



**DISTRICT OF COLUMBIA GOVERNMENT  
DEPARTMENT OF MENTAL HEALTH**

**RESPONSE TO  
THE DISTRICT OF COLUMBIA  
OFFICE OF INSPECTOR GENERAL'S REPORT,  
"AUDIT OF UNUSUAL INCIDENT REPORTING  
PROCEDURES AT THE DISTRICT OF COLUMBIA  
DEPARTMENT OF MENTAL HEALTH"  
(OIG NO. 01-1-06RM(C))**

**ISSUED APRIL 15, 2003**

**Response Date: June 4, 2003**

**Note: The DMH response included the following information that is not a part of this report: (1) DMH Incident Investigation Guidelines, (2) DMH Unusual Incident Reporting Policies Dated 10/16/01, 5/9/02, 12/17/02, (3) DMH, Office of Accountability Memorandum dated June 18, 2002 to All Providers Regarding Unusual Incident Follow Up with Tracking Form, (4) Various correspondence between DMH and OIG regarding DC Law 13-104. This information can be obtained upon request to the OIG.**

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#5: Correspondence Between the OIG and DMH Regarding the Mandatory UI Report Temporary Act of 1999, DC Law 13-104 and OIG Management Alert Report (MAR) No. A-02-04 DMH Memorandum to Providers dated May 5, 2003 Regarding Compliance With DC Law 13-104 While in Effect	

## INTRODUCTION

This document represents the District of Columbia Department of Mental Health's ("DMH") response to the Office of Inspector General's ("OIG") Report entitled, "Audit of Unusual Incident Reporting Procedures at the District of Columbia Department of Mental Health" (OIG No. 01-1-06RM(c)) for the Period June 1, 2001 through June 30, 2002."

In 2001 Mayor Williams and DMH Director Knisley requested the OIG to review specific aspects of the operations of the new Department of Mental Health, as the Department was being created and taking over operations from the Court Ordered Receiver in *Dixon v. Williams*. This request was made explicitly to determine areas where operations required substantial improvement for the City and Department to meet mandates in mental health services oversight and service delivery.

As with previous reviews requested by this new Department, DMH welcomes constructive criticisms regarding various functions related to the delivery of services to persons with mental illness. These constructive suggestions have, in several instances, enabled DMH to improve the operations of this new Department to better serve the consumers in the District of Columbia. The DMH functions addressed by the OIG's report have indeed presented challenges for DMH. These functions are continuously being reviewed and changed to improve their effectiveness. Set forth in Part I of this two part response are actions that DMH took to improve the unusual incident reporting system, the mortality review process and security at St. Elizabeths Hospital ("SEH") and those that DMH plans to take to continue to improve these systems. Moreover, DMH agrees with all fourteen (14) of the OIG recommendations to improve these systems. DMH is already well underway with improvements cited in this report and has used the OIG Report to develop a detailed Work Plan with an implementation timetable to implement all of the OIG recommendations. That plan is included with this response.

In Part II, DMH sets forth its disagreement with several issues raised by the OIG concerning DMH's efforts to reform the quality of care provided in the District of Columbia. The OIG concludes that the DMH Office of Accountability (OA) did not effectively fulfill its oversight responsibilities for the reporting of unusual incidents. The Office of Accountability was created in mid 2001 and has aggressively undertaken its new tasks as illustrated on pages 11 through 14 of this response. As noted on page 15 of this response, DMH disagrees with the OIG that there is a need for mortality reviews and autopsies in all cases where a person receiving mental health services dies. Many persons seen by providers in the mental health system die of natural causes or other reasons totally unrelated to their mental health care. Further OIG makes certain assumptions regarding the "controls" that are needed over individuals served by St. Elizabeths without taking into full account the legal and clinical role of the Hospital. An explanation of this disagreement is noted in more detail on page 15 of this response.

**PART I. DMH CORRECTIVE ACTIONS TAKEN AND ACTIONS PLANNED REGARDING  
OIG FINDINGS**

**DOCUMENTING AND RESOLVING REPORTS OF UNUSUAL INCIDENTS (OIG**

*Finding #1 - Page 9 of OIG Report - "DMH did not always follow its established policy for managing more than 500 reports of unusual incidents, which identified unanticipated deaths, abuse, or neglect of the District's mentally ill patients.")*

While DMH disagrees with the OIG's overall conclusion, DMH has taken the following actions, which address the OIG findings on unusual incident reporting procedures:

**1. Office of Accountability Procedures Reviewed and Revised, Leadership for OA/Division of Quality Improvement ("DQI") Hired, Unusual Incident ("UI") Investigations Guidelines and Death Reporting and Mortality Review Procedures Developed**

DMH readily admits that the UI process has been a challenge to develop and implement and needs continuous assessment to ensure that it operates effectively and efficiently. The OA and DQI leadership have made significant improvements in this regard by: developing incident reporting guidelines and providing the Consumer Rights staff daily supervision on UI investigations; developing a working draft for the DMH Clinical Director's use to implement the death reporting and mortality review process; and, leading the UI policy revision that resulted in the December 17, 2002 policy. The Incident Investigation Guidelines and the draft of the Death Reporting and Mortality Review Procedures are included in **Tab #1**. In addition, the leadership has already identified additional improvements that DMH needs to make in the system, as well as resources that DMH needs to have and has drafted a policy to address UIs that fall outside of the current policy. That draft policy also appears in **Tab #1**.

**2. Numerous DQI Activities Undertaken Since Hiring of DQI Leadership To Improve Incident Reporting and Investigations**

These activities include the following:

• **Increased Staff Supervision**

- Initiated daily reviews and "triage" of all Major Unusual Incidents ("MUIs") presented to OA.
- All MUIs are routinely assigned to staff for investigation.
- Provided staff training on Incident Investigations.
- Initiated quarterly audit of all MUIs assigned to investigators for current status.

• **Assessed and Improved OA Database**

- All UIs reported in 2001 and 2002 were reviewed and recoded for consistency. The ACCESS Incident database was revised to:

- Allow for coding of incidents by type.
- Allow for initial “triage” of cases by DQI.
- Allow for documentation of triage, assignment of investigator, follow-up documentation, and status of case.
- Allow for generation of reports in usable format.

- **Revised and Issued Major Unusual Incident Reporting Policy**

- Reviewed with DMH Policy Committee the Major Unusual Incident Policy (“MUI”) issued on May 9, 2002.
- MUI Policy revised and issued on December 17, 20002.
- Presented MUI Policy to Mental Health Rehabilitation Services (MHRS) provider clinical and quality improvement directors in January 2003.

- **Drafted Other Related DMH Policies**

- Drafted Death Reporting/Investigation Policy and forwarded to Chief Clinical Officer.
- Reviewed and commented on Restraints and Seclusion Rule.
- Drafted incident policy to capture incidents that are not considered MUIs.

- **Trained Staff on Preparing Standard Reports**

- Trained staff assistant on standard reports.
- Prepared reports on incidents and deaths for Director, Deputy Director and Risk Management Committee.

