

DISABILITY RIGHTS CONNECTICUT

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# INVESTIGATIVE REPORT

Whiting Forensic Hospital and Connecticut Valley Hospital

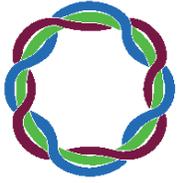


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**FINAL REPORT**

November 2019





## **Disability Rights Connecticut (DRCT)**

**Securing & Protecting the Rights of Connecticut Citizens with Disabilities**

Disability Rights Connecticut (DRCT) is the designated Protection and Advocacy System for individuals with disabilities in Connecticut.

Operating pursuant to federal law, DRCT is authorized to investigate allegations of suspected abuse and neglect of persons with disabilities; to monitor conditions in facilities and community programs and to pursue legal, administrative and other remedies to protect the civil rights of people with disabilities. Specific authority to conduct investigations of suspected abuse and neglect can be found in the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act 42 U.S.C. § 10801 et seq. and the Developmental Disabilities Assistance and Bill of Rights (DD) Act, 42 U.S.C. § 15001 et seq.

Other mandated activities include providing information and referral services; educating policymakers and members of the public about disability rights issues; and advocating for clients and applicants of vocational rehabilitation and certain Social Security programs.

Part of a nation-wide network of similar non-profit entities that have been designated in each state and territory, DRCT is the successor to the Connecticut Office of Protection and Advocacy for Persons with Disabilities (OPA), which was abolished by legislation that took effect June 30, 2017.

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November 26, 2019

This Investigative Report is a Call to Action - a call for wholesale organizational culture change at both Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH).

It is not a repeat of the disturbing Spring 2017 news reports of staff abuse of patients and the subsequent actions taken in the aftermath. Rather, it is a significantly deeper look at the everyday, pervasive culture that led to such abuses - and which, to an alarming extent, continues to exist today.

Disability Rights Connecticut (DRCT) began operations on July 1, 2017, several months after the abuse of patients at Whiting Forensic Hospital had been exposed, staff terminated, and the legislature awakened. As the federally mandated “protection and advocacy system” for the state of Connecticut, DRCT is responsible for protecting the civil and human rights of people with disabilities, including the right to be free from abuse and neglect.

Confident that what became known through media reports was not the totality of what needed to be investigated and revealed, DRCT launched its own investigation, peeling back layers of bureaucracy and custom in order to better understand the issues of concern that continued to exist, as a vital step towards having systemic changes made that would ensure the safety and rights of individuals in the state’s care.

This report - the product of interviews, research and investigation - details those findings and makes recommendations for critical changes in policy and procedure.

While some improvements have been made at both CVH and WFH, Disability Rights Connecticut fervently hopes that the Department of Mental Health and Addiction Services, the Whiting Task Force, and the Connecticut Legislature heed our Call to Action and make sweeping changes that bring about true, broad reforms that result in improved outcomes for patient treatment and recovery.

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# BACKGROUND

## What Prompted this Investigation?

In November, 2017, Disability Rights Connecticut (DRCT) opened an investigation into allegations of abuse and neglect of patients at Connecticut Valley Hospital (CVH), the only remaining large, state-operated psychiatric hospital in Connecticut. The investigation was initiated after a series of television and newspaper stories had, over the preceding months, reported multiple incidents of physical abuse perpetrated upon William Shehadi, a patient in the Whiting Services Division of CVH.<sup>1</sup>

The media reports indicated that the abuse involved multiple staff members, including at least one nurse; that criminal investigations had led to arrests; and, that an internal personnel investigation had resulted in disciplinary action against Whiting staff members, most of whom had either resigned or been fired. Much of the evidence used in those investigations had been in the form of video recordings taken from cameras located in Mr. Shehadi's room and adjacent corridor – cameras that recorded physical assaults as well as multiple other abusive acts. While the cameras had been in place for some time, they had apparently not been routinely monitored by supervisors.

As troubling as the media revelations were in themselves, at DRCT they also elevated concerns about the death of another person who had been living in the same unit of the Whiting Forensic Division. That individual, Andrew Vermiglio, was a 25-year-old man who had been civilly committed to CVH approximately one and one-half years before his death. Originally assigned to a unit in CVH's general psychiatry division, he had been arrested and held in jail for a week for his alleged involvement in an altercation with another patient. Following a court appearance, he was sent directly to the Whiting Division's maximum-security building. His death five months later had been reported to DRCT's predecessor agency, (the soon-to-be-abolished Office of Protection and Advocacy for Persons with Disabilities), which was also notified that the Medical Examiner had conducted an autopsy and found the cause of death to be asphyxia due to choking on a bolus of food – cookies that Mr. Vermiglio had apparently been given as a snack. DRCT inquired further about Mr. Vermiglio, and found sufficient information to raise serious questions about the circumstances surrounding his death, and the way Whiting staff had been responding to his needs. In fact, some of the accounts related by other patients on the same unit described a pattern of abusive treatment toward Mr. Vermiglio that was in many ways similar to the news accounts concerning Mr. Shehadi.

As news accounts revealed more details about what had happened to Mr. Shehadi, and as more was learned about Mr. Vermiglio's treatment and death, DRCT initiated an investigation pursuant to its authority under the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI) (42 U.S.C. §10801 *et seq.*). The original purpose of the investigation was to:

- 1) examine the circumstances surrounding the abuse and/or neglect of certain specific individuals (William Shehadi and Andrew Vermiglio), for whom DRCT had received reports;

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<sup>1</sup> / At that time, Whiting operated as a "forensic services" component of CVH. Legislative changes have since established it as a free-standing forensic hospital, operating independently from CVH.

- 2) identify institutional and/or programmatic practices, which may have contributed directly or indirectly to recurring incidents of abuse, neglect, inadequate care and treatment and/or violations of patient rights.

In the process of inquiring into those questions, DRCT investigators became aware of rights-related issues affecting others who were housed within the Whiting Services Division. Some of those individuals had, like Mr. Vermiglio, been admitted from other units at CVH. Unsure as to the true extent of problems that were surfacing at Whiting, and aware that similar dynamics might also exist throughout CVH, DRCT investigators began a systemic, comprehensive investigation.

### **Recent and Concurrent Investigations by Other Entities**

While DRCT's investigation proceeded, focusing on issues related to abuse, neglect and civil rights, scrutiny from other sources was causing a reexamination of the basic structure and accountability mechanisms that defined the hospital's operations in law and policy. The federal Center for Medicare and Medicaid Services (CMS)<sup>2</sup>, acting through its subcontractor, the Connecticut Department of Public Health (DPH), initiated an inquiry into the abuse reported regarding William Shehadi, and, in July, 2017, DPH completed an unannounced, detailed survey of the Whiting Services Division. Ultimately, the DPH inspectors found numerous serious violations of federally required "conditions of participation" at Whiting, including:

- failure to protect patients from abuse, neglect and harassment;
- failure to involve patients in treatment planning and to engage them in treatment;
- failure to maintain safe environments;
- unnecessary use of restraints;
- failure to follow appropriate incident review protocols;
- failure to obtain informed consent from legal representatives for certain intrusive procedures;
- failure to monitor safety-related video feeds and to implement patient observation orders.

CMS determined that those violations created a situation of "immediate jeopardy" meaning that patient safety was at risk, and that corrections were urgently needed. When CMS finds violations in most cases it requests a "Plan of Correction" from hospital administrators which details the steps they will take to bring the hospital into compliance.

However, in the wake of the CMS/DPH findings from its survey at Whiting Forensic Division in July, 2017, and the irrefutable evidence of cruelty that had been allowed to exist unchecked in one of its units, there was to be no mere plan of promised corrections from administrators at CVH. Instead, the Department of Mental Health and Addiction Services (DMHAS) voluntarily "de-certified" (i.e., withdrew from the federal program) the 91 beds located in the Whiting Services Division's buildings, retroactive to April, 2017 – the month that the abuse of William Shehadi came to light.

In terms of its operating budget, this was no doubt a costly step for DMHAS. But, by voluntarily de-certifying, DMHAS was signaling it understood that the problems in the Whiting Services Division ran deep, and that extensive work lay ahead to address them. In fact, after reviewing the video recordings of Mr. Shehadi being abused, the DMHAS Commissioner removed both the Director of the Whiting Division and Whiting's Director of Nursing, replacing them with interim

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<sup>2</sup> / CMS oversees the federal Medicare program, which helps fund CVH.

appointments. Shortly thereafter, DMHAS initiated a nationwide search for a new CEO for Whiting. Ultimately, the entire leadership team at the facility was replaced.

It is important to note that there is a lengthy history of adverse findings from federal complaint investigations at CVH, including other CMS/DPH inspections that found failures to meet “conditions of participation.” The findings from these previous federal investigations resulted in numerous plans of correction. In addition, in 2007, the U.S. Department of Justice (DOJ) issued highly critical findings after an investigation it conducted pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA).<sup>3</sup> DOJ identified multiple violations of patients’ Constitutional rights throughout the hospital, including overuse of seclusion and bodily restraints, inadequate assessments of patients’ treatment needs, inadequate treatment planning, insufficient provision of therapies and rehabilitation, inadequate suicide prevention measures, and a general failure of risk management systems to monitor conditions and track trends. The findings from the DOJ investigation led to an enforcement action in Federal Court which resulted in a consent agreement promising significant changes.<sup>4</sup>

### **Executive Order, Legislative Inquiry and Statutory Changes**

The State’s response to the revelations about the abuse at the Whiting Services Division extended well beyond the steps taken by DMHAS. On December 29, 2017, Governor Malloy issued Executive Order 63, administratively separating Whiting from CVH, and instructing DMHAS to directly oversee development of new, separate policies and procedures for Whiting. This step was taken, at least in part, because federal law requires that when a particular unit of a Medicare-certified hospital is singled out for de-certification, it can no longer be administered under the umbrella of that hospital’s governing structure.

On the legislative front, the General Assembly’s Public Health Committee also took decisive action, holding a lengthy public hearing on November 13, 2017, and raising a bill which led to significant changes in Whiting’s enabling legislation. Public Act 18-86 formally separated Whiting from CVH, establishing it as a stand-alone psychiatric hospital to be known as the Whiting Forensic Hospital (WFH), operated under and directly reporting to DMHAS’ central administration. It also took major steps to improve accountability, requiring among other things that WFH be subject to the Department of Public Health’s psychiatric hospital licensing requirements.<sup>5</sup> Recognizing that a number of questions about the operations and future configurations of both WFH and CVH warranted further study, the same legislation that separated the two hospitals also created a legislatively-appointed task force to research and recommend further changes.

### **The Facilities Today**

#### *Whiting Forensic Hospital (WFH)*

WFH is located in Middletown, CT, on grounds contiguous with CVH. It is comprised of two distinct buildings: Whiting Maximum Security Building (constructed in the 1970s and originally

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<sup>3</sup> / 42 U.S.C. § 1997

<sup>4</sup> / Joint Motion for Entry of Settlement Agreement, January 20, 2009. *U.S.A v. Connecticut*, Civ. No. 3:09-CV-85 (D.Conn.)

<sup>5</sup> / Ironically, Whiting’s parent institution, CVH, which had been responsible for overseeing the Whiting Services Division when the abuse scandal broke, and which has been the subject of a long history of complaints and violations of various requirements (as mentioned above), remains statutorily exempt from the ongoing scrutiny inherent in state licensing.

called Whiting Forensic Institute) and Dutcher Hall, an older, re-purposed CVH building which houses an enhanced (but not “maximum”) security program. According to the DMHAS website:

*Whiting Forensic Hospital specializes in providing inpatient services to individuals involved in the criminal justice system. The hospital consists of 91 maximum security beds and 138 enhanced security beds. Services are provided to individuals who are admitted under the following categories:*

- *Psychiatric Security Review Board commitment*
- *Criminal court order for restoration of competency to stand trial*
- *Civil commitment (voluntary or involuntary)*
- *Transfer from the Department of Correction (during period of incarceration or at end of sentence)*

Despite characterizing Whiting as “specializing” in providing services to individuals involved in the criminal justice system, many of the patients at the Whiting maximum-security unit have not been placed there secondary to a criminal proceeding. Rather, DMHAS administrators have long had the option to admit an individual who is otherwise in their custody pursuant to a civil commitment into the Whiting maximum security unit if a determination is made that the individual cannot be safely served elsewhere. At present, a number of the “long-term” residents at the Whiting maximum security unit reside there pursuant to a civil commitment, and have no current involvement in the criminal justice system. Since Whiting has now become a freestanding DPH-licensed hospital, formal admission and discharge planning processes will need to be observed.

