other children across the state and beyond.

What DCF knew and did in transitioning children out of Lake Grove

Ironically, it was only in the final months of Lake Grove's operation that it employed a qualified clinical director, a full compliment of qualified clinicians, and even a pediatric nurse practitioner (PNP) with extensive experience in the care of children with developmental disabilities and complex medical conditions. For the first time resident children at Lake Grove had updated medical records as the PNP culled through documents unearthing prescriptions for eyeglasses, specialty consults, and blood lab work. He worked his way through the children conducting health assessments and developing individual care plans. The PNP also attended treatment team meetings with the clinical team that included, in addition to clinicians, a school representative, representatives from the children's cottage personnel, and recreation staff. At the last minute, a treatment team and cross discipline coordination of care had been initiated.

Despite the fact that the children at Lake Grove were being prepared for transition to new placements though, the DCF caseworker participation remained sporadic. In fact, planning for new placements reflected the historical pattern common for children with developmental disabilities. Children were moved with little information or preparation. Citizen concern calls to the Office of the Child Advocate reflected children and families in states of confusion and stress. Requests to DCF to intensify caseworker visits were tempered with the claim that an increased presence of DCF caseworkers on site would only serve to alarm the children. The OCA staff heard concerns from many children at Lake Grove about the uncertainty of their futures.

DCF began moving children from one of their own facilities, High Meadows, in order to accommodate Lake Grove children. This had a domino effect of haphazard planning and sudden change on more than just Lake Grove residents. A number of children were transferred to facilities far out of state. For example, the Office of the Child Advocate was represented at a meeting with DCF regarding the transfer of one boy to an out-of-state facility. The boy, his family, and his attorney were all concerned that he had recently begun weekend home visits, that his parents needed to be engaged in family therapy with him, and that traveling such a distance was not only going to be a hardship but likely interfere with his ongoing progress. The BBHM psychologist formerly assigned at Lake Grove was now working on discharge arrangements. Her comment at this particular meeting was that if arrangements for this boy were made for him to be placed in a Connecticut facility close to his family then some other child would be placed out of state in an "inappropriate placement". The message was that children would be placed where placements could be found and some were going to be inappropriate. The OCA and the child's attorney insisted that DCF continue the boy's weekend home visits and transportation be provided for his parents to attend family therapy. The DCF representatives agreed to these demands, but six months later those accommodations had yet to be made.

What the DCF should have done in preparation for transition

Moving for any child in any circumstance is difficult. And even as bad as Lake Grove performed, it was the familiar to many of the children for a long time. The DCF failed those children long before the summer of 2007 when the agency consistently refused to plan for and develop more appropriate accommodations for them. However, it is unlikely that any child welfare agency could identify homes and placement for a sudden influx of over 65 children. Removing that many children from one facility is a crisis. The DCF should have responded accordingly in an organized, comprehensive and interdisciplinary fashion.

There should have been an interdisciplinary team charged with identifying and developing placements for the children that matched their individual needs. Rather than rely upon institutional settings, the team should have looked to recruiting foster families, providing them with specialized training and enhanced supports and funding. Likewise, enhanced contracts could have been offered to group home providers. For those children who still needed institutional placements, careful attention should have been given to their needs and which identified facilities could meet those needs. And at no point should the accommodation of one child been at the expense of another. While we consistently heard that DCF administrators had little confidence in Lake Grove the agency, we consistently heard that the new clinical team and nursing service had much improved. If these reports were accurate, perhaps the DCF could have considered contracting with the exceptional members of the Lake Grove staff to continue to provide care for a small cohort of children either at Lake Grove or elsewhere until better accommodation could be located. It was certainly a moment requiring creative and careful thinking.

The DCF should have also assured heightened involvement of caseworkers to provide support to their assigned children. The absence of caseworkers at treatment team meetings indicated that the caseworkers were not communicating with the Lake Grove clinicians to engage their support in preparing the children. In most scenarios, the Lake Grove staff were not even aware of the children's destinations and consequently neither where the children. The absence of caseworkers at the meetings also meant that the Lake Grove clinicians were not able to guide the workers in their interactions with the children around transition issues.