- **Drafted Job Description to Recruit Staff to Fill Vacant UI Investigator Position and Currently Recruiting**

**3. Numerous OA/DQI Actions Are Planned**

DMH, through OA/DQI plans to take the following actions over the course of the next few months to address any reporting issues:

- Issue additional policy to cover missed portions of MUI.
- Improve documentation of investigations.
- Develop standard investigation workflow.
- Develop and use:
  - a. Receipt letter template to send to reporting agency once a MUI is reported and received by OA.

- b. 30-day follow-up review letter template to send to reporting organization if there remains any outstanding information.
  - c. Template letter requesting consumer death information from organization - Consumer Death Determination form.
- Create individual hard copy case file for each consumer who is the subject of a MUI report.
  - Develop standardized database to be used by all reporting organizations.
  - Complete research on, develop and utilize web-based, encrypted system for ease of data entry. Two options being considered: the New York State DMH Incident Database and the Missouri Outcomes approach.
  - Mandate monthly summary UI reporting from all CSAs, CRFs, St. Elizabeths in “new” incident policy and monitor the incidents. Organizations will be required to report UI status to OA/DQI. OA/DQI will develop a monthly summary report format that will be utilized and reviewed in DMH Risk Management Committee.

**MORTALITY REVIEWS AND PATIENT AUTOPSIES** *(OIG Finding #2 - Page 16 of OIG Report - “[P]atient deaths had not been thoroughly investigated and root cause analysis were not employed. DMH procedures for reviewing and approving mortality reviews were not current.”)*

**1. Mortality Review Process Revised**

Though we disagree that CMHS Policy 50000.115.3E requires that every “patient” death undergo mortality review or that every death is the subject of an autopsy, in order to improve the investigation and evaluation of the cause of consumer deaths, DMH has already developed the following procedures for death reporting and mortality review:

- OA, through DQI, will conduct the field investigation of a consumer’s death.
- Following that investigation, the Mortality Review Committee, led by DMH’s Chief Clinical Officer or his designee, will review the initial investigations findings, the circumstances surrounding the death, and may recommend program and service improvements to reduce or eliminate the possibility of future deaths resulting from similar circumstances.

*See Tab #1* for a full description of these procedures.

- 2. DMH Will Request That Consumer Autopsies Be Performed by the ME’s Office Where Appropriate and Will Request Copies of the Autopsy Reports.**
- 3. To the extent that the provider conducts its own mortality review or requests the autopsy, DMH will review the provider’s findings.**

**CONTROLS OVER FORENSIC PATIENTS** *(OIG Finding #3 – Page 23 of OIG Report - “DMH’s procedures for ensuring that bench warrants are issued for forensic on unauthorized leave are insufficient.”)*

DMH strongly disagrees with many of the assumptions on which OIG Finding #3 is based – that persons who are mentally ill are inherently dangerous and alleged security weaknesses results in danger to themselves and the public (page 2, paragraph 5; page 17, paragraphs 2- 5; page 23) – nevertheless, DMH has taken the following actions:

**1. Improved security measures at St. Elizabeths by:**

- Conducting an external review regarding risk assessments and procedures used at St. Elizabeths' John Howard Pavilion (JHP) for granting or denying privileges to forensic patients and making recommendations to the courts for their conditional or unconditional release to the community.
- Assessing and granting or denying privileges, passes, etc. for the acute and long-term areas of the hospital as determined by the internal review board for ground privileges and by the court for escorted off-ground privileges at JHP.
- Changing security contractors.
- Consolidating the operations on the east side of the campus, thereby reducing the campus perimeter.

**2. DMH plans to take these additional corrective actions:**

- Implement recommendations from external review for risk assessment.
- Evaluate appropriateness of recommendations and conduct internal review for the acute and long-term areas of the hospital.

The DMH Risk Manager, Chief Clinical Officer, Chief Executive Officer of St. Elizabeths Hospital will be responsible for implementing the recommendations and assessing the impact.

**WORK PLAN TO IMPLEMENT OIG RECOMMENDATIONS**

DMH has already made modifications in its operations that would address several of the OIG recommendations; however, DMH accepts all of the OIG recommendations and has developed the Work Plan for Corrective Action included in **Tab #2** to implement the recommendations.

DMH's Work Plan includes the following:

**OIG Recommendation #1: Create an oversight mechanism (committee) or internal audit team to monitor the efforts of the OA to ensure that the unusual incident reporting system is operating effectively. Monitoring efforts should include monthly reports to the Director, DMH.**

**Action Taken:** Incidents are reviewed on a monthly basis in the DMH Risk Management Committee. Incident reports are a standing agenda item. Certified Core Service Agencies ("CSAs"), including the public CSA, and St. Elizabeths Hospital are expected to submit monthly reports of unusual incidents to the Risk Management Committee. The OA/DQI has prepared a

template for reporting unusual incidents to Risk Management. OA/DQI will report Major Unusual Incidents to the Risk Management Committee.

**Action Planned:** OA/DQI will issue an Unusual Incident Reporting policy in 2003 to complement the Major Unusual Incident Policy issued in December 2002. OA/DQI will audit all CSAs starting in 2003 for compliance with the Unusual Incident Reporting policy. The Risk Manager will report to the Director of DMH a summary report of all CSA and Hospital unusual incidents.

**OIG Recommendation #2: Develop and implement performance standards for the OA.**

**Action Taken:** Performance standards are already included in OA Deputy Director's performance contract.

**OIG Recommendation #3: Develop procedures to ensure that the OA reports, investigates, and resolves all unusual incident reports in a timely manner.**

**Action Taken:** OA issued Major Unusual Incident Reporting policy in December 2002.

**Action Planned:** OA now in process of hiring staff for incident investigations. OA will revise and disseminate unusual incident reporting policy to include the MUI policy and reporting requirements for CSAs, CRFs and St. Elizabeths Hospital.

**OIG Recommendation #4: Take corrective action against providers who do not report unusual incidents in a timely manner.**

**Action Taken:** DMH already takes corrective actions as appropriate and has authority to sanction CRF providers who fail to comply with standards.

**Action Planned:** OA to include the use of Corrective Action Plans in the new Unusual Incident Reporting policy and take corrective action and sanctions, where appropriate, against providers who do not report unusual incidents in a timely manner.

**OIG Recommendation #5: Develop and implement a computerized database to document and track all reports of unusual incidents.**

**Action Taken:** OA Major Unusual Incident database was reconfigured in early 2003 to improve UI documentation and tracking capability.

**Action Planned:** OA presently investigating the use of more comprehensive database systems, including possible use of the New York State Incident Reporting System.

**OIG Recommendation #6: Review and evaluate security procedures at St. Elizabeths Hospital to ensure the safety and security of mentally incapacitated persons.**

**Action Taken:** DMH Director requested external review of these procedures. Phase I of this review has been conducted.

**Action Planned:** Complete Phase 2 of the review process by summer 2003.

**OIG Recommendation #7: Revised the CMHS policy 50000.115.3E to require periodic reviews of mortality review reports.**

**Action Taken:** OA/DQI has prepared Incident Investigation Guidelines, Consumer Death Determination procedures and documentation forms, and drafted new Mortality Review Policy. Draft policy on Death Investigations and Mortality Review need review and approval by Policy Committee. OA will disseminate policies and train providers thereafter.