Dutcher, the enhanced security building, is primarily used as a “step-down” unit for individuals at the Whiting maximum security unit who have been deemed to no longer require placement in a maximum security setting, but who have nevertheless been deemed to require an enhanced degree of restriction and support not otherwise afforded by any other state inpatient psychiatric facility.

The CEO of Whiting Forensic Hospital now reports directly to the Commissioner of Mental Health and Addiction Services, and, by operation of Public Act 18-86, as of July 1, 2018, the hospital is subject to licensure and oversight by the Connecticut Department of Public Health.

### *Connecticut Valley Hospital (CVH)*

CVH currently consists of two divisions: General Psychiatry and Addiction Services. On the Middletown campus, inpatient programs are located in Merritt, Battel and Woodward Halls. An inpatient program for young adults, or Young Adult Services (YAS), is located in Merritt Hall. The number of beds for CVH is approximately 350. (The CVH Hartford Campus, also known as Blue Hills Hospital, operates under the auspices of the Addiction Services Division and has 42 beds.) Beyond inpatient services, CVH hosts a number of other DMHAS divisions and programs, including the Safety Security Division (DMHAS Police), Consulting Forensic Division, and an Education and Training Division. The Local Mental Health Authority, River Valley Services, also operates programs on the campus. At its peak in 1950, CVH served a population of 3,000 inpatients. Many of the buildings were built in the 19<sup>th</sup> and early 20<sup>th</sup> centuries, and, while listed on the National Historic Register, are no longer occupied.

CVH's inpatient psychiatric units are statutorily exempt from licensure by DPH. However, those units do participate in federally funded programs administered by the Centers for Medicare and Medicaid Services (CMS), and as such, must meet certain "conditions of participation". CMS contracts with the Connecticut Department of Public Health (DPH) to periodically survey participating facilities and investigate complaints related to conditions of participation. As previously stated, over the past 25 years, CVH has been the subject of a number of federal investigations, including inquiries in response to patient elopements, suicides and allegations of abuse and neglect.

# INVESTIGATIVE PROCESS

## TRACKING PEOPLE AND PRACTICES IN A CHANGING ENVIRONMENT

Conducting the inquiry proved to be more complicated than originally thought, largely because new questions emerged as Whiting's administrative terrain shifted and efforts to improve practices evolved. Beyond the major changes to structure, leadership and oversight noted above, Whiting's current leadership has launched "Whiting 2020 Moving Forward," a campaign to comprehensively re-examine assumptions and effect positive changes in policy, practices and organizational culture. As DRCT investigators found, and the current leadership at Whiting well knows, there is an urgent need for such changes. However, there are also significant barriers, and the history of previous attempts at reform at CVH suggests that bringing transformative change to the hospital's culture presents a formidable challenge. While the ultimate success of this effort can only be judged with the passage of time, the DRCT investigation did identify concrete steps that could lead to accelerated and long-lasting improvement in this area.

The investigation process was greatly assisted by the openness and cooperation of the administrative team at Whiting. Meetings with the CEO and other managers provided an opportunity to discuss observations and inquire about plans, including the introduction of new policies, staff training, and incident review processes, as well as efforts to address the permissive climate and supervisory gaps that had allowed the egregious abuse of Mr. Shehadi to persist. From these activities, and through observations made at various team and clinical meetings, a picture emerged of an institution that was sincerely trying to change for the better, but which is still struggling to raise consciousness and cultivate new competencies at all organizational levels. Currently, the fairest, most accurate way to describe Whiting Forensic Hospital would be to say that it is a work-in-progress. Accordingly, this report is as much about the current status of that still-evolving progress as it is a final account of DRCT's completed inquiry into discrete questions.

The DRCT investigation was not intended to examine all aspects of clinical and administrative practices at CVH/Whiting and has not done so. Consistent with its statutory mandates, DRCT's focus is on the civil rights of the hospital's patients. However, in a psychiatric hospital where people are involuntarily confined, whether through civil commitment processes or as a result of criminal proceedings, and where the exercise of fundamental rights is severely restricted, there are both legal requirements and an ethical obligation to provide effective treatment. Accordingly, the DRCT investigation did inquire into the content of individual treatment plans, the fidelity with which those plans and relevant administrative policies are being implemented, the relative effectiveness of certain treatment modalities, the nature of staff/patient interactions, and the apparent strength of newly implemented safeguarding mechanisms. To assist in this aspect of the investigation, DRCT contracted with Rafael Gallegos, Psy.D., who is a recognized expert in developing and implementing successful treatment plans and programs for people with needs similar to those of the patients at CVH and WFH.

Despite the heavy emphasis on issues that arose at Whiting, in conducting its inquiry DRCT felt it important to also direct attention to CVH. CVH was administratively responsible for Whiting's operation at the time that Andrew Vermiglio died and William Shehadi was being abused. In a very real sense, Whiting's failure was also CVH's. Further, some of the patients DRCT interviewed had been transferred from other units at CVH to the Whiting Services Division – sometimes going back and forth several times. Examinations of their CVH records revealed, among other things, unacceptable delays in securing evaluations and developing and

implementing individual treatment plans, as well as failures to ensure that relevant health information was transmitted as patients moved within the campus.

## **INVESTIGATIVE STEPS**

In reaching their findings and recommendations, DRCT investigators relied upon the following:

### **Facility Visits**

DRCT investigators made numerous in-person, on-site visits to patient common living areas of the various units in the maximum-security building of WFH and the enhanced security unit program at Dutcher. The vast majority of these visits were unannounced, were unaccompanied, and occurred in the morning, afternoon, and early evening. The earliest on-site visit occurred at 8:00 a.m. – the latest concluded at 9:00 p.m.

### **Patient Interviews, Including Patient Survey**

Confidential interviews were held between DRCT investigators and multiple patients. In addition, DRCT investigators offered long-term patients at the Whiting Services Division the opportunity to participate in a standardized survey regarding their experience, or their perception of, the “culture” at the Whiting Services Division. The survey questions were based upon principles outlined by the federal Substance Abuse and Mental Health Services Administration (SAMSHA) regarding “trauma-informed care” which set forth certain guidelines SAMSHA has determined to be necessary in creating a safe, therapeutic environment. Participation in the survey was voluntary, anonymous, and the interviews were conducted in private. In all, nineteen of the long-term patients chose to participate in the survey.

### **Record Reviews**

With the permission of the patients, or of patients’ conservators, DRCT investigators conducted comprehensive reviews of the facility records for several patients. These reviews were assisted by consultations with Dr. Gallegos. DRCT investigators also reviewed video recordings of various events involving some of the patients whose records were reviewed.

### **Internal and Third Party Investigation Reports and Plans of Correction**

DRCT investigators gathered and reviewed numerous investigative reports pertaining to the Whiting Services Division, Whiting Forensic Hospital and CVH. Below is a list of reports reviewed:

- Office of the Chief Medical Examiner Post-Mortem Report on Andrew Vermiglio
- Connecticut State Police Investigation Report regarding the death of Andrew Vermiglio
- Centers for Medicare and Medicaid Services (CMS) Surveys & Findings 7/12/17
- Department of Public Health (DPH) Statement of Deficiency Reports for surveys dated 9/14/17; 10/28/17 (resurvey); 1/18/18; 12/4/18; 4/12/19; 5/2/19 (Whiting only); 6/16/19.
- CVH and WFH Plans of Correction, dated 10/6/17; 11/1/17; 12/8/17; 2/28/18; 1/25/19 (amended); 5/10/19; 5/17/19; 6/27/19.
- DMHAS and Whiting Forensic Hospital Policies and Procedures
- United States Department of Justice Civil Rights Division CRIPA (Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997) Investigation of the Connecticut Valley Hospital, Middletown, CT, August 6, 2007.
- United States District Court for the District of Connecticut Joint Motion for Entry of Settlement Agreement, January 20, 2009. *U.S.A v. Connecticut*, Civ. No. 3:09-CV-85 (D.Conn.)

## **FINDINGS**

To better understand what is at stake for the people living at CVH and WFH, DRCT investigators became acquainted with a number of the people housed there. Their willingness to share their stories and information from their records provided both the factual basis for, and much of the interpretive insight behind the findings of this investigation. Perhaps more importantly, getting to know these people drove home the injustice of keeping them hospitalized in environments that are characterized by low expectations and indifferent treatment. Detailed profiles of several of these individuals are located in the appendix of this report and excerpts from these profiles are included in the body of this report to illustrate the urgent need to change institutional dynamics. There are many more “long term” patients like these individuals at CVH and WFH, each awaiting a genuine chance at recovery.

Investigations into abuse, neglect and civil rights violations in human service programs typically yield a statement of facts found, an analysis of the evidence that supports those findings, and, if warranted, recommendations for remediation. While DRCT investigators did find a number of specific facts, they also observed an on-going process of administrative reform at WFH— an active, iterative process which, while far from complete, holds hope for further, genuine organizational change. What follows is both a statement of specific findings regarding the initial questions that prompted the DRCT investigation, and a report on the current status of reform efforts at Whiting, accompanied by recommendations for further changes that should be implemented at both WFH and CVH.

### **Some things are changing for the better at Whiting Forensic Hospital.**

In response to deficiencies identified by the various inspections and surveys conducted in the wake of abuse revelations, and in anticipation of needing to meet DPH licensing requirements, the new team of Whiting Forensic Hospital administrators developed revisions to policies, and established new oversight procedures and training requirements for staff. The new policies place heavy emphasis on reporting incidents and ensuring various levels of administrative review. Hospital-wide supervisory meetings now occur on a daily basis to review incidents and discuss responses. In addition, many of the vacancies created by the departure of staff who resigned or were terminated as a result of investigations, have been filled (although some of those who were terminated have been returned to duty through arbitration).

Most notably, the hospital has expanded its Quality Assurance and Patient Advocacy Services by adding Advocates and Recovery Support Specialists to its staff, and hiring both a Quality Improvement Manager and a Behavior Management Intervention Specialist. Steps have also been taken to involve patients in efforts to improve the overall “climate” including sponsorship of intramural basketball games, cook-outs, and other recreational activities, as well as creation of a patient-led Steering Committee for the Whiting Maximum Security Building. (The Dutcher Enhanced Security Program already had such a committee.) These changes appear to be having a positive effect, as measured by a reduction in the number of complaints (“grievances”) filed by patients.

## **However, very significant problems persist.**

It is clear that major issues remain, at Whiting Forensic Hospital, which recently underwent, and in important respects failed, its first DPH licensing inspection. In many ways, the most difficult challenge facing leaders at Whiting involves reforming the hospital's organizational culture - the inter-related patterns of beliefs, roles, informal practices and expectations which subtly but powerfully define the identities and influence the experiences of both patients and staff, and, less directly, project messages to the outside world about the hospital and the people it serves. That challenge is made all the more difficult by the less-than-coherent mix of mandates, founding assumptions, systemic needs and general cultural stereotypes that surround a "maximum-security" hospital. Presumably, the legislatively appointed task force that is currently studying issues at Whiting and CVH will be able to thoughtfully re-consider the effects of Whiting's multiple, externally defined mandates, whether they are expressed in statute or in DMHAS policy. However, DRCT investigators found certain problematic practices that can be addressed internally and promptly that operate to thwart the stated goal of patient recovery, and that have contributed to the permissive culture in which abusive treatment has occurred. They are as follows:

### **1. Use of Restraint for Discipline in Lieu of Treatment or for the Convenience of Staff**

Section 46a-152(c) of the Connecticut General Statutes prohibits the use of restraint or seclusion except "as an emergency intervention to prevent immediate or imminent injury to the person at risk or to others, provided the restraint [or seclusion] is not used for discipline or convenience and is not used as a substitute for a less restrictive alternative..." This law has been on the books since 1999. In 2002, DMHAS issued Commissioner's Policy Statement #22-B, which cites the Connecticut statute as well as federal Medicare/Medicaid rules, and standards from the Joint Commission on Accreditation. The DMHAS policy essentially restates the rule articulated in statute:

[T]he use of restraint as a means of coercion, discipline, convenience or retaliation by staff shall not be tolerated.

Restraint shall only be used as a time-limited, emergency safety measure for patients who are at imminent risk of physically harming themselves or others, and only after all other interventions have failed or found to be inappropriate.

Despite the clear language in both statute and policy, DRCT investigators reviewed a video recording of an August, 2019 incident which confirmed that mechanical restraints are still being used at Whiting as a means of punishment and/or for the convenience of staff, and in circumstances where there was no immediate or imminent risk of injury. The incident involved two patients who became involved in a physical altercation in a unit bathroom. The altercation was broken up by staff, the combatants were separated and ceased struggling. The staff then escorted one of the individuals to the restraint room, where he cooperatively laid down on the restraint bed and calmly allowed staff to apply restraints to his wrists and ankles. The video recording shows that at one point a unit psychiatrist entered the room and briefly examined the man, and that at another time he was offered a glass of water, which he drank while still in restraint. At no time did he offer any resistance or appear to be struggling; he remained calm for the entire duration of the restraint, which lasted a total of 33 minutes. DRCT investigators viewed the video recording of the incident with senior administrative and senior clinical staff, none of whom indicated they saw any problem with the way the incident had been handled.