The DCF could have mobilized all of their own mental health and adolescent experts to develop guidance for caseworkers to properly prepare the children. Rather than rely upon top-down electronic communications from a bureau chief who may or may not have been fully informed himself, it would have been a reasonable idea for all caseworkers assigned children at Lake Grove to meet together with the experts and the people who were most informed about the facility. In just a short meeting all parties could have been updated about the situation and expectations upon them clarified. That would also have been an opportunity for investigators and monitors assigned to Lake Grove to confirm protocols for reporting concerns about individual children or observations made on visits to the facility. We do not believe that caseworkers or Area Office managers were well informed about the problems at Lake Grove, though they should have been.

The children at Lake Grove did not get preparation for transition to new settings. After years of waiting for treatment for the conditions they were placed for, they were suddenly and precipitously uprooted and moved. Even with the improvements in the quality and ability of health and clinical staff in the final days of Lake Grove, there was insufficient time to address mental and developmental health needs, much less introduce the children to new families and housemates and teach them the skills and coping they would need for successful transition. In addition to being informed of where he or she was going, each child should have had the opportunity to meet the people he or she would be living with. There should have been opportunities for interactions and even therapeutic work done as introductory processes in a time of crisis. Likewise, the children should have been introduced to their new schools, teachers and people and places that would become their worlds.

What investigators found: Children were moved and not followed up

The last Connecticut children at Lake Grove were moved to a variety of settings, some appropriate and some not. Since moving, there have been inconsistencies in following up with the children to ensure they transitioned safely and were able to deal with the impact of events at Lake Grove in their lives.

What DCF knew and did about moving and following the children

We reviewed a cohort of 65 Connecticut children who were discharged starting in February 2007, shortly after the final medical care crisis and since admission stopped at the facility. The good news is that a number of the children have been returned to community settings (see Table 2). Three state agencies were involved in assisting the Lake Grove residents with being placed in new places to live. Those residents who had aged out of DCF services during their long tenure at Lake Grove became eligible for services through the Department of Mental Health and Addictive Services (DMHAS) or the Department of Developmental Services (DDS). The DDS also assisted the children who were placed at Lake Grove through Voluntary Services with DCF.³⁷ The memorandum of understanding (MOU) between the DDS and DCF had transferred responsibility for the children’s care and placement to the agency with proven expertise in developing supports for people with developmental disabilities. That agency’s philosophy has long embraced community-based living for people with developmental disabilities, and was reflected by the placements of their clients accordingly. The rest of the children were placed and are overseen by DCF.

Table 3. Placement of Children Removed from Lake Grove

Agency	Home with Services	Apartment	Group Home	Institution
DMHAS	1	1	2	
DDS	2		7	
DCF	4 (2 in Foster Care)		22	26

³⁷ Under Voluntary Services, children may receive assistance with mental health services from DCF without commitment.

There were a total of 39 children placed in community-based living arrangements. Given the range of lengths of stay at Lake Grove being 10 to 78 months with an average of 26-months, two questions arise: (1) if all of those children have been able to transition safely into home-like settings, could they have gone there sooner, in other words, why did the DCF leave them at Lake Grove for so long? And (2) are those children prepared for living in the community — what have DCF and the other two state agencies done to ensure their transition home will be successful?

Twenty-six children from Lake Grove were placed in yet another institution. For most of them this was not their second residential placement but their third, fourth and more. The message they have received from DCF is not one of success or progress, particularly among the ten children who were sent out of state as far away as Maine, Illinois and South Carolina. At least two of those out-of-state children have been hospitalized in psychiatric hospitals, one for a suicide attempt and one for self-harm. At the time of this writing, the child who had attempted suicide had not been visited by DCF since being placed or being hospitalized. In fact, among children placed out of state, between September 2007 and March 2008, DCF case records indicated a range of visits by DCF staff from zero to four with one visit being most common. Only one child received four visits and those were in the nature of being transported back to Connecticut for home visits.

