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Speaking out for people with
Intellectual & Developmental Disabilities

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Widespread Abuse, Neglect and Death in Small Settings Serving People with Intellectual Disabilities 2003 - 2005

Since 1997, VOR has been tracking media coverage highlighting the increasing need for more effective federal and state protections in the ever-expanding community system of care for people with Intellectual and Developmental Disabilities

NOTE: LINKS IN SOME OLDER ARTICLES MAY NO LONGER BE ACTIVE

Virginia

Times-Dispatch, December 18, 2005
New stakes for study of group homes

A legislative study of group homes is expected to produce proposals for new laws to toughen the regulation of group homes in Virginia and require a closer look of how public money is spent on the care of troubled youths.

For state and local policymakers, there is evidence that Virginia isn't doing a good enough job in making group homes accountable for the care they provide at public expense under the Comprehensive Services Act, or CSA.

"The state has a laissez-faire approach to regulation and monitoring," he said, "resulting in a system that is extremely costly and not necessarily providing the quality of care that the kids deserve."

A legislative subcommittee plans to introduce legislation that would:

- Make the state put the new law into effect immediately.
- Tighten the standards for licensing and regulating group homes.
- Order a study by the Joint Legislative and Audit Review Commission of the rates charged under the Comprehensive Services Act, which pays for treatment of children primarily through a combination of state and local funds. The federal Medicaid program also contributes money for care under the system.

The state licenses and regulates group homes, as well as other kinds of treatment facilities, through four different agencies that in some way handle children with problems. The system includes children in foster-care, special-education and mental-health programs, and the juvenile-justice system.

Washington, D.C.

The Washington Post, November 29, 2005
4 Deaths in D.C. Group Homes Raise Concerns About Neglect

The District government is failing to provide adequate care for mentally and physically disabled residents in its group homes, according to a court monitor who found that a pattern of neglect led to four deaths in the past year. One woman and three men "are dead because they did not receive timely and competent health care," court

monitor Elizabeth Jones said in a newly released report. Jones expressed "grievous concerns" about the health and safety of hundreds of disabled people who live in the group homes, especially those with special health risks. The deaths, she warned, "reflect the lack of meaningful safeguards in the system." The four deaths might have been prevented if the city's Mental Retardation and Developmental Disabilities Administration had followed up on earlier recommendations for improving care in the homes -- and if the agency's case managers had been more vigilant in addressing critical problems, wrote Jones, whose staff reviewed medical records and death investigations. Sandy Bernstein, legal director for University Legal Services, which represents the plaintiffs in the suit against the District, criticized what she called "short-term approaches" to dealing with such serious failings by the city. The suit covers about 700 plaintiffs, all former residents of Forest Haven, a now- defunct institution for the mentally retarded. Another 1,300 plaintiffs are special-needs clients of the agency.

http://www.washingtonpost.com/wp-dyn/content/article/2005/11/28/AR2005112801887.html

Washington State

Seattle Post Intelligencer, Nov. 16 – 18, 2005
Public Protection, Private Abuse (Mentally disabled preyed upon in state system)

11 articles in a three part series look at for-profit companies, contracted by the state, to closely supervise dangerous developmentally disabled people in the community. While the costly program does protect the public in many cases – most of the clients are sex offenders – it has left other vulnerable adults with developmental disabilities at risk of abuse and neglect.

The investigation of the Community Protection Program was based on multiple public disclosure requests to the Department of Social and Health Services which led to the release of more than 12,000 pages of documents. That included incident reports, recertification reviews of residential providers, financial reports and policy documents. http://seattlepi.nwsource.com/specials/protect/

South Carolina

The State, October 28, 2005
State needs investigators to handle abuse and neglect cases, group says

Reports of abuse and neglect of disabled South Carolinians are too often mishandled and those responsible are rarely held accountable, according to a watchdog group. Protection and Advocacy for People with Disabilities Inc. released a report on a two-year study Thursday, highlighting 50 cases that included physical and sexual abuse and deaths in state-funded community-based residential facilities. The authors, who focused the study on the state Department of Disabilities and Special Needs, say the report portrays a broken system that provides little protection for those who cannot protect themselves. The report found flaws in the way many of the cases were handled, stemming largely from the practice of allowing facility administrators to conduct their own investigations into abuse claims rather than alerting law enforcement immediately. The state should create an independent agency, preferably within the State Law Enforcement Division, to investigate all abuse claims immediately, the report says. The agency would include specially trained investigators who know how to work with mentally disabled adults. The issue of abuse at state-funded care facilities came to the fore in recent years when a series of audits of the Babcock Center uncovered cases of abuse, neglect and exploitation of its residents.

