

OFFICE OF THE STATE INSPECTOR GENERAL

Report to Commissioner Debra K. Ferguson

*Review of Critical Events:  
Environmental Safety at the Commonwealth  
Center for Children and Adolescents*

September 2014



**June W. Jennings**  
**State Inspector General**

**OSIG Report Number 2014-BHDS-010**



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September 8, 2014

Debra K. Ferguson, PhD, Commissioner  
Virginia Department of Behavioral Health and Developmental Services  
1220 Bank Street  
Richmond, VA 23219

Dear Commissioner Ferguson:

The Office of the State Inspector General (OSIG) performed a follow-up review of a series of critical events at the Commonwealth Center for Children and Adolescents (CCCA) as a secondary component of the OSIG staff's unannounced inspection that occurred April 14–15, 2014.

We interviewed members of the management team and direct care staff, completed an environmental check, and reviewed documentation relevant to the events. The OSIG staff's review covered the facility's deficiency of dedicated security personnel and the differing perception between facility management and the direct care staff on environmental safety. Overall, OSIG staff found the facility completed an internal examination of safety protocols immediately following critical events and promptly made corrections to the physical environment.

On behalf of OSIG, I would like to express our appreciation for the assistance the CCCA leadership team and staff provided during our review.

If you have any questions, please call me at 804-625-3255 or email me at [june.jennings@osig.virginia.gov](mailto:june.jennings@osig.virginia.gov). I am also available to meet with you in person to discuss this report.

Respectfully,

A handwritten signature in black ink that reads "June W. Jennings".

June W. Jennings  
State Inspector General

CC: Paul Reagan, Chief of Staff to the Governor  
Suzette Denslow, Deputy Chief of Staff to the Governor  
Dr. William A. Hazel, Jr., Secretary of Health and Human Resources

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## Executive Summary

The Office of the State Inspector General (OSIG) performed an environment safety follow-up at the Commonwealth Center for Children and Adolescents (CCCA) as a secondary component of the OSIG's annual unannounced inspection that took place April 14–15, 2014. The environmental safety follow-up focused on the facility's response to a series of critical events that occurred in December 2013, and late January/early February 2014.

The first event was in late December and involved an allegedly planned elopement by a person who had been court-ordered to the facility for a psychiatric evaluation. The individual was able to escape after successfully kicking open one of the magnetically locked safety doors. The elopement prompted law enforcement concerns regarding community safety because of the nature of the individual's prior offenses and events that occurred after the elopement.

The second series of events involved disturbances at the facility, which occurred on two consecutive weekends in January and February. One staff member sustained a significant injury during the second disturbance. All other injuries to staff and persons served were minor. In both disturbances, local law enforcement had to be called to the facility to help secure the scene.

To its credit, the management team, led by the facility director, completed an internal examination of safety protocols immediately following these critical events and promptly made environmental corrections.

On the other hand, the OSIG noted that leadership team and direct care staff perceptions regarding overall environmental safety were dissimilar. Greater than 50% of the direct care staff interviewed reported not feeling safe in the environment, primarily as a result of the disturbances. In contrast, the facility management team principally viewed the events as a convergence of unique factors, and that it was unlikely the events would happen again.

This disparity in perception between management and direct care staff regarding key safety events within this setting has been noted in previous OSIG reports. The repeated nature of this organizational variance in perception warrants further examination by the Department of Behavioral Health and Developmental Services (DBHDS). In addition, the lack of dedicated and trained security staff to add support to the mission of this facility impedes management's efforts to enhance environmental safety.



## Purpose and Scope of the Review

An environmental safety follow-up was conducted by the Office of the State Inspector General (OSIG) as a secondary component of the OSIG's annual unannounced inspection that took place at the Commonwealth Center for Children and Adolescents (CCCA) April 14–15, 2014. The environmental safety follow-up review, pursuant to the *Code of Virginia (Code)* [§ 2.2-309.1](#) (B)[1][5], focused on the facility's response to a series of critical events that occurred in December 2013, and January and February 2014.

The OSIG routinely monitors critical events that occur within the state-operated behavioral health facilities and training centers. In the context of this review, a critical event is broadly defined as an unexpected occurrence that has the potential for a negative outcome on the environment of care. The 2013 Joint Commission Standards for Behavioral Healthcare facilities identifies three elements to the overall environment of care, which include:

- The physical plant; the building or space, how it is arranged, and special features that protects the people served, staff and visitors.
- The equipment used in support care, treatment, or services, or necessary to ensure safe operation of the building or space.
- The people—including those who work within the organization, individuals served, and anyone else who enters the environment—all of whom have a role in minimizing risks.