Several of the children currently in group homes were placed temporarily in DCF facilities first, either Connecticut Children's Place (CCP) or High Meadows (HM). That meant additional disruptions in their lives. It also meant the disruption of the care and treatment of children who were already at CCP or HM. Eighteen former Lake Grove residents were placed and most remain at those two facilities, displacing at least 18 who were already there. Most of the children displaced were girls. Similar to the experience of the girls in the juvenile justice system, little planning has occurred to meet the specific needs of girls with developmental disabilities. Four of the ten children who went out of state from Lake Grove were girls, representing a disproportionate number of girls in residential care. An entire unit of girls, nearly 20, at High Meadows was displaced to accommodate boys coming from Lake Grove and that is now a boys-only facility. There is no such single sex facility to accommodate the girls and given DCF's 5-year delay in building a girls' juvenile justice treatment facility, we do not foresee any such program development for girls with developmental disabilities. It is clear there was a domino effect resulting from the long-term lack of planning for the children with developmental disabilities and girls in particular.

A number of children are not doing well. In addition to the two children in out-of-state psychiatric hospitals, there were two in Connecticut hospitals as well with unclear plans for next steps. We cannot help but wonder whether the closing of Lake Grove sparked the crises that lead to hospitalizations or whether those children were acutely ill while at Lake Grove and simply not being assessed or provided with appropriate care? Further, many children are not being followed closely by their DCF caseworkers, particularly the children placed out of state. Only two or three children have seen family members since being sent out of state. We are very concerned about sending children hundreds and even thousands of miles away without carefully checking on them and proving to the children that the State of Connecticut does care about them. Currently there is no central oversight for follow-up of the children removed from Lake Grove to ensure they are safe, receiving appropriate treatment, and any problems they have developed associated with the move are addressed.

What the DCF should have done

According to DCF policy children placed out of their homes should be visited within two working days of placement and then one time each week for 30 days. Then they should be visited one time every other week until the first administrative case review after which visits should occur monthly.³⁸ Additionally, a caseworker from an Out-of-State Visitation Unit should visit the child on a bi-monthly basis and document all monitoring, visits and information collected in the child's LINK case record.³⁹ In fact, visitation policy for a child placed out of state is based upon Connecticut State law mandating that in-person visits occur with such a child no less than every two months in order to ensure the child's well-being.⁴⁰ The DCF has not only violated its own policy but also broken the law.

The DCF should have and should continue to intensify monitoring of the children who were moved from Lake Grove. This would ensure their safety and determine the extent of negative impact caused by the deleterious placement at Lake Grove and subsequent sudden removal. Follow-up should include the children who were placed by other agencies with opportunities for comparisons in service access and progress in general.

This unfortunate experience provides an opportunity for learning. The DCF should be reviewing every level of their involvement with the children at Lake Grove and the facility itself in order to identify improved practices and policies. That includes the regulatory responsibilities of oversight of the institution, the protection of the children, the consumption of mental health services, the response to long term and crisis-related incidents, and the transition of children with subsequent follow-up. Further evaluations that compare placements, supports and evaluation by the three state agencies now serving the children may help to identify better practices over all.

CONCLUSIONS

In August 2005 serious problems with the health care of children residing at the Lake Grove at Durham residential treatment center became apparent to the Offices of the Rhode Island and Connecticut Child Advocates and the Attorney General. As Lake Grove came under examination, the problems were found to have spread beyond health care to the clinical program, the residential program, the physical plant, the child care staffing, and every aspect in between. These were not new, acute events, but what came to be recognized as chronic and continuous deficient, neglectful, and even abusive care of children placed there. In fact, a review of thousands of records at DCF revealed that the DCF had been aware of these serious problems for years.