National

The Wall Street Journal, September 20, 2005
Difficult Choices: Needing Assistance, Parents of Disabled Resort to Extremes

Nationwide, an estimated 80,000 developmentally disabled people are waiting for in-home help or an opening in a group home. Some have been on waiting lists for more than a decade. In Texas, there are 46,000 people waiting for such help -- or about four times the number of people actually receiving assistance. Requests are increasing as the nation's 4.6 million developmentally disabled, like the rest of the population, are living longer. Meanwhile, their parents are aging too, making it harder to keep up with caretaking.

Long waits for help have prompted lawsuits in two dozen states, charging violations of a 1999 Supreme Court decision requiring states to make diligent efforts to serve disabled individuals in their community. Florida settled one suit in 2001, promising services to 17,000 people on waiting lists. By increasing spending, it did. Since then, the waiting list has ballooned again, to more than 15,000.

Indeed, even though public spending to provide community services to people with developmental disabilities grew by 17% between 2000 and 2002 – to about $27 billion -- demand for those services continues to outpace availability. Federal funds, primarily Medicaid, provide 50% of that $27 billion, with states kicking in 46% and local funds the remaining 4%.

"Unless you're in a crisis, you don't get services. I'm sure that's the case in most states," says Tony Paulauski, executive director of ARC of Illinois, part of a national, nonprofit organization for the developmentally disabled.

National

The Wall Street Journal, September 13, 2005

Safe Place: Disabled People Find Group Homes Can Be Broken too – Patients Gain Independence, But Oversight is Spotty; Challenges of Monitoring

Over the past three decades, there has been a concerted effort to move people with developmental disabilities out of large institutions, which had been long criticized for being overcrowded and isolated. A widely lauded effort to move people into smaller group homes has succeeded in bringing the developmentally disabled into communities where they can learn new skills, get jobs or attend special schools. But this progress has come at a price. It has strained the systems that support people living in the smaller settings and created big gaps in oversight.

Twenty-five years ago, people with developmental disabilities lived in about 16,000 publicly funded homes. Today, they are scattered in about 140,000.

"The systems of quality monitoring have really been taxed beyond what they can manage," says Charlie Lakin, who heads a University of Minnesota program that tracks services to the developmentally disabled. "By and large, a lot of it is pretty loosely organized and pretty loosely monitored."

Only a half-dozen states require that residential programs serving the developmentally disabled be accredited by an independent third-party organization. Developmental disabilities, which affect about 4.6 million people in the U.S., include a range of mental and physical impairments, such as cerebral palsy, autism and mental retardation. Babcock (South Carolina community provider) offers a stark look at the flawed monitoring of group homes, which sometimes leaves family members and other advocates feeling they need to police the care themselves.

The U.S. Department of Health and Human Services -- which pays about half of the $27 billion spent annually on community services for the developmentally disabled -- is ultimately responsible for their protection. But the federal agency assigns the creation and enforcing of rules over such homes to each state. As a result, laws and monitoring vary by state. States aren't required to report all incidents of abuse or neglect to the federal agency. The federal government typically only gets involved if families, advocates or employees of homes provide credible concern about the thoroughness of a state investigation. HHS, which oversees the Centers for Medicare and Medicaid Services, is drafting new procedures following a 2003 report from the General Accounting Office, saying states should be required to report more information about how they protect people with developmental disabilities.

Thousands of nonprofit group homes offer well-supervised programs for the developmentally disabled. But problems exist to some degree in nearly every community, says Curtis Decker, executive director of the National Disability Rights Network, a nonprofit group. Investigators may overlook flaws, he says, because of a lack of other housing options. "They don't know what to do with these folks if they closed a place down." The number of

abuse and neglect cases among the developmentally disabled isn't collected nationwide. Many states don't keep central databases on employees involved in such cases, allowing workers to move from one agency to another. "You put people in tough jobs, who are underpaid, not well-trained or supervised, and the potential for abuse is big," says Mr. Decker. "It's endemic to the country."