**OIG Recommendation #8: Develop and implement procedures to ensure that all deaths are investigated and mortality review reports are timely performed and properly completed.**

**Action Taken/Planned:** See action taken in response to Recommendation #7 above.

**OIG Recommendation #9: Initiate procedures and assign responsibility to ensure root cause analyses are performed on all unexpected occurrences involving death or serious psychological injury.**

**Action Taken/Planned:** See action taken in response to Recommendation #7 above.

**OIG Recommendation #10: Require OA to report the completion status of all mortality reviews to Director, DMH on a monthly basis.**

**Action Taken/Planned:** See response to implement Recommendation #1 above  
Drafted policy on Death Investigations and Mortality Review to be reviewed and approved by Policy Committee.

**OIG Recommendation #11: Require all operators of community residence facilities to retroactively report, for the time period in which the law was in effect, all unusual incidents as required and defined by D.C. Law 13-104 (from April 3, 2001 to November 14, 2001) and D.C. Law 14-70 (from February 27, 2002 to October 10, 2002), to the Inspector General of the District of Columbia.**

**Action Taken:** DMH provided OIG's Patient Abuse Coordinator with a list of CRFs on February 19, 2003 that included contact information; OA Division of Licensing trained CRF operators on DMH's unusual incident reporting in October 2002 and again in May 2003. OA/Division of Licensure has sent a memorandum to CRF operators requesting that they report all unusual incidents that occurred for the period in question directly to OIG.

**OIG Recommendation #12: Revise the monthly mortality review report to reflect current organizational responsibilities.**

**Action Taken/Planned:** See response to Recommendation # 7 above.

**OIG Recommendation #13: Establish procedures to confirm the issuance of all bench warrants requested for forensic patients on unauthorized leave or to request the issuance of new bench warrants where appropriate.**

**Action Taken/Planned:** Within the next 60 days, DMH will review the procedures to verify the issuance of bench warrants and will establish appropriate mechanisms where indicated.

**OIG Recommendation #14: Negotiate a memorandum of understanding with the U.S. Attorney's Office and the Office of Corporation Counsel to confirm the issuance of bench warrants and to provide dates and case numbers for all bench warrants issued.**

**Action Taken/Planned:** Within the next 30 days, DMH will discuss this recommendation with the United States Attorney's Office, the Corporation Counsel and the U.S. Marshal Service to determine what agreements are necessary and attainable.

Please note that we have set forth responsible DMH parties, fiscal impact and due dates in the Work Plan contained in **Tab #2**.

Following are our general observations about the report and discussion of findings with which DMH disagrees.

**PART II. GENERAL OBSERVATIONS/DISAGREEMENT WITH OIG FINDINGS**

**1. DMH Documentation and Resolution of UIs Must Be Viewed in Light of DMH's Formative Stage**

- **Efforts to Develop OA and The Unusual Incident Reporting Process Were Not Given Proper Consideration in General**

The OIG report recognizes that DMH was only created in May 2001. There was no staff hired at that time to conduct incident reviews or to conduct any of the Department's required quality improvement and licensing functions, which were pivotal considerations in creating a new Department. The Mental Health Service Delivery Reform Act (hereinafter referred to as the "Establishment Act") contemplated that a year or more start up was required for the Department to actually carry out these functions.

As the OIG report correctly noted, the OIG audit was conducted shortly after the Department was created. It is important to note that during the previous Receivership period, 1997 through 2001, attempts to address monitoring, oversight and quality improvement were ineffective. Though the Commission on Mental Health Services (CMHS) had an unusual incident reporting policy in place, that policy needed to be revised to establish a new central reporting authority and procedures.

The new DMH leadership immediately established the Office of Accountability ("OA") and hired a highly qualified Director in July 2001 at a Deputy Director level reporting directly to the DMH Director. DMH first undertook a complete overhaul of residential licensure, which was immediately done. DMH then moved rapidly through its other critical areas of oversight, including incident reporting, in very short order making up for years of benign neglect. Consequently, OA leadership faced the challenge of having to work almost simultaneously on this important task, among the many others<sup>1</sup> to develop a UIR system and work with the Office of Consumer and Family Affairs (OCFA) to transition consumer rights investigations. Over the course of the next two months, OA worked through DMH's Policy and Planning Committee<sup>2</sup> to develop the first DMH/OA UIR policy, which was issued on October 16, 2001, to establish OA as the central office for verbal and written notification of all major UIs. That policy is included herein under **Tab #3**. The second policy dated May 9, 2002, which is referenced in the OIG

<sup>1</sup> OA is also responsible for oversight of DMH's Certification, Licensing, Quality Improvement and Policy and Planning Divisions. The Certification staff was the only staff in place during June 1, 2001 up until mid September 2001 and the rest either had to be hired or transferred from former Commission on Mental Health Services offices. The licensing staff had to be hired and trained by September 30, 2001 in order to meet the mandate of the Establishment Act for DMH to begin licensing Mental Health Community Residential Facilities ("CRFs") on October 1, 2001. OA had to screen, hire and arrange training for that staff in the process of trying to establish a UIR system, prepare the Certification staff to implement the provider certification process for the Mental Health Rehabilitation Services (MHRS) program and review rules, policies and procedures that needed immediate development or revision to comply with the Establishment Act mandates.

<sup>2</sup> The Policy and Planning Committee consists of DMH executive leadership staff, including division directors of both Delivery Systems Management and Office of Accountability, as well as the General Counsel and Chief Clinical Officer.

audit, was developed and issued to change DMH contact information for UI reporting and to add a section to the policy requiring out-of-state providers to report any UIs involving DMH consumers. In addition, it required the Office of Delivery Systems Management (“DSM”) and OA to coordinate a response to the UI. That policy is also included under **Tab #3**.

DMH hired leadership for the Office of Accountability’s Division of Quality Improvement (“DQI” or “QI”) in September 2002 that had the expertise to further overhaul the UIR system. With QI leadership now in place, DMH developed a third policy and procedure and issued it on December 17, 2002, to provide that all events defined in the policy as MUIs are to be reported to OA and all UIs to DMH’s Risk Management Office. Further, it requires providers to report a follow up disposition to OA within ten days of the initial report on all MUIs; requires the use of seclusion and restraints and unauthorized leaves be reported as MUIs; and, requires notification of law enforcement officials and families where indicated. That policy is in effect at this time and is included in **Tab #3**.

- **The OIG Report Does Not Recognize that Some Incidents Did Not Require OA Action**

The OIG report on page 16, paragraph 2 states that OIG staff reviewed “OA’s correspondence files on more than 508 reports of unusual incidents some of which involved unexpected deaths and alleged patient abuse or neglect during the one-year period ending June 30, 2002.” The report continues, “We found little evidence or documentation to suggest that the OA initiated investigative action on any of the 508 reports.”

