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Disability Rights Connecticut

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846 Wethersfield Avenue
Hartford, CT 06114

February 23, 2020

Dr. Linda Schwartz and Michael Lawlor, Esq., Co-Chairpersons
CVH Whiting Task Force
c/o Public Health Committee
Legislative Office Building, Room 3000
Hartford, CT 06106

Dear Dr. Schwartz and Attorney Lawlor:

This letter is in response to questions posed by the Whiting Task Force during the January 27, 2020 presentation by Disability Rights Connecticut (DRCT) regarding DRCT's Whiting Forensic Hospital (WFH) and Connecticut Valley Hospital (CVH) Investigative Report, dated November 26, 2019.

1) How many patient records were reviewed directly by DRCT Investigators during the course of the DRCT investigation?

Records of seven patients were reviewed directly by DRCT investigators. Four patients were PSRB acquittees residing at WFH long-term. One patient was civilly committed to CVH and subsequently committed to WFH. One patient was civilly committed to CVH. One patient resided on a competency restoration unit.

In addition, DRCT conducted patient-focused reviews on eight (8) DPH investigations that were completed from from July 12, 2017 to June 6, 2019. These reviews included thirty-nine (39) distinct patients at CVH and nine (9) distinct patients at WFH.

2) How many patients were interviewed?

Thirteen patients(13) were interviewed directly by DRCT investigators during the course of the DRCT investigation. Nine patients (9) were PSRB acquittees residing at WFH and Dutcher Hall long-term; one (1) patient resided at both WFH and CVH, including the Young Adult Services Unit (YAS) at CVH; and three (3) patients resided on the competency restoration unit at WFH. In addition, nineteen (19) patients were surveyed on long-term units 4 and 6 at WFH.

3) How many staff persons were interviewed?

Twelve (12) staff members were interviewed directly by DRCT Investigators during the course of the DRCT investigation. Staff members interviewed represented the following disciplines: Human Resources; Nursing; Occupational Therapy; Clinical Psychology; Quality Improvement/Assurance; Program Management; Psychiatry; Medical/Health Services; and Advocacy.

In addition, DRCT engaged in numerous discussions with WFH and CVH Administrators; DMHAS Agency Police; Clients Rights Officers; CLRP Attorneys and a Public Defender assigned to PSRB cases.

4) How did DRCT determine who to interview?

A number of the interviews conducted directly by DRCT Investigators were complaint-driven. Client rights violations and/or allegations of abuse/neglect were reported directly to DRCT Investigators during the course of their frequent and ongoing facility visits. Subsequent interviews were conducted with patients and staff members to obtain additional information regarding the circumstances surrounding these allegations and rights violations issues.

A number of patient interviews also occurred organically, as patients requested to speak privately with DRCT Investigators during the course of their facility visits. Concerns expressed by patients during these interviews frequently involved matters such as client rights; concerns regarding the implementation of the level system and the awarding of privileges; individual treatment plans and treatment plan reviews; the nature of staff interactions with patients; and the role of the Psychiatric Security Review Board (PSRB).

Nineteen (19) long-term WFH patients also voluntarily participated in a standardized survey developed by DRCT investigators. The survey instrument was based upon principles outlined by the federal Substance Abuse and Mental Health Services Administration (SAMSHA) regarding "trauma-informed care."

DRCT interviews with administrative and clinical staff members were conducted to obtain additional information regarding facility policies and procedures and various programmatic and treatment-related practices.

5) How did DRCT determine which patient records to review?

DRCT Investigators directly reviewed records of patients who themselves reported allegations of abuse/neglect to DRCT or on whose behalf such allegations had been reported.

6) Regarding DRCT's findings and recommendations concerning the use of restraint/seclusion and PRN use, what is DRCT comparing its findings to? What are the statistics, if such data exists, regarding the rate of restraint/seclusion and PRN use in forensic hospitals?

Our findings were based upon qualitative rather than quantitative analyses. DRCT is authorized to investigate specific allegations of abuse, neglect and rights violations. The findings and recommendations are not comparative but rather the outcome of evidence

gathered from specific investigations, DRCT does not engage in a comparative analysis of other facilities.

Since any level of abuse, neglect, exploitation, unreasonable restriction upon liberty interests or other rights is unacceptable, DRCT focuses on making recommendations that lead toward upholding the civil and human rights of people with disabilities.

7) Will DRCT continue to visit/monitor WFH and CVH?

DRCT will continue to have a presence at WFH and CVH, both for investigations, monitoring, advocacy, and working with the administration on improvements, some of which have commenced or are in the planning stages. Just as it is counterproductive for patients and staff to live in a "them" and "us" culture, it is counterproductive for DRCT and the administration of WFH, CVH, and DMHAS to operate within that dynamic.

8) Will DRCT follow-up regarding the implementation of its recommendations?

DRCT will continue to follow-up on the findings and recommendations through consultation with the DMHAS Commissioner and other Administrators, providing input to this Task Force, providing information to the General Assembly, and by continuing to monitor and investigate at WFH and CVH. DRCT will continue to provide individual advocacy and/or legal representation as necessary.

Shortly before DRCT issued its report, we reported the circumstances of a patient death at CVH which warranted investigation. Although CVH remains exempt from licensure, it is a "participating provider" for the Center for Medicare & Medicaid Services (CMS). DPH, after communicating with CMS and obtaining authorization, was instructed to conduct an investigation under CMS authority. DPH found that the circumstances of this particular death resulted in the "Condition of Participation for Nursing" being out of compliance. (CMS assesses "standards" and "conditions", the later being the most serious). CVH developed its own "internal corrective action plan", dated September 4, 2019, and indicated that staff involved in this medical emergency "responded adequately". The DPH Investigation and Statement of Deficiencies Survey, dated September 19, 2019, and DRCT investigation do not support that assertion.

DRCT concludes that "neglect" is substantiated in this case and, while a DMHAS investigation did occur, that investigation was not on the order of, nor consistent with, the Abuse/Neglect/Exploitation investigation systems available for the elderly, children, and individuals with intellectual disability in the state of Connecticut. The outcome of this investigation also highlights the necessity of concentrating on monitoring activities at CVH.

Thank you for the opportunity to present and discuss our Whiting/CVH Investigative Report.

Sincerely,

Gretchen Knauff
Executive Director