Missouri

Missouri State Auditor, September 2005
Report No. 2005-62: State mental health clients not fully protected from abuse and neglect due to problems with incident investigations and abusive workers still employed

This audit reviewed how well the Department of Mental Health tracks, investigates and handles incidents and investigations of individuals committing abuse or neglect against its 140,000 clients. All such allegations, including client deaths are tracked in the department's Incident and Investigation Tracking System, which reported 5,689 incidents from July 2003 through August 2004. This audit also followed up on recommendations from a 2001 audit and found systemic problems with abuse investigations. The audit found continuing problems in several areas, including continued employment of known felons and abusers, leading to more abuse, and overall lack of independence and consistency in abuse investigations.

Maryland

The Baltimore Sun, April 10-17, 2005
A failure to protect – Maryland's troubled group homes.

In an investigation of state oversight of group homes going back a decade, The Sun found that:

- Mistreatment of children has gone unpunished.
- People with criminal convictions can -- and do -- work at group homes.
- Taxpayers' money is often wasted on poor care, denying youths a range of services.
- Maryland subsidizes high salaries and perks.

The Sun examined the regulation of care, spending and staffing at 25 companies that ran 120 homes for children. Reporters studied 15,000 pages of inspection reports, case files and other records obtained under the state's Public Information Act and conducted more than 150 interviews.

Florida

The Miami Herald, March 26, 2005 Deaths at group homes being probed

In light of cost-cutting changes in nursing care, an investigation is under way into the deaths of four disabled Floridians at group homes. A federally-funded watchdog group is investigating the recent deaths of four disabled Floridians amid an aggressive state campaign to cut millions of dollars from programs that provide medical care for disabled people in community settings. In 2001, the state hired a private company, Maximus Inc., to look for ways to save $24 million annually. The company's actions have been upheld in 97 percent of the appeals to state officials. Advocates for the disabled insist the quality of medical care for disabled people in group homes has suffered since September when Maximus and the state began requiring group homes to pay for nursing care from the state's Medicaid plan. That plan covers rotating nurses, not the more stable nursing care provided under a previous plan for disabled people.

National

People with Mental Retardation & Sexual Abuse - The Arc of the United States
(author: Leigh Ann Reynolds, M.S.S.W., M.P.A., Health Promotion & Disability Prevention Specialist)

More than 90 percent of people with developmental disabilities will experience sexual abuse at some point in their lives. Forty-nine percent will experience 10 or more abusive incidents (Valenti-Hein & Schwartz, 1995).

Other studies suggest that 39 to 68 percent of girls and 16 to 30 percent of boys will be sexually abused before their eighteenth birthday. The likelihood of rape is staggering: 15,000 to 19,000 of people with developmental disabilities are raped each year in the United States (Sobsey, 1994).

North Carolina

The Charlotte Observer, January 16, 2005 Millions Wasted – The Cost of Kids' Lives

Since 2001, the state has wasted tens of millions of dollars paying group homes for workers who were never hired, making the industry so lucrative that hundreds of new homes opened – so many that the state couldn't regulate them. The error helped create a system that's failing some of the state's most vulnerable youngsters and cheating taxpayers who pumped more than $165 million into homes last year. In the past three years, as group homes multiplied and regular inspections ceased, many group home owners exploited the system's weaknesses. Many ignored even the state's minimal standards, putting children at risk.

California

California Department of Developmental Services (DDS), October 27, 2004 California Releases Mortality Studies

During the late 1990s, a series of epidemiological studies of death rates in California mental retardation institutions compared community residential settings was issued by the University of California Riverside. These reports found risk of mortality to be 83% higher in community settings than in institutions (see, http://www.lifeexpectancy.com, link Articles, Comparative Mortality). These studies prompted the California Department of Developmental Services to commission two follow-up studies. Comparing quality of care provided by developmental centers, community care facilities, intermediate care facilities and other settings, the report indicates, "there were few statistically significant differences in the quality of care, "though it was noted that the developmental centers provided a 'higher quality of care.'" One problem in determining the adequacy of health care for this study was the lack of documentation. Except for developmental centers, the lack of documentation was an issue for all other types of facilities. Another issue pointed out by the authors of the report is the need for health education appropriately geared for the developmental level of the consumer. An earlier report (1994) noted that "residents at developmental centers were significantly less likely to die from preventable causes than those residing [in] skilled nursing facilities, intermediate care facilities, or community care facilities." The preventable deaths were primarily due to "inadequacies in the quality of care" followed by "inadequacies in the medical management of common health concerns."

http://www.lifeexpectancy.com/articles.shtml

Maryland

The Baltimore Sun, August 1, 2004
Safeguards meant to protect the disabled in Maryland group homes failed this time