The OIG report does not appear to recognize that many of the incidents reported to OA already had dispositions when the provider submitted them, were being adequately addressed by the provider, or were being handled by other District agencies, including law enforcement or adequately by the provider. Based on the OA data reported for the period August 2001 to April 2002, over two-thirds of the UIs reported were not deaths or alleged patient abuse or neglect. The OIG acknowledges in its report that the range of incidents in the OA database for this period of time included not only deaths, assaults and abuse and neglect allegations, but also voluntary and involuntary hospitalizations and medical problems, elopements, consumer injuries, including falls and a large number of “other” UIs ranging from consumer use of contraband, drugs or alcohol, to car accidents with consumer involvement. Most of these incident reports were submitted with a disposition or a plan to address the issue that was acceptable to OA. In the case of the AWOL/UL/Missing incidents, the UI reports generally stated whether the consumers/residents had returned to the facilities, or in the case of St. Elizabeths, whether law enforcement authorities had been notified.

If these UIs occurred in CRFs, which DMH regulates under Title 22 DCMR Chapters 31 and 38, or, if the CRF failed to file a report, these instances were investigated, a Statement of Deficiency (SOD) was issued, and the provider was required to send a Plan of Correction (POC) in response. Those SODs and POCs are filed in the CRF files. OA staff does not know whether OIG staff reviewed those files. OA staff acknowledges that a more effective management tool would have been for OA staff to send the provider separate notification in all cases that the disposition or plan of correction was acceptable to OA, establish an individual file for each consumer involved

in a UI, and centrally file this individual file. OA is in the process of instituting this notification and filing procedure.

As mentioned above, DMH acknowledges that OA staff and OIG staff met at least three times during the course of the audit regarding the UI reporting process. At the first meeting, which took place in early June 2002, the OIG staff indicated that, in his opinion, overall OA UI follow up was inadequate. In response to this feedback, on June 18, 2002, OA staff wrote to all providers that had reported incidents to OA requesting that they send follow up information to OA within five (5) business days from receipt of the letter. OA included a follow up tracking form with the request. That memorandum and form are included in **Tab #4**. Thereafter, OA assigned OA QI/Consumer Rights staff to begin the process of determining whether the follow up information was adequate or whether further OA action was required. OIG staff was well-aware that OA had initiated this follow up effort while the OIG audit was still in progress, but did not mention this effort in its report.

OIG staff and OA staff met again on July 15, 2002, this time to discuss the OIG's concern that DMH had not implemented D.C. Law 13-104, the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 1999. This law had expired by the time OA and OIG staff met and therefore, OA staff was unclear as to its obligations with respect to it and the OIG staff's demand for immediate enforcement. OA staff turned this matter over to DMH's General Counsel, who responded to the OIG's subsequent Management Alert that is contained in the draft report. The law, the OIG's Management Alert and the DMH General Counsel's response are included in **Tab #5**.

Though DMH does not appear to have any obligation under this law to require the providers to report to the OIG, nevertheless, on February 19, 2003, OA provided the OIG's Patient Abuse Coordinator with a list of all CRFs so that the OIG staff could contact them about compliance. In addition, DMH sent a memorandum to CRF operators directing them to comply with the law for the period of time it was in effect. A copy of that memorandum is also included in **Tab #5**.

The OIG staff finally concluded the on-site audit in OA in July 2002 and requested to meet with OA staff for an exit interview, which took place on July 31, 2002. During the exit interview, the OIG staff presented a total of thirty-four (34) cases out of the 508 the OIG staff alleged to have audited where the OIG staff believed that follow up was lacking or did not believe that the action taken by OA was appropriate. Much of the follow up that the OIG staff recommended that DMH take on these thirty-four matters extended beyond DMH's control and authority. For example, with respect to the deaths that providers had reported, the OIG staff suggested that DMH require an autopsy. It is unclear whether DMH even has the authority to request an autopsy in any particular case, and even if it does, whether the District Medical Examiner's Office is required to honor that request. The OIG indicated in its report that the OIG requested, but did not receive from the Medical Examiner's Office, autopsy information on the reported deaths of mentally ill persons. In other cases that the OIG staff discussed with OA staff, the OIG staff recommended that DMH/OA take enforcement action against housing providers that operated supported independent living ("SIL") facilities (for example, the two cases the OIG referenced where one consumer was found dead in her apartment and the other where the consumer was injured both occurred in a residence rented to the consumer by a SIL operator). At the time DMH did not

have any legal authority to take any enforcement action against the provider. DMH took the initiative to address this lack of oversight authority. DMH worked for several months with staff, advocates, consumers and providers to write regulations to ensure that DMH has the authority to require that this type of housing provider comply with strict health and safety standards and that DMH can monitor them for compliance. Those regulations were published in January 2003 and implementation is underway. In still a few other cases, the OIG staff demanded that DMH initiate investigations of UIs that other District agencies, such as the Child and Family Services Administration (“CFSA”), had already investigated and resolved and already required the provider to take corrective action. The OIG should note that as a matter of course, CFSA sends DMH the outcome of its UI investigations involving children that CFSA places in residential treatment centers for children and youth (“RTCs”), since DMH is the agency that certifies RTC services. DMH and CFSA have in some cases jointly investigated UIs that have occurred in facilities in the District, but both agencies are clear that CFSA remains responsible for investigation and initiation of corrective actions since it is the placing agency.

The OIG staff did not identify either then or subsequent to the exit interview any other failures in performing the UI function beyond the thirty-four cases identified. OA immediately reviewed those cases and continued the follow up effort it had begun in mid-June 2002 to determine whether DMH had received complete follow up information, needed to request information needed to conduct an investigation, or needed to require the provider to take corrective action.

- **The OIG Report Lists “Sample” Cases That Are Not Representative of the UI Reports Received in OA**

There are several examples in the OIG report that selectively “sample” various documents or reports external to the OA to draw conclusions about OA actions taken or required on UIs. For example, the OIG reports that it “identified other unusual incidents that went unreported and instances where additional attention to patient needs may have resulted in different outcomes.” The OIG did not provide any additional information about these instances, where they were discovered, or what DMH could have done differently, so that DMH could take corrective action with respect to them. Specifically on page 13, paragraph 3, the OIG report states that OIG staff sampled some of the reports on assaults and abuse where OA did not take action. Again, there is no information about how the OIG arrived at this “sample” and whether it fairly represents the types of reports made to OA. In fact, they do not. According to the OIG’s own data, assaults and abuse reports comprise one third of the UIs reported to OA. Yet, the OIG presents these samples, in all cases, in a highly generalized manner. Rather than selectively sample cases, DMH suggests that use of quantitative methods of analysis would have yielded a fairer presentation of the range of UI reports received in and reviewed by OA.

- **The OIG Report Does Not Recognize that Consumer Deaths Had Been Categorized to the Extent Possible in the OA Database**

The OIG, on page 10, paragraph 6, reported that 37 of the 58 deaths reported to OA by various providers were not categorized in the database by OA as “expected or unexpected” and were listed simply as “deaths” and that is true. This database, however, contains details regarding the

manner of the individuals' death in other data fields. The OA staff maintaining the database had clearly entered the details of the death, but took the information about "type of incident" directly from the UI hard copy form. According to a sample of OA data from August 2001 to April 2002, a total of 58 deaths had been reported up to that period and could easily be categorized as follows from the information available in the database:

Unexpected:	9
Natural:	41
Expected:	4
Suicide:	4

Though cumbersome, the hard copy UIs are maintained in binders in OA and are filed in an easily retrievable fashion. These hard copies serve as the fail-safe back up to any data systems problems and OA will continue to maintain them.