Environmental safety is an essential component to any comprehensive therapeutic program of treatment, and the series of critical events discussed in this report deal, in some capacity, with each element described above.

Even though environmental safety encompasses a broad array of areas, the scope of this review was limited to the following:

- Facility management's response to the critical events.
- Direct care staff-to-patient ratios at the time of the events.
- Availability of dedicated security personnel.
- The environmental safety perceptions of facility management and direct care staff.



## Background

### *CCCA*

The CCCA is the only DBHDS inpatient psychiatric facility dedicated to the care and treatment of children and adolescents. The DBHDS overall bed capacity for this population was reduced to the 48 beds following the closing of the 16-bed inpatient adolescent unit at Southwestern Virginia Mental Health Institute (SWVMHI) in Marion, Virginia in July 2010.

CCCA, by mission and practice, is an acute care facility. As such, CCCA is designed to provide comprehensive diagnostic services, crisis stabilization, and intensive short-term treatment. Treatment at CCCA is managed through multidisciplinary teams consisting of psychiatrists, clinical psychologists, nurses, social workers, activities therapists, teachers, and behaviorally trained direct care staff. Patients and patients' families receive specialized individual treatment.

There are two treatment programs at the facility. The Child and Pre-Adolescent Program typically serves children ages five to 13 years. The Adolescent Programs serves individuals between the ages of 13 to 18 years. These programs provide for a full range of treatment modalities, including, but not limited to, individual, group, and family therapy. There is also an educational component to the care and treatment received by patients, provided through the Staunton public school system.

CCCA has a unique function within the overall DBHDS service system, and, as such, is challenged with the need to periodically review key dimensions of facility management and operations, including the nature of the services it offers, the population it serves, and the manner in which the organization itself is structured. Traditionally, facility management has, in consultation with DBHDS Central Office, engaged in reviewing these key dimensions.

The OSIG's review revealed that management teams at the facility and the Central Office have been working together to develop strategies for addressing a number of key indicators that impact environmental safety, such as the implementation of trauma-informed care, decreased use of restrictive procedures, and creation of full-time security positions for added physical safety within the setting.



## Review Methodology

The OSIG's follow-up review was a secondary component of the overall FY2014 unannounced inspection. The design for the review was created following the completion of an extensive literature search of environmental quality indicators for behavioral healthcare facilities, and, more specifically, those facilities serving children and adolescents. The quality indicators for the environment of care were derived from several sources, including program experts, academics, and standard-setting organizations, such as The Joint Commission, the Centers for Medicare and Medicaid Services (CMS), and the DBHDS Office of Licensing and Office of Human Rights.

Over the two-day inspection, the OSIG staff:

- Interviewed members of the leadership team and direct care staff regarding the specific events that occurred.
- Conducted a staff survey that included questions on environmental safety and was completed by available staff on duty across the three shifts.
- Did an environmental walkthrough of the physical plant.
- Reviewed policies and procedures related to elopement and other areas where environmental risks occurred.
- Reviewed relevant documents, such as the Facility Risk Management Plan and Environmental Maintenance Protocols.



## Summary of Events

### ***Critical Event #1—Elopement***

A DBHDS Media Alert was received by an OSIG staff member on December 30, 2013 indicating that on December 29, 2013 at approximately 6:00 p.m., an adolescent eloped from the facility by kicking open a gymnasium door that was secured by a magnetic lock. Media Alerts are routinely forwarded to the OSIG from DBHDS when events occur that are outside the normal operations of the facility.

When there are elopements from CCCA, the first plan of action involves a perimeter search by staff, with the assistance of security personnel from Western State Hospital, when necessary. There was some evidence this elopement had been planned since it appeared there was a car on grounds waiting for the individual. When the individual was not immediately located, local law enforcement was notified.

A law enforcement media alert was issued that named the individual, but did not identify CCCA as the place from where the elopement occurred. Typically, this type of disclosure is unusual because of regulations surrounding confidentiality, but the disclosure occurred because law enforcement viewed the adolescent as “potentially dangerous.” The adolescent had been admitted on a Temporary Detention Order (TDO) from a juvenile detention center approximately two weeks prior to the event. The adolescent had been charged with entering a bank armed with intent to commit larceny.

Law enforcement’s decision to issue the alert was in part based on suspicions that the adolescent may have been involved in two robberies that occurred on the night of his elopement. The individual was recovered in April 2014 in Louisiana and returned to Virginia, but did not return to the facility.

