UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, et al.,

Plaintiffs,

v.

Minnesota Department of Human Services, an agency of the State of Minnesota, et al.,

Defendants.

Civil No. 09-1775 (DWF/FLN)

MEMORANDUM TO THE COURT

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SUMMARY

Unprecedented changes are in the works for the facility now known as MSHS-Cambridge. Soon, for the first time since 1925, the property will not be devoted to institutional care for people with intellectual disabilities.[1] "Since 1925, the remedies have moved from growing the facility to diminishing its size, and from custodial care to transition to community care."[2]

DHS is establishing a state-wide community program of dispersed housing and associated services as "successor" to the METO/MSHS-Cambridge facility under the Settlement Agreement. The Court's orders will apply to the new program, which has yet to acquire a fixed name.[3] Also, under the *Olmstead Plan*, Anoka Metro Regional Treatment Center (AMRTC) and Minnesota Security Hospital (MSH) will be changing and dozens of individuals will be moving to the community.

In this changeover, the Court Monitor believes it is important for the Department of Human Services to attend carefully to establishing a culture in the dispersed Cambridge successors, and in the department generally of attending to the lessons of the proceedings in this case, establishing a shared institutional memory, and of compliance with the Court's orders.

As DHS moves into implementation of the *Comprehensive Plan of Action*, recent events suggest the need for deep learning within the Department of the responsibilities of all officials' and staff in this case. DHS needs not only to learn from mistakes, but proactively to examine why, at times, that learning has not taken place. Those responsibilities are not simply to the Court, for the Court stands for ensuring the safety and well-being under its orders for the vulnerable individuals with disabilities who are the intended beneficiaries.

Accordingly, the Court Monitor urges that DHS examine the deep learning which may be needed to bring about understanding of this litigation and the nature of compliance with court orders, and to act upon the results of that examination. Absent DHS undertaking this effort voluntarily and promptly, the Court Monitor may make recommendations for action by the Court.

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[1] *See* Court Monitor, *Status Report on Compliance* at 22 ff (June 11, 2013) (Dkt. 217).

[2] *Id.* at 22. This year, DHS stated that it intended to utilize Cambridge for some patients at the Minnesota Sex Offender Program; that action is on hold.

[3] The current name is Community-Based Minnesota Life Bridge Program.

SEVERAL EXEMPLARS

Especially in recent months, DHS has moved in a positive direction to acknowledge responsibilities and unmet expectations, regarding compliance. At the recent special conference ordered by the Court on the Comprehensive Plan of Action, DHS, led by Commissioner Jesson, made commitments to expanded relief and to more intensive management of implementation. DHS promises a well-staffed professional team to oversee *Jensen* compliance. The closure of MSHS-Cambridge and the development of successor treatment homes appears to be the subject of intensive self-conscious planning.

That said, one must have in mind recent failures – not to cast or re-cast blame but as exemplars of what is not to be done, and also to serve as inspiration to act positively and responsibly to address challenging issues which will surely arise in the months to come.

The five circumstances summarized below illustrate such issues as lack of training, inadequate training, lapses in candor to the Court, failure to act on reports of problematic practices, and client care which repeatedly falls below standard. Implementation of the orders in this case will best be served if these concerns are analyzed at a 'root cause' level, and not one by one. The conclusion of this memorandum urges DHS to undertake that deeper examination.

1. **Repeat Licensing Deficiencies Found by Office of Inspector General.** Earlier this month, in a February 12, 2014 Correction Order, the DHS Office of Inspector General found MSHS-Cambridge "to be in violation of these state or federal laws::

- Providing and documenting annual staff training on vulnerable adult maltreatment.
- Prominently posting the program's maltreatment reporting policy
- Obtaining informed consent for administration of psychotropic medications
- Ensuring coordination and evaluation of service delivery.
- Providing outcome-based services based on identified needs and updating plans.
- Developing supports and methods to accomplish outcomes.
- Providing services in least restrictive environment, ensuring doors are locked only to protect consumers, and in accordance with program policy to ensure access to common areas
- Ensuring a safe and hazard free environment
- Completing daily assessment of risk

- Developing specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability areas
- Providing financial statements at the frequency requested when handling consumer funds[4]

These bulleted findings are set forth as quoted on the first two pages of this 13 page report.