**2. The OIG Conclusion about the Need for Mortality Review and Death Investigations in Every Case Is Not Based on Generally Accepted Practices**

The OIG conclusion that "patient deaths are not always investigated" appears to be based upon the belief that DMH is required to review the circumstances of the death of all individuals who have contact with the DMH service delivery system regardless the remoteness of the contact. As we explain further below, many patient deaths are from natural causes and do not require investigation. Because an individual receives DMH services or is diagnosed with a mental illness and happens to expire does not mean that his or her death automatically must be investigated. DMH has reviewed the practices of other states on this matter and most states only investigate "suspicious" deaths. The OIG report makes no distinction with regards to "natural" or "suspicious" deaths and it makes the same sweeping flawed assumptions about the need for autopsy reports, death certificates, mortality reviews and root cause analyses. Not all deaths result in autopsies, nor should they require mortality reviews or root cause analyses.

**3. The OIG Assumptions Regarding the Need for "Controls Over Forensic Patients" Are Inconsistent with DMH Mandates**

**• The Report Minimizes the Complexity of the Security Issues at St. Elizabeths**

The overall security issue at St. Elizabeths is extremely complex. St. Elizabeths sits on a 300-acre campus divided into large sections. The perimeter is over four (4) miles long. There are 144 buildings on the campus. The challenges of securing the campus without creating a prison-like environment are enormous and would be costly. Recently DMH completed an eighteen-month process of relocating the entire St. Elizabeths operations on the southern end of the east campus in sixteen buildings at a cost of \$6 million from the capital budget in one year alone. This move dramatically reduced the hospital's perimeter and attendant security size.

District officials are negotiating with federal officials for the long-term ownership and use of these magnificent grounds. A broad planning process is underway that will address security

concerns. Thus, adding a prison-like perimeter, as your report seems to suggest, is unwarranted. OIG staff never inquired about any plans to address the security concerns during or after the audit.

- **The Report Overemphasizes “Security” versus Treatment and Community Integration of Persons With Mental Illness and Shows a Lack of Understanding of the Various Populations Serviced by DMH**

The OIG report is replete with references that further stigmatize the consumers of services by suggesting that they present security risks by the very nature of their illnesses and that persons who are treated at St. Elizabeths are all there because they pose a danger to themselves or the public, must be treated against their will and should be secured. There is nothing further from the truth. DMH attempts in this response to provide information about who is treated at St. Elizabeths in order to present a proper perspective.

There are several problems with the OIG statement on page 17, that “[a] number of high-risk patients, who had been civilly committed to Saint Elizabeths Hospital, fled the Saint Elizabeths Hospital campus on unauthorized leave during the period October 1, 2001 to June 30, 2002.” First, this statement incorrectly assumes that every person who took unauthorized leave from St. Elizabeths during that period was “high-risk” and was civilly committed. These errors betray a lack of appreciation for the fact that St. Elizabeths serves a heterogeneous population of persons with varying clinical needs and differing legal statuses -- contextual information critical to an objective, dispassionate evaluation of unauthorized leave data from the hospital.

For instance, Acute Care patients are both voluntary and involuntary patients who come into the hospital for an expected brief hospitalization, usually less than 14 days. Most people have sufficiently stabilized within just a few days and are able to leave the hospital as part of their recovery and reentry into the community. Passes may be given for home visits, return to work, or for social services appointment. Planned departures, visits, and community re-integration are often key components of their treatment programs. Voluntary patients have the absolute right to sign themselves out of the hospital on 48 hours notice. Those Acute Care patients who are admitted involuntarily are converted to voluntary status once their condition improves to the point that they would not endanger themselves or others upon discharge. Once converted to voluntary, these persons have the same right to discharge themselves as those who admitted themselves to the hospital voluntarily.

Chronic or Long Term Patients have been hospitalized at St. Elizabeths for upwards of 35 years. Many of these patients are voluntary patients who remain at the hospital awaiting housing in the community. Many are employed in the community; others attend treatment programs and social events in the community. Some of these persons are committed to the Department for mental health services, but inpatient confinement is not a provision of the commitment. It is important to recognize that part of the treatment-of-choice of many of these persons who reside at the hospital is active participation in the community. When such a person is tardy for dinner or remains in the community overnight, the report of unauthorized leave must be considered in the context of the individual’s legal and treatment status.

In short, there are many patients at St. Elizabeths Hospital who are neither “high-risk”, nor civilly committed, yet the OIG report labels all of the eloped patients as such. By coupling such generalizations, with overly dramatized terms like “fleeing,” and anecdotal accounts of worst case scenarios, the report paints a subjective and misleading picture of security at the hospital.

The OIG’s report also evinces a lack of appreciation for the role of St. Elizabeths Hospital as a hospital rather than a place of incarceration. DMH has an affirmative legal obligation to foster each person’s recovery and ensure that they progress to less restrictive settings, taking into account their needs, as well as the community’s safety. In commenting on a Supreme Court ruling that unnecessary institutionalization constitutes discrimination under the Americans with Disabilities Act, the President’s Commission on Mental Health stated as recently as January 2003 that “confinement in an institution severely diminishes the every-day life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment” and “institutional placement of persons who can handle and benefit from a community setting perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life and cultural enrichment.” These same concerns gave rise to the class action lawsuit in *Dixon v. Williams*, which ultimately resulted in the Court-ordered plan that guides virtually everything the DMH does.

- **DMH Follows the Process for Seeking and Issuing Bench Warrants for Individual Who Leave St. Elizabeths Without Authorization**

The OIG report goes too far in its conclusion that DMH has no documentation on file regarding the disposition of bench warrants, and that “as a result” the whereabouts of several forensic patients remain unknown.

The fact that a patient has not been returned from unauthorized leave does not mean that a procedural default has occurred. As the OIG report acknowledges, DMH requests a bench warrant whenever a forensic patient takes unauthorized leave. By statute, the U.S. Attorney’s Office has the responsibility for requesting that the court issue the warrant. See D.C. Code § 24-501(i). Upon the U.S. Attorney’s motion, the court issues the warrant. The warrant is filed in the court jacket and a copy is sent to the U.S. Marshal Service. The Marshal’s office enters the warrant in the NCIC, a nation-wide law enforcement information system, and it remains in the system indefinitely until executed. DMH has no reason to believe that the U.S. Attorney’s Office, the courts, or the Marshal Service have failed to carry out their duties under the law.

It is not surprising that the U.S. Attorney’s Office and the Superior Court “had no record of bench warrants being issued” in 26 of 30 cases as the OIG report indicates. It appears that the United States District Court committed those 26 consumers prior to court reorganization; therefore the Superior Court would have no record at all in those cases. Bench warrants in those cases would have been requested from and issued by the District Court. DMH can understand why the U.S. Attorney’s Office would not have copies of the bench warrants, because the warrants themselves are not distributed by the courts to anyone but the Marshal Service. In fact, the Warrant Office at the Superior Court will not permit review of warrants on file there.

