Report on Critical Incidents in Virginia's State Operated Facilities October 1, 2021 - September 30, 2022

Prepared by

The disAbility Law Center of Virginia

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Introduction

The disAbility Law Center (dLCV) is a private non-profit organization, operating under the authority of federal law and designated by state law to act as the protection and advocacy system for people with disabilities in Virginia.

The Code of Virginia requires that all facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) must report to the disAbility Law Center of Virginia within 48 hours of a "critical incident." DBHDS is then required to provide all other known information within 15 days. A "critical incident" is any event resulting in death or loss of consciousness or an event requiring medical attention.

During Federal Fiscal Year 2022, dLCV received a total of 410 Critical Incident Reports from facilities operated by the Department.

Executive Summary

Since 2018, dLCV has brought areas of concern arising from the Critical Incident Reports to the attention of the Department of Behavioral Health and Developmental Services (DBHDS). In Federal Fiscal Year 2022 (FY22), there were several significant areas worth highlighting.

There was a slight, yet noticeable, increase in the reports of incidents involving Self-Injurious Behavior (SIB). The rise in SIB incidents, although small, warrants a serious discussion of the implementation of Trauma Informed Care (TIC). The merits of implementing TIC in DBHDS-operated facilities is analyzed further in the report.

Also noteworthy is the significant rise in reports in the categories of Alleged Peer Assault and Alleged Peer Sexual Assault. dLCV believes that the rise can be partially attributed to staffing ratios at DBHDS-operated facilities that cannot effectively serve increasingly overcrowded hospitals. Suggested efforts to address this issue, such as addressing the Extraordinary Barriers to Discharge List, are further elaborated on later in the report.

In FY 22, the total number of deaths significantly decreased. There were 45 deaths in FY 22, compared to 66 in the previous year. We believe the dramatic decrease in deaths can largely be attributed to fewer Geriatric deaths at Piedmont Geriatric Hospital (PGH) and Eastern State Hospital (ESH), as well as the lessened impact of COVID-19.

dLCV continues to see issues with the quantity and quality of reports of critical incidents in FY 22. We are working to resolve these data issues and strongly encourage DBHDS-operated facilities to do the

same. However, with regard to data integrity, we believe the overall trends gathered from the data remain accurate.

dLCV would like to clarify why FY 22's report does not discuss incidents on per capita rate at each DBHDS-operated facility. In past reports — as is the norm — dLCV addresses per capita data throughout the report. However, for the first time in recollection, dLCV has not received census data from DBHDS. Unfortunately, this issue has persisted for approximately 6 months in spite of numerous requests. Going forward, dLCV sincerely hopes DBHDS takes the necessary actions to remedy this problem.

Background

Virginia's Department of Behavioral Health and Developmental Services (DBHDS) generates Critical Incident Reports (CIRs) on occurrences in their institutions resulting in injury that necessitated medical treatment and on occurrences resulting in loss of consciousness or death. This report will detail CIR trends in DBHDS-operated facilities during the 2022 Federal Fiscal Year (FY 22).

dLCV's CIR data is based on reporting from:

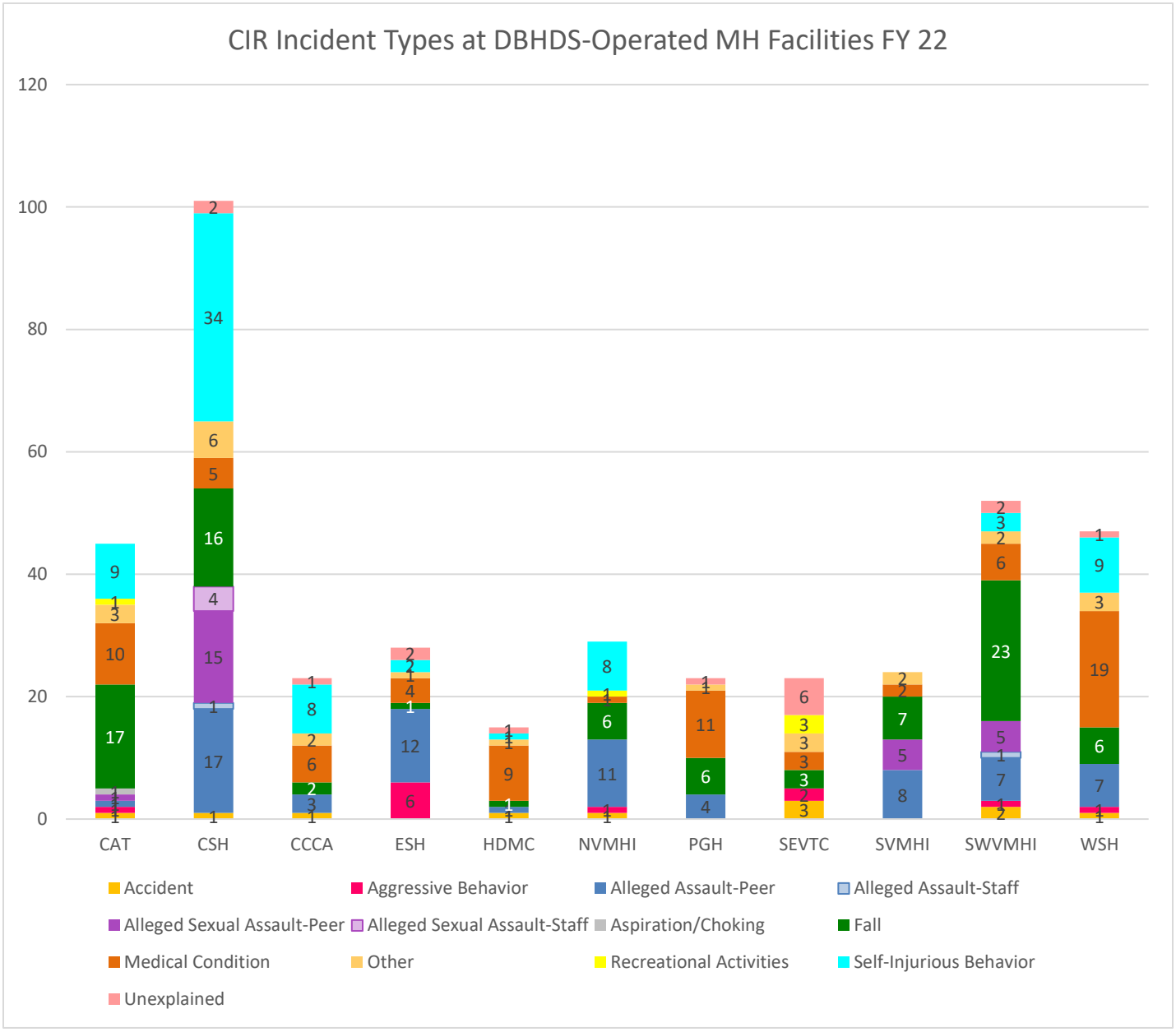
- Catawba Hospital (CAT)
- Central State Hospital (CSH)
- Commonwealth Center for Children and Adolescents (CCCA)
- Eastern State Hospital (ESH)
- Northern Virginia Mental Health Institute (NVMHI)
- Piedmont Geriatric Hospital (PGH)
- Southeastern Virginia Training Center (SEVTC)
- Southern Virginia Mental Health Institute (SVMHI)
- Southwestern Virginia Mental Health Institute (SWVMHI)
- Western State Hospital (WSH)

While CCCA and PGH serve age-specific populations, they are still DBHDS-operated facilities and are compared with other facilities for the majority of the report, except where explicitly stated.