In response to such dismal performance, DCF, in its competing roles as regulatory authority for Lake Grove, as the authority responsible for the needs of children at Lake Grove

³⁸ DCF 36-15-1.1 Responsibilities of Treatment Worker: Contact Standards.

³⁹ DCF 36-15-1.3 Responsibilities of Treatment Workers: Out-of-State Visitation Standards.

⁴⁰ Conn Gen Stat § 17a-151aa (b) Out-of-state residential placements by Department of Children and Families.

(including in many instances being the statutory parent or custodian of the children) and also as the consumer parent who contracted for services at Lake Grove, was consistently unresponsive and seemingly immune to the low level of performance at the facility. Children did not receive the care or treatment the state bargained for and the state, at the insistence of the DCF, continued to spend large amounts of taxpayer dollars for substandard care.

Although a DCF psychologist was sent to be on site by the DCF Bureau of Behavioral Health and Medicine to oversee the clinical program and admissions in the fall of 2005, nothing else was done by DCF to assure that the identified deficiencies were addressed or resolved. The astounding lack of communication between DCF bureaus resulted in assumptions of follow-up activities that never occurred. Even the DCF commissioner believed her staff had responded effectively enough to make public claims of a response that never occurred. In addition to profound lack of intra-agency communication, the allocation of resources within the DCF appeared at best to be poorly strategized and at worst utterly deficient. That a full scale program review would be initiated only to be abandoned shortly after when another problem arose elsewhere in the state showed serious shortcomings in the DCF to plan, respond and utilize state resources effectively. The bickering that ensued between bureaus in regards to assigning responsibility was exacerbated by the dismissal of the views of DCF medical professionals and their concerns for the safety of the children. Given the seriousness of the negligent medical care of children with diabetes at Lake Grove, it is remarkable that a child's death was avoided. It should not take imminent risk of serious physical harm or death to children with complex health conditions to get DCF to act responsibly.

The conditions at the Lake Grove facility were dismal. The physical plant of Lake Grove was worn, dirty and far from therapeutic. The DCF continued to cite the same deficiencies in the physical plant over and over again without ever appearing to stop and consider the impact of the miserable surroundings on the children's well being and ensure improvements.

Lake Grove's therapeutic clinical program, the very reason children were there, was essentially non-existent. Ironically, the 2004-2005 DCF review to determine a new reimbursement rate clearly unearthed a lack of a therapeutic program or even the ability to articulate what a therapeutic program would be. Yet the reimbursement rate was increased and DCF continued to place children there when it was now documented that there was no ability for Lake Grove to provide therapeutic services effectively. A profound absence of consistent clinical expertise and a hierarchy with no professional sense of residential treatment characterized Lake Grove's organizational structure. The few experts who were employed by the facility, a psychologist and a psychiatrist, were only contracted for mere hours a week on site. The expectation that they could provide comprehensive service and supervision in less than ten hours a week was seriously flawed. In some scenarios, one child may typically receive the same number of hours of attention from a psychiatrist or psychologist each week that was available to 116 children at Lake Grove. Interestingly, the three residential facilities that DCF owns and operates each accommodates less than half the number of children that Lake Grove had and yet those facilities employ full time pediatricians, psychiatrists and a full compliment of nursing and clinical staff. The disparity of available services is not easily comprehended.

Nursing care at Lake Grove was grossly deficient. While the LPN staff meant well, they should have known the limitations of their practice. Further, the Lake Grove administration, as well as regulatory oversight by DCF, should have clearly flagged the fact that exclusive reliance on LPNs for all of the nursing care at Lake Grove was wholly inappropriate. Safe and effective care clearly required a great deal more. DCF should have demanded that Lake Grove employed appropriate health care staff with proper supervision in accordance with state law.

If there were any good outcomes from the experience of Lake Grove it is the use of DCF registered nurses and advanced practice registered nurse in program reviews. The commissioner told us that August 2005 was the “first time we included nursing as part of program review,” and, “It was extremely useful having that expertise.” This slightly contradicted what other DCF officials reported about the use of nurses but it did underscore one inter-bureau problem that was noted in many interviews. The BCQI did not historically employ nurses. The BBHM did and they were used for specific purposes: overseeing a medication administration program and training foster parents. On occasion, it was reported, BBHM would “loan” nurses to BCQI for program reviews or investigations.