The use of restraint as a punishment and means of control is apparently deeply ingrained in the culture at Whiting – so deeply that no one involved appeared to recognize how inappropriate and illegal it was to place into restraints an individual who was, at the time, perfectly calm and no longer presenting any risk of injuring himself or others. The review and unselfconscious approval of the incident by senior administrators and clinicians is an indication of the level and type of re-training that will be necessary to impact this area of Whiting culture.

## **2. Inadequate Individual Assessment and Treatment Programming**

Patients at WFH are generally categorized and sorted according to their legal status – those who have been committed to the Psychiatric Security Review Board (PSRB);<sup>6</sup> those accused of crimes who are being assessed for competency or for restoration of competency to stand trial; those who have been transferred from the Department of Correction; and, civilly committed patients who have been transferred from another psychiatric care setting. For treatment purposes, however, neither a person's legal status nor the records that may accompany them upon admission are likely to provide sufficient background and diagnostic information to allow the hospital to formulate an effective individual treatment plan. In fact, while very different life paths may bring people to WFH, one thing many share is a history of ineffective prior interventions - a history which is often rooted in inadequate assessment of their identities and needs by treatment and educational professionals. It follows, therefore, that the first order of business for a newly admitted patient should be development of a thorough, comprehensive assessment – one which seeks to understand the biological, psychological and social factors that have influenced the person's development, and which must be considered if treatment efforts are to succeed in supporting recovery. And, the next step should be formulation of a comprehensive, individually-relevant treatment plan – one that is informed by both the best that behavioral science has to offer, and the insights about individual identity and needs that have been revealed by a sound assessment.

In contrast to this approach, the treatment records reviewed by DRCT and its expert consultant, Dr. Rafael Gallegos, often reflected deficiencies in both assessment practices and individual treatment planning. Dr. Gallegos prepared the following summary of his review of the treatment plan of a young man with autism who is committed to the PSRB and resides in WFH:

The records reviewed, however, reveal treatment that is centrally focused on containing and managing aggressive behavior and effecting an absence of maladaptive behavior, rather than teaching and reinforcing specific adaptive behavior (i.e. functionally equivalent behavior). [The patient's] treatment plan is heavily reliant on a unit level system that is inherently coercive and punitive. The psychiatric formulation [diagnostic impression] that exists lacks precision, while the functional analysis/positive behavior support plan does not meet minimal standards of practice with regard to the measurement and manipulation of contingencies associated with discrete behaviors. The records suggest that habilitative interventions are offered through individual and group psychotherapy and activities, yet there is no clearly articulated rationale for why this patient is assigned and must attend a certain number of specific groups or how his individual psychotherapy and psychopharmacological treatment intersects with his overall treatment plan. Overall, there is significant inconsistency and lack of clarity in this patient's treatment plan/goals across

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<sup>6</sup> / The PSRB's mission is stated as: [t]o protect the safety of Connecticut citizens by ordering treatment, confinement or conditional release of persons acquitted of a crime by reason of mental disease or defect. (C.G.S. Section 17a-580 et seq.) The PSRB reviews reports regarding acqutees' treatment and holds periodic hearings to review the appropriateness of their placements. It can consider requests for changes, usually to less restrictive settings.

the ITP [Integrated Treatment Plan], the behavioral guidelines developed for this patient, and the essential components of the unit level system.

Additionally, it has been variously documented that [the patient] has a history of trauma, yet the established unit behavioral interventions, which were made applicable to this patient, do not appear to be trauma informed. Instead, it appears from the records reviewed that [the patient] has responded by isolating, which is a common maladaptive strategy for traumatized persons. He does not attend groups with any type of consistency and spends much of his time either "resting in his room" or "sleeping," for which he is penalized through the level system. Finally, the records reviewed and collateral communication with [the patient's] mother reveal that she is not closely involved in his treatment. This, in effect, neglects an important systemic factor identified in the etiology of this patient's problematic behavior.

In conclusion, it is doubtful that the current clinical approach, which appears to be heavily informed by existing clinical practice/culture on [the] Unit...rather than an individualized approach, will help this patient effect positive behavioral change. Based on the records made available for review, there also appears to be a systemic lack of awareness of iatrogenic factors [problems caused or exacerbated by the treatment he is given] imbedded in the current milieu and little consideration for the fact that [the patient] has immutable neurological/clinical conditions that make it very unlikely that he will ever [meet the criteria that have been stated as necessary for him to move to a less restrictive environment.] (See Appendix for further information.)

Unfortunately, the experience of this patient is not atypical. In response to DRCT's survey questions, several patients who have more ability to consciously control their behavior indicated that while they did not really agree with what was written in their treatment programs, they "went along with the program," attending group meetings just to get "signatures," and otherwise "making no waves" in hopes that favorable reports to the PSRB would help "get me out of here."

### **3. Denial of Patient Rights by DMHAS Police**

During the course of investigating Andrew Vermiglio's death, DRCT encountered disturbing evidence that the DMHAS Police had, without apparent justification or subsequent challenge by Whiting officials, acted to deny Mr. Vermiglio his right to receive visitors. On one occasion, he was denied an opportunity to visit (under close 2:1 observation) with his mother, who had come to see him. Further, on the day before he died, Mr. Vermiglio was also denied a visit with an attorney from the Connecticut Legal Rights Project (CLRP).<sup>7</sup> In addition to constituting stark violations of patients' rights (CGS 17a-547 specifically guarantees patients the right to receive visitors, including family members and attorneys), these incidents reflect the degree to which decision-making authority at Whiting is fragmented in administratively isolated domains. Even when the patient's rights are explicitly protected in law, they can apparently be disregarded without explanation or consequence by the DMHAS Police.

### **4. Dependence on Frequent, Regular Use of PRN, STAT and IM Psychotropic Medications**

At both CVH and WFH, the application of mechanical restraints to a patient is frequently accompanied by intramuscular (IM) injections of powerful, sedating psychotropic medications that

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<sup>7</sup> / CLRP is an independent source of advocacy and legal representation for DMHAS patients. It is supported by DMHAS in accordance with the terms of a federal consent decree.

are administered STAT (urgently).<sup>8</sup> In addition, many patients' Integrated Treatment Plans call for the use of PRN (as needed) psychotropic medications that can be administered on top of those that are given to them on a regularly scheduled basis. Indeed, some of the treatment records reviewed by DRCT investigators revealed that PRN psychotropic medications were being used with such frequency that they could be considered as part of the patient's routine regime of medication. For instance, the records of one of the individuals profiled in the appendix indicated that in the sixty-one (61) day period between December 1, 2017 and January 30, 2018, she received PRN psychotropic medications on seventy (70) separate occasions. Additionally, over the course of her three-year commitment at CVH (which included several stays at Whiting) she has been placed into mechanical restraints 37 times, receiving IM injections of psychotropic drugs on 21 of those occasions. Yet neither the frequency with which PRN psychotropic medication was administered, nor the episodes of restraint (some of which resulted in injuries), nor the use of STAT, IM psychotropic medication, resulted in any adjustment to her Integrated Treatment Plan. In fact, the records from regularly scheduled treatment plan reviews for this patient reflect no discussion or review of the use of PRN, STAT or IM psychotropic medications, the episodes of restraint, or the injuries she sustained. Treatment records of other patients reflect similar omissions. DRCT investigators found the administration of PRN, IM or STAT psychotropic medications, and episodes of restraint are recorded in nursing notes and unit logs, but are seldom noted or considered in reviewing patients' treatment plans.

Part of the problem lies with the fact that medical orders for the PRN psychotropic medications at both CVH and WFH indicate that psychotropic medications can be used to respond to signs of anxiety and/or agitation – general terms that are subject to varying interpretations by unit staff and which do not require much detail about, or analysis of the particular circumstances that may have given rise to whatever problem the medications are intended to address (e.g. the “antecedents” that preceded particular behavior). However, the real problem stems from a culture, prevalent in both institutions, that views programmatic interventions and supports as being separate from, and of secondary importance to pharmacological, molecular-level interventions (despite the descriptor of its individual treatment plans as “integrated”). Between the frequency with which PRN, STAT and IM psychotropic medications are being used, and the disconnect between individual behavioral support programming and these medication practices, DRCT has determined that patients' rights were violated when WFH and CVH failed to comply with the requirements of Section 46a-152(c) of the Connecticut General Statutes, which states:

No provider or assistant may use a psychopharmacologic agent on a person at risk without that person's consent except (1) as an emergency intervention to prevent immediate or imminent injury to the person or to others, or (2) as an integral part of the person's established medical or behavioral support plan, as developed consistent with section 17a-543 or, if no such plan has been developed, as part of a licensed practitioner's initial orders. ***The use of psychopharmacologic agents, alone or in combination, may be used only in doses that are therapeutically appropriate and not as a substitute for other appropriate treatment.***

(Emphasis added.)

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<sup>8</sup> / “Chemical restraint” can also refer to the routine administration of psychotropic drugs in high dosages so as to limit freedom of movement and/or ability to interact with others.

## **5. Use of the “Level System” as a Mechanism of Control and Default Treatment Plan**

The “level system” used in the WFH assigns different “levels” of restrictions and privileges to patients, based on their conformance with behavioral expectations. While considered to be part of the “therapeutic milieu”, and often mentioned as an element in patients’ “Integrated Treatment Plans”, as it is actually implemented, the level system is more about facility management than therapeutic treatment. Theoretically, uniform criteria are used to determine whether patients move up or down the level steps. However, there are notable variations in implementation between the different living units, and DRCT investigators observed that changes in individuals’ level status are often made, or threatened to be made based on arbitrary judgments by staff (e.g. “If you do that again, you’ll lose a level.”). In the enhanced security building (Dutcher Hall) opportunities to exercise earned privileges are frequently curtailed as they are contingent upon staff availability (e.g., time off the unit, out of the building, etc.).

The level system may be especially counter-productive for individuals with intellectual, cognitive and developmental disabilities, as it often requires compliance with expectations that they either cannot meet or which have little meaning for them (e.g. maintaining orderly personal space and attending group meetings where discussions may be difficult to follow or not seem relevant). When they fail to meet those expectations, the system punishes them, depriving them of access to rewarding experiences that could be incorporated as reinforcers in behavioral programs that would actually help them acquire skills and learn more adaptive behaviors. For some, the punitive aspects of the system may also exacerbate feelings of anger and resentment rooted in previous life experiences, provoking counter-productive, responses – responses which further lock them into the system’s lowest levels. In a similar way, the level system also works to the particular disadvantage of individuals who, due to a variety of neuropsychiatric conditions, are subject to compulsive behaviors or are otherwise unable to control their impulses. (See Appendix regarding Andrew Vermiglio.)

Less obvious, but no less important, because the level system is seen as part of the “therapeutic milieu” and is so frequently mentioned in patients’ Integrated Treatment Plans, it purports to occupy space on the therapeutic continuum that should properly be filled by individually-tailored, trauma-informed programs. DRCT investigators learned that the level system is currently under review at the Whiting maximum security building. Hopefully, that review will conclude not only that continued reliance on such an arbitrary and archaic mechanism is undesirable, but also that it should be replaced by much more thoughtfully developed, individually designed and competently implemented therapeutic approaches.

## **6. Inadequate Abuse and Neglect Reporting and Investigation Protocols**

Whiting Forensic Hospital’s Operational Procedure Manual (as revised June 5, 2018) describes the processes used for “Patient Safety Event and Incident Management” including the investigation of allegations of abuse, neglect and exploitation of patients by facility staff.<sup>9</sup> The procedure manual defines five broad groupings of reportable events or conditions (incidents; patient safety events; adverse events; sentinel events; and critical incidents) and lists 60 distinct types of incidents that must be reported, each of which is assigned a unique code number. Forms are to be completed according to detailed instructions, statements submitted in written form by

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<sup>9</sup> / While the Manual is “new” in that it has been tailored to reflect the organization of the recently established WFH, many of its provisions, including an elaborate system for classifying, tracking and assigning different layers of responsibility for responding to incidents, are similar to the already existing procedures in use at CVH.

witnesses, and initial reviews made by unit directors or supervising nurses. Incident reports are tracked in an automated Risk Management and Notification System (RMANS), and, depending on the nature of the incident or condition, are reviewed at multiple administrative levels.