There are two DBHDS-operated facilities included in the sample that are not primarily designated as mental health (MH) facilities. SEVTC specifically serves individuals with developmental disabilities (DD) and is not considered to be a hospital. HDMC serves both individuals with MH and DD, but primarily provides nursing and other medical care. We have included SEVTC and HDMC in the majority of the data analysis, except where the data specifically references "MH Facilities."

dLCV regularly monitors conditions in state facilities and responds to complaints from residents and consumers. dLCV reviews CIRs on a regular basis and analyzes quantitative data from the reports to identify overarching trends. Qualitative and quantitative data from the reports inform dLCV's work in the state facilities.

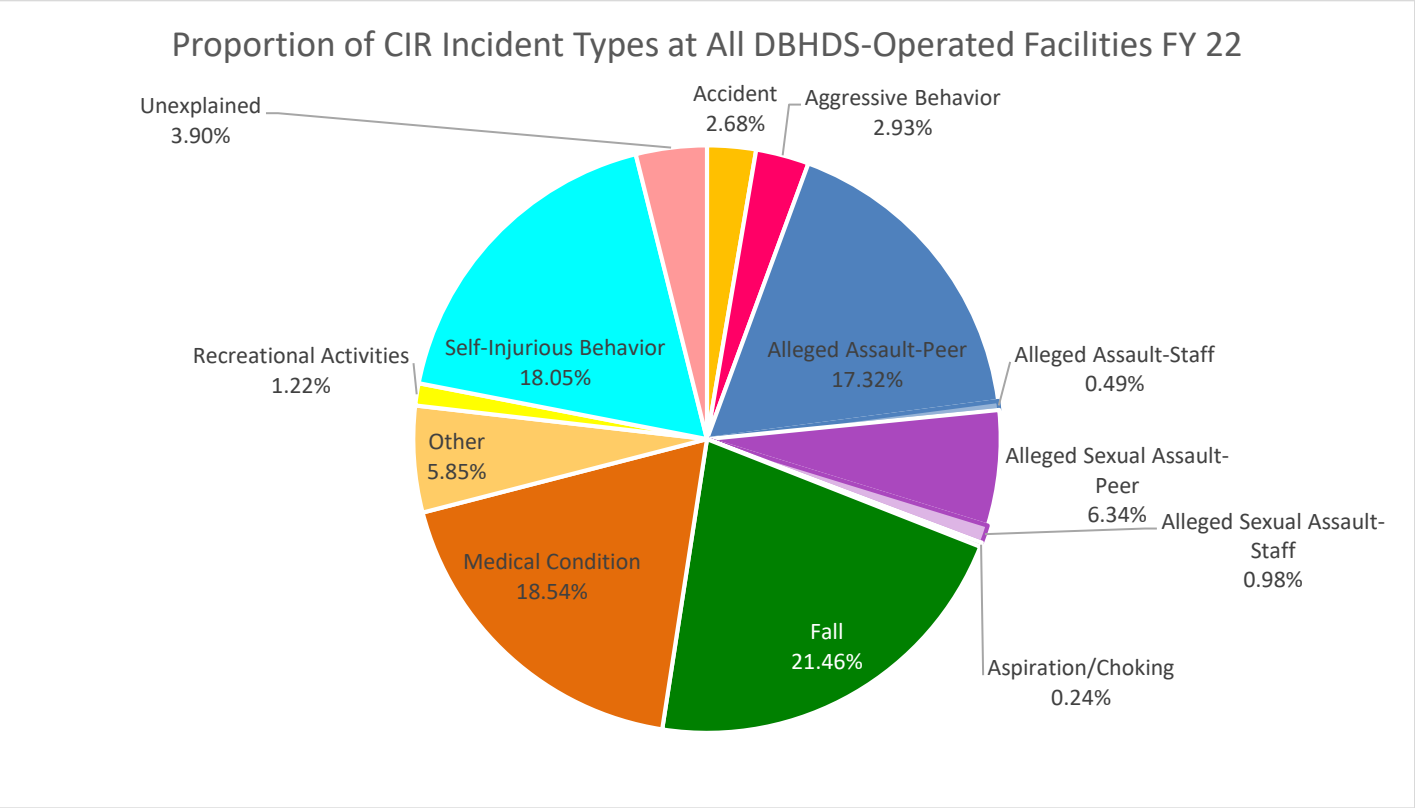
Incident Types and Reporting



In FY 22, DBHDS-operated facilities reported 410 Critical Incidents. CSH reported the greatest number of incidents (101), followed by SWVMHI (52). CSH, in particular, reported nearly twice as many critical

incidents as any other facility. In FY 21, CSH also led reporting. However, many of the incidents they reported were voluntarily reported Medical Conditions (52 reports in FY 21). dLCV appreciates the effort put forth by CSH in filing these reports. In FY 22, the number of medical conditions reported by CSH tapered off significantly (5 in FY 22), while other incident types, such as Peer-to-Peer Assaults (17), Peer Sexual Assaults (15) and Falls (16), increased significantly. We will delve deeper into the issue of Peer-to-Peer incidents at the bottom of this page.

ESH reported far fewer incidents in FY 22 (28), compared to FY 21 (45). dLCV largely attributes the decrease in reports to under-reporting, due to an administrative change at ESH.



In FY 21, Medical Conditions—primarily voluntarily reported ones—made up a whopping 36.75% of all incidents, which was by far the largest incident category. In FY 22, CSH and WSH, in particular, reported far fewer non-fatal medical incidents. As of result of this decrease, Medical Conditions made up only 18.54% of all reported incidents. Falls were the second most prolific incident type reported across all DBHDS-operated facilities (21.46%). The rate of falls stayed consistent with FY 21 (21.58%).

Peer-to-Peer Incidents

Two categories of particular concern are Alleged Assault-Peer and Alleged Sexual Assault-Peer, which both increased substantially between FY 21 and FY 22. Alleged peer assaults made up 17.32% of

incidents in FY 22, compared to only 10.47% of incidents in FY 21. Meanwhile, alleged Peer Sexual Assaults rose exponentially, making up 6.34% of incidents in FY 22, compared to just 1.28% of incidents in FY 21.

Based on our recent discussions with patients at DBHDS-operated facilities, dLCV believes the rise in alleged peer assaults and alleged peer sexual assaults can be at least partially attributed to hospitals being unable to function as needed due to overcrowding and dangerous staff vacancy levels. This is not simply a supervisory issue—multiple patients have vocalized their frustration to advocates about the overall reduction in privileges at their respective facilities that are the direct result of staff not being available to facilitate those privileges. As a result, patients have had fewer opportunities to engage in positive behavioral outlets and more time to engage directly with their peers.

In having fewer positive outlets and more time to interact with peers, it appears that some patients are more likely to engage in hostile behavior, such as peer assault and peer sexual assault, towards their peers. In an effort to mitigate the rise of future peer assaults and peer sexual assaults, dLCV encourages DBHDS-operated Facilities to reduce the unsafe census levels by prioritizing the discharge of clinically ready individuals on the Extraordinary Barriers to Discharge List.