The problem with these arrangements, as became clear in several instances at Lake Grove, was that nurses from one bureau had responsibilities from that bureau. Even though they may have been loaned to another bureau, they were not relieved of their original responsibilities and therefore were not able to maintain a presence for very long. The nurses who first reviewed the situation at Lake Grove in 2003 and again in 2005 were soon after gone, despite the seriousness of their findings. The disconnect was in the fact that most everyone at DCF believed the nurses were still there and the BBHM only sent a psychologist to the facility, without a thought of following up on the work their own nurses did earlier because the nurses did that work for another bureau. Furthermore, the lack of clear communication throughout DCF regarding the BBHM psychologist’s role at DCF, complicated by the apparent lack of appreciation for the critical importance of therapeutic milieu by the BBHM administration, ensured a void in oversight at Lake Grove. In 2000 Lake Grove’s sister agency, Haddam Hills, was closed in a flurry of scandal. The DCF had allowed that facility to operate despite substantiated abuse and neglect of children placed there and a staff fully out of control. The same pattern of persistent refusal to improve or maintain proper care of children at Lake Grove should have been recognized for what it was immediately. In a February 2008 news article, the then bureau chief of BCW, now the Chief of Staff, “referred to the Haddam Hills debacle as a ‘learning experience’ for the agency.”⁴¹ Eight years later what the DCF learned is just not apparent.

Given the growing complexity of children in residential care today, it is critical that the appropriate personnel be employed to oversee their care. It is equally important that caseworkers are held responsible, as surrogate parents, to check on the health care of their child charges. The health of children in the care of the DCF has been neglected for too long. Even the commissioner reasoned that as a protective service agency the DCF has not historically had a perspective of health care. Ensuring the whole child has all of his or her needs met, including any medical needs, is the essence of child welfare.

⁴¹ Poitras, C., Insider Gets Child Welfare Job. *Hartford Courant*, February 17, 2008, ppB1-2.

The inherent internal tension at DCF as both consumer and regulator severely impeded DCF's ability to appropriately respond to serious concerns at Lake Grove. These would be difficult roles to balance for any agency regardless of level of competence. The dysfunctional relationship between the consumer bureau (BBHM) and the regulatory bureau (BCQI) and the disparate distribution of power in the agency between those two bureaus was disastrous here. The tendency for the Bureau of Child Welfare to relegate oversight of health and clinical care of the children to the other two bureaus left a huge void in the protective layer that is child welfare.

Lake Grove at Durham is closed now and the resident children are scattered. The Department of Children and Families supported the deficient facility for many years, all the while acknowledging that Lake Grove would never provide the care the children needed. Then when faced with closing Connecticut admissions to 116 beds that DCF had come to rely upon for so long, for such "tough" kids, DCF persisted in its callous practice of placing children with developmental disabilities wherever anyone would take them. While the operation and oversight of Lake Grove reflected high tolerance of chronically poor quality of care for children with developmental disabilities at DCF, the sudden and thoughtless discharge fiasco that followed the DCF decision to cease referring children to Lake Grove underscored the lack of respect for the children and their needs. The events further underscored the absence at DCF of any strategic long term planning or commitment to supporting children with disabilities in their homes and communities, or at the very least in functioning and therapeutically appropriate residential programs where necessary.

