



Disability Rights Group Calls For More Oversight of Whiting Forensic

by Christine Stuart | Nov 27, 2019 5:00am

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HARTFORD, CT – A disability rights group issued a report Tuesday and called on the state to do more to improve patient care and oversight at Whiting Forensic Hospital.

Disability Rights Connecticut, a nonprofit organization, put together a [41-page report](#) outlining the problems at the state's psychiatric hospital and recommending changes that could be made

to prevent prolonged abuse and neglect that made headlines in 2017.

The report acknowledges actions already taken by the General Assembly, including the enactment of legislation formally separating the Whiting Services Division from Connecticut Valley Hospital, requiring it to become a licensed, standalone psychiatric hospital now known as the Whiting Forensic Hospital.

Following the long-term abuse of a patient, disciplinary action was initiated against more than 25 staff members, and criminal charges were filed against 10. The entire senior leadership team was replaced, policies were revised, and new positions added, according to the report.

The same legislation established a task force to study and make recommendations about further changes that may be warranted at both Connecticut Valley Hospital and Whiting Forensic Hospital, which is supposed to serve those involved in the criminal justice system but has been housing individuals who were committed through civil proceedings.

The task force is expected to review the report.

Whiting Forensic Hospital consists of 91 maximum-security beds and 138 enhanced-security beds. There are approximately 350 beds available at Connecticut Valley Hospital.

DISABILITY RIGHTS CONNECTICUT

INVESTIGATIVE REPORT

Whiting Forensic Hospital and Connecticut Valley Hospital



In order to put together the report, Disability Rights Connecticut made frequent, unannounced facility visits; conducted patient interviews and a patient survey; held discussions with family members and patients' legal representatives; met with administrative staff; and reviewed patient treatment records, surveillance video recordings, facility policies, and multiple reports from federally sponsored inspections and surveys.

The report found misuse of restraints; denial of patient rights by Department of Mental Health and Addiction Services Police; inappropriate use of psychotropic medications; arbitrary restrictions of patient privileges; inadequate investigations of abuse, neglect, and a patient's death; and inadequate levels of constructive staff engagement with patients.

The report details the events leading up to the 2016 death of Andrew Vermiglio, who choked on cookies, and details the complicated case histories of two other individual patients, who are identified in the report by their initials. The report also details the abuse of [William Shehadi](#), which was revealed in 2017.

"This investigation was necessary to bring to light ongoing, disturbing practices that must be addressed," said Gretchen Knauff, executive director of Disability Rights Connecticut. "Our mandate and our responsibility is to investigate, advocate and educate to assure that the rights of individuals with disabilities are protected and they are free from abuse and neglect."

The recommendations include a call for independent investigation of all unanticipated deaths, removal of CVH's statutory exemption from psychiatric hospital licensing requirements, evaluation of the use of physical and chemical restraints, elimination of punitive and counter-therapeutic patient treatment, establishment of "genuine" interdisciplinary treatment teams, and training of police concerning patient rights.

A spokeswoman for the Department of Mental Health and Addiction Services said they are reviewing the report.

"As a system of care, we continually strive to evolve and identify ways in which we can improve our services. The role of independent agencