

Testimony of Al Shehadi
Before the Public Health Committee
Public Hearing Monday November 13, 2017

My name is Al Shehadi. I am the brother and co-conservator of Bill Shehadi, until now the unnamed patient at the center of the Whiting abuse scandal. I am here today to give him a name, to tell a part of his story and to encourage this committee to continue the work it is doing to investigate the abuse that happened.

My brother has been disabled most of his adult life. When he was younger he was quite smart and, in his own way, engaging. In school he was interested in government and was a pretty good amateur photographer. He graduated from Greenwich High School and received an Associate's degree. He fell into a deep depression at the age of 21 and has been seriously mentally ill since, institutionalized most of that time. During the past ten years while at Whiting, he has become increasingly psychotic, divorced from reality, and physically frail, including difficulty speaking. In addition to mental illness, he suffers from a range of autism spectrum symptoms. He is poor at reading social cues and prone to inflexible, ritualistic behavior such as walking around a room repeatedly tapping each of the four walls, or flipping a light switch on and off, over and over again. His illness does not fit into a simple diagnostic box.

My brother is also not an angel. He killed my father 22 years ago. Our father. He didn't know what he was doing because of his illness, but the loss is the same. He is prone to self-harm, including attempted suicide when he was younger. He is not easy on himself or those around him, whether family, other patients or staff.

I tell you this last part not because it is relevant to the abuse he suffered. I tell it precisely because it is *irrelevant* to that abuse. I tell you this because you may already have heard soft whispers of blame the victim. From advocates for the accused, who have tried to explain away the events as part of the challenge of dealing with a difficult patient; or from DMHAS leadership, who want you to believe this was an isolated incident. For anyone who has read the arrest warrants, it strains credibility to argue that what happened was simply an isolated incident involving a difficult patient.

So let's talk about the abuse.

The abuse my brother suffered is hard to imagine. I saw four to five hours of videos of the abuse in late May. Despite being warned in advance about the content of the videos by both DMHAS and State Police staff, I was completely unprepared for what I saw. For those who aren't familiar with the nature of the abuse, let me quote two incidents described by in the arrest warrants:

"...on March 7, 2017...at approximately 6:05 [staff #5] [enters] the patient's room with a cup of liquid. The patient is motionless on the bed with [staff #2's] feet near the patient's chest and face on the bed. [Staff #5] pours the liquid on the patient's head causing the patient to jump up and knock the cup from [staff #5's] hand...[Staff #5] is seen...leaving the room and returning at approximately 6:10 with a mop and rolling bucket. [Staff #5] ...places the mop on the patient's head and mop's the patient's head...several times. [Staff #5] [wrings] the mop out...and returns to mopping the patient with the mop. [Staff #2] and [staff #9] were present for this incident."

“...on March 18, 2017 at approximately 21:43...[staff #25] is seen on video walking into the patient’s room where the patient is seen sitting on the bed. [Staff #25] approaches the patient and bends forward...takes hold of the patient’s mattress and flips the patient off the bed onto the floor...then flips the mattress onto the floor on top of the patient before leaving the room. [Staff #8] and [staff #29] are both present when this incident occurs.”

Beyond almost daily acts of similar abuse, the videos convey an atmosphere of constant menace. It wasn’t just staff kicking my brother. It was the long periods in between kicks with staff resting their feet and legs on his bed, next to his head and body, their feet constantly tapping, stretching, moving. As if to remind him they could kick again whenever they wanted. It wasn’t just staff pushing him down on his bed or kicking him off his bed, it was the staff circling around his bed again and again, leaning over and staring at him. It was the feeling of cats playing with a cornered mouse that was most disturbing.

The sheer scale of the abuse is incomprehensible. As part of my own efforts to grapple with what happened to my brother, I created a spreadsheet of every incident in the ten arrest warrants. Incidents in chronological order down the side and staff names across the top. I submitted a copy of the chart with my testimony for your reference. Here are a few observations from the chart that begins to convey the sheer scale of what happened. The warrants are based on videos preserved by DHMAS that cover the 24 day period from February 27th to March 22nd. There are roughly 50 incidents of abuse described in the warrants during those 24 days. There was at least one incident on 21 of those 24 days. There were two or more incidents on 14 days. Five or more incidents on four days. The granddaddy of all days was March 11th, with separate incidents caught on video at 1:04, 5:57, 8:14 and 8:19 AM, and 7:02, 7:36 and 9:05 PM. As for staff, in addition to the ten who have been criminally charged so far, another 22 are named in the warrants as witnesses. The Department of Public Health and CMS report this summer, based on the same videos, put the number of staff involved in or aware of the abuse at more than 40.