Toby Adele Heller died of colon cancer 11 months after caretakers failed to follow a physician's advice to see a gastroenterologist. Toby's case exposes holes in the state system of care for 5,000 people with developmental disabilities living in licensed group home facilities. Employee turnover is high – 42 percent a year among aides – and wages are low. Even with the recent state-imposed increases, caregivers on average make less than $10 an hour. Quality of care varies with their skills and compassion. And regulators rely heavily on the facilities and families of residents to report problems. But, with nearly 7,000 people on a waiting list for residential services, relatives are often afraid to complain, fearing that their loved ones would have nowhere else to go. Still, Toby's family, like other families, had every reason to expect that she was getting good care: The state was paying top dollar for her to receive round-the-clock staffing at a cost of $127,672 a year. Her provider, Autumn Homes, received $2.6 million from the state to provide services for 32 clients in 2003.

Virginia

The Washington Post, May 23 – 27, 2004 Assisted Living in Virginia

In a series of articles this week, The Washington Post reported that residents at the facilities have suffered thousands of incidents of harm, including death, abuse, neglect and serious injuries. The state is home to 627 facilities licensed to care for more than 34,000 residents who need supervision and care but who are not sick enough to qualify for a nursing home. The problems stem from several causes, including poor staff training, insufficient resources and relatively weak enforcement by state regulators, according to records and interviews.

Michigan

The Detroit News, May 5, 2004 Group home abuses escalate

The March 29 beating joins a growing number of complaints about abuse at Michigan group homes, where many of the state's most vulnerable citizens are cared for by employees with low wages and limited training. Last year, the state of Michigan fielded 1,898 complaints about adult group home conditions. That represents a sharp rise compared to 2002, when there were 1,300 total complaints statewide. An estimated 35,000 people live in more than 4,200 state-licensed adult foster care facilities in Michigan. In general, the staff members are paid fast-food wages and given about two weeks of training before they take over the care of the mentally ill and developmentally disabled adults in the homes.

Massachusetts

The Patriot Ledger, March 20 – 23, 2004
Special Report: Retarded at risk; System failures

When it comes to medical care, some of the state's most vulnerable residents, the 8,700 adults who live in group homes for persons with mental retardation, are treated as second-class citizens. Since 2002, three group home residents died because of medical neglect and nine other deaths are under investigation. Since 1999, more than 260 cases of physical abuse and medical error involving the disabled have been substantiated each year. Often, when something goes wrong, on one is held accountable.

Virginia

The Virginia Pilot, February 29, 2004
Special Report: Virginia's treatment of the mentally disabled

Was it truly their time to die, or could their deaths have been prevented? The answers are difficult to find, mostly because the state, which used to be the primary caregiver for the mentally disabled, has surrendered much of that role to a patchwork system of community-based programs, such as group homes. The homes, 106 of them in South Hampton Roads, operate with low-paid, minimally trained workers. They churn along with a steady stream of money from the state and federal government, but with little oversight from either. The state employees 12 inspectors to monitor 2,468 mental health, mental retardation and substance abuse service locations, including group homes. That's an average caseload of 206 locations per inspector. A single inspector has responsibility for all of South Hampton Roads, except Portsmouth. Accidents and injuries are supposed to be self-reported by the provider, but may go unreported. Deaths do not have to be reported to the medical examiner. State records that do exist show problems. Of 34 group home providers in South Hampton Roads, 18 have been cited for state licensing violations and 11 for client abuse or neglect in the past three years. The state has legal authority to fine violators but never has done so. Only one provider's license has been revoked in the past three years. [Internet Access: http://www.hamptonroads.com/pilotonline/]

Indiana

The Times Newspapers of Northwest Indiana/S. Chicago, January 25, 2004
Caring for our invisible citizens; Developmentally disabled caregivers often overworked, undertrained, unqualified

A severe shortage of direct care providers across the country has stemmed from a mass exodus of state institutional care. The result is an annual turnover rate ranging from 50 to 75 percent due in part to low wages. Indiana had no state standards for direct care providers until late 2002. These standards, however, still allow the hiring of individuals regardless if they have employment experience or training of any kind. In addition, no required registry exists for these employees if they are fired from one agency for alleged neglect or abuse and then hired at another agency. Critics said the old threat of state-run institutionalized care has been replaced by a new danger - the big business of private care. That machine is fed by money from the Medicaid waiver program, a financing arrangement that relieves clients from traditionally strict care regulations. In 2003, Indiana's Family and Social Services Administration received 467 formal complaints against some of the approximately 850 approved private providers. Some complaints were minor, some more significant, resulting in corrective actions.