Hospitals have repeatedly shown that they cannot support basic patient needs and safety with their current censuses and staffing vacancy levels. Despite a public push to hire and retain appropriate staff, state hospitals have largely been able to do so in a way that meets current census needs. This demonstrates that DBHDS' proclivity towards institutionalization is not, cannot be, and should not be sustained. The best hope for creating safer institutions where they already exist is to get people out of them.

At last publication count (9/30/2022), 182 patients at DBHDS hospitals were on the Extraordinary Barriers to Discharge List, meaning that these people have been determined to be clinically ready for discharge for 7 or more days, but have not been released to the community. Despite being clinically cleared for discharge, patients on the EBL remain institutionalized at DBHDS-operated facilities due to "extraordinary barriers." However, as dLCV has repeatedly iterated, many of the barriers are by no means extraordinary in nature. To discharge 182 people would free up a number of beds greater than Catawba Hospital and Southern Virginia Mental Health Institute combined.

In order to provide safe and effective treatment to those individuals in State Hospitals who do need inpatient treatment, dLCV asserts that the Commonwealth and DBHDS must prioritize discharge and invest in community infrastructure to end dangerous institutionalization and address the ongoing violation of individual's rights to community-based care.

Self-Injurious Behavior

Self-Injurious Behavior (SIB) made up 18.05% of all reported incidents in FY 22, a slight increase from 15.6% in FY21. SIB was most common at large facilities with many court-involved residents. CSH reported the highest rate of SIB, with 34 instances, which made up 33.66% of all their FY 22 Critical Incidents Reports. CAT reported 9 incidents of SIB, which consisted of 20% of their reports. Similarly, WSH also reported 9 incidents of SIB, but it only made up 19.15% of their total reports.

While looking at the data is important to examining SIB at DBHDS-operated facilities, nuance and context are also important. At CSH, in particular, it appears that the rate of SIB was largely driven by a small number of acute residents with multiple SIB episodes.

The vast majority of individuals who engage in SIB as part of their clinical presentation often have long histories of trauma. The link between trauma—particularly in childhood or young adulthood—and self-harm is well-documented. Over the years, dLCV has repeatedly urged DBHDS to adopt a Trauma Informed Care (TIC) approach. DBHDS, however, has largely only given lip-service to the concept of Trauma Informed Care. Indeed, countless residents have reported that they rarely, if ever, receive individual therapies. Residents have also reported that trauma-informed treatment modalities (such as Dialectical Behavioral Therapy and Cognitive Behavioral Therapy) are not widely available.

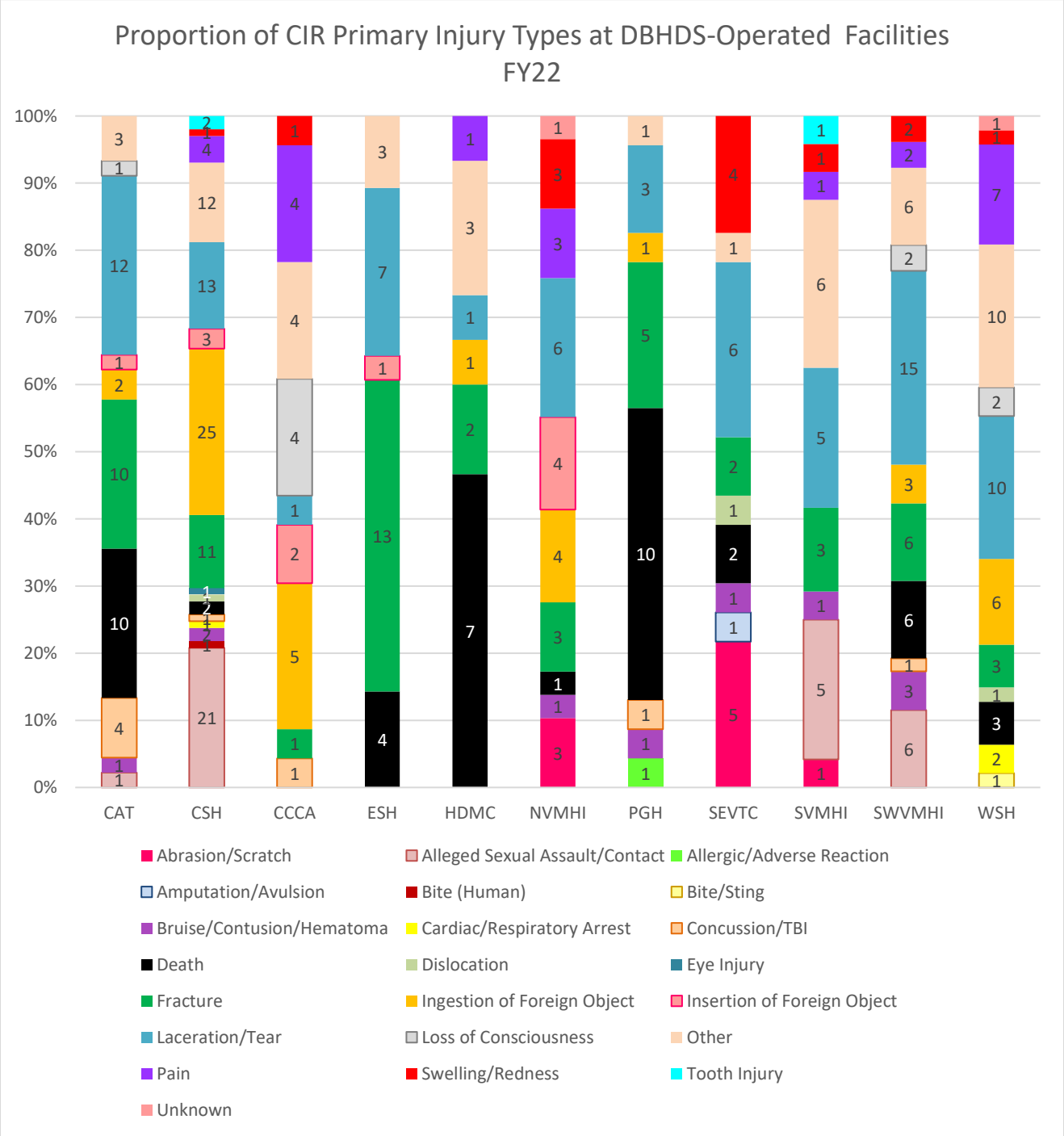
Arguably of greater concern, is the fact that residents who report trauma triggers rarely see those triggers comprehensively or accurately documented. In the rare instances where trauma triggers *are* appropriately documented, they are routinely ignored during behavioral crises. Providing patients with meaningful Trauma Informed Care at a clinical level is imperative in addressing high rates of SIB across DBHDS-operated facilities.