In addition to requesting bench warrants in all cases of unauthorized leave, St. Elizabeths periodically make efforts to update the status of forensic patients on unauthorized leave (or "UL"). For example, approximately four years ago, the staff at St. Elizabeths' JHP conducted a painstaking review of all UL cases and updated the status of those individuals. In addition, in April 2000, St. Elizabeths requested in writing that the U.S. Attorney's Office follow-up on forensic patients who remained on UL and provided that office with a current list.

The OIG report contains some statements that indicate a flawed understanding of the District's forensic commitment laws and procedures. For instance the report states that the hospital's review board presents findings to the "sentencing court." However, persons committed to JHP following a not-guilty-by-reason-of-insanity adjudication are not "sentenced" but committed for an indeterminate period until the court determines after a hearing that they have recovered sufficiently that their release will not endanger themselves or the public. *See* D.C. Code § 24-501. The report also errs in making reference to 18 U.S.C. § 4241, which is a federal statute under which the United States District Court commits defendants to the custody of the Attorney General, who typically places them at various U.S. Bureau of Prisons medical centers around the country, not at St. Elizabeths.

The same page of the report observes that the average length of stay for criminally committed patients at St. Elizabeths is 20 years, and that, "[a]lthough DMH personnel maintained no formal records," some patients are granted passes to leave the campus for short periods of time after at least ten years. The next page makes a clearly inaccurate reference to a "60-year committed patient." Taken together, these comments create the impression of a psychiatric warehouse from which chronically ill persons, after long-term confinement, are granted unsupervised access to the community at the whim of hospital staff. Nothing could be further from the truth.

First, the statement regarding a lack of formal records is ambiguous and misleading. *Every* pass to leave the campus is documented by a doctor's order written in the patient's chart. Second, while the average length of *commitment* is in the range of 20 years, commitment does not equate with *hospitalization*. From the moment a person is committed to the hospital, DMH bears the legal duty to provide treatment designed to foster the person's recovery so that he or she can eventually return to the community without endangering self or others. Forensic consumers, just like their civil counterparts, have the right to be treated in the least restrictive appropriate setting. Therefore, the hospital must allow patients gradually expanding opportunities for access to the hospital grounds as their conditions improve and their risk potential abates. This process is not guided by a pre-determined timetable that would forbid a patient from having access to the grounds for ten years or more. The hospital's review board will extend the patient grounds privileges when his or her condition warrants it, taking into account public safety. In any event, only the court, after a motion and hearing, can grant unsupervised access to the community; and the person remains *committed* unless and until the court grants unconditional release from commitment.

The OIG report cites the "more recent case" of a patient who was charged with a homicide while on unauthorized leave. In response to this alleged homicide, which occurred after the close of the OIG audit period, DMH convened a panel of outside experts to evaluate the process the

hospital uses to assess forensic consumers' readiness for expanded access to the grounds or the community. The OIG report should have at least included discussion of this action since it included these facts. DMH has also taken other steps that should result in enhanced security of the hospital grounds and a reduced incidence of unauthorized leave. As noted above, DMH has completed the painstaking process of consolidating all of the hospital's operations on the east campus, thereby substantially reducing the hospital perimeter. DMH has also recently improved the caliber of our security force.

Having said that, DMH must emphasize, that St. Elizabeths Hospital is a hospital, not a prison. The hospital will continue to grant patients, both civil and forensic, unaccompanied access to the hospital grounds in order to meet obligations under *Dixon v. Williams* to promote their recovery and satisfy the requirement of the least restrictive setting. Balancing a patient's needs for recovery against public safety is often a delicate balance, but one DMH must undertake countless times every day. Though DMH strives to employ best practice methods in making these decisions, in the end they are not guided by precise scientific methods. It is inevitable that hindsight will "prove us wrong" at times. The best DMH can do is minimize the frequency and the consequences of such incidents. The only way to guarantee such incidents do not happen is to lock the hospital door and throw away the key. There are strong, legal, moral, and fiscal reasons why DMH cannot do that.

**4. The OIG's Conclusion that the Recommendations Have No Monetary Implication May Be Accurate, However There Are Serious Budgetary Consequences**

The "Summary of Potential Benefits Resulting From Audit" that appears on page 26 of the OIG report contains a cost benefit analysis that concludes that there are no monetary implications in accepting all of the recommendations; however, there are serious budgetary implications that will require additional funding. Clearly the OIG Recommendations #3-6 and 8 have staffing and training implications that could amount to millions of dollars.

For example, based on a current DMH assessment of OA staffing needs, to implement OIG Recommendation #3, OA/DQI would need to hire at least two additional staff, beyond its current staffing of three full-time equivalents<sup>3</sup> to investigate and resolve all UIs, as you have recommended. Note that the current OA/DQI staff also conduct and resolve dozens of patient rights investigations per month that do not rise to the level of a UI and are generally not reported in the UI database.

The OIG Recommendation #5 to "develop and implement a computerized database to document and track all UI reports" also has budget implications; any data systems enhancement implicates spending for that enhancement. Staff would need to be trained on how to use the system enhancement, so there is an additional cost associated with the training. In addition, the OIG staff may have misunderstood DMH operations with respect to the database that is needed for UI reporting by the Department, St. Elizabeths and the public Core Services Agency. Each would need its own reporting system, not one that is joined. DMH requires that St. Elizabeths and the

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<sup>3</sup> The current OA/DQI staff that handles the MUIs will soon be transferred to the Office of Consumer and Family Affairs where they will be responsible for processing consumer grievances and not investigating UIs.

reporting by the Department, St. Elizabeths and the public Core Services Agency. Each would need its own reporting system, not one that is joined. DMH requires that St. Elizabeths and the PCSA report UIs like any other provider and investigates them and requires corrective action as it would from any other provider.

To implement OIG Recommendation #6, for example, to improve security procedures at St. Elizabeths, has huge budgetary and management implications. DMH has already conducted an assessment to improve security, which indicates as much.

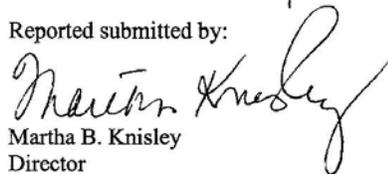
To implement OIG Recommendations #7 –9, to develop a procedure for mortality reviews and root cause analysis have both staffing and training implications. Current and any new staff would need to receive expert training on the techniques to conduct both.

Despite the budget implications, DMH is moving forward to implement the OIG recommendations, as DMH believes that they will further streamline UI reporting, mortality reviews and St. Elizabeths security.

#### CONCLUSION

In closing, DMH urges the OIG to take a more balanced view of the improvements that DMH has made to improve its UI reporting process, death reporting and mortality review process and security at St. Elizabeth and fairly represent the progress that DMH has made to date and plans to make in the near future. DMH has committed significant resources in the past to improve a number of functions referenced in the OIG report well before the report was issued. DMH continues this commitment to direct resources it needs to make the needed improvements in the system and to timely implement the Work Plan that it has provided with this response.