To be clear: the chart covers a 24 day period last spring and only includes incidents serious enough for the State’s Attorney to believe worthy of criminal charges. I can’t help but ask: is this just the tip of the iceberg? What else we would find if we had access to more than 24 days of videos?

The warrants are unequivocal that my brother did not instigate the abuse. Each warrant includes the following sworn statement from the submitting detective: “upon viewing the...video footage, at no time did the affiant observe behavior on behalf of the patient that would give cause to believe that he was the primary aggressor in those incidents”. Roughly two-thirds of the incidents mentioned in the warrants happened at night, between 9:00 PM and 7:00 AM. Before many incidents my brother was simply sleeping in his room. It’s hard to instigate something when you are asleep.

I recommend the members of this committee see the videos themselves to fully understand what happened and how systemic it was. If you do, you will understand it is impossible to argue that what happened was just an isolated incident or just about a difficult patient.

That was the abuse. Now let’s talk about Whiting.

As my brother’s conservator, I’ve interacted with Whiting for more than 15 years. The culture of Whiting is not pretty. I might describe Whiting as an awkward marriage of a prison and a hospital, with the culture of toughness, insularity and control more common in a prison usually winning out over the culture of compassion, respect and recovery that one expects of a psychiatric hospital. Whiting’s culture is not only insular, it is resistant to change and accountability. In 2007, CVH was investigated by the U.S.

Department of Justice for gross inadequacies in its “conditions and practices”. As a result, CVH became subject to a federal consent decree. It’s now 10 years later and we are again confronted by gross inadequacies in the conditions and practices there. There have been rumors of abuse and neglect for years. My brother was held in physical restraint for the better part of three years, largely tied to a bed. His medical records include letters he wrote to Whiting staff alleging abuse. One letter from 10 years ago that I recently received a copy of says: “Today I was put in seclusion. I was threatened, humiliated and abused.” That was far from the only letter. I’d like to hear from Whiting management what was done in the wake of such letters.

In my experience, Whiting management has been reactive and weak. In particular, there appears to be no concept of risk management or internal controls. Two statements by the DMHAS Commissioner in the NPR segment aired in September illustrate what I mean. When asked about the use of videos at Whiting, her response was “the purpose of the cameras....was to have them in place to review them if a report was made”. Let me repeat the last part: “...to review them if a report was made.” This is not just the Commissioner’s perspective. I heard almost the exact same words from a senior CVH manager six months earlier when I was first notified of the abuse and was struggling to understand how so much abuse could have gone undetected for so long. The Commissioner also gently tries to frame the abuse as an exception, saying several times “this is not who we are...” I have to respectfully disagree with the Commissioner. When more than 40 out of 200 staff at Whiting are implicated in an abuse scandal; when there is such an absence of accountability that staff feel free to abuse a patient *knowing* there is a camera in the room, it may not be who you want to be, but it is absolutely part of who you are. Acknowledging there is a problem is the first step to fixing it. DHMAS leadership have been slow to acknowledge the true scope of the problem and, frankly, I doubt their ability to fix it.

My critique of Whiting notwithstanding, Whiting is needed. It needs to be reformed and not closed down. Patients like my brother who are too mentally ill to live in a community setting need someplace to be cared for. The alternative for too many seriously mentally ill persons is the prison system or the homeless shelter, neither of which is an effective or cost efficient way of addressing mental illness. Likewise, we need to be careful not to paint Whiting staff with too broad a brush. Over the years I have met some incredible staff at Whiting who care a lot, are compassionate and have tried to do the best for my brother in a place that does not make that easy. Any changes to Whiting need to make their jobs easier, to make their good examples the cultural norm of Whiting and not in spite of Whiting’s culture.

In closing, I thank this committee for the work you are doing and for holding this hearing. I urge you to dig deeply to find out what went wrong, to look for best practices from other states which have addressed similar challenges, and to work to see that the abuse my brother experienced never happens again – to him or anyone else. Such best practices must include: greater transparency and accountability, particularly to the family members and legal representatives of patients; an overhaul of the state Psychiatric Security Review Board, the hiring of more staff with lived experience of mental illness; and more funding for community-based care for individuals when they are ready to leave Whiting.

I hope that the suffering inflicted on my brother at Whiting will lead, through the work of this committee, to a safer facility, a more accountable Department and a higher quality of life for all patients at Whiting.