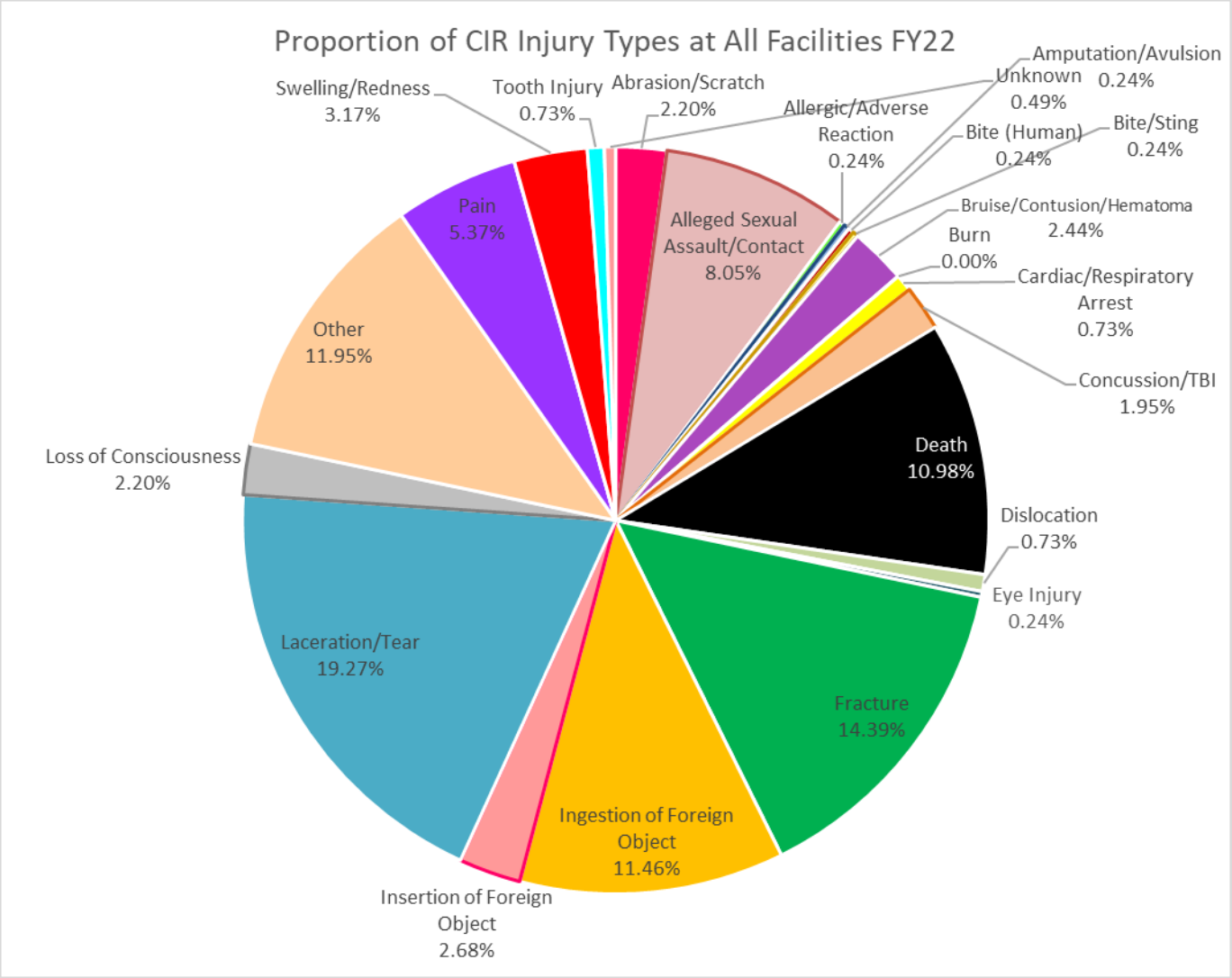
Moving forward, DBHDS can lay the groundwork for TIC by implementing Trauma Informed Universal Precautions. The TIC approach, developed by Rutgers' State Hospital Psychiatric Rehabilitation Initiative, has five core tenants: take into consideration the impact of pervasive crises (i.e. COVID-19), use therapeutic communication, "no room for judgements[1]," create a healing environment, and practice self-care. dLCV believes the application of these core tenants – if applied successfully – has the potential to improve the facilitation of long-term mental health treatment by acknowledging and

[1] The term "no room for judgements" is taken directly from the Rutgers' initiative. In action, "no room for judgements" means that Staff approach all client interactions with dignity and respect and do not form assumptions based solely on a client's history.

addressing the bidirectional relationship (i.e. causal nature) between trauma and psychological disorders.

Injury Types and Reporting



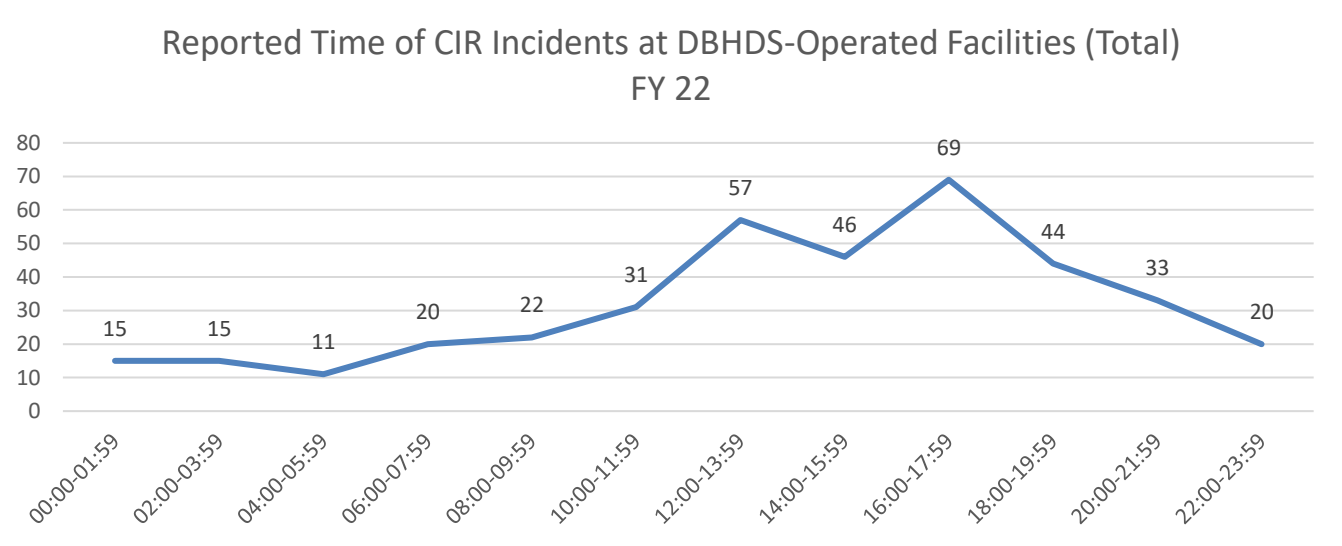


dLCV also monitors the types of injuries reported at all DBHDS-operated facilities every year. "Laceration/Tears" made up the highest proportion of CIR injury types reported, accounting for 79 instances, or 19.27% of injury types reported. Interestingly, the number and proportion of Lacerations and tears actually decreased, compared to FY 21 (19.44%). However, due to the decrease in reported medical conditions and increase in other types of injury, "Lacerations/Tears" became the most prevalent injury type.