RECOMMENDATIONS WITH DISCUSSION

Several themes emerge from our investigation and analysis of Lake Grove and the DCF oversight. Significantly, many of the themes are substantially the same as those that were reported in great depth in our May 30, 2002 report concerning DCF oversight of Haddam Hills Academy and in our September 19, 2002 report concerning the Connecticut Juvenile Training School. Accordingly, we make the following recommendations:

- 1. The DCF must enforce regulations and nationally recognized professional standards of medical, nursing, and mental health care at all DCF-licensed facilities and programs. The articulation of those standards must be evident in program goals and descriptions, contract language, staff training and supervision, and quality assurance reviews.**

The provision of health care and therapeutic services to children placed at Lake Grove at Durham was grossly inadequate. The failures in delivering health care, in some instances, created a significant risk of serious physical injury or death. Nevertheless, this poor health care and therapy system operated at Lake Grove for quite some time, under the watchful eyes of the DCF. The DCF failed to take meaningful timely action to correct the problem.

The DCF has multifaceted responsibilities here. First and foremost, the Department is also the statutory parent or otherwise responsible as the consumer of services for placing many children at residential treatment centers. In addition, the state agency also has regulatory authority over all facilities in the State of Connecticut that require DCF licenses to operate.

Clearly provision of health care and therapy services to children, especially children with complex medical needs and multifaceted mental health needs, is an essential component of proper care for those children. The Department of Children and Families should set forth clear standards for the provision of health care and therapy to children in DCF licensed residential treatment centers, and then enforce those expectations or when necessary, stop using those services that do not deliver them as expected. Furthermore, the regulatory activities of the DCF should be supported by professionals with the expertise to evaluate therapeutic milieu, adequacies of staffing and all of the other attributes that make a residential program therapeutic.

2. The DCF must ensure that no residential program will ever be licensed without absolute proof of a functioning, evidence-informed therapeutic program that incorporates a gender-sensitive, trauma-informed, developmentally appropriate design.

It was a colossal failure of the stewardship of state resources for the DCF to license and reimburse Lake Grove for the delivery of mental health therapeutic services. It was also a dangerous insult to the children, all of whom had intellectual disabilities, many of whom were victims of traumatizing abuse and neglect with complicated mental health sequelae. The DCF must be equipped with the expertise to recognize authentic therapeutic programming and the authority to take action when such programming fails to be delivered. The DCF must be prepared with contingencies for when programs fail so that children can be removed if necessary and placed in safe havens where appropriate therapeutic services can be mobilized to minimize further trauma.

3. DCF oversight of state operated facilities serving children must demonstrate independence from DCF functions associated with program development and administration to ensure that DCF decisions are objective and based solely on the best interests of children.

The DCF had divided interests and loyalties in overseeing Lake Grove. As the child welfare agency the Department is always under great pressure to place children in available programs. This was clearly the case at Lake Grove, which was the only residential treatment facility in Connecticut serving children with intellectual disabilities and some with additional sexually reactive behaviors. Unfortunately, the DCF turf issues interfered with DCF oversight. The Bureau of Behavioral Health and Medicine (BBHM) claimed “program ownership” and appeared to guard that turf, except when it came time to accept responsibility for oversight failures. The Bureau of Continuous Quality Improvement (BCQI) on the other hand appeared to have acted in deference to the BBHM whom they perceived to be the “program owner” and perceived by BCQI staff to have primary responsibility for interacting with Lake Grove. This confusion was also present with respect to the various conflicting understandings within DCF concerning the role of the BBHM psychologist assigned as the liaison with Lake Grove. It was further exacerbated by BCQI having to “borrow” health care professionals from BBHM to evaluate health care services at Lake Grove who could not remain to follow-up.

The BCQI is a large bureau within DCF. It employs anywhere from 100 to 175 staff members depending upon who is reporting. This staff should include professionals of all of the disciplines necessary to provide oversight to all of the facilities that DCF is responsible for.

And they should have the specialized skills for conducting quality improvement operations. Further, regardless of which DCF component is the “program owner” for any facility, the BCQI should be clearly and unequivocally charged with responsibility to provide fully independent oversight of such facilities. This should include direct reporting either to the DCF Commissioner or to a Deputy Commissioner other than one responsible for providing services to children in order to ensure that significant concerns with respect to any facility can be addressed at the highest management levels of the DCF.

