



STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

NED LAMONT
GOVERNOR

MIRIAM E. DELPHIN-RITTMON, Ph.D.
COMMISSIONER

December 31, 2019

Gretchen Knauff, Executive Director
Disability Rights Connecticut
846 Wethersfield Avenue
Hartford, Connecticut 06114

Dear Ms. Knauff:

This letter is in response to Disability Rights Connecticut's (DRCT) investigative report into treatment of patients at Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH) that I received on November 26, 2019.

The role of independent agencies, such as DRCT, is an important one as they provide an opportunity for an outside review of government, industry and organizations in the public realm. The Department of Mental Health and Addiction Services (DMHAS) shares DRCT's goal that all people, including those with disabilities, are provided their human, civil and legal rights. As such, we value input and feedback from DRCT. I am aware that DRCT staff often meet with DMHAS staff. In the future, I recommend meetings, such as our previous meeting on October 28, 2019, include agenda items that address concerns DRCT may have so that we may discuss and address them, if necessary, in a timely manner.

Upon review of the report, it's important to note inaccuracies that, in part, may be the result of outdated information. Moving forward, DMHAS would be happy to review reports in draft format to help ensure the accuracy of future reports and that recommendations are based on current information.

Due to pending litigation, the Department is limited in some of the information we can provide related to this report. State and federal privacy laws prohibit the Department from commenting on specific individuals or protected health information included in your report. Below, please find a few items within the report that were noted by the Department after its release that are of concern:

- Page 6 of the final investigative report indicates that the Department's decision to no longer participate in the Center for Medicare and Medicaid Services (CMS) program was related to a number of violations of federally required "conditions of participation". To clarify, the decision to no longer participate in the CMS program was made due to the limited ability of forensic patients to fully participate in discharge planning due to strictures of their legal status.

- Page 13 of the final investigative report suggests WFH “in important respects failed its first DPH licensing inspection.” This characterization is inaccurate. In July 2018, WFH participated in an unusual licensing process. It is uncommon for a hospital serving patients to apply for a license. As is common with regulatory inspections, some minor issues were identified, mostly environmental in nature (e.g., a broken shower tile), that needed to be addressed before a license was issued. WFH has been licensed since August 21, 2018.
- On page 18 of the final investigative report it states, “if there is patient-to-patient altercation an [abuse, neglect and exploitation] investigation is not triggered unless there is an allegation that a staff member violated a work rule which then resulted in an altercation.” This statement is false. All patient-to-patient altercations are tracked in our incident tracking system. Each incident is subject to a multilevel review and, depending on the circumstances and severity of the event, may qualify as a critical incident, which follows a separate process from an ANE or work rule violation investigation. All critical incidents are reviewed and appropriate actions are taken to prevent similar incidents from occurring in the future. Additionally, clients are able to report issues, including those they have related to other clients or staff, to the DRCT or the facility’s Clients Rights Officer.
- Page 21 of the final investigative report and page 9 of the report’s executive summary indicate the level of staff engagement as a concern, specifically the tendency for staff to congregate in the unit’s “bubble”. This concern was addressed in the WFH Nursing Policy and Procedure Manual Policy 9.4 “Milieu Management” that was implemented throughout the hospital on May 13, 2019. Compliance and adherence to this policy is audited on a daily basis.
- Page 27 of the final investigative report and page 11 of the report’s executive summary recommends independent investigations of all unanticipated deaths that occur at the facility. DMHAS’ past and present practice is to report any death to the State’s Attorney Office, which reviews any police investigations into unexpected deaths. Further, and, pursuant to Connecticut General Statutes § 19a-127n, adverse events are reported to the Department of Public Health (DPH), which may initiate investigations at any licensed hospital. Finally, pursuant to Connecticut General Statutes §17a-451(d), unanticipated deaths are reported to the state’s Protection and Advocacy for Individuals with Mental Illness (PAIMI) organization, which is currently DRCT. The state’s PAIMI organization is able to investigate any unanticipated deaths in the hospital per 42 USC § 10805 (a)(1)(A).

Gretchen Knauff, Executive Director

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- On page 29 of the final investigative report and page 12 of the report's executive summary recommendations are made to using quality improvement practices and measures to reduce the use of restraints. In fact, the Department regularly monitors the use of restraints across all facilities. The data shows that the use of restraints in WFH and CVH is well below the national average according to the National Association of State Mental Health Program Directors Research Institute. Other measurable patient outcomes currently used by the Department include data on incident reports, allegations, seclusion and constant observation as presented to the CVH/WFH Task Force on June 17, 2019.

I would like to schedule a meeting with you so that we can discuss the report and I may clarify and contextualize additional components of the report. I am always available to you and can be reached at miriam.delphin-rittmon@ct.gov or (860) 418-6676. I look forward to meeting with you and working together with DRCT so that we can better serve the individuals across the DMHAS system.

Sincerely,



Miriam E. Delphin-Rittmon, Ph.D.
Commissioner