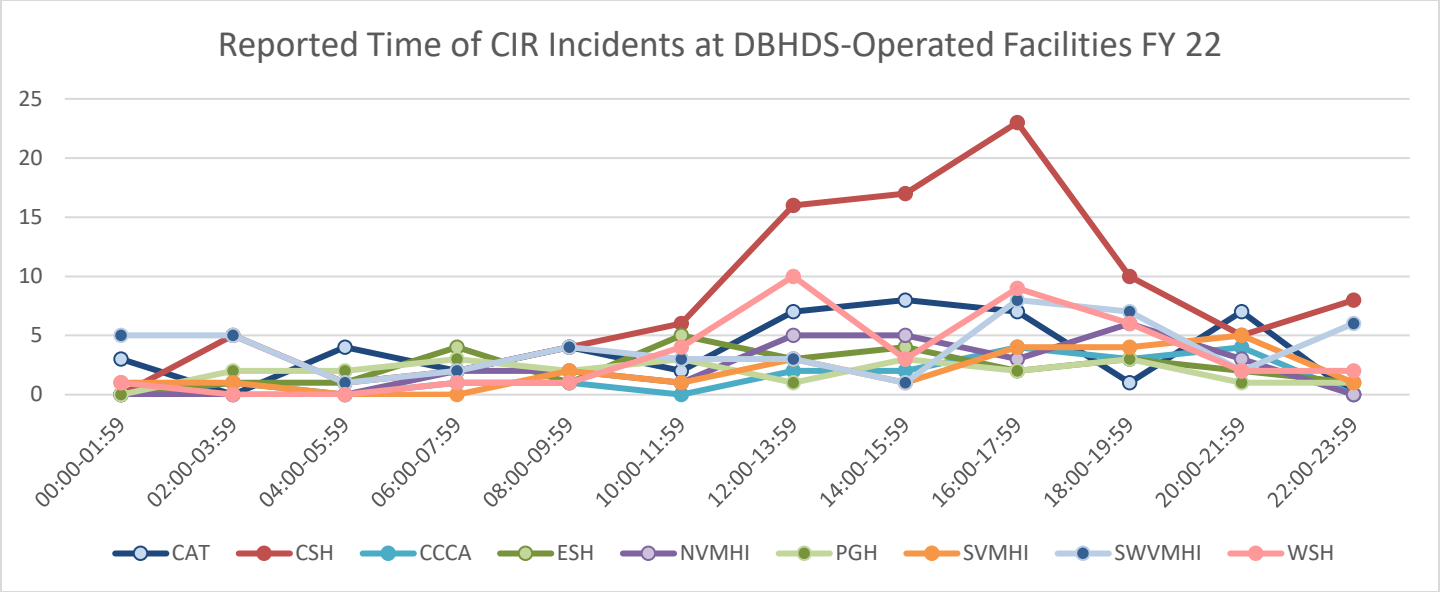
Deaths in FY 22 made up a smaller proportion of CIR injury types compared to FY 21, accounting for 45 instances (compared to 66 in FY 21), or 10.98% of injuries reported. We will explore Deaths in greater detail beginning on page 12.

As the number of reports concerning Alleged Peer Sexual Assault increased in FY 22, we felt the need to change one of our incident categories to reflect the times. We expanded our category of "Alleged Sexual Assault" as an injury type to also include "Alleged Sexual Contact." This is because many of the reports we saw, particularly at CSH, did not clearly constitute sexual assault. Some of the information in the reports, rather, were indicative of consensual sexual contact. In an effort to honor the agency of our constituents, dLCV felt the need to delineate the difference by modifying our category to capture these incidents. The newly named category, "Alleged Sexual Assault/Contact", saw a major increase in FY 22 (from 7 in FY 21 to 33 incidents in FY 22).

Incident Timing

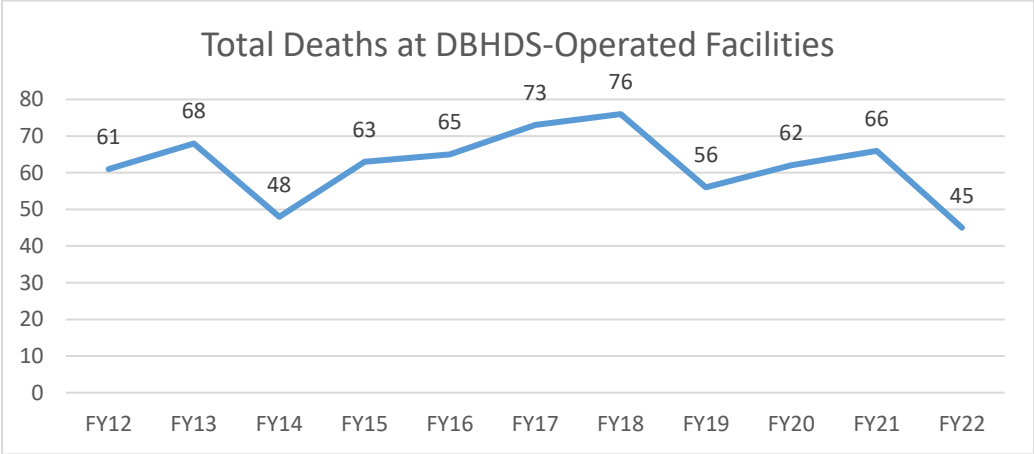


dLCV observed a disproportionate number of Critical Incidents occurring between 4-6pm. Upon closer inspection, it appears this trend is being driven almost exclusively by CSH. This trend, similar to the reported Incidents in FY 21, is concerning. More information, however, is needed to understand why there is such a significant increase in incidents during that time frame. Possible factors include staff shortages and lack of structured programming. dLCV will adjust monitoring practices accordingly.

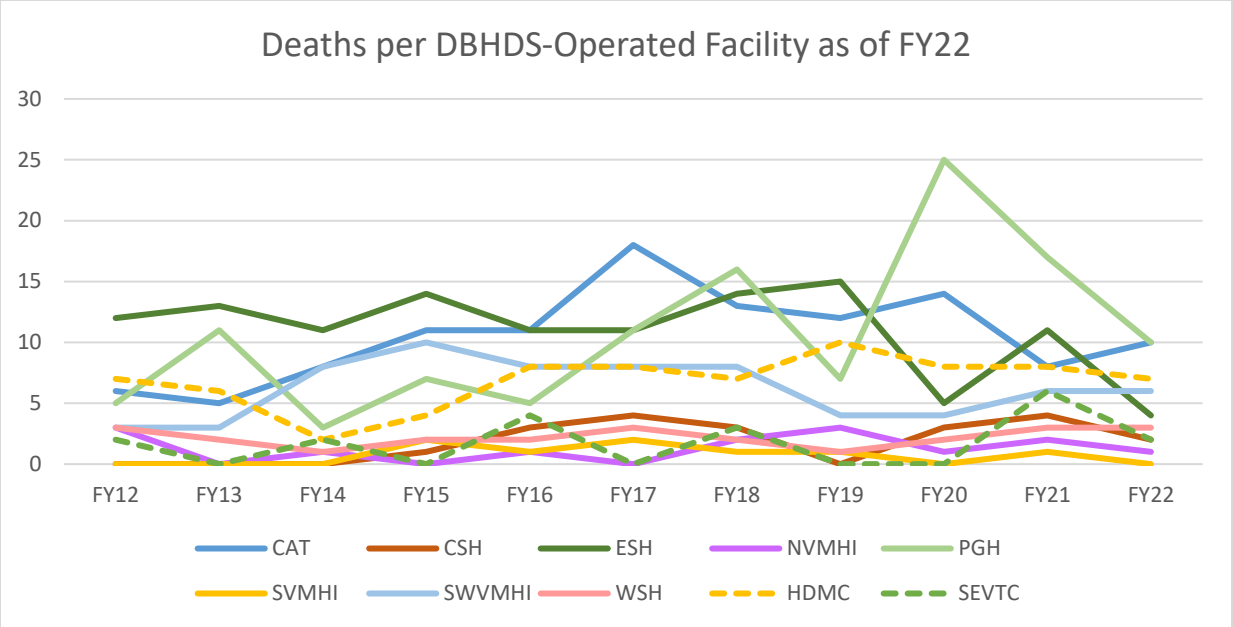


Data on Reported Deaths

dLCV has long been concerned about the number of deaths occurring at DBHDS-operated facilities. While this is still a concern, FY 22 saw a considerable drop in the number of deaths reported (from 66 in FY 21 to 45 in FY 22), marking the fewest number of deaths since we have been tracking this issue.