### ***Critical Event #2—Disturbances***

On February 4, 2014, the *Staunton News Leader* reported a disturbance at CCCA in which local law enforcement had been called to help secure the facility. It was the second event of its type in two weeks. The previous disturbance occurred on January 25, 2014. According to the news report, officers from the Staunton Police Department were called out to CCCA around 11 p.m. on Saturday, February 1, 2014, after some patients at the center attacked staff members. The incident between staff and patients, which reportedly started in the dayroom area, had moved out into the courtyard area by the time officers arrived on the scene. The local law enforcement officers were able to enter the courtyard because one of the adolescents had kicked open a magnetic door between the unit and the secured courtyard. Police were able to successfully secure the scene. Both disturbances occurred during the late evening when the facility was less staffed. Staffing levels were minimal because several members were out sick. Reportedly, the staff ratio was three staff members to 11 adolescents.

According to the facility director, the events initially involved two adolescents who “egged each other on,” in what was viewed as a premeditated act to disrupt the environment. Shortly after the event started it escalated through “the contagion effect” when two additional adolescents initially fighting each other, turned together and started fighting staff. No patients were injured, and the majority of staff members involved sustained only

minor injuries from punches, bites, and kicks. One staff member was treated for a mild concussion at the local hospital.

Initially CCCA staff and Western State Hospital security tried handling the situation, but were unable to maintain control. Once local law enforcement arrived on the scene, the situation was quickly contained. Physical force did not have to be used by law enforcement, as it appears the number of law enforcement respondents was the primary factor that quelled the event.

The overall safety of the staff and patients at CCCA was previously identified by OSIG as a concern. By its very nature, CCCA serves a population of children and adolescents defined as needing a high level of care due to symptoms consistent with a serious mental illness and imminent risk to self or others. All the staff interviewed related that one of CCCA's primary functions is to provide a safe and therapeutic environment, yet greater than 50% of staff reported, either through direct care staff surveys or interviews, feeling unsafe in the environment.

According to statements made by the leadership team and OSIG staff's observations, children of both genders were often placed together on the same living and treatment unit, and had a variety of difficulties, including:

- Severe psychiatric problems
- Intellectual disabilities
- Forensic involvement
- Assaultive behaviors
- Sexual predation
- Autistic spectrum disorders
- A history of severe sexual and/or physical abuse

Each child presents with highly varied and challenging individual needs that require acute care strategies. These strategies promote stability while effecting changes in preparation of community-based, long-term services. As a result, treatment teams must rapidly engage in evaluating and treating individuals, which is most effectively accomplished and sustained through direct staff. Effective treatment strategies can only be accomplished in the context of a safe environment.



## Detailed Findings

### *Issue #1—Facility’s Response to the Critical Events*

- A. Proper notifications of this critical event occurred as required by policies and procedures.
  - A review of policies and procedures in conjunction with clinical documentation revealed that facility management notified the proper authorities for assistance with handling the events and with sharing information regarding the circumstances following their occurrence.
  - Notifications included a media alert, and a report to DBHDS leadership, the Secretary of Health and Human Resources, and the OSIG.
  
- B. Environmental corrections were immediately identified and addressed.
  - According to the facility director:
    - Despite routine door maintenance, undetected grime build-up made the magnetic lock less effective.
    - Closer examination of the door by facility maintenance revealed that sustained abuse—kids kicking it and/or slamming it shut—had resulted in enough minor bending of the door that the surface area of magnetic contact was lessened, resulting in its failure when kicked by the adolescent who eloped.
    - The Virginia State Fire Marshal’s Office approved the installation of a non-magnetic door replacement as long as the gymnasium was not used for assemblies and alternate means of egress were not blocked.
      - This door had already been installed when OSIG staff performed their walkthrough of the facility.
    - The magnetic doors to the courtyards are being replaced. Permission was granted by the Virginia State Fire Marshal’s Office for the magnetic locks to be placed at a higher location on the door making them more difficult to force open.
    - Since the unit disturbances, two additional staff positions have been added. The positions will straddle second and third shifts, from 7:00 p.m. to 3:30 a.m., providing extra support.
    - One additional supervisor has been added as well. The supervisory position will float among the units to assess the units’ “tone and temperature” while adding additional support for the staff.
    - Western State Hospital assigned a part-time security staff member to the facility. The security staff member is at the facility for parts of the second and third shifts.
  - A copy of the new protocol for magnetic-locked door maintenance was reviewed by OSIG staff during the site visit. There was documentation the protocol was being followed as required by building and grounds staff.

#### **ISSUE #1—RECOMMENDATION**

No recommendation.