All allegations of abuse, neglect and exploitation (ANE) are considered to be critical incidents, and must be reported and tracked accordingly. The manual also clearly indicates that all allegations of ANE must be investigated. However, the ANE investigation process focuses on determining whether there has been a “work rule violation” by staff members, seldom examining the issues that may have contributed to underlying, problematic conditions, including possible facility neglect. For example, if there is a patient-to-patient altercation an ANE investigation is not triggered unless there is an allegation that a staff member violated a work rule which then resulted in the altercation. There may be a referral to the DMHAS Police or State Police to undertake a criminal investigation, but there is no trigger on the part of DMHAS to conduct an abuse or neglect investigation. Without a work rule allegation, an ANE investigation is not required even though the altercation may have resulted from a failure of the treatment team to note background conflicts, or avoid placing certain patients together, or failing to program for a patient’s triggers, or missing behavioral clues that may have been misunderstood due to inadequate training or support resources for staff. While these issues might be identified through one of the other, multi-level incident review processes described in the procedure manual, they do not seem to fall within the scope of ANE investigation protocols. Thus the single-minded focus on work rule violations limits the usefulness of ANE investigations in protecting the rights and safety of the patients and, undercuts its potential as an organizational learning tool. In situations where both work rule violations and systems issues may have contributed to patient neglect, the interconnection between the two is obscured and inadequately explored under the present system for investigating complaints.

Recently, the Commissioner issued a new “Client Abuse” Policy, replacing Commissioner’s Policy #29 on 9/18/18 in response to the requirements of Section 2 of P.A. No. 18-86. This is an important, positive step, especially in light of the longstanding abuse of Mr. Shehadi, which occurred in the maximum-security building while it was still operating as a division of CVH. Long before the video recordings that confirmed the egregious nature of that abuse were finally reviewed by administrators, Mr. Shehadi had reported, on multiple occasions, that he was being abused by multiple staff members. Those reports were dismissed because he was perceived as a chronic complainer – someone who made frequent, groundless allegations. Indeed, a formal protocol existed for disregarding allegations made by individuals who had made two or more unsubstantiated allegations of abuse against staff members. A less formal, parallel practice may also have existed with respect to patients whose thought processes were not always coherent. For example, during his stay at the Whiting Division of CVH, progress notes indicate that, on five separate occasions, Andrew Vermiglio made allegations of abusive treatment. However, despite later statements made to DRCT investigators by other patients, and a report filed by Mr. Vermiglio’s attending psychiatrist, both of which support Mr. Vermiglio’s claims of being mistreated, there are no records of anyone ever following up on his allegations. There may be very limited circumstances under which individual protocols of that nature could be justified by a patient’s history of delusion or manipulation. However, such exceptions to the “all allegations will be investigated” rule must be approached with extreme caution, and periodically tested by actually conducting full-blown investigations. Patients with “reputations” for reporting allegations (i.e., Mr. Shehadi), or who are affected by disorganized cognitive processes (i.e., Mr. Vermiglio) are among the most vulnerable to actually being abused and neglected.

## 7. Inadequate Death Investigations

During the course of investigating the death of Andrew Vermiglio statements were taken by DMHAS Police from witnesses and from participants in the events surrounding the incident (see appendix). The DMHAS Police investigation concluded that there was: “no evidence to support that a criminal act was committed pertaining to the death of Andrew Vermiglio.” However, the Police investigation appears to have been less than thorough. At least some of the claims made in the statements signed by the two Forensic Treatment Specialists (FTSs) who were supposed to be closely observing Mr. Vermiglio, and who were admittedly involved in restraining him immediately prior to his death, are not supported by a video recording made from a surveillance camera located in the corridor outside Mr. Vermiglio’s room. More specifically, the FTSs’ claimed that Mr. Vermiglio entered the corridor from his room several times, the last time “running out” of his room, swinging his arms in a hostile manner, looking as if he was going to punch them. They further claimed that they then took him by the arms and “escorted” him back into his room.

The video recording tells a different story: Mr Vermiglio is seen to enter the corridor several times, but each time returns, unescorted, to his room. After he re-entered his room for the last time, the FTSs, who were stationed outside the room, one seated, the other standing, are seen to rush into the room. As the video camera was located in the hallway, it could not capture what happened next, in Mr. Vermiglio’s room. However, the recording makes clear that at no time did Mr. Vermiglio rush out of his room into the corridor, swinging his arms or acting in a hostile manner. Yet, the DMHAS Police report makes no mention of the discrepancies between the statements of the two FTSs and the recorded video evidence. Nor do the investigator’s notes from witness interviews indicate that either of those two staff members were questioned about those discrepancies. Their statements about the nature of the restraint hold they applied to Mr. Vermiglio (a brief “escort hold”) were accepted without question, and repeated to other investigating agencies, including the State Police and the Office of the Chief Medical Examiner (OCME). The Medical Examiner who conducted the post mortem examination had not been initially informed that Mr. Vermiglio was subjected to any restraint immediately prior to his death. She learned that a physical hold had been used after reading a CMS/DPH investigation report, and then requested that the State Police investigate. Assured by a State Police investigator that the DMHAS police investigation had been thorough, and that the restraint hold used was a “brief escort hold”, the OCME’s finding that Mr. Vermiglio’s death was caused by “asphyxia due to obstruction of airway by food bolus” was allowed to stand.

As indicated in the Appendix, DRCT investigators were not able to determine exactly what happened in Mr. Vermiglio’s room on the evening of December 1, 2016. The “food bolus” referred to by the OCME was presumed to be comprised of Fig Newton cookies he had been given as a snack. However, it is important to note that, on autopsy, the Medical Examiner found no physical evidence of an obstruction in Mr. Vermiglio’s airway. She reached her conclusion about the cause of Mr. Vermiglio’s death based on information that had been reported to her by others - information that originated with staff at Whiting. However, there may also have been other factors that were not reported. According to notes made by one of the responding nurses, Mr. Vermiglio “vomited fluid and that a sweep of his mouth cleared a large amount of debris, unable to get airway.... Suction machine used – large amount of liquid debris removed.” According to the unit nurse who first attempted resuscitation, Mr. Vermiglio “projectile vomited” and also lost and regained consciousness several times during the episode, suggesting the possibility that the fatal airway

obstruction he experienced was due to aspirated stomach contents rather than the direct result of choking on food.

Given the discrepancy between the recorded video evidence and the description of events provided by the two Forensic Treatment Specialists, a more thorough inquiry by investigating officers might have asked additional questions such as: exactly what prompted the two FTSs to rush into Mr. Vermiglio's room from the hallway (as they are seen doing on the video recording); why did they claim that Mr. Vermiglio rushed at them, emerging into the hallway swinging his arms "in a hostile manner" when the video recording shows no such activity; how and exactly where in Mr. Vermiglio's room did they restrain him; and at what point during their intervention was it recognized that he was in distress? <sup>10</sup>

## **8. Incoherent Mix of Patient Identities and Needs**

According to the WFH page on the DMHAS website, patients are admitted to the 91-bed Whiting Maximum Security Building in one of four ways:

- Psychiatric Security Review Board (PSRB) commitment
- Criminal court order for restoration of competency to stand trial
- Civil commitment (voluntary or involuntary)
- Transfer from the Department of Correction (during period of incarceration or at end of sentence)

Of the five populated "units" that comprise WFH, two are designated for patients committed to the PSRB, and three are designated for competency determination/restoration. However, many of the patients at WFH do not fit neatly into either of the designated unit categories. These are people who have been civilly committed to DMHAS, many of whom have transferred from CVH and/or from other hospitals because they presented risks of harming themselves or others that apparently could not be safely contained in the general psychiatric units to which they had been originally assigned. While these individuals have no current involvement with the criminal justice system, they are inter-mixed amongst the various units, principally within the PSRB units. And, as is also true of those under PSRB commitment orders and those for whom competency to stand trial is an issue, these "civilians" present a variety of disability profiles, some having been identified as intellectually or cognitively disabled, autistic or manifesting organically-based behavioral challenges which neither the CVH nor WFH are well prepared to meet.

The forensic lens is powerful, and the realities of PSRB scrutiny can influence clinical perceptions of patient needs, even among those who are civilly committed. Instead of trying to fit people who do not truly need and, do not benefit from the "maximum-security" environment, into units where their identities and programmatic needs are not recognized and cannot be met, resources would be better spent creating or strengthening alternatives. Even selected individuals who have been committed to the PSRB could potentially benefit from enhanced alternative programming that is made available beyond the walls of WFH. While creating new options of this nature may be beyond the capacity of Whiting itself, some reconfiguration of the current unit structure would offer

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<sup>10</sup> / Unfortunately, DRCT investigators were unable to interview the FTSs, as they had both been terminated from employment as a result of the investigation into the abuse of William Shehadi. For a more detailed description of the video recording and the DMHAS police investigation, please refer to the Appendix Section of this report.

the opportunity to improve outcomes for individuals with dual diagnoses, and would help demonstrate the value of developing discrete program environments for particular populations.

### **9. Lack of Interdisciplinary Team Processes**

A number of successful community-based programs that serve individuals with significant behavioral disorders depend on interdisciplinary treatment teams to develop, adjust, and monitor treatment and support efforts. Those teams include representatives from relevant clinical disciplines and the direct service workers who support the particular individual. They meet frequently, helping to ensure that information and insights are communicated and discussed, learning needs are identified, observations and data collection are validated across disciplines, and that the dynamic nature of behavioral change is anticipated and can be accommodated on an on-going basis. Perhaps most importantly, the team meetings also allow clinically trained professionals and direct service workers to genuinely collaborate, focusing on the particular individual being supported, who is also often included in team discussions. Team members can check-in with each other, reporting on how things are going and discuss how they, themselves, are reacting to the work in which they are engaged.

In contrast, the treatment teams at WFH tend to be dominated by the discipline of psychiatry, with other clinical disciplines assuming lesser roles, and the Forensic Treatment Specialists, who interact most directly with patients, playing little or no role. The result is a stratified, hierarchical model of treatment delivery – one that leaves those with “hands on” roles more likely to trust informal leaders within their own ranks than senior clinicians. The absence of genuine, fully functioning inter-disciplinary treatment teams is felt most acutely in supporting patients who present significant behavioral challenges, as those individuals most need to be surrounded by competent, collaborating team members. (See Appendix regarding M.C.)

### **10. Levels of Staff Engagement with Patients**

Over the course of multiple visits, DRCT investigators noted a tendency for Forensic Treatment Specialists and other unit staff to congregate in “the bubble” – the central, windowed office area located in each of Whiting’s six living units which serves as a nurses’ station, supervisory office and unofficial staff sanctuary. The investigators also observed that it was much easier for them to get the attention of unit staff who were in “the bubble” than it was for the unit’s patients. WFH administrators started to address this phenomenon after it was brought to their attention by DPH inspectors. The underlying issue, however, involves the level and type of engagement unit staff have with patients. Continued efforts are needed to support and supervise FTS staff in constructively engaging with patients in meaningful activities. This is a critically important element in any effort to address organizational culture change at WFH.

### **11. Persistent Problems Remain at CVH Similar to Those at WFH**

With stunning revelations about abuse at the Whiting Services Division and the subsequent separation of Whiting Forensic Hospital from CVH, attention has understandably focused on efforts to address problems at Whiting. However, this focus has had the unfortunate effect of leaving persistent problems at CVH in the shadows. The long history of CMS surveys of federally certified units at CVH, replete with multiple deficiency findings, all responded to with promissory plans of correction, is but one indicator of the persistence of those problems. Another can be found in the records of individual patients whose recovery is limited by unacceptable delays in obtaining necessary evaluations and appropriate, individual support programs; by potentially

dangerous lapses in communication; and by assumptions about chronicity that translate into low expectations. M.C.'s experience exemplifies these concerns.

Approximately three years ago (when she was 21 years old) M.C. was admitted to CVH, after aging out of special education and DCF eligibility. With the exception of an unsuccessful six-week stay with a community service provider, she has lived in one or another unit of either CVH or WFH ever since. With few exceptions, the same issues described above (existent in WFH), became evident in the care and treatment M.C. received from CVH. For example, M.C.'s experience with PRN, STAT and IM psychotropic medications. While at CVH, between December 1, 2017 through January 30, 2018, M.C. received PRN psychotropic medications on seventy (70) separate occasions. On thirty of those occasions, she requested those PRN psychotropic medications herself. They included 1.0 mg of Ativan, a benzodiazepine tranquilizer; 5.0 mg of Zyprexa, an atypical anti-psychotic drug; 5.0 mg of Haldol, an older type of anti-psychotic neuroleptic; and 50 mg of Benadryl, an antihistamine used to induce drowsiness. These powerful psychotropic drugs were taken in combination with each other; PRN ("as needed") in addition to M.C.'s regularly prescribed psychotropic medication.