While it is important to note the overall drop in death rates at DBHDS-operated facilities, it is equally important to understand the breakdown of deaths occurring at each DBHDS-operated facility, shown in the graph below.

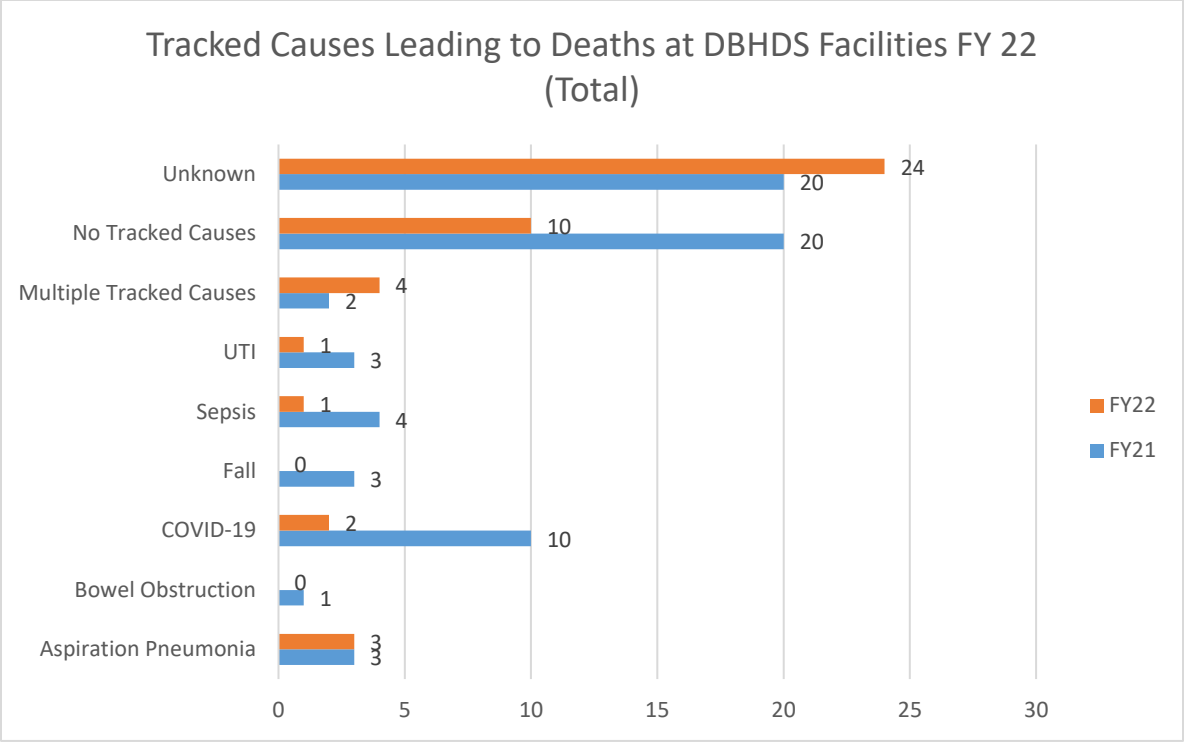


Every DBHDS-operated facility that serves adults had at least one death in FY 22, with the exception of Southern Virginia Mental Health Institute (SVMHI). The only facility to report a greater number of deaths compared with FY 21 was CAT (from 8 in FY 21 to 10 in FY 22). PGH, CAT, and HDMC reported the greatest number of deaths during FY 22.

It appears that the decrease in deaths across facilities may have been driven primarily by two factors: decreases in Geriatric deaths at PGH and ESH, and the diminished impact of COVID-19.

Both PGH and ESH reported far fewer deaths in FY 22, compared to FY 21 (PGH fell from 17 to 10 deaths and ESH fell from 11 to 4 deaths). Given the concerns we enumerated in our FY 21 report, we sincerely hope that this is due to proactive efforts and not mere coincidence.

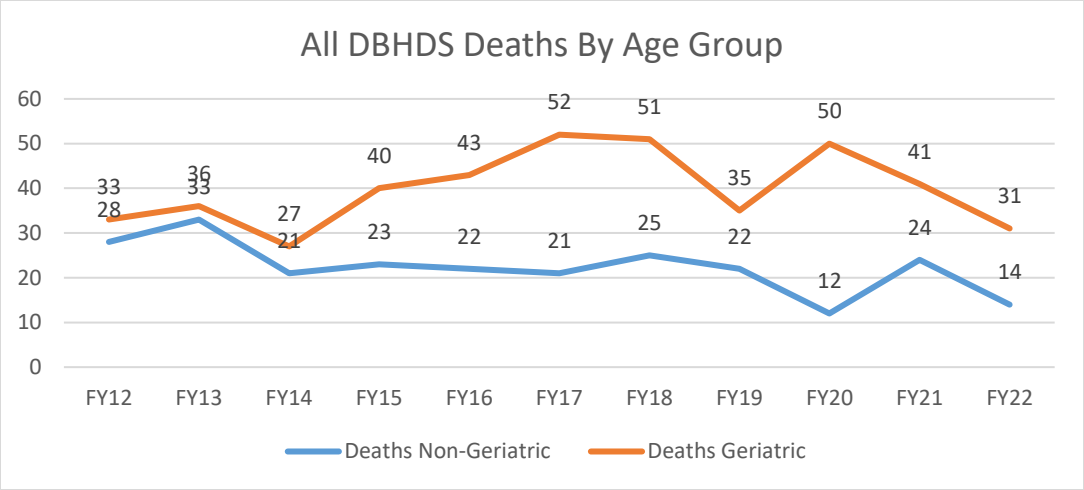
To better understand what is driving the rate of deaths, we have examined six conditions that dLCV has committed to tracking on an ongoing basis. These include the following categories: Aspiration Pneumonia, Bowel Obstruction, COVID-19, Falls, Sepsis, and Urinary Tract Infections (UTI).



It is of increasing concern that 24 out of the 45 total patients who died are identified as having a seemingly "unknown" cause of death. The proportion of people whose death reports did not include enough information to discern whether one of these factors was at play increased from 30.3% in FY 21 to 53.3% in FY 22. We understand that it is not always possible to immediately determine an individual's cause of death if the death is unexpected. However, even in the follow-up reporting that the facilities submit weeks after the incident, facilities are routinely failing to identify the very factors leading to patient deaths.

dLCV has, over many years, investigated poorly reported deaths. In many of these cases, we have found significant issues with supervision, failure to follow service plans, and a lack of adherence to best clinical practices. While many factors can lead to poor reporting, DBHDS has an obligation to enumerate these factors as they come up. Without a greater level of detail, dLCV must continue to treat poorly reported deaths as suspicious.