## ***Issue #2—Perceptions Regarding Environmental Safety***

- A. There is a significant difference between facility management and direct care staff perceptions regarding environmental safety.
- Greater than 50% of staff reported not feeling safe in the environment.
  - The reasons cited by staff included:
    - The turnover of staff, particularly on the second shift.
    - The lack of a dedicated security officer.
    - Inadequate staffing patterns.
    - Mixing of forensic and non-forensic populations on the same units.
  - While facility management referred to the events as disturbances, direct care staff called them “riots.”
  - Facility management summed up the events as a convergence of unique factors, and that it was unlikely events would happen again, while the direct care staff repeatedly discussed, not just the disturbances that occurred two weekends in a row, but the constant acts of aggression they endure.
    - Interviews with staff revealed that in addition to the events identified in this report, staff were routinely subjected to verbal threats of harm and acts of aggression, such as being hit or kicked, having hair pulled, getting scratched or tackled, or other acts of physical aggression. Staff interviewed reported that while most events did not result in injury, the frequency of occurrence added to staff’s generalized fear regarding personal safety.
    - The direct care staff stated that facility management was not concerned about the safety issue because they did not experience the violence themselves and were rarely onsite during the evenings, nights, and weekends when acts of violence were more likely to occur.
    - Direct care staff reported they would appreciate a greater sense of cohesion with facility management on all levels and believed it could be accomplished through increased communication, inclusion regarding decisions that affect their work life, and increased opportunities to interact with senior management, particularly staff on the second and third shifts.
  - OSIG staff observed that many direct care staff were only a few years older than the patients they were serving and interviews revealed they had limited life and career experience that is essential to establishing professional boundaries and developing therapeutic relationships.
- B. Direct care staff reported the mix of forensic and non-forensic patients was the largest challenge they faced in addressing environmental safety.
- According to direct care staff, CCCA’s admitted forensic population consisted of adolescents who were court-ordered for 10-day pretrial evaluations or for post-sentence treatment.
  - Direct care staff stated that higher functioning adolescents from correctional settings often preyed on the more vulnerable children, were less tolerant of the symptoms of peers who were actively psychotic or cognitively impaired, and often brought a “gang” mentality to the setting, which in some cases resulted in “gang-related rivalries” being acted out in the facility.
  - Clinical and administrative staff informed the OSIG that continuous risk assessments were conducted during leadership team meetings in order to address a variety of risk factors

associated with serving diverse populations within the acute care structure, particularly as it pertained to the forensic population.

#### **ISSUE #2—RECOMMENDATION**

That CCCA work to increase communication between direct care staff and facility management to help mitigate differing perceptions between direct care staff and facility management.

#### **DBHDS RESPONSE**

DBHDS concurs with this recommendation. CCCA leadership will identify additional opportunities to enhance the communication with direct care staff and engage them in decisions that affect their work life. CCCA leadership will also make sure that midlevel and senior leadership routinely interact with direct care staff on evening and night shifts.

#### ***Issue #3—Lack of Dedicated Facility Security Staff***

- A. CCCA does not have dedicated facility security staff to support ongoing environmental safety.
  - Both facility management and direct care staff reported that a dedicated security presence within the facility would serve as a deterrent for some of the peer-to-peer and peer-to-staff aggression that occurs at CCCA.
  - According to the facility management and direct care staff interviewed, increased facility-based security would also diminish the likelihood of repeated events, such as the recent disturbances described in this report.
- B. Security services have traditionally been provided by Western State Hospital.
  - Interviews with facility management revealed the following:
    - CCCA receives basic operational infrastructure support from Western State Hospital, and security is one of these support services, which also includes other services like housekeeping, maintenance, and food service.
    - Facility management reported that Western State Hospital security services have not always been available in a timely manner in the past because Western State Hospital's security needs have taken precedence due to the need to share Western State Hospital's limited resources.
    - The current distance between the two facilities is greater than in the past, increasing response time even when Western State Hospital security staff are available.
    - Another problem with sharing security personnel with an adult facility is that officers are not always adequately trained in dealing with aggressive behavior as manifested by children and adolescents, more specifically adolescent gang behavior.
- C. The lack of adequate funding for dedicated security staff has been the primary barrier in securing necessary positions.

- Since the OSIG’s 2011 unannounced inspection at CCCA, facility management and DBHDS Central Office leadership have explored additional funding options to create a dedicated security force at the facility. As reported by facility management, the planned positions would mainly cover evening and night shifts when there are fewer staff onsite.
- The facility director stated that a request for general funds to finance the additional positions was submitted by DBHDS Central Office in the FY2015 budget request.<sup>1</sup>

**ISSUE #3—RECOMMENDATION**

No recommendation. The OSIG staff will monitor security staff acquisition and deployment during future follow-up inspections.

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<sup>1</sup> The budget passed by the 2014 General Assembly approved the addition of \$336, 320 in FY2015 and \$336,893 in FY2016 for adding security staff to CCCA.