M.C.'s frequent self-medicating with PRNs continued in the Spring of 2018. A monthly note prepared by the assigned psychologist on March 7, 2018 indicated that the frequency of required observational checks on M.C. had been reduced during 1<sup>st</sup> and 3<sup>rd</sup> shifts, "as she has been reported to be sleeping through the night and continues to be free of aggression toward self and others." On each of the preceding 5 nights however (March 2, 2018 through March 6, 2018), M.C. had received PRN psychotropic medications on third shift.

Also related to medication concerns was the administration of Thorazine to M.C. While M.C. was at CVH between May 17, 2017 through September 2017, physician order sheets and treatment plans stated M.C. had drug allergies/hypersensitivity to Thorazine. During that timeframe, M.C. received Thorazine on thirty-seven (37) occasions by mouth and on nine occasions IM. When M.C. was transferred to WFH things did not improve. During October 2018 (while at WFH), M.C. received Thorazine on three occasions (twice IM and once by mouth) even though her records still noted it as one of her drug allergies/hypersensitivity. Lastly, on September 26, 2018, a physician's order appeared in M.C.'s records for chlorpromazine (Thorazine) to be administered to M.C. for nausea/vomiting for a thirty-day period.

Medication errors were not the only problem reflected in M.C.'s records. Despite knowing about her propensity for self-injury (and having been initially admitted primarily due to incidents of self-injury), CVH failed to protect her from numerous opportunities to ingest foreign objects and/or insert them in her ears. For example, the following excerpt was recorded in a Facility Record Note dated June 12, 2018 at 3:00 p.m.:

[Patient] seen and examined. Left ear had a crumpled blue colored foil embedded at 10 o'clock position in left ear and clear tape at 4 o'clock position. [Patient] stated she "found a foil piece on floor and placed in her ear a few days ago."

Once the objects were discovered in her ear, M.C. was seen and examined by facility doctors on four occasions between June 12, 2018 and June 26, 2018. She complained of left ear pain on six separate occasions (6/18, 6/22, 6/23, 6/24, 6/25 and 6/26/18) and in return was given medication for pain. The foil and tape were finally removed on June 26, 2018 by an Ear, Nose and Throat Specialist. This is but one example of M.C.'s history of self-injury. Between December 3, 2017 and June 12, 2018, M.C. was reported to have placed foreign objects in her ear nine

times. This followed a psychological evaluation dated March 20, 2017, which indicated that “[s]he has lost hearing in one of her ears due to self-injury.”

Equally troubling was CVH’s response to M.C.’s pattern of self-injurious behavior related to ingesting foreign objects. During the time periods of July 5, 2017 – September 21, 2017; January 31, 2018 – March 29, 2018; and, April 30, 2018 – June 25, 2018 (total 6 months 11 days) M.C. ingested inedible objects on seven occasions. On three of those occasions she had to undergo endoscopies at a nearby hospital to remove the foreign objects. The endoscopy on May 15, 2018 was identified as “urgent/emergent upper endoscopy.” Unfortunately, M.C. continues to be at risk in her present program at CVH. A review of more recent records lists six more incidents of ingesting inedible objects (between January 30, 2019 and July 12, 2019) and, five out of six Suicide Risk Assessments completed between January 30, 2019 and April 30, 2019 indicated she was at high risk of suicide.

M.C.’s records also reflect a pattern of inordinate delays in securing needed evaluations and interventions. A CVH Annual Update Psychological History and Assessment document dated January 31, 2018 states, “M.C. is at significant risk for sexual and physical assault ...she is at most significant risk of intentionally or unintentionally injuring or killing herself.” Tragically, M.C.’s treatment team failed to take prompt action related to this finding before two reports of alleged sexual contact between M.C. and residents of the facility occurred. Following one of those incidents M.C. received post-exposure HIV prophylaxis medications. The same Annual Update had identified “A DMHAS Case Conference may be the most usual forum in which to discuss all facets of treatment and placement options for M.C.” A full DMHAS Case Conference was indeed held, but it convened on September 24, 2018, eight months after the need had been identified. Such a delay in responding to recommendations for interventions does not appear to be anomalous. A Psychological Examination Report dated March 21, 2017 recommended an updated occupational therapy evaluation, structured vocational experience with 1:1 support, and the incorporation of movement-based activities into M.C.’s daily schedule. However, with the exception of the updated O.T. evaluation (which occurred 18 months later), those recommendations appear to have been ignored. Instead, M.C. continues to receive PRN, STAT and/or IM psychotropic medications (32 times between January 30, 2019 and April 30, 2019) and to be subject to restraints (six times between January 30, 2019 and July 12, 2019). And, again, neither the frequency or circumstances surrounding the use of those PRN, STAT and/or IM psychotropic medications or restraints were evaluated as part of M.C.’s regularly scheduled Integrated Treatment Plan Reviews.

M.C. is only one of approximately 350 patients living at CVH. While DRCT investigators did not examine the records of others, they did review the results of repeated CMS/DPH surveys and complaint investigations – inquiries which found similar delays and multiple failures to safeguard the rights and wellbeing of patients. A CMS/DPH Summary of Deficiencies dated April 12, 2019 found a situation of “immediate jeopardy” in that CVH failed to ensure that care was delivered in a safe setting, with adequate supervision, in an environment free from hazards. Nursing standards were also found to be deficient, with failures to ensure proper positioning, grooming, and reviews of patients for self-harming behaviors, and failure to search a patient’s room as directed by a physician. Most notably, on April 30, 2019, CMS issued an “Initial Notice of Termination of Medicare Agreement Between Connecticut Valley Hospital and CMS”, indicating that as of April 12, 2019, CVH’s “deemed status” was removed, and that “survey jurisdiction has

been transferred to the State Agency (DPH)".<sup>11</sup> Even more recently, a DPH Summary Statement of Deficiencies dated June 16, 2019, again identified "immediate jeopardy", indicating that the hospital failed to ensure that the patients received care in a safe setting, specifying that its staff had failed to maintain continuous observation of certain patients, that it failed to adequately supervise patients, and that it failed to ensure that a patient was free from accidental hazards.

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<sup>11</sup> / "Deemed status" reflects an assumption of compliance with Medicare/Medicaid requirements based on third-party accreditation. The loss of deemed status and transfer of survey jurisdiction effectively increases the frequency of surveys, and reduces response times for complaint investigations.

# RECOMMENDATIONS

## **1. Remove CVH's statutory exemption from psychiatric hospital licensing requirements.**

The number of CMS/DPH surveys that have found CVH to be out of compliance with Medicare "conditions of participation" in recent years is exceeded only by the numerous "plans of correction" that have been submitted in response (sometimes with supplemental amendments). If this were merely a bureaucratic paperchase it could be marginalized in importance. But those surveys found serious problems – major deviations from accepted professional practices, potentially life-threatening conditions, and inappropriate intrusions on patients' rights (e.g. excessive use of restraints and seclusion).

The need for DPH licensing at this time is clear and unavoidable as it was for WFH through P.A. No. 18-86. For at least twelve years, CVH has been found deficient in areas such as: i) the provision of mental health treatment; ii) safeguarding patients' rights; and, iii) and maintaining the health and safety of its patients. The CMS survey process alone has not been able to effectuate long term or systemic change. Patients are better protected in facilities that are licensed by DPH because, as the licensing authority, DPH can respond more quickly to complaints and reported problems. Lives are at stake. CVH should be held to the same standards of accountability as other psychiatric hospitals in Connecticut.

## **2. Establish genuine interdisciplinary treatment teams that include direct care staff as well as clinicians, involve patients in development of treatment plans, and conduct frequent progress reviews.**

Client treatment records that were reviewed by DRCT's investigators and expert consultant reflect a hierarchical treatment planning process, with psychiatry as the dominant discipline. Although they may have significant insights to contribute, practitioners from other clinical disciplines (e.g. psychologists, therapists, nurses, social workers), and forensic treatment specialists are accorded lesser roles in evaluations, treatment planning and decision-making. The team process itself focuses primarily on formulating initial plans, conducting required periodic reviews and responding to incidents. However, if treatment teams included direct care staff and, in appropriate ways, patients themselves, there would be opportunities for feedback and communication about how a plan is working, what needs adjustment, how everyone is doing, whether people are clear about what they are supposed to be doing, etc. Including patients in full team planning processes (as opposed to more limited monthly Treatment Plan Reviews) would also ensure that their insights and the effects of their experiences could also be considered. Lastly, by creating genuine inter-disciplinary teams, senior clinicians could model and reinforce the approaches that other team members may need to practice.

Routine treatment team check-ins, which include clinicians and direct care staff, and, where possible, clients themselves, are considered good practice in community programs serving individuals with significant behavioral disorders. Implementing a similar approach at Whiting would help counter fragmentation between organizational layers and disciplines, and facilitate patient engagement goals. The patients at Whiting need to have their voices heard, and their recovery support needs responded to by true treatment teams. Investing in this area would be an important step toward establishing a positive culture of recovery.

### **3. Begin with an accurate understanding of each individual's identity and needs.**

If WFH and CVH are to be components of a “recovery system of high quality behavioral health care”, as described in the DMHAS vision statement, it is important that treatment be based on an accurate understanding of the identity and needs of each patient. This would start with a comprehensive biological-psychological-social evaluation of each new patient, followed by the development of treatment plans that would be individualized, trauma-informed, reflect sound principles of behavioral science, and would demonstrate respect for patients’ fundamental human rights. However, when a limited number of patients’ treatment records from CVH and WFH were reviewed by DRCT’s expert clinical consultant, he found that important details about patients’ personal histories, prior treatment experiences, and the individual contours of developmental and/or neurologically-based conditions were decidedly lacking.

In the absence of carefully researched, detailed, individual-specific information, treatment planning tends to follow generic pathways, often achieving little success in terms of measurable outcomes. Increasing the levels of professionalism and rigor applied to the tasks of individual evaluation and treatment planning would elevate all areas of practice in the hospital. A one-step-at-a-time, unit by unit project aimed at comprehensively re-evaluating individual patients and the “fit” between their needs and their treatment plans, could contribute to both significant improvements for patients, and positive changes in institutional culture.

### **4. Eliminate the “level system” as currently designed and implemented at WFH.**

As alluded to in the consulting psychologist’s report for J.B., Whiting’s reliance on the “level system” currently in place is deeply problematic. (See Appendix regarding J.B.) Privileges and punishments are theoretically awarded based on adherence to various rules and requirements, such as avoiding conflict, maintaining one’s room in an orderly fashion, and attending a certain number of group meetings. However, as actually implemented, criteria about level changes vary between units according to the interpretations and preferences of the unit directors. Thus, individual decisions concerning patients’ levels are often arbitrary and inconsistent. Even when implemented as designed, the level system is primarily used as a mechanism of institutional control. It is intrinsically punitive, and, especially for individuals for whom its requirements have little meaning, or who, due to disability-related factors, simply cannot adhere to expectations, it produces counter-therapeutic results. To ensure staff and client safety, maintaining an orderly environment is important, but doing so need not be at the expense of patient treatment.

In addition, in the enhanced security building (Dutcher Hall) opportunities to exercise earned privileges are frequently curtailed as they are contingent upon staff availability (e.g., time off the unit, out of the building, etc.). This negates even the limited purpose of a level system.

The current level system should be retired. To the extent that community expectations concerning personal conduct need to be articulated, the newly-established, patient-led Steering Committee should be consulted on how best to define and re-enforce norms. And, to the extent that the level system is intended to serve as an adjunct to patient treatment plans, more individualized behavioral programming is needed.

**5. Develop relevant, discrete programs and services for people with specific needs, particularly those with intellectual and developmental disabilities.**

In the absence of alternatives, people with ID/DD who are involved in the criminal justice system are sometimes sent to WFH, where, whether they are being evaluated for competency to stand trial, or are committed to the PSRB, they can become tangled up in expectations they cannot meet, and do not have access to the types of behavioral supports and learning opportunities they need. In its strategic plan for 2017-2018, the PSRB identified a need to engage in “collaborative planning with DMHAS and DDS to address systems issues and best practice protocols”. However, DRCT investigators found few referrals to DDS initiated by PSRB or DMHAS. Such efforts need to continue, focusing on collaboration, not finger-pointing. Finding more appropriate ways to deliver programming for people with ID/DD who are living at WFH should be a priority.