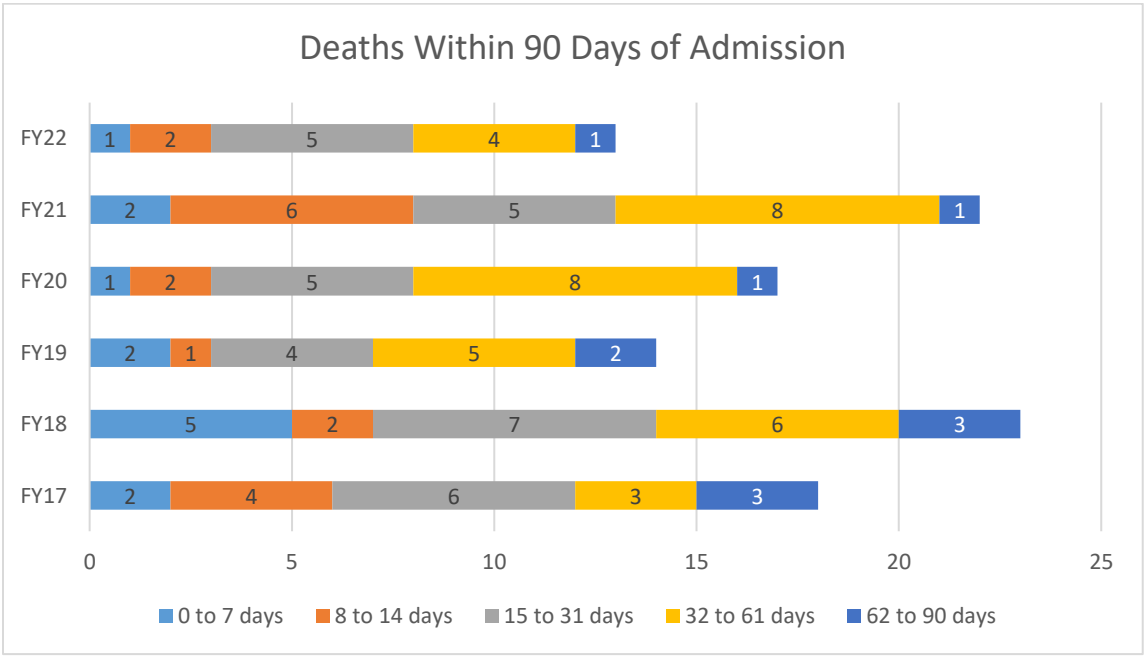
Several tracked factors, particularly COVID-19, decreased substantially (from 10 deaths to just 2) between FY 21 and 22. It is important to note that deaths related to sepsis, bowel obstructions, and UTIs also decreased. There were no instances in which deaths were explicitly linked to falls.



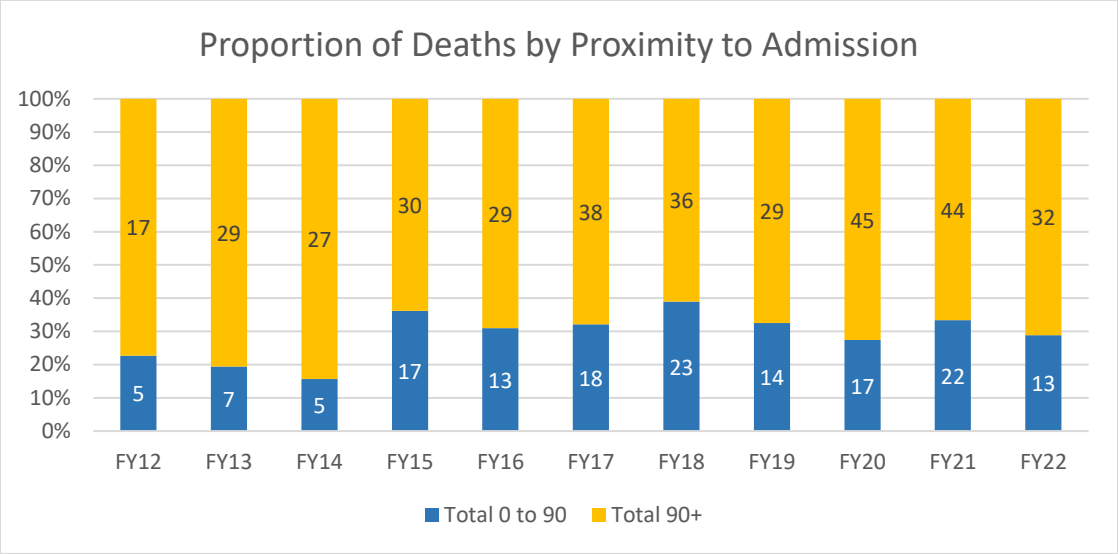
The majority of the deaths that occurred at DBHDS-operated facilities were, as is usually the case, attributed to geriatric patients. There was a somewhat notable decrease in the number of non-geriatric deaths (from 24 in FY 21 to 14 in FY 22). This decrease seems consistent with the overall decrease in deaths across age ranges.

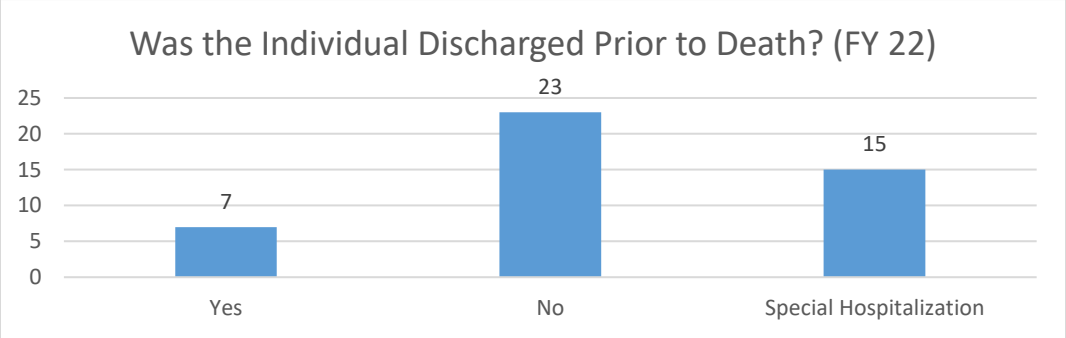
Deaths, Admission, and Discharge

dLCV is fundamentally concerned with the number of deaths occurring within the first 90 days of admission at DBHDS-operated facilities. Oftentimes, these deaths are due to medically-inappropriate admissions.



In the years since the 2014 Bed-of-Last-Resort Legislation, dLCV has observed a dramatic increase in deaths occurring within 90 days of admission to DBHDS-operated facilities. While the number of deaths happening in the first three months of hospitalization initially made up a large proportion of overall deaths, leading to concerns about inappropriate medical admissions, this was much less of a concern in FY 22. In FY 22, there were only 13 deaths that occurred within the first 90 days of admission, compared to FY 21 where there were 22 deaths.