One year earlier, on February 1, 2013, the Office of Inspector General issued a 13 page Correction Order on MSHS-Cambridge.[5] The 2014 report cites the following as "**Repeat Violations**" (emphasis in original) of those in the 2013 report:

- Obtaining informed consent for administration of psychotropic medications
- Providing outcome-based services based on identified needs and updating plans.
- Ensuring a safe and hazard free environment
- Developing specific actions a staff person will take to protect the consumer and minimize risks for the identified vulnerability areas
- Providing financial statements at the frequency requested when handling consumer funds.

2. RW "Transitioned to the Community." When it became known that a client, RW, had eloped from MSHS-Cambridge into a waiting car to parts unknown, and was lost track of, DHS responded mainly with analysis of how and why staff couldn't have forseen or prevented his departure; it was explained that a staff person should not have used the word "AWOL" in an official spreadsheet.

Within the litigation, however, the point was that DHS had filed an untruthful report with the Court, explicitly stating that RW was "transitioned to the community" under specific settlement requirements on community placement.[6]

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[4] DHS, Office of Inspector General, February 12, 2014, *Correction Order, MSHS-Cambridge*, **Attachment A.**

, [5] DHS, Office of Inspector General, February 1, 2013, *Correction Order, MSHS-Cambridge*, **Attachment B.**

[6] *See* Court Monitor, *Report to the Court, Client R.W.: AWOL v. Transitioned to the Community* at 5 (November 7, 2013) (Dkt. 251).

3. SAB Abuse and Neglect Reporting. When it became known that there were concerns about possible mistreatment of SAB, an AMRTC client, DHS responded with various documentation such as excerpts from treatment records, and reports on whether or not SAB was physically abused.

Within the litigation, however, DHS' obligation was to submit a report specific to the Court's questions of "whether the individuals and institutions involved are mandatory reporters pursuant to Minn. Stat. § 626.557, with regard to possible abuse (causing the injury which led to SAB's hospitalization) and possible neglect (whether prior falls and self-injury were the result of lack of appropriate treatment and programs)." Order of December 12, 2013 at 2 (Dkt. 258). That report has yet to be submitted.

4. "No Touch and Retreat" Approach. It has taken a year for DHS to address at Cambridge a safety issue identified by the Court Monitor twice during the past year.

On February 22, 2013, the Court Monitor provided the *Preliminary Report on Client and Staff Safety* ("Report"). The Report emphasized the importance of staff training as a "foundation for keeping clients safe." The Report recommended: "Direct care staffing should be reviewed. There appears to be a risk of serious harm to clients or staff, due to lack of supervision, or in the case of a medical or other emergency."[7]

The February 2013 Report critiqued a questionable "no touch and retreat" approach by staff: "In two (2) cases, staff reported they retreated to the office or behind a hallway door and permitted a destructive series of action to take place without staff interference."[8]

Four months later, in the June *2013 Status Report on Compliance*, the Court Monitor again criticized the "no touch" and "retreat" practice as posing a "significant risk of serious injury to staff or clients:"

> It is apparent, and a subject on which Cambridge staff are outspoken, that the restraint restrictions in the settlement, and follow up scrutiny, are a major disincentive to the use of even manual emergency restraint. Whether this is a *sub silentio* argument for permission for additional restraint techniques, or an over-reaction to accountability, or has another basis, cannot be determined. *It is clear, however, that staff need to be reminded that, in an emergency as defined in the decree, manual*

[7] *Report* at 8.

[8] *Report* at 3.