4. The DCF must clearly define the role of health care professionals as medical, nursing and mental health decision makers and integrate their expertise in every bureau, including quality improvement and child protection services.

Our examination of the failures of health care delivery at Lake Grove, and the failures of DCF oversight concerning such health care included a review of DCF systems for overseeing health care. We identified a number of areas needing improvement. These include (1) the need for health care professionals to be integrated into the highest levels of DCF administration; (2) the need for sufficient health care professionals in the BCQI in order to provide regulatory oversight for delivery of health care services at facilities that the DCF is responsible for; and (3) better systems for overseeing the health care needs of each specific child in DCF care.

The DCF is a social service agency well stocked with social workers, psychologists and other mental health professionals at all levels of the agency, including all levels of management. By training and experience these numerous mental health professionals ought to be able to facilitate and oversee care for the mental health needs of children. But it is medical and nursing professionals who have the expertise to facilitate and oversee the general and specialized health care of children in DCF custody.

While there are some doctors and nurses (including APRNs and RNs) at DCF in a variety of roles, none of them are in empowered senior administrative positions at DCF. This is a serious shortcoming. Looking at what happened at Lake Grove it is clear that there were non-health care personnel, including the BBHM bureau chief, who dismissed and/or disregarded concerns about health care raised by medical doctors and nurses within DCF. This simply should not be. The DCF should create a position in its senior administration with the same access to the Commissioner and Deputy Commissioners as DCF bureau chiefs for a highly credentialed health care professional such as a medical doctor and/or nurse. That position should be empowered with authority and responsibility for development and implementation of systems and guidelines to ensure proper delivery of health care for children in DCF’s care. This would bring a very important perspective into the mix at DCF and also avoid situations in the future where serious concerns by health care professionals about health care issues could be brushed to the side by DCF managers who were not doctors or nurses.

Next, the BCQI should not have to borrow health care personnel from other bureaus in order to review delivery of health care services at facilities under DCF oversight. Reviewing the delivery of health care should be a standard component of DCF oversight on an ongoing basis. The BCQI should have sufficient permanent staff of its own to perform these responsibilities expertly and independently of other DCF bureaus.

Finally, the DCF should have adequate systems for reviewing the health care needs of each individual child in DCF care. At present, the Bureau of Child Welfare assigns a DCF caseworker for each individual child. Those caseworkers are supposed to ensure that all needs for all children are provided for. The Area Offices have BCW nurses who are available to the caseworkers as a resource for health care issues. However, according to the BCW bureau chief during this investigation (who is now the DCF Chief of Staff), the individual caseworkers do not watch for the health care needs of individual children because they are not themselves healthcare professionals. We ask the question: if the caseworkers do not monitor the health care needs of assigned children, who does?

Most natural parents are not health care professionals. Yet, if such natural parents fail to ensure that their children receive needed health care services, the DCF will act on charges of medical neglect. Who acts when an agent of the DCF is medically neglectful?

Clearly the DCF needs to put in place a proper system for tracking the medical needs of each child in DCF care. There should be no confusion about who is responsible, be it the caseworkers or someone else. Indeed, for each specific child it should be possible to identify a specific DCF employee responsible for ensuring proper health care. The DCF management system should hold each such employee, along with the responsible managers in the chain of command, accountable for ensuring that health care services are properly delivered.

5. The DCF must comply with Conn. Gen. Stat. § 17a-61a that mandates DCF to achieve accreditation through the Council on Accreditation.

The standards set by the Council on Accreditation for residential treatment centers reflect the quality and intensity of care, including the level of ability of staff best fit to meet the needs of children with conditions so complex they require residential treatment. The General Assembly passed legislation in 2005, now codified at Conn. Gen. Stat. §17a-61a, mandating that DCF be accredited but the agency has yet to comply. The challenges of working with children with complex conditions in a residential therapeutic milieu demands those organizations serving them recruit the best educated and experienced staff possible, and conform to the highest standards of care recognized.