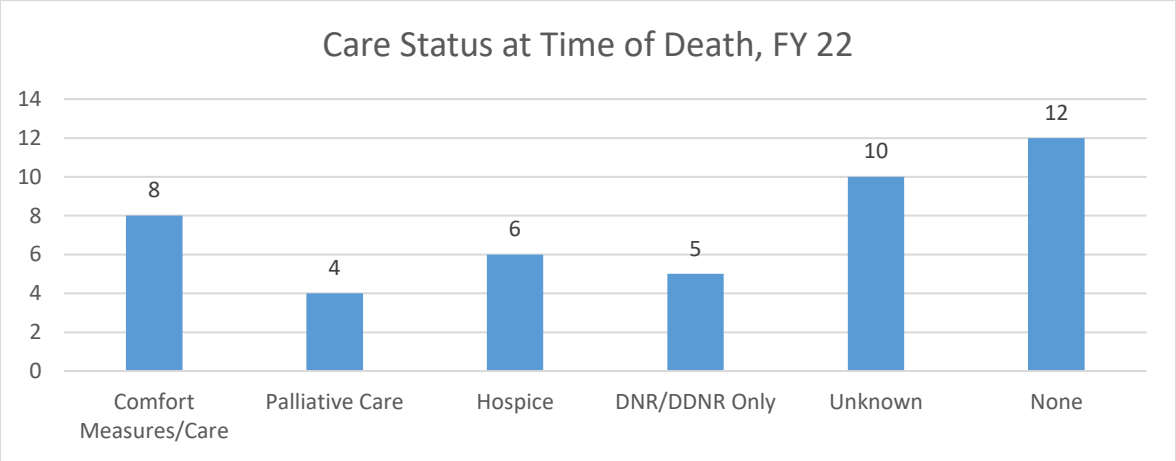




In FY 22, we saw a slight increase in the number of individuals dying while on the premises of State Operated facilities, versus deaths following discharge or occurring on “special hospitalization.” For the purpose of this report, Special Hospitalization includes individuals who were officially admitted to

DBHDS-operated facilities while receiving care at medical hospitals, and individuals who were discharged to medical hospitals, rather than community providers, just a few days before their deaths.[2]

It is disturbing that, while the overall number of deaths decreased substantially during FY 22, the number of individuals who died while physically *at* State Facilities increased from 22 to 23 deaths, or from 33.3% of deaths to 51.1% of deaths, proportionally. If all of these individuals died due to natural but unforeseeable causes, we would not have such a concern. However, many of these deaths appear to be the result of medical deterioration or other causes simply not described in the often-vague reports. As hospitals are intended to be therapeutic environments, we question how the other patients on the unit are traumatized and their recoveries hindered after watching their peers die.



For the past few years, dLCV has attempted to analyze the data provided by DBHDS to determine if individuals' deaths happened expectedly or unexpectedly. dLCV does this by examining which patients had comfort measures, palliative care, hospice, a DNR, DDNR, or none of the above at the time of their death. We understand that these statuses do have nuance and that, particularly for individuals who have Do Not Resuscitate (DNR) or Durable Do Not Resuscitate (DDNR) orders, death is not always immediate or expected. However, from a functional perspective, we most commonly see individuals

[2] We understand this is not the traditional definition of Special Hospitalization, but considering some hospitals' propensity to officially discharge individuals to medical hospitals when the individual appears close to death, combining traditional hospitalization and discharge to medical hospitals allows us to compare two functionally similar practices that are different only in technicality.

and family members being approached about DNR and DDNR orders once the individual has reached a stage where they are not expected to live.

In our analysis, dLCV concluded that the majority of individuals (23) who died while at DBHDS-operated facilities had a DNR or were enrolled in an end-of-life care status shortly before death, suggesting that about 51% of the deaths reported by DBHDS-operated facilities were at least somewhat expected. While many of these individuals were put on special hospitalization, dLCV questions whether they would have benefitted from being placed in more medically-intensive facilities earlier in lieu of admission to a DBHDS-operated facility. We also question, for those whose death could not have been prevented, why more people were not allowed to spend their final days at home with their loved ones in less restrictive settings.

Due to inadequate detail in reports, dLCV was unable to determine the status of care for 10 individuals.

A Word on DDNRs

dLCV would like to acknowledge and highlight the very specific and sometimes problematic role of Durable Do Not Resuscitate (DDNR) Orders. In Virginia, a "Durable Do Not Resuscitate Order" means a written physician's order issued pursuant to Va. Code § 54.1-2987.1 to withhold cardiopulmonary resuscitation from a particular patient in the event of cardiac or respiratory arrest. The thing that makes a DDNR "durable" is that they stay in effect and can travel between healthcare settings.

Many adults may find it useful and even comforting to have a DDNR in place to enforce their wishes. However, Virginia allows substitute decision makers to initiate a DDNR on an incapacitated person's behalf, in conjunction with that person's physician. Again, dLCV does not see a problem with this practice when it is legitimately honoring the expressed wishes of the incapacitated person, but we see far too much potential for DDNRs to be used abusively against people with disabilities who have been found to lack capacity.

We have witnessed cases in which doctors have advised families to create a DDNR because they do not believe a disabled life is worth living. We have also seen instances in which family members with known and documented histories of abuse have been given legal power over their victims' lives by using a DDNR. In Virginia, it is not a requirement that a person be terminally ill to obtain a DDNR. Substitute decision makers do not have to point to a person's history or prior wishes to obtain a DDNR.

With so many loopholes, dLCV sees DDNRs as tools which have tremendous potential for abuse when the person creating the document is not the person whose life will end as a result.

Throughout this report, we used “DNR” and “DDNR” orders as a combined category. We did so, not because these documents are equivalent, but because the terms were often used interchangeably by reporters. Virginia considers “other” DNR orders (that are not official DDNR orders or verbal orders from a physician) to be “a physician’s written DNR order when it is in a format other than the State form.” The State has provided guidance that EMS providers should honor these “when the patient is within a licensed health care facility or being transported between health care facilities if the DNR includes the same information as required for DDNR orders, although a patient/authorized representative need not sign the order.” Due to reporting quality, we have not been able to ascertain which type of order was in effect in most cases.

Conclusion

In publishing the FY 22 CIR Report, the disAbility Law Center hopes to shed light on a number of important issues. With regard to the rise of Self-Injurious Behavior, dLCV would like to once again stress how imperative it is for DBHDS and, in turn, DBHDS-operated facilities, to adopt a Trauma Informed Care approach. The adoption of more actionable practices regarding Trauma Informed Care—and especially Rutgers’ Universal Precautions approach—could significantly increase the overall efficacy of mental health treatment at DBHDS-operated facilities while also helping to address the vicarious trauma and burnout experienced by staff.

The tremendous rise in reports of Alleged Peer Assaults and Alleged Peer Sexual Assaults is also concerning to dLCV. Over the past several years, the number of reports has seemed to steadily rise. As indicated earlier in the report, dLCV believes the rise in reports can partially be attributed to DBHDS’ inability to staff facilities safely or appropriately and, as a result, the overall diminishment of patient privileges. In an effort to address the heart of the issue, DBHDS-operated facilities must meaningfully address the Extraordinary Barriers to Discharge List. In addition, DBHDS is responsible for ensuring there are adequate community treatment options available. It is also incumbent upon the Virginia Legislature and Executive branch to support DBHDS in these endeavors. Reducing the number of patients on the EBL allows DBHDS-operated facilities to be in a better position to restore patient activities and privileges.

Reporting adequacy is another pertinent issue raised in this CIR Report. There is considerable room for improvement with regard to the quality of reports and quantity of reports filed. Indeed, the lack of clarity and the overall quality of information in some reports is concerning. A considerable number of reports lack even the most essential or rudimentary of information. This is only reinforced by the fact that the number one tracked cause of deaths was “unknown.” In FY 23, dLCV hopes to see a significant increase in the overall quality and quantity of reports.

dLCV looks forward to the opportunity of working with DBHDS-operated facilities towards these goals.