Reported submitted by:

  
Martha B. Knisley  
Director

Cc: Mr. John A. Koskinen, City Administrator  
Ms. Carolyn Graham, Deputy Mayor for Children, Youth, Families and Elders

District of Columbia  
 Department of Mental Health  
 Office of Accountability  
 6/4/03

**Work Plan for Corrective Action Plan in Response to D.C. OIG Auditor Report**

**"Audit of Unusual Incident Reporting Procedures at the District of Columbia Department of Mental Health"**

#	OIG Recommendation	Corrective Actions Taken	Corrective Actions Planned	Responsible Party	\$ Impact	Due
1	Create an oversight mechanism (committee) or internal audit team to monitor the efforts of the OA to ensure that the unusual incident reporting system is operating effectively. Monitoring efforts should include monthly reports to the Director, DMH.	Incidents are reviewed on a monthly basis in the DMH Risk Management Committee. Incident reports is a standing agenda item for the Risk Management Committee. CSAs and Saint Elizabeths Hospital will submit monthly reports of unusual incidents to the Risk Management Committee for review, discussion and action. The OADQI will report Major Unusual Incidents to the Risk Management Committee.	OADQI will issue an Unusual Incident Reporting Policy in 2003 to complement the Major Unusual Incident Policy issued in 12/2002. OADQI will audit all CSAs starting in 2003 for compliance with the Unusual Incident Reporting Policy. The Risk Manager will report to the Director of DMH a summary report of all CSA and Hospital unusual incidents.	Risk Manager, CSAs, SEH, DQI	none	Summer 2003
2	Develop and implement performance standards for the OA.	Performance standards already included for OA - Deputy Director's performance contract.	This activity has been completed.	Director DMH/Deputy Director OA	none	Complete
3	Develop procedures to ensure that the OA reports, investigates, and resolves all unusual incident reports in a timely manner.	OA issued Major Unusual Incident Reporting Policy 12/2002. OA in process of hiring staff for incident investigations in Summer of 2003.	Revise and disseminate unusual incident reporting policy to include the MUJ policy and reporting requirements for CSAs, CRFs and Saint Elizabeths Hospital; OADQI to prepare staffing need analysis and submit to Director DMH.	Deputy Director OA; Director Quality Improvement	OA/DQI staff needed to investigate MUJs, audit and monitor community providers in their implementation of unusual incident reporting	Summer 2003
4	Take corrective action against providers who do not report unusual incidents in a timely manner.	DMH takes corrective actions as appropriate and has authority to sanction providers who fail to comply with standards.	Include the use of Corrective Action Plans in the new Unusual Incident Reporting Policy. Take corrective actions against providers who do not report unusual incidents in a timely manner, including issuing Notices of Infractions.	Deputy Director OA; OA Directors Quality Improvement and Licensure	OADQI staff needed to investigate MUJs, audit and monitor community providers in their implementation of unusual incident reporting	Summer 2003

5	Develop and implement a computerized database to document and track all reports of unusual incidents.	OA Major Unusual Incident database updated and revised in early 2003 to have reporting and monitoring capability; OA presently investigating the use of more comprehensive database systems in 2003 (i.e., NYDMH Incident Reporting System)	Develop options for this area. Review possible use of NYState Incident Reporting System.	Chief Information Officer; Deputy Director OA; Director of Quality Improvement	Preliminary estimated programming costs approximately \$100,000 for software modifications	Fall 2003
6	Review and evaluate security procedures at Saint Elizabeths Hospital to ensure the safety and security of mentally incapacitated persons.	Conducted Phase 1 evaluation of the risk assessment and procedures used at St. Elizabeths JHP for granting or denying privileges to forensic patients.	Complete Phase 2 of the evaluation.	CEO, Saint Elizabeths Hospital	facility modifications estimated at approximately \$6 million	Summer 2003
7	Revised the CMHS policy 50000.115.3E to require periodic reviews of mortality review reports.	OAI/OI has prepared Incident Investigation Guidelines, Consumer Death Determination procedures and documentation forms, and drafted new Mortality Review Policy. Reviewed by Chief Clinical Officer. Policies to be forwarded to Policy and Procedure Committee for review and approval.	Drafted policy on Death Investigations and Mortality Review to be reviewed and approved by Policy Committee; disseminate and train providers thereafter.	Chief Clinical Officer; Director of Quality Improvement	One (1) FTE needed to Coordinate Mortality Reviews	Fall 2003
8	Develop and implement procedures to ensure that all deaths are investigated and mortality review reports are timely performed and properly completed.	see above	see #7 above	Chief Clinical Officer	see above	Summer 2003
9	Initiate procedures and assign responsibility to ensure root cause analyses are performed on all unexpected occurrences involving death or serious psychological injury.	see above	see #7 above	Chief Clinical Officer; Director of Quality Improvement	see above	Summer 2003
10	Require OA to report the completion status of all mortality reviews to Director, DMH on a monthly basis.	see above	see #7 above	Chief Clinical Officer	see above	Summer 2003
11	Require all operators of community residence facilities to retroactively report, for the time period in which the law as in effect, all unusual incidents as required and defined by D.C. Law 13-104 (from April 3, 2001 to November 14, 2001) and D.C. Law 14-70 (from February 27, 2002 to October 10, 2003, to the Inspector General of the District of Columbia.	DMH provided OIG a list of CRF operators; CRF operators trained by DMH/Division of Licensure (DOL) on unusual incident reporting in October 2002 and again in May 2003. DOL sent a memorandum to CRF operator informing them that they must report all UIs that occurred for the period the law was in effect.	Monitor for compliance through licensing reviews.	Deputy Director OA, Director of Licensure	none	On-going
12	Revise the monthly mortality review report to reflect current organizational responsibilities.	see #7 above	see #7 above	Chief Clinical Officer	see above	Summer 2003

13	Establish procedures to confirm the issuance of all bench warrants requested for forensic patients on unauthorized leave or to request the issuance of new bench warrants where appropriate.		Within the next 60 days, DMH will review the procedures to verify issuance of bench warrants and will establish appropriate mechanisms where indicated.	DMH General Counsel	unknown	Aug-03
14	Negotiate a memorandum of understanding with the U.S. Attorney's Office and the Office of Corporation Counsel to confirm the issuance of bench warrants and to provide dates and case numbers for all bench warrants issued.		Within the next 30 days, DMH will discuss OIG recommendations with U.S. Attorney's Office, Corporation Counsel and U.S. Marshal Service.	DMH General Counsel	none	Jul-03

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Office of the Inspector General**

Inspector General



August 20, 2002

Martha B. Knisley  
Director  
Department of Mental Health  
77 P Street, N.E., 4<sup>th</sup> Floor  
Washington, D.C. 20002

Dear Ms. Knisley:

The purpose of this Management Alert Report (MAR No. A-02-04) is to inform you that the Department of Mental Health (DMH) urgently needs to inform operators of Consumer Residence Facilities (CRFs), under contract with the DMH, of the reporting requirements of D.C. Law 13-104, as amended by D.C. Law 14-070, Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2001. This need became evident during our ongoing review of the DMH's unusual incident notification and reporting procedures.

