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April 3, 2019

Dr. Hughes Melton
Commissioner
Department of Behavioral Health and Developmental Services
1220 Bank Street
Richmond, Virginia 23219

Dear Commissioner Melton,

With this letter, I am presenting you with our most recent analysis of critical incident reports from mental health facilities, for federal fiscal year 2018. As you know, dLCV is the designated protection and advocacy organization for the Commonwealth of Virginia. We receive these critical incident reports under state law. Among our many responsibilities as a protection and advocacy system, we routinely monitor DBHDS-operated institutions. We regularly collect and analyze data from DBHDS.

We recently completed our annual analysis of critical incidents as reported through the PAIRS system. This year's review reinforced concerns that we brought to your attention last year. In last year's report, we noted that 2017 was the deadliest year in the state's mental health facilities. I am saddened to say that 2018 has now claimed that title. Especially troubling, the numbers and percentages of individuals dying within 3 months of being admitted to a state mental health facility continue to grow.

We are aware that the incident reports we receive do not necessarily constitute reliable data. However, those reports do tell us that conditions preceding death at DBHDS-operated facilities have historically been (and remain) primarily "Medical Condition." Medical Conditions made up the vast majority of deaths again this year.

As you know, last year we shared our speculation that the changes enacted by the legislature in 2014 to Virginia Code § 37.2-809, specifically making state hospitals the facilities of last resort, may be contributing to this pattern. That remains our best guess as to the cause.

As we are sure you are aware, a state hospital is not an appropriate place for someone who needs intensive medical care. Placing someone in a psychiatric bed who should be served in a medical bed is tantamount to neglect. Although DBHDS has little ability to regulate its admissions, the Department can take steps to stem the increasing instance of death for newly admitted individuals and to identify whether there are specific providers who are transferring medical patients, possibly in violation of federal law.

We are also aware that many DBHDS facilities face serious staff shortages – shortages that are exacerbated by the high numbers of patients who are ready for discharge but have no community placement available to them.

Regardless of the cause of this new deadliest year, dLCV urges the Commonwealth to take specific steps to try to mitigate this pattern. We urge you to:

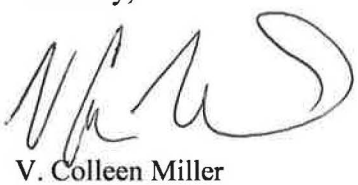
- Determine the source of admission for every death that occurred within 90 days of admission, in every mental health facility operated by the state, to determine whether there are any obvious, problematic sources of admission,
- Conduct a complete analysis of each death, regardless of admission date, to determine whether any death was related to one of the "7 Triggers." In our experience, many deaths related to one of these triggers (aspiration, bowel obstruction, decubitus ulcers, dehydration, seizure, sepsis, and urinary tract infection) can be avoided with improved staff training and appropriate resources,
- Evaluate staffing levels at each facility, especially for medical staff,
- Increase staff training to be able to identify and respond to medical conditions, and
- Review the falls protocol in each of the state's mental health facilities.

As noted with last year's report, we are aware of qualifying incidents at multiple state hospitals that have gone unreported to dLCV. We continue to work with specific facilities as we learn of those incidents. We urge the Department of Behavioral Health and Developmental Services to strengthen and clarify reporting responsibilities under Virginia Code § 37.2-709 and § 37.2-709.1.

As always, we would be happy to discuss with you and the Department the specific findings and recommendations in this report. Our mutual goal is to improve the quality of services and safety for individuals served in DBHDS-operated facilities.

We anticipate making our review of the incident reports available to the public within 30 days. If you have additional information that would inform our conclusions, we welcome it and will incorporate it into our report as appropriate.

Sincerely,



V. Colleen Miller
Executive Director

Cc: Daniel Herr, Deputy Commissioner