

Office of Protection and Advocacy for Persons with Disabilities
Fatality Review Board
March 27, 2013

Present: Mr. James McGaughey, Ms. Patricia Mansfield, Attorney John DeMattia, Dr. Gerard Kerins, Ms. Lakisha Hyatt; and Ms. Anne Broadhurst, Ms. Barbara Roy, Ms. Diana Lincoln, and Mr. Peter Hughes (OPA staff).

Absent: Professor Timothy Palmbach and Ms. Holly Olko.

1. Mr. McGaughey introduced Board members to Ms. Lakisha Hyatt, the new Director of Health and Clinical Services for DDS. Mr. McGaughey briefly summarized how the Board works and the role of the DDS Liaison.
2. The Board discussed the series of articles published by the Hartford Courant regarding the deaths of persons with intellectual disabilities, where abuse or neglect may have been a contributing factor. Mr. McGaughey noted that the articles prompted Senator Chris Murphy to call for a federal investigation into deaths of people with intellectual/developmental disabilities in federally funded facilities nationwide. Mr. McGaughey also noted that since the publication of the articles, DDS and OPA have met to review DDS protocols for ensuring that family members are contacted if an investigation is initiated following a person's death. (It was noted that several family members reported to the Courant that they were unaware of an investigation having been initiated due to a suspicion of abuse/neglect following the death of their family member.) Mr. McGaughey noted that DPH, DDS and OPA will soon be meeting to discuss the development of a collaborative dysphagia training initiative to be implemented in extended care facilities, as well as other issues of concern raised by the Courant articles and the FRB, through its reviews, surrounding nursing home care.
3. Dr. Kerins and Ms. Broadhurst briefly summarized a meeting held with the Director of Education and Training for DDS, staff from the UCED, private and public sector provider registered nurses, and a DDS self-advocate regarding improving medical care for persons with intellectual/developmental disabilities in a number of healthcare settings. The group agreed that there is a need to inform and empower support staff, case managers, family members and other caregivers so they can more effectively advocate for people in these settings. The group agreed on a series of "next steps", which are to: (1) Identify what training modules regarding improving health care outcomes are currently being used by providers; and (2) Identify if and what mandates are may be tied to these trainings. The group agreed to meet again in May 2013 to review the information obtained from this inquiry, to discuss possible funding sources, to develop a short-term implementation plan, as well as a long-term plan/vision.
4. The Board discussed an apparent rise in cases involving the failure of support staff to initiate CPR. Several suggestions were made for improving the outcomes in these cases, including conducting emergency drills, reviewing events after they occur in a non-judgmental way in an effort to capture what worked and what didn't, and using the information obtained as a result of these reviews to inform the re-education process. It was also suggested that support staff could be surveyed in order to gain a better understanding of what might keep them from initiating CPR, and whether they feel their training in this area is adequate.
5. Executive Session and Case Review
6. The meeting was adjourned at 4:00 PM.

The next FRB meeting is scheduled for Wednesday, May 15th, 2013 at the Grimes Center in New Haven.