New Mexico

The Albuquerque Journal, November 18, 2003
State Probes Abuse of Disabled

Gov. Bill Richardson has ordered an independent inquiry to track down former residents of the now-closed Los Lunas Hospital and Training School. Richardson's order follows publication of news stories about three developmentally disabled women who were discharged from the Los Lunas facility more than 20 years ago and placed in the unlicensed home of a staff housekeeper and her husband. The goal of the investigation announced Monday is to find whether any more of the former residents may have "slipped through the cracks," receiving no state services and no monitoring. [Internet Access: http://www.abqjournal.com]

New Mexico

The Albuquerque Journal, November 3, 2003
Judge Won't Halt Disability Suit: State's Request for Stay Rejected

The Jackson class action lawsuit, filed in 1987, resulted in the closure of Los Lunas and Fort Stanton State Developmental Centers and the court-ordered transfer of residents into group homes and other community settings. In 1997, the parties reached an agreement intended to be a blueprint for ending the lawsuit once certain benchmarks were reached. Oversight has since ended in about two-thirds of the areas. The state's motion to dismiss the case, arguing that all requirements have been met, failed in light of evidence that there remained pronounced shortcomings in providing safety for New Mexicans with severe disabilities. Attorney for the plaintiffs, Peter Cubra, told the judge that there had been more than one death of class members per month over the past 20 months. The state lacks an effective system for dealing with neglect and abuse when it occurs and for preventing its recurrence, plaintiffs argued. Arc attorney Maureen Saunders cited instances where guardians for clients had learned of problems at group homes operated by contract providers and had informed both providers and the state about them. She said she received no response or one that was delayed for months.

Illinois

The Chicago Tribune, September 1, 2003
Report blasts group homes – Dirty, unsafe conditions cited

Developmentally disabled residents of six Chicago-area group homes endured filthy and unsafe living conditions, frequently going without toilet paper, while the homes' owners spent thousands of dollars of leased cars and other perks, a disability-rights watchdog group said in a new report. Surprise inspections at the homes, operated by These are God's People Too, found dark, "foul-smelling" homes, walls smeared with feces, bathrooms without toilet paper and "unkempt yards strewn with garbage," said the report by a non-profit group that the state has designated to "protect and advocate" for the disabled. The investigation, conducted from March 2002 to June 2003, also found safety hazards, such as blocked exits and easily accessible cleaning products, as well as staff members unfamiliar with proper techniques for restraining unruly residents, the report said.

National Policy Research Brief (University of Minnesota), September 2003 Medicaid Home and Community-Based Services: The first 20 years

HCBS and other community services for persons with mental retardation and developmental disabilities have grown at an extremely rapid rate during the past decade. This growth and the nature and flexibility of HCBS have brought enormous challenges in monitoring of service quality and protecting persons receiving them. States have not been able to expand quality assurance (QA) systems commensurate with this growth. But even if they had, they would have had to adjust to new expectations. What was considered "quality" in community services in 1982 or even in 1992 no longer satisfies contemporary values. Today, definitions of quality in human services require attention to dimensions of quality of life in addition to protection of health and safety. A few states have established systems for quality review that attend to the new concepts of quality (see Bradley & Kimmich, 2003; www.qualitymall.org) and over the past decade there have been persistent concerns about whether they attend sufficiently even to the basics of health and safety. A March 19, 1993, House hearing called by Rep. (now Senator) Wyden examined the quality of community services and concluded, "State public officials charged with their oversight had little or no knowledge of the conditions within their homes…or at best found out only after terrible events had occurred." The Wyden hearing was followed by newspaper stories of the inadequate, life-threatening, sometimes life-ending quality in community services published in several major newspapers in the late 1990s and early 2000s (e.g., Washington Post, San Francisco Chronicle, Minnesota Star Tribune, Hartford Courant). They stimulated emotional reactions, defensive responses, and promises to do better. But, in June 2003 the General Accounting Office (GAO) issued a new report critical of QA in Medicaid HCBS. Although focused primarily on HCBS for elderly people, it recommended that the federal government: "1) establish more detailed criteria regarding necessary components of HCBS QA systems; 2) require states to submit more specific information about QA approaches prior to approval; 3) ensure that states provide sufficient and timely information in their annual reports on efforts to monitor quality; 4) develop guidance on the scope and methodology for federal reviews of state programs; 5) ensure allocation of sufficient resources for conducting thorough and timely reviews of quality in HCBS and hold regional offices accountable for such reviews" (GAO, 2003, p. 5). Clearly, addressing challenges of creating effective quality assurance systems will require leaders that believe that the safety, well-being and quality of life of people with mental retardation and developmental disabilities deserves public investment in a time when other substantial needs are competing for that investment.

