CONNECTICUT

Disability Rights group finds ‘pervasive’ problems remain after scandals at Whiting Forensic and Connecticut Valley Hospitals

By JOSH KOVNER
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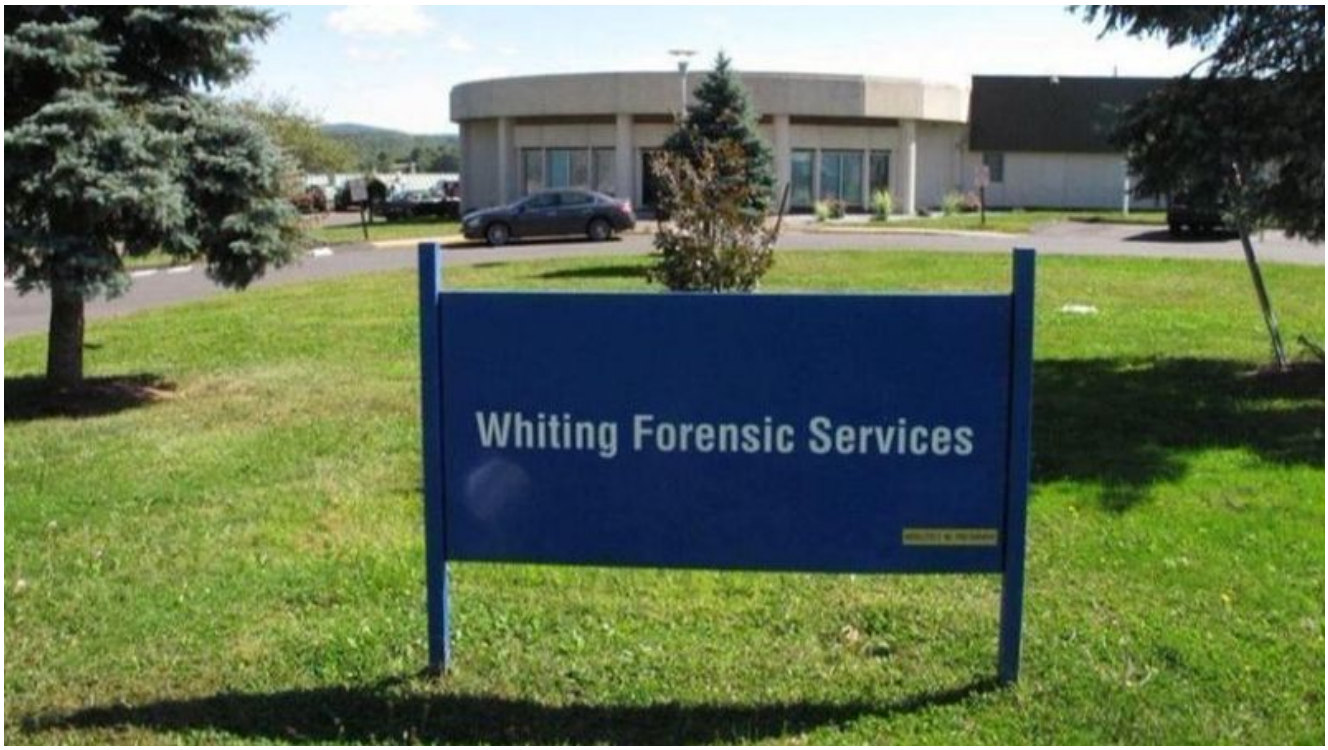

Disability Rights Connecticut has found ‘pervasive’ problems remain after scandals at Whiting Forensic and Connecticut Valley Hospitals. (Hartford Courant file photo)

Spurred by an abuse scandal and a patient who choked to death in front of workers, an investigative group has found that “pervasive” problems remain at the state’s Whiting Forensic and Connecticut Valley psychiatric hospitals despite massive publicity, jailing of some staff members, and tens of millions of dollars spent on “patient care.”

The nonprofit Disability Rights Connecticut, in a report on the two Middletown facilities released Tuesday morning, said its investigation had found:

- Investigations of patient deaths at the hospitals are inadequate.
- Restraints are routinely used on non-combative patients for the convenience of staff.
- The Department of Mental Health police have on occasion violated patients’ rights.
- Treatment plans for patients are often generic and deficient, resulting in yearslong stays with little progress.
- Inquiries into abuse or neglect reports usually focus on whether staff members violated work rules, “seldom examining the issues that may have contributed to underlying, problematic conditions.”

Disability Rights Connecticut is the state’s designated advocate for people with disabilities. It was created in 2017 after the state Office of Protection and Advocacy lost its federal funding.

In November of 2017, the group began its own investigation of Connecticut Valley Hospital and the Whiting Forensic Division after a scandal broke about the prolonged and unprovoked abuse of patient William Shehadi — events that were captured on videotape and led to the arrests of 10 Whiting staff members and the dismissal of more 35 employees. Disability Rights found that some of the dismissed workers have won their jobs back through arbitration.

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CVH, with 350 beds, is the state’s only remaining public psychiatric hospital for indigent adults, and Whiting, with 91 beds, is a maximum security facility for people found not guilty of crimes by reason of insanity.

In an attempt at reform, Whiting has now become a separate hospital with new managers on the CVH grounds.

Disability Rights Connecticut executive director Gretchen Knauff said they were also interested in the case of 25-year-old Andrew Vermiglio, a Whiting patient who died in front of staff members after choking on cookies during a snack break.

Vermiglio, who was plagued by obsessive and ritualistic behaviors, had made the universal sign—a hand to the neck – that he was choking and couldn't breathe. Some of his movements were apparently misinterpreted by staff members, and he was physically restrained on his bed, face down, as he was choking.

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During the course of the inquiry in Whiting and CVH, Disability Rights came to focus on the experiences of two other patients, whose experiences Knauff said illustrated an over-reliance on restraints, the pressing needs for individualized, rather than cookie-cutter, treatment plans, and the periodic inability of staff members to protect self-injurious patients from harming themselves.

In one instance, the Disability Rights investigators watched a video of a Whiting patient who had been involved in an altercation with another patient. Staff members broke up the fight, and both patients were calm. One of the patients, even though he was compliant, was led to the restraint room, "where he cooperatively lay down" and was placed in four-point restraints.

After remaining calm for 33 more minutes, the restraints were removed.

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an individual who was, at the time, perfectly calm," the report says.

Among the recommendations are that Connecticut Valley Hospital's exemption from licensing and inspection requirements be removed; that all patient deaths are investigated by an independent group, that Department of Mental Health police receive additional training in patients' civil-rights; and that policies on the use of physical and chemical restraints and the reporting of instances of abuse, neglect and exploitation be reviewed and reformed.

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Disability Rights also questioned whether some Whiting patients who were civilly committed and had no involvement with the criminal justice system even belonged at the facility. The report found "an incoherent mix" of patients at Whiting.

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