**Issues**

Our review noted that the DMH's Office of Accountability (OA) had not provided the oversight needed to effectively manage unusual incidents. Our review indicated the OA did not take follow up actions needed to ensure that all unusual incidents were investigated.

A preliminary review of DMH's unusual incident notification and reporting procedures has identified more than 500 instances where operators of CRFs have not fully complied with the promulgated reporting requirements cited above. We also identified approximately 80 incidents reported by Saint Elizabeths Hospital where OA had no documentation to indicate investigations were performed.

**Background**

On January 10, 2000, the Council of the District of Columbia enacted the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 1999 (Act), which became D.C. Law 13-104, effective May 9, 2000.<sup>1</sup>

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<sup>1</sup> D.C. Law 13-104 was a temporary legislative provision that expired on December 20, 2000; however, the D.C. Council enacted follow-on temporary legislation shortly after the prior year's provision expired in 2000 and 2001. On December 21, 2000, the D.C. Council enacted the Mandatory Autopsy for Deceased Wards of

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Section 2 of the Act provides:

- (1) “Unusual incident” means any incident that results in injury or illness to a ward or resident of a nursing home, community residence facility, or group home for persons with mental retardation as those terms are defined in section 2 of the Health Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Code 32-1301) (“Health Facilities Act”).
- (2) “Ward” means any person in the official custody of the District government on a temporary or permanent basis, because of neglect, abuse, mental illness, or mental retardation.

*Id.*

Section 3 of the Act requires the Chief Medical Examiner or a qualified pathologist to perform an autopsy within 72 hours of a person’s death, if the deceased was a ward of the District of Columbia government or a resident of certain residential facilities and had not been diagnosed as terminally ill. *Id.*

Sec. 4(a) of the Act also provides that operators of the above facilities immediately notify the Department of Health and the Inspector General for the District of Columbia (OIG) of any unusual incident.

### **Findings**

#### **Operators of CRFs Under Contract With the DMH Are Not in Compliance With D.C. Law 13-104, as amended by D.C. Law 14-070.**

*Discussion.* While our final review is not yet complete, a preliminary review of DMH’s unusual incident notification and reporting procedures has identified many instances wherein operators of CRFs under contract with the DMH have not complied with statutory reporting requirements. Specifically, a review of unusual incident reports for the period January 1, 2001, to date identified more than 300 unusual incident reports for unexpected deaths, injuries, or patient abuse that had not been reported to our office.

We noted many instances where autopsies had not been performed or the results of autopsies had not been obtained for individuals who died while residing at a CRF, thereby preventing investigations and other follow-up actions. In addition, we noted one instance in which a

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the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2000, which became D.C. Law 13-244, effective April 3, 2001. D.C. Law 13-244 expired on November 14, 2001, but on November 19, 2001, the D.C. Council enacted the Mandatory Autopsy for Deceased Wards of the District of Columbia and Mandatory Unusual Incident Report Temporary Act of 2001, which became D.C. Law 14-070, effective February 27, 2002. D.C. Law 14-070 expires on October 10, 2002. Finally, please note that none of these temporary laws have been codified in the D.C. Code.

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CRF patient's prior unreported injuries could have signaled patient abuse. A reporting of those injuries may have prevented the patient's unexpected death.

**DMH's Office of Accountability Has Not Provided Independent Oversight or Effectively Managed Unusual Incidents**

*Discussion.* DMH policy Notice 500000.480.1 established the OA as the central location for receipt of written copies of all major unusual incident reports. The policy applies to DMH's Community Service Agency, Saint Elizabeths Hospital, CRFs and all other providers of mental health services or mental health supports that are licensed or certified by the DMH.

Our review of over 500 unusual incident reports forwarded to the OA for the period January 1, 2001, to date, indicated no follow-up investigative action taken by OA on any of the reported incidents. About 80 of these incidents occurred at Saint Elizabeths Hospital and involved unexpected deaths, alleged assaults, and attempted suicides. OA procedures for reviewing Saint Elizabeths Hospital's unusual incident reports consisted of and were limited to filing the incident reports. OA made no requests for additional information, took no follow up actions, and performed no investigations.

We recognize that by definition, D.C. Laws 13-104, 13-244, and 14-070 do not mandate that Saint Elizabeths Hospital report unusual incidents to the OIG or the Department of Health. However, we believe that the intent of these laws was and is to provide both the Department of Health and the OIG with oversight authority for independent investigations of unusual incidents. DMH's OA was also, in our opinion, established for the same purpose. Our review indicates OA needs to implement an effective oversight program to ensure appropriate follow up on reported unusual incidents and to ensure that incidents reported by Saint Elizabeths Hospital have been fully and independently investigated. Given the OIG's investigative purview and the absence of investigations into unusual incidents reported to OA by Saint Elizabeths Hospital, we believe that an amendment to D.C. Law 14-070, and any permanent legislation that may follow, requiring Saint Elizabeths Hospital to report unusual incidents to the OIG may be appropriate. Once you have responded, we will share this concern with the Office of the Corporation Counsel and seek their counsel on implementing a legislative change.

**Recommendations**

In light of the issues raised in this MAR, we recommend that the Director, Department of Mental Health:

1. Modify all existing contracts with Community Residence Facility operators to incorporate the provisions of D.C. Law 14-070.

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2. Require all operators of Community Residence Facilities to retroactively report all unusual incidents, as defined by D.C. Law 14-070, to the OIG from the enactment of the D.C. Law 13-104 to the present.
3. Require Saint Elizabeths Hospital to retroactively report to the Inspector General for the District of Columbia all unusual incidents from enactment of the D.C. Law 13-104 to the present.

**Conclusion**

Although there is a time lapse between the expiration date of a prior year's temporary legislation and the effective date of the succeeding temporary provision, it seems clear that the D.C. Council's legislative intent was to maintain an unbroken succession between those temporary laws. Therefore, if your records reflect that an "unusual incident" occurred at a nursing home, CRF, or group home for persons with mental illnesses on a date where there was a brief lapse in legal coverage, we believe the spirit of the law would require reporting those incidents to this Office.

Please provide your comments and responses to the recommendations by **August 30, 2002**. Your response should include actions planned or taken, target dates for completing planned actions, and reason(s) for any disagreements with the issues and recommendations. You may suggest alternative actions that would resolve the conditions disclosed in this report.

Our intention is to limit the distribution of this Management Alert Report until comments are received. Therefore, please circulate it only to those personnel who will be directly involved in preparing your response. The findings in this MAR are part of a work in process, with additional audit work progressing on the overall issue of unusual incident reporting. The completed audit of unusual incident reporting will be the subject of a separate report that incorporates the preliminary results shown in this MAR.

Should you have questions concerning this report or desire a conference before preparing your response, please call me or William J. DiVello, Assistant Inspector General for Audits, at (202) 727-2540.

Sincerely,

  
Charles C. Maddox, Esq.  
Inspector General

CCM/ws

cc: John A. Koskinen, City Administrator