6. The DCF must revamp its management structure and protocols for internal communication to ensure and document timely and accurate information sharing among administrators, caseworkers, and providers.

The experience of the Department of Children and Families with Lake Grove reflects a serious management failure: managers simply did not interact with each other properly. There are numerous examples of internal communication shortcomings at the DCF Central Office concerning Lake Grove. There are also examples of DCF administration, including the Commissioner herself, conveying inaccurate information about Lake Grove to other state officials. This should not be the case.

In short, various components of the DCF interacted very poorly or not at all. Turf issues and confusion about respective roles clearly hampered the ability of the BBHM and the BCQI to interact with each other effectively. This significantly impeded proper DCF oversight of Lake Grove. Critical information did not always reach the right place. The BCW administration appeared to be almost uninterested and information pathways to line staff thus

ineffectively used. Senior managers and DCF executive staff either knew or should have known that there were serious problems at Lake Grove at Durham. Changes must be made to ensure that timely and accurate information is presented to responsible managers in order for appropriate action to be taken. Memorializing those communications provides a means to follow up and measure change. The DCF must communicate better with itself and keep a record of communications.

7. The DCF must develop a long term planning unit that operates separately from program administration to understand the needs of children, identify and track trends, and anticipate future needs and reform.

There is little doubt that the DCF delayed action against Lake Grove because of the belief that no other provider would serve the children with cognitive disabilities. The numerous problems encountered at Lake Grove also reflected a wholesale failure to properly plan for the needs of this population of children.

The DCF should undertake a comprehensive analysis, on an ongoing basis, of the needs of all children under its supervision as well as future trends with respect to such needs. This exercise should be part of a systematic long-term planning effort, integral to anticipating and meeting the needs of children. DCF should be projecting out over the next 10 to 20 years in order to have programs on line when they are needed.

A meaningful planning function should be separate and independent from those divisions of DCF responsible for program administration. The DCF's experience with Lake Grove at Durham — very similar to its experience with other facilities in the past — demonstrates that decision-making suffers when the pressures of the day drive functions that should be independent. Proper long term planning involves careful assessment of future needs, matching those needs to existing programs and ascertaining what change is needed in order to serve the children. The desired result is ensuring that there are always appropriate services on line for children who need those services.

8. The DCF must develop and implement training programs for all DCF personnel and contractors that promote understanding of, and vision for, children with intellectual and developmental disabilities

While it is laudable that the DCF is finally coordinating efforts with the Department of Developmental Services (DDS) concerning children with developmental disabilities, a memorandum of understanding between the two agencies does not remove DCF responsibility for the protection of those children. While the DDS certainly has the expertise, experience and vision to promote optimal services and support for children with developmental disabilities, the DDS cannot be expected to be the sole resource for this population. There will always be children and family members, including adults, who have needs based upon developmental disabilities. The DCF must develop the capacity to assess those needs and recognize the best interventions to address them. The State of Connecticut can no longer tolerate substandard care based on the perceived ability of client's to differentiate quality.

There are a number of resources available to promote a culture of understanding and support among DCF personnel and providers. The DCF should be fully committed to building relationships with, beyond the DDS, the state Council on Developmental Disabilities, the

Office of Protection and Advocacy for Persons with Disabilities, the Family Support Council and the many advocacy and family support organizations around the state. An initiative to promote such relationships and vision should be launched with full support of the Commissioners immediately.

9. The DCF must be held accountable for the ongoing care and support of all former Lake Grove residents and should be required to produce periodic reports of their status.

Given the chronic deficiency of services and oversight of care the children placed at Lake Grove experienced, they may be at particular risk in new placements. The DCF should be asked to produce periodic comprehensive reporting of where the children and young adults are, how they have accessed appropriate therapeutic services, what the status of their health is and what the long term plan for their success is.

Dated at Hartford, Connecticut, this the 9th day of October, 2008.

JEANNE MILSTEIN
CHILD ADVOCATE

RICHARD BLUMENTHAL
ATTORNEY GENERAL