**6. Train DMHAS police concerning patients’ civil rights.**

The incidents where DMHAS police denied Andrew Vermiglio visits from his mother, and later, from a lawyer from the Connecticut Legal Rights Project, represent egregious violations of law and patient rights. Section 17a-547 of the Connecticut General Statutes clearly protects patients’ rights to visits by family members, attorneys and members of the clergy. According to the statute, visits from family members can only be suspended if the head of the hospital determines that such visits are “medically harmful”. In Mr. Vermiglio’s case, no such determination was made yet, the DMHAS Police denied the visit, as well as a subsequent visit from a lawyer. The DMHAS police force should be instructed and its officers trained on this and all other sections of state and federal law pertaining to patients’ rights.

**7. Secure independent investigations into all unanticipated deaths.**

The investigation conducted by the DMHAS Police into Andrew Vermiglio’s death left important questions unasked and, therefore, unanswered. Death investigations should be conducted by an independent system (including law enforcement agencies) capable of investigating allegations or reports of abuse, neglect, patient injury, and deaths, with skilled and competent staff who are not accountable to the facility’s administration. Such a system, independent of DMHAS, CVH and WFH, would increase confidence in the objectivity of the results, and better identify deficiencies in patient treatment and safety.

**8. Evaluate the effectiveness of the implementation of Section 2, P.A. No. 18 – 86 concerning the DMHAS Abuse, Neglect and Exploitation (ANE) reporting and investigation system as it pertains to WFH and CVH.**

All phases of investigations should be conducted by an “outside” entity – one that is not housed on hospital grounds and that operates independently of the administrative structure of the hospital. Policy pronouncements should also clearly state that the identities of reporters of suspected ANE will be protected from disclosure unless either disciplinary or law enforcement proceedings ensue.

The WFH Procedures Manual should also be amended to allow incidents of patient-to-patient violence or exploitation to be investigated by that same independent entity. Patient-to-patient events may be a result of neglect by facility staff, and/or may reflect systemic issues. Interviews

and record reviews by independent investigators may surface “ground-level” information that eludes administrative incident review protocols.

During the course of this investigation, DMHAS began to implement Section 2, PA No. 18 – 86, effective October 1, 2018. This section of the Public Act establishes an ANE reporting and investigation system for persons receiving behavioral health services, including patients at WFH and CVH. An evaluation of the implementation of this legislation is recommended to assure that it is effective and provides the requisite independence from the administrative structures of WFH, CVH and other behavioral health facilities and programs.

**9. Comprehensively evaluate the use of physical and chemical restraints, PRN psychotropic medication, and the occurrence of patient injuries in Integrated Treatment Plan reviews.**

When staff resort to unplanned interventions frequently, or when injuries occur, that should serve as an indicator that it is time to adjust an individual’s treatment plan. Developing internal guidance identifying the events which must be addressed at regularly scheduled intervals may reveal a need for staff training, for further evaluations, or for further inquiries into particular circumstances. Rather than being ignored, these events should be considered in regular treatment plan reviews. It is particularly important to determine whether and what type of de-escalation strategies were pursued prior to development of an acute situation, and to ensure that post-event debriefings are faithfully executed and yield useful information.

**10. Provide specific, individualized instructions regarding the nature of the behaviors or symptoms that warrant administration of PRN psychotropic medications.**

Simply stating that a particular drug or combination of drugs may be administered for “agitation” or “aggression” provides staff with too little information concerning the indicators that would justify administration of PRN medications. Indeed, vague instructions invite subjective judgments, which may be influenced by environmental factors (e.g. unusual commotion or background conflict.) While PRN medication is supposed to be administered “as needed” best practice requires that it be administered *only* as needed.

**11. Decrease over-reliance on PRN, STAT and IM psychotropic medications.**

The frequency with which PRN and STAT psychotropic medications are administered is indicative of the hospital’s culture as much as it is the level of acuity presented by patients’ psychiatric illnesses. Encouraging someone to learn about and practice self-calming, self-caring strategies reflects very different expectations for recovery and healing than does encouraging that same person to frequently request habit-forming PRN medications. By consciously decreasing reliance on PRN and STAT psychotropic medications, and conscientiously teaching and encouraging adoption of other approaches for dealing with stressors, thoughts and feelings, WFH and CVH will be taking an important step toward realizing their recovery missions.

Tracking and reporting the frequency with which PRNs and STAT psychotropic medication are used would be one way of monitoring progress in this area. This type of review might be performed by a modified peer support committee whose purpose is to review the use of behavior modifying medications and behavioral support plans for patients. Comprised of professionals, including a psychiatrist, this committee would ensure behavior modifying medications are

clinically sound, supported by proper documentation and rationale, and are being proposed for use in conformance with current standards of medical practice and department policies.

**12. Consistently implement quality improvement practices and measures at WFH and CVH.**

Changes being implemented by the current administration at WFH are hopeful. However, achieving enduring change in the culture of an institution is an iterative process – one which takes time and requires openness to self-examination, organizational learning, adoption of valid measures and consistent leadership. The more consistently quality improvement efforts can be implemented, the greater the likelihood that positive changes will be internalized and will endure. Transparency regarding the metrics used to track trends is critically important. Measures chosen should focus on patient outcomes including; reductions in the use of restraints, reductions in PRN psychotropic medication use, and other measurable outcomes and safeguards.

## CALL TO ACTION

Many outside eyes have scrutinized WFH and CVH over the past twelve years, most especially since April 2017 when the story of William Shehadi broke on the front pages of Connecticut's media outlets. As a result of those inquiries settlement agreements and corrective action plans have been written and re-written and a Legislative Task Force was commissioned. While the Task Force is charged with evaluating "the operations, conditions, culture and finances" of CVH and WFH, *inter alia*, its final report is not due until January 1, 2021, more than a year away.<sup>12</sup>

In the meantime, abuse, neglect and patients' rights violations continue to be substantiated time and again by DPH and now DRCT. People's lives are in jeopardy. Not just the lives of forensic patients but the lives of Connecticut's entire community of people with mental illness who, like M.C. or Andrew Vermiglio, may by default be relegated to Connecticut's mental health institutions.

Accordingly, immediate action is required, not a year from now after more reports are issued, but now. Based on the current findings of this report and recent DPH surveys the Connecticut General Assembly must act in the 2020 legislative session to place CVH under the licensure of DPH. Second, the Commissioner of DMHAS must enact immediate reforms in the areas identified above which include:

- cessation of the use of restraint for discipline or in lieu of treatment or for the convenience of staff,
- independent investigations of abuse, neglect, exploitation and deaths,
- reduction and guidance in the use of PRN, STAT and IM medications,
- individualized treatment plans as opposed to a one-size-fits-all level system,
- programs, supports and services for patients with intellectual or neurodevelopmental disabilities,
- inter-disciplinary teams to regularly review behavior support plans, injuries, use of restraints, and PRN, STAT and IM medications,
- training of all personnel on patients' rights.

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<sup>12</sup> / Indeed, it is uncertain a final report will be issued by the date prescribed in P.A. No. 18-86 as the members of the Task Force were not appointed in a timely manner and the "preliminary report" that was supposed to be issued by January 1, 2019 has yet to be completed.

# APPENDIX

## PEOPLE BEHIND THE FINDINGS

During the course of their inquiry, DRCT investigators became familiar with the stories of a number of patients. As a reminder that there are real people behind the findings and recommendations contained in this report, brief profiles of three of those individuals are presented below. The first to be profiled is Andrew Vermiglio, who DRCT investigators could only “get to know” through records and interviews of those who knew him. To protect the confidentiality of the others, they are referred to by fictitious initials.

### Andrew Vermiglio

Andrew Vermiglio was admitted to CVH as a young adult, having first been hospitalized at age 21 in a private psychiatric hospital. Described as having a passion for music, especially the guitar and writing his own songs, he was also a talented, award-winning artist. Following an eight month stay at CVH he was discharged to live with a family member. However, a year later his psychiatric symptoms became more pronounced, and, after a number of visits to a local hospital’s emergency department, he was again admitted to CVH. Discharged less than a month later to a private, out-of-state hospital, he soon returned to Connecticut, where he was again brought to the local hospital’s emergency department, this time for “displaying odd behavior at the local soup kitchen.” From there, he was admitted to CVH for a third time, on June 30, 2015, where he resided for the next year in a unit in the Battel building. On June 29, 2016, Mr. Vermiglio was discharged to the Hartford Correctional Center pursuant to an arrest warrant that had been issued following an altercation on his unit. He had allegedly displayed aggressive behavior toward another patient. One week later, he was sent from court to CVH’s Whiting Division, where he was placed onto the same unit that housed William Shehadi.

On admission to Whiting, Mr. Vermiglio’s psychiatric diagnoses were listed as schizophrenia and obsessive-compulsive disorder (OCD). His records note that he manifested various symptoms sometimes associated with schizophrenia, including delusions, auditory hallucinations, disorganized speech and disorganized behavior; and that related to his OCD diagnosis, he experienced recurrent and persistent urges which he was unable to suppress, exhibiting repetitive behaviors including handwashing and checking, as well as repetitive motions with his fingers and shuffling his feet. One observer noted he seemed driven to perform those repetitive motions, and that they appeared to be aimed at preventing or reducing anxiety or distress. The unit’s psychiatrist requested a neuro-psychological evaluation because Mr. Vermiglio also seemed to be experiencing notable difficulty remembering things from one day to the next – a phenomenon that had not been observed by clinicians who had previously been involved in his treatment. I.Q. testing indicated that he had a full-scale I.Q. score of 71 (just above the threshold for being considered Intellectually Disabled in Connecticut), although the examiner noted that his performance on the test was likely impacted by his psychiatric diagnoses, particularly his obsessive thinking.

Notations made in Mr. Vermiglio's records at the time of his admission also indicate that he was "a fast eater". Recognizing that his compulsive behavior was not under his conscious control, and that it could sometimes create risks to himself or to others, the unit psychiatrist ordered that he be kept under "close observation" by two staff members. The staff members assigned to observe Mr. Vermiglio were supposed to be within easy reach of him at all times, except when he was sleeping, when they would sit outside his room, periodically observing him through the dim light of a nightlight. Objectives identified in his treatment plan included reduction in the symptoms of psychosis and OCD, and management of agitation and aggression. Attendance at regularly scheduled group meetings was identified as one measure of how well those objectives were being met. During the five months he lived at Whiting Division, unit records indicate that Mr. Vermiglio attended only ten of those meetings.

While a patient in the Whiting Division's maximum-security building, Mr. Vermiglio was physically and/or mechanically restrained thirteen times, including the incident when he died (although no restraint report was completed for that restraint). He received intramuscular injections of psychotropic drugs on 12 of those occasions, including twice during an episode of restraint which lasted for three hours and ten minutes. For ten of those restraint incidents, there are no indications in the records of any attempts at de-escalation or re-direction by staff prior to initiation of the restraint. Records do indicate that Mr. Vermiglio sustained injuries during seven of those thirteen episodes, although it is not clear that the official CVH restraint/seclusion records captured all injuries. Both the CVH Seclusion Report and a Nursing Progress Note prepared for one restraint episode indicates that he reported no injury or pain at the time of restraint. However, notes prepared by the physician on call at the time of that same incident state: "Andrew went into physical take down followed by 4-point restraint. In the process, he fell on the floor and hit his nose, which caused bleeding. On exam, acute bleeding had stopped. Clean with mild saline. No nasal padding needed as bleeding has stopped. Tylenol as needed, cold pack as needed."

In addition to IM injections of drugs during restraint episodes, while at Whiting Mr. Vermiglio also received PRN psychotropic medications 42 times, refusing them on nine occasions. The standing order for those PRN medications stated they were to be used to address anxiety or agitation – general criteria somewhat open to subjective interpretation. No specific guidance was given regarding objectively observable signs, expressions of thoughts or feelings, or behavioral thresholds to help unit staff gauge the degree of anxiety or agitation that warranted administration of PRN medication. Nor were the circumstances surrounding the use of PRN psychotropic medication, Mr. Vermiglio's occasional refusals, or any of the injuries he received in the course of being restrained the subject of discussion in any of the regular Treatment Plan Reviews that were conducted.

During his stay at Whiting, progress notes indicate that, on five separate occasions, Mr. Vermiglio made allegations of abusive treatment. However, the facility failed to follow-up on any of those allegations. Nor was there follow-up on an allegation reported to the attending psychiatrist by another patient who, after Mr. Vermiglio had died, stated that he had previously witnessed Mr. Vermiglio being abused by one of the staff members who had restrained him on the day he died. (The psychiatrist dutifully reported the allegation, but the information was not pursued.) There is, however, glaring evidence that on at least two occasions Mr. Vermiglio's civil rights were violated by the facility. DRCT investigators learned that on one occasion, DMHAS police denied Andrew an opportunity to visit (with close 2:1 observation) with his mother who had come to see him.