> *restraints are permitted. In current circumstances, the "no touch" approach poses a significant risk of serious injury to staff or clients.*[9] (emphasis added).

On February 4, 2014, MSHS-Cambridge received written notice from the Minnesota Occupational Safety and Health Division (MNOSHA) of the Department of Labor and Industry that a notice of hazards at the institution had been reported. The alleged hazards included safety of individuals at Cambridge. It was not until after the above complaint that MSHS-Cambridge finally and formally rejected the "no touch and retreat" approach.

One year after the Court Monitor raised the question, Cambridge on February 13, 2013 adopted new procedures titled *Temporary Safety Guidelines for Small Spaces,* which: forbid the staff "retreat to the office" approach and require that, instead, staff are "expected to engage therapeutically in the living environment" during an incident."[10]

The *Guidelines* provide*:*

1. Only one direct care staff (staff in ratio) can be in the office at any one time. This includes times when an incident is occurring. Staff in other parts of the home must not retreat to the office during an incident.

2. The door to the office shall be closed and locked at all times unless staff are entering or exiting the office. Staff are safer not being trapped and if need be can exit outdoors.

   [## 3 and 4 omitted]

5. Staff in the common area of the home will not go into the office while the event is occurring until absolutely sure the situation is calm and safe. Staff is expected to engage therapeutically in the living environment which can be done more safely in those larger spaces.

In the year since the Court Monitor's safety report, staff and clients have been injured during incidents such as those to which the 2014 Guidelines are now addressed. Returning to the staff training mandate cited earlier in this discussion, Cambridge staff (many of whom will be moving out to the new

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[9] Court Monitor, *Status Report on Compliance* (June 11, 2013) at 71.

[10] Included with Steve Jensen, *Memorandum to All Cambridge Staff*, February 13, 2014, **Attachment C**.

community successors) remain unclear and uncertain about when and how to intervene with clients exhibiting challenging behavior.[11]

5. Licensure of MSHS-Cambridge. The Settlement Agreement required that MSHS-Cambridge was properly licensed. It was not licensed when the settlement was approved or for months thereafter.

The situation, addressed by the Court in the Order of December 17, 2013 (Dkt. 259), is brought forward here to acknowledge the finding that "DHS consciously concealed and misled the Plaintiffs and the Court" or "was indifferent to both the violation and the expectation of candor." *Id*. at 5. Equally important at this time is that "the issue was not immediately forwarded to the appropriate superiors and acted upon." *Id*.

LESSONS

Many lessons may be learned from these four situations; many have hopefully already been learned, at least within the leadership of DHS. Among those lessons may be:

- the duty of candor to the Court and its Monitor;
- the necessity of obedience to the orders of the Court in matters large and small;
- the importance of taking seriously the mandated standards and to report compliance concerns;
- the need to be proactive on a comprehensive basis (not simply item by item) when issues are raised;
- that training and immersion in the court's orders and the foundational principles of the Settlement Agreement are a prerequisite for DHS officials and staff.

CONCLUSION

As DHS moves into implementation of the *Comprehensive Plan of Action*, a recent events suggest the need for deep learning within the Department of all officials' and staff responsibilities in this case. Those responsibilities are not simply to the Court, for the Court stands for ensuring the safety and well-being under its orders for the vulnerable individuals with disabilities who are the intended beneficiaries.

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[11] *See* Minutes, *Safety-Programmatic, Ad-Hoc RE: Safety Concerns per Labor/Management Meeting* (November 26, 2013), **Attachment D**.

Accordingly, the Court Monitor urges that DHS examine the deep learning which may be needed to bring about understanding of this litigation and the nature of compliance with court orders, and to act upon the results of that examination. For example, a root cause style analysis may be useful. New approaches to education and training, or other steps, may be useful. Absent DHS undertaking such efforts voluntarily and promptly, the Court Monitor may make recommendations for action by the Court.

Respectfully submitted,

David Ferleger
Court Monitor

February 19, 2014