Colorado

The Denver Post, August 11, 2003
State Medicaid program a mess, participants say; Oversight at issue in waiver care

Medicaid clients and advocates report failures by state officials to adequately monitor the care patients received through the state home and community-based waiver program. State regulators have known about holes in quality oversight since a scathing report two years ago, but say that policing home care is tough with the little power state legislators have given them. Complaints range from theft and negligence by in-home caregivers to allegations that aides forced patients to sign false time sheets and that caseworkers kept people from qualifying for service. Some clients say they've waited for years for the state to address complaints about shoddy service or forgotten care – with no response. A report issued by the Colorado state auditor in June 2001 found that investigators of Medicaid waiver-related complaints sometimes waited months to follow-up, spent far less time investigating complaints than other states did, kept inadequate records of investigations, and were far less likely than investigators elsewhere to cite health providers with deficiencies even after multiple complaints.

National

U.S. General Accounting Office, July 2003
Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should Be Strengthened (Report No. GAO-03-576)

Despite a growing number of home and community-based waiver beneficiaries (up to almost 700,000 as of 1999), State waiver applications and annual reports for waivers contain little or no information on state mechanisms for assuring quality in waivers, thus limiting the information available to the federal government. GAO's analysis of available federal and state oversight reports for waivers serving beneficiaries identified oversight weaknesses and quality of care problems. More than 70% of the waivers that GAO reviewed documented one or more quality of care problems. The most common problems included failure to provide necessary services, weaknesses in plans of care, and inadequate case management. The full extent of such problems is unknown because many state waivers lacked a recent CMS review, as required, or the annual state waiver report lacked the relevant information. GAO recommends strengthened federal oversight.

Georgia

The Atlanta Journal-Constitution, February 24, 2003
Agency failed clients; Poor service may be linked to 6 deaths

Mismanagement by a state-funded community service board in northwest Georgia might have contributed to the deaths of six disabled people, according to a written state review. A scorching report on the performance of the Highland Rivers Community Service Board also found payments to employees who might not exist; long delays in serving mentally ill and mentally retarded patients; and high staff turnover. The state Department of Human Resources has given Highland Rivers until the end of February to come up with a plan for fixing 12 "critical" problems cited in the report. Highland Rivers has another month to address the other issues noted in the 30- page report.

Massachusetts

The Boston Globe, February 4, 2003 Audit
alleges misuse of $1 million

Since 1997, the state Disabled Persons Protection Commission has investigated 19 complaints of client injury at Community Group, Inc., facilities and substantiated three cases involving neglect. Another six cases are pending. Officials said they were concerned about the well-being of many of the 85 clients the firm was caring for at 21 group homes in Eastern Massachusetts. The for-profit company was hired by the state to provide housing and job training for people with mental retardation. In addition to the accusations relating to poor care, a state audit recently found that the company had secretly raised more than $1 million selling products made by its clients with disabilities and used the money for a Mercedes-Benz, country club membership, and other perks for company management. Community Group, Inc. of Wakefield also kept $673,000 in profits from group homes and support services – three times the amount allowed by its approximately $4 million contract with the state. The state Department of Mental Retardation fired the company last fall, accusing it of providing poor care, in addition to the alleged financial misdeeds.

Connecticut

The Hartford Courant, January 4, 2003 Study: DMR
Clients Died Needlessly

A legislative committee has concluded that some mentally retarded residents of group homes in Connecticut needlessly died "tragic" deaths, which were then not investigated properly because poor oversight by state agencies. In a voluminous report on group home deaths, the Program Review and Investigations Committee also found that the state Department of Mental Retardation created a conflict of interest by investigating deaths itself, and said it should transfer that responsibility to another state agency. The legislature late last year asked the committee to review deaths in DMR group homes after a Courant investigation found evidence of neglect, staff error or other questionable circumstances in one out of every 10 deaths over the past decade. As part of the lengthy report, the committee reviewed the 36 cases identified by The Courant and 177 others chosen randomly to see if there were any patterns of neglect. The committee report concluded: "Tragic things happened that but for a different set of circumstances might not have." It also pointed out that systems were in place to address the risks to DMR clients, but for one reason or another were not carried out.