Further, on the day before he died, Mr. Vermiglio was also denied a visit with an attorney from the Connecticut Legal Rights Project (CLRP). In addition to constituting stark violations of patients' rights (CGS 17a-547 specifically guarantees patients' right to receive visitors, including family members and attorneys), these incidents reflect the degree to which decision-making authority at Whiting is fragmented in administratively isolated domains. Even when a patient's attending psychiatrist has given approval, and the patient's rights are explicitly protected in law, those rights can apparently be disregarded without explanation or consequence by the DMHAS Police.

The events surrounding Mr. Vermiglio's death on 12/1/2016, speak to many of the same issues that defined his experience at CVH. However, it is also notable that other patients on his unit described his treatment by unit staff as abusive. Patient interviews and surveys conducted by DRCT investigators with patients on Mr. Vermiglio's unit elicited descriptions of staff conduct eerily similar to those that surfaced several months after he had died, during the investigation into the mistreatment of William Shehadi.

*Regarding the death of Andrew Vermiglio on December 1, 2016*

- Mr. Vermiglio was 25 years old when he died. An autopsy performed by the Office of the Chief Medical Examiner (OCME) determined his death was a result of "asphyxia due to obstruction of airway by food bolus." The OCME report also included background information indicating that Mr. Vermiglio "has a history of mouth stuffing with soft cookies."
- An investigation into the circumstances surrounding Andrew Vermiglio's death was conducted by the DMHAS Public Safety Division (DMHAS Police). Staff members who participated in restraining Mr. Vermiglio immediately prior to his experiencing distress, and several others who witnessed or intervened in events as they unfolded were interviewed. The DMHAS Police concluded that, "As of 12/12/16 [the date the report was written], there is no evidence to support that a criminal act was committed pertaining to the death of Andrew Vermiglio."
- The signed statements collected by DMHAS Police from the two Forensic Treatment Specialists (FTSs) assigned to closely observe Mr. Vermiglio indicate that, on the evening that he died, one of the two FTSs had asked Mr. Vermiglio to eat his snack in his room. They took up station outside his room, watching him through the open door. When Mr. Vermiglio left his room and entered the hallway, they instructed him to return to his room to eat his snack. Their statements indicate that Mr. Vermiglio then jammed his snack (Fig Newton cookies) into his mouth while leaning close to one of them, re-entered his room, asked them whether they were "tough guys", and gave them the finger. They state that Mr. Vermiglio then started to bang on his dresser, wildly flail his arms and came back out of his room. Their signed, written statements and statements made orally during the DMHAS Police interview indicate that they again instructed him to return to his room, which he did. They state that shortly thereafter, Mr. Vermiglio again rushed out, arms flailing in a threatening manner. At that point they state they initiated an "escort hold" on Mr. Vermiglio's arms to return him back into his room.
- DRCT investigators viewed the video recording taken from a camera mounted in the corridor outside of Mr. Vermiglio's room. The recording does verify that Mr. Vermiglio entered the corridor from his room several times. On one occasion he is seen to lean close to the staff member who was seated outside his room (the other FTS was standing),

moved his hand close to his face, shuffled his feet in front of the FTS who was standing, and then turned and walked into his room. (Note: it is well documented that among Mr. Vermiglio's ritualistic behaviors, he frequently shuffled his feet and held up his hands, fanning his fingers. Although the video recording is somewhat grainy, Mr. Vermiglio's motions with his hands and feet appear to be consistent with descriptions of that behavior.) The recording does not verify that Mr. Vermiglio "ran out" of his room, or that he appeared at the doorway "flailing his arms" as the statements from the FTS's claim. Rather, seconds after Mr. Vermiglio re-entered his room for the last time, both FTSs are seen to suddenly rush through the door into the room.

- In addition to the DMHAS Police investigation, CVH conducted an internal Death Review, as required by its policies. The review largely focused on staff omissions. More specifically, it identified a failure to recognize the potential risk posed by Mr. Vermiglio's unsafe eating habits, which had been noted on his admission to Whiting and subsequently observed by unit staff, but not recognized as presenting a risk of choking. The death review also cited a failure to respond to Mr. Vermiglio's airway obstruction in accordance with hospital policy and standards of practice, including incorrect placement of a backboard under, rather than on top of the mattress in his room to facilitate CPR.
- Because Mr. Vermiglio had been physically restrained before an obstruction in his airway was detected, CVH was obligated to report a restraint-related death as a "sentinel event" to the Center for Medicare and Medicaid Services (CMS). CMS, acting through its contractor, DPH, also conducted an inquiry. As part of that inquiry, DPH interviewed staff, and reviewed records of prior incidents and Mr. Vermiglio's overall treatment at Whiting. Findings of the DPH investigation went considerably further than the CVH inquiry, indicating that "conditions of participation" in federal programs had not been met with respect to both patients' rights and nursing services, and that a situation of "immediate jeopardy" existed due to the hospital's "failure to provide care in a safe setting." In support of those findings, DPH cited, a number of factors, including the hospital's failure to maintain the 2:1 observational status specified for Mr. Vermiglio by physician orders and by hospital policy.
- Dr. McGuire, the Medical Examiner who conducted Mr. Vermiglio's autopsy, first learned that he had been physically restrained just prior to his death by reading the DPH investigation report. On 2/15/2017, she requested that the Department of Public Safety/State Police conduct an inquiry regarding the type and duration of the restraint. According to the resulting State Police report, "Dr. McGuire stated that she was not clearly advised what type of restraint was placed on the victim. She needed to know if it was a contributing factor to the victim choking, as choking was the reported cause of the victim's rapidly deteriorating condition that led to the medical code being sounded. She also stated that she was advised that the victim had choked on fig newton cookies, yet she had found no airway obstruction during the post mortem examination."
- The State Police reviewed the DMHAS Police investigation report and found it to be thorough. Concurring that no evidence of criminal wrongdoing had been found, the State Police report stated: "It was documented that the hold was brief and consisted of two staff members, each taking an arm in an escort type hold. Contrary to Dr. McGuire's initial perception that the incident could possibly have been undocumented as part of a possible cover up or possible inadequate or inappropriate action by staff, all of her questions were

answered when provided the information from the official reports and a viewing of a surveillance video.”

- DRCT investigators sought to interview Dr. McGuire, but found she was no longer employed by the OCME. They did ask Dr. James Gill, Chief Medical Examiner, to review the findings from the autopsy and relevant investigation reports. Dr. Gill did so, and explained that because all accounts agreed that the physical hold/restraint had not resulted in any chest compression, in his opinion the asphyxia that had caused Mr. Vermiglio’s death could not be attributed to physical restraint.
- In response to the question, : “Is there any aspect of the management of this case that might have been done differently?”, which appears on the CVH Death Review Report form, the attending psychiatrist wrote the following: “a) Not putting patient in a physical hold face down on his bed while he was choking. Not letting patient eat in his room with the door closed without being observed, despite the fact he was on a 2:1 observation. b) There needs to be better training of the line staff working with the patients.” Although the attending psychiatrist was not present during the events that led to Mr. Vermiglio’s death, hospital policy required that, as the attending psychiatrist, she participate in the Death Review process.
- DRCT’s own investigation included a review of relevant records from the Whiting Division of CVH and Middlesex Hospital’s Emergency Department, which indicated that EMTs had suctioned considerable quantities of liquid material from Mr. Vermiglio’s airway at the scene. DRCT also reviewed all other investigation reports, which included detailed statements from participants. Attempts were made to interview the unit (attending) psychiatrist, who responded that she was uncomfortable being interviewed as litigation concerning Mr. Vermiglio’s death was pending.
- DRCT was informed that the Registered Nurse who had responded to Mr. Vermiglio’s room when the code had been called had retired. However, he did agree to be interviewed over the phone. During that interview he reported that when he arrived in Mr. Vermiglio’s room, Mr. Vermiglio was being held by his arms against a wall by the two FTSs, kicking his legs. (His written statement indicated that Mr. Vermiglio was kneeling and kicking, indicating that he was being held with his face against the wall.) The nurse initially tried to hold Mr. Vermiglio’s thighs, assisting in the restraint. Mr. Vermiglio then vomited. Realizing that he was in distress, the nurse ordered the FTSs to release their hold and began to administer back blows, and soon thereafter, applied the Heimlich maneuver. The nurse noted that once Mr. Vermiglio realized people were trying to help him, he relaxed and stopped struggling. However, he continued to vomit and lost consciousness, although he may have regained consciousness once or twice prior to being transported to Middlesex Hospital.
- The statements from the two Forensic Treatment Specialists (FTSs) who had been assigned to directly observe Mr. Vermiglio, the unit R.N. who initially responded to calls for help from those FTSs, and a third FTS who had pushed the “code” button in the nurses’ station in response to calls of ,“code, code” (which came from another patient in the unit) and then rushed to Mr. Vermiglio’s room, all reflected somewhat differing descriptions of the position in which Mr. Vermiglio was being restrained, and the sequence of events they observed. The third FTS, who arrived shortly after the unit R.N., told the DMHAS Police investigators that she “observed Andrew Vermiglio’s upper body on the bed with his legs

on the floor.” (When interviewed by DPH investigators, one of the two staff members who was holding Mr. Vermiglio explicitly denied that they had ever held him face-down on his bed.) The unit nurse told DPH investigators that when he got to his room, he saw Mr. Vermiglio “kneeling on the floor, kicking.”

- It is not unusual for witness accounts of dynamic, traumatic events to vary somewhat. To some extent, the differing characterizations of the physical restraint used and the location of Mr. Vermiglio (on the bed, on the floor, kneeling, etc.) may be referring to different points in time. They may also be a product of imperfect memories, or even reflect an attempt to minimize the role that applying a physical restraint played in either causing, or delaying a response to Mr. Vermiglio’s obstructed airway. However, upon viewing the recording from the video camera located in the corridor outside Mr. Vermiglio’s room, it became clear to DRCT investigators that some of the assertions made about Mr. Vermiglio’s conduct immediately prior to the incident by the two FTSs assigned to “close observation” were not in accordance with the video record. In contrast to statements made to other investigators, each time Mr. Vermiglio entered the hallway he returned to his room on his own, without being physically touched, guided or held by anyone. The video recording does not reflect that Mr. Vermiglio “rushed the door” or entered the hallway with his arms flailing “in a hostile manner”, or that he repeatedly slammed the door to his room, as claimed in the statements signed by the two FTSs.
- DRCT investigators were unable to determine with any certainty exactly what triggered the staff to rush into Mr. Vermiglio’s room and initiate a restraint. Nor could they discover sufficient evidence to either corroborate or disprove allegations that a prone (face-down) restraint technique was used during this incident, or to corroborate or disprove the accounts of the FTSs that they only applied a brief, “escort hold”. (In fact, it may be that at some point during the event, Mr. Vermiglio vomited while being restrained against the wall of his room, or while lying on his side or possibly even face-up while he was unconscious, raising the possibility that he aspirated on vomitus, rather than directly on too-hastily consumed cookies. However, in the absence of more concrete evidence, DRCT cannot reach any conclusion regarding either the nature of the restraint that was used or the exact mechanism that led to the fatal obstruction of Mr. Vermiglio’s airway.)
- While questions may remain about the exact sequence of events after Mr. Vermiglio became distressed, there is little question that his propensity to hastily consume food, while recognized, was not understood to be potentially hazardous. Information recorded in his admission papers indicated that Mr. Vermiglio manifested a number of psychiatric symptoms, including shuffling his feet, flapping his fingers, and experiencing recurrent and persistent urges that he was unable to suppress. An Admission Nursing Assessment Nutritional Screen, also completed on his admission, identified him as a “fast eater”. Moreover, a staff member told DPH investigators that he/she “had observed the patient ‘shovel’ food rapidly into his mouth on more than one occasion and had to cue him/her [sic] to slow down.” The DPH investigation found that the staff member “identified that he/she did not inform anyone of [Andrew Vermiglio’s] unsafe eating behavior.” Apparently, the risk of aspiration presented by his compulsive “fast eating” was not recognized by anybody at the hospital, despite the fact that facility records dated 8/18/16 [over three months prior to A.V.’s death] indicate that “after taking meds patient got his snacks then proceeded to run into unit bathroom. Reports that he was trying to get a piece of Fig Newton out that was stuck.”

- There is also some question as to whether the required level of close observation that had been determined to be necessary for Mr. Vermiglio’s safety was in place when he received his snack that afternoon. The 2:1 close observation had been ordered for a reason: Mr. Vermiglio’s compulsive behaviors could quickly put his health and safety at risk. The attending psychiatrist’s review of the incident pointed out that allowing him to eat the snack unobserved, in his room, possibly with the door closed, created a situation of jeopardy inconsistent with the order for 2:1 close observation monitoring.
- As noted earlier, Mr. Vermiglio’s records may tell only part of the story of his treatment at Whiting. Patient interviews and surveys conducted by DRCT investigators with patients on his unit elicited descriptions of staff conduct eerily similar to those that surfaced several months after Mr. Vermiglio died, during the investigation into the mistreatment of William Shehadi. Significantly, the two men were housed on the same unit and served by the same unit staff. In fact, both of the FTS’s who were assigned to observe Mr. Vermiglio on the evening that he died – the men who rushed into his room and restrained him and then signed statements about what had happened that were not supported by video evidence - were subsequently implicated in the abuse of Mr. Shehadi and were no longer employed at Whiting when DRCT conducted its investigation.
- Also as noted earlier, according to statements and survey responses from other patients on the unit:
  - “They cracked Andrew’s head during a restraint and his pillow was full of blood.”
  - “They f\*\*\*\*d with him all the time, e.g. flipping lights on and off, making fun of him, calling names, if you don’t stay there we are going to medicate you, restrain you.”
  - “Two weeks before he died, staff screaming at Andrew to get out of the hallway, pushing him back and closing the door. Always slamming his door. A lot of bullying.”

## **M.C.**

M.C. is a 24-year-old young woman who was admitted to CVH when she was 21, after aging out of special education and services from the Department of Children and Families. With the exception of an unsuccessful six-week stay with a community service provider, she has lived in one or another unit of either CVH or Whiting ever since. Like a number of other people currently living at CVH and Whiting, M.C. manifests both psychiatric and intellectual disabilities. Having experienced considerable trauma as a young child, during adolescence she was placed into a residential school for students with emotional and behavioral support needs – a place that provided space and programmatic support for girls like her to practice self-calming strategies, practice adaptive skills, engage in academic learning and envision positive futures for themselves. Although M.C. responded well to the school’s program, the suicide of a fellow student with whom she had developed a close friendship further traumatized her. In fact, that loss continues to haunt her.

Shortly after her admission to CVH’s Young Adult Services, M.C. tried a brief stay in a community program. The placement proved unsuccessful, however, likely because it did not provide dedicated space or programmatic support for her to pursue the self-regulating strategies she had learned at the residential school. (She was told it would be unfair to other residents if a quiet space was to be set aside for her use.) Soon she was reverting to some of the self-destructive

behaviors she had engaged in years earlier – principally ingesting inedible objects and engaging in self-harm and suicidal behavior. After repeated trips to the local emergency room, she was re-admitted to CVH, where she has been transferred between units seven times, including two stays at the former Whiting Services Division, and, another five-month stay there after WFH was established as a separate hospital. She is currently living at CVH.

When they met M.C., DRCT investigators noted her lively, engaging personality, and her interest in other people and in life. It was clear that she possesses both curiosity about the world outside the hospital and well-developed social skills. As they reviewed her records, however, the investigators learned that M.C. was at continuing risk of exploitation and self-harm. In fact, for someone who has ostensibly been hospitalized for her own safety, she has repeatedly injured herself with objects she has found in the hospital environment. Moreover, in the absence of a consistent program of positive behavioral supports, DRCT investigators are concerned that M.C. is becoming “institutionalized”. For instance, on her current unit she is encouraged to make “good” choices, one of which is requesting PRN tranquilizers whenever she is feeling anxious, rather than being encouraged to practice more adaptive, less chemically-dependent self-calming strategies that could be employed in a community setting. It does not help that she has transferred between units so many times. Each move requires adjustment to different surroundings and staff, and whatever behavioral intervention program had been developed for her in the previous unit is usually left behind. It also does not help when unit staff project negativity. While visiting, her conservator has heard CVH staff call her “fat”, and tell her that she is “never getting out of this place”.

M.C.’s records indicate that, since her admission, she has been restrained 30 times in various units at CVH, and seven times during her most recent admission to WFH (8/30/2018 - 1/30/2019). She received IM injections of psychotropic drugs (commonly referred to as chemical restraints) during 21 of the restraint episodes at CVH, and five of those that occurred at WFH. During two of those restraint episodes at WFH, she also sustained injuries. However, neither the use of chemical restraints nor the injuries M.C. sustained while being restrained were reviewed during Treatment Team Reviews. Nor did the frequency with which she received PRN psychotropic medications – whether as a result of her own request or determinations made by others – trigger any reviews. During the same Whiting admission, M.C. received oral PRN psychotropic medications on 74 occasions, and IM PRNs on 10 occasions (5 of which involved the use of mechanical restraints, as referred to above). Medical orders for the PRN medications indicated they could be used to respond to signs of anxiety and/or agitation – general terms that are subject to varying interpretations by unit staff.

Ironically, or perhaps tragically, as her school records make clear and her conservator attests, when she has been encouraged to focus on a positive goal, and when she is afforded appropriate options and programmatic support, M.C. is quite capable of forgoing harmful activities (such as ingesting inedible objects) and achieving considerable progress. In fact, her experience during her last stay at Whiting illustrates this point. One of the therapeutic needs identified during treatment planning at CVH involved Occupational Therapy. Nineteen months after the need was identified, an O.T. evaluation finally took place (by that time M.C. was a patient at Whiting). The Occupational Therapist worked with her to develop adaptive strategies for dealing with her negative thoughts and feelings – the use of breathing techniques and relaxation devices, such as a stretch ball - activities she could initiate herself, and for which she received recognition and reinforcement through the program the therapist worked with her to establish. After the program was initiated, M.C. experienced an 80% reduction in the use of PRN medications, and notations entered into her records documented “good progress” toward treatment goals. Ultimately, she was discharged from WFH and re-admitted to CVH. Unfortunately, however, transfers between

units have usually signaled program discontinuity. Examination of M.C.'s treatment records reveals a pattern of delays in developing behavioral support plans, or of ignoring already-developed plans as she has been transferred between units at CVH. For instance, although she was re-admitted to CVH from WFH on January 30, 2019, a Positive Behavioral Support Plan was not implemented for her on her new unit until April 23, 2019.

While she still carries the scars from earlier trauma, and clearly needs considerable support, M.C. is a dynamic, engaging young woman who possesses the skills and, when prompted to talk about her future goals, still has the desire to contribute much more to the world than her current circumstances allow. The keys to helping her realize her potential – insightful programming and supportive human relationships - have not been attended to with anything approaching the consistency and competency that she needs. Instead she has gotten drugs, restraints, and periodic trips to the emergency room.

## **J.B.**

Unlike M.C. and Andrew Vermigio, J.B. did not enter the DMHAS hospital system via a civil commitment to CVH. Rather, he was admitted directly to the Whiting Services Division' maximum security building, having been charged with a serious crime, and subsequently found "not guilty by reason of mental disease or defect" (NGRI) pursuant to the provisions of Section 53a-13 of the Connecticut General Statutes.<sup>13</sup> After finding J.B. NGRI, the Court committed him to the Psychiatric Security Review Board (PSRB), which, as it is established in Connecticut law, has authority to order the type and level of security within which NGRI acquitees are to be treated. The PSRB determined that J.B. should be placed in the Whiting Maximum Security Building.

J.B. has been diagnosed with both psychiatric and developmental disabilities (autism). In school, he received special education services, experiencing successes when assisted by a one-to-one aide, but running into considerable disciplinary difficulty when his school system withdrew that support. Throughout his childhood, J.B. was exposed to periodic violence, bullying, and considerable trauma, which, in combination with his disabilities, has left him with a sense of being picked-on, and little understanding of either how to control his anger, or of the effect his actions have on others. At Whiting, he withdraws to his room, sleeps a great deal and frequently resists efforts to get him to comply with expectations for showering, cleaning his room and participation in group meetings. People who know J.B. and are familiar with the nature of his developmental disability question whether he can accomplish those tasks without close, direct assistance.

Concerned that little progress was being made toward the treatment goals outlined in J.B.'s Integrated Treatment Plan, and that the criteria his unit psychiatrist had set for him to eventually leave the maximum security environment might not be realistically achievable, or even necessary, the Public Defender assigned to represent him obtained a review by the same independent psychologist with whom DRCT had contracted to assist in reviewing treatment records of other individuals, Dr. Rafael Gallegos. Dr. Gallegos has considerable expertise in assessing, treating and developing programs that meet the needs of individuals with profiles similar to J.B., and, in fact, has designed and helped develop programs for others who have successfully left CVH and

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<sup>13</sup> / The phrase "not guilty by reason of mental disease or defect", however arcane and objectionable, is used in Connecticut Statutes to mean the same thing as the term "not guilty by reason of insanity" used in many other jurisdictions. It refers to a finding by a Court that a criminal defendant, "lacked substantial capacity, as a result of mental disease or defect, either to appreciate the wrongfulness of his conduct or to control his conduct within the requirements of the law." CGS§ 53a-13(a) Notwithstanding this statutory language, the term "NGRI" is still often used in Connecticut as an informal shorthand reference.

Whiting to live, with appropriate supports, in community-based residential and work programs. Dr. Gallegos identified a number of shortcomings in Whiting's understanding and approach. After describing what J.B. needed, and what a sound programmatic approach would look like, he summarized what Whiting was missing as follows:

The records reviewed, however, reveal treatment that is centrally focused on containing and managing aggressive behavior and effecting an absence of maladaptive behavior, rather than teaching and reinforcing specific adaptive behavior (i.e. functionally equivalent behavior). J.B.'s treatment plan is heavily reliant on a unit level system that is inherently coercive and punitive. The psychiatric formulation [diagnostic impression] that exists lacks precision, while the functional analysis/positive behavior support plan does not meet minimal standards of practice with regard to the measurement and manipulation of contingencies associated with discrete behaviors. The records suggest that habilitative interventions are offered through individual and group psychotherapy and activities, yet there is no clearly articulated rationale for why this patient is assigned and must attend a certain number of specific groups or how his individual psychotherapy and psychopharmacological treatment intersects with his overall treatment plan. Overall, there is significant inconsistency and lack of clarity in this patient's treatment plan/goals across the ITP [Integrated Treatment Plan], the behavioral guidelines developed for this patient, and the essential components of the unit level system.

Additionally, it has been variously documented that J.B. has a history of trauma, yet the established unit behavioral interventions, which were made applicable to this patient, do not appear to be trauma informed. Instead, it appears from the records reviewed that J.B. has responded by isolating, which is a common maladaptive strategy for traumatized persons. He does not attend groups with any type of consistency and spends much of his time either "resting in his room" or "sleeping," for which he is penalized through the level system. Finally, the records reviewed and collateral communication with J.B.'s mother reveal that she is not closely involved in his treatment. This, in effect, neglects an important systemic factor identified in the etiology of this patient's problematic behavior.

In conclusion, it is doubtful that the current clinical approach, which appears to be heavily informed by existing clinical practice/culture on [the] Unit...rather than an individualized approach, will help this patient effect positive behavioral change. Based on the records made available for review, there also appears to be a systemic lack of awareness of iatrogenic factors [problems caused or exacerbated by the treatment he is given] imbedded in the current milieu and little consideration for the fact that J.B. has immutable neurological/clinical conditions that make it very unlikely that he will ever [meet the criteria that have been stated as necessary for him to move to a less restrictive environment.]

As the findings of this report make clear, the "level system" referred to by Dr. Gallegos has long been a ubiquitous feature of life at Whiting. Its stated purpose is to, "increase the structure on the unit; clarify expectations of the treatment team; increase recognition of positive behaviors, and provide incentive for positive behaviors," The "positive behaviors" referred to typically include attendance at group sessions, and maintaining personal hygiene and orderly personal space. The group sessions may have little meaning for someone with a cognitive disability or autism diagnosis, just as maintaining hygiene and a clean room may be beyond their reach without direct assistance. In addition to potentially unachievable "positive" behavioral expectations, the level system also operates to deprive such patients of privileges that could be used to reward positive behaviors they actually could be learning (if competent, positive behavioral programming was available for them, which, for the most part, it is not).

According to the level system description;

[I]f a patient becomes violent, or physically or verbally threatening...or if they are placed on continuous observation for concerns other than medical reasons, their level will be reduced to level 1 (i.e. from level 2 or 3 where patients have access to additional privileges and/or can opt out of attending a treatment group once a month)."

As applied to J.B., and to other patients with intellectual and developmental disabilities such as autism, and to those who may not be able to establish conscious control over impulsive, angry outbursts or self-abusive acts without the type of programmatic supports that are notably missing at Whiting, the unit level system can be both discouragingly punitive and counter-productive. (Hence Dr. Gallegos' reference to "iatrogenic factors" that are contributing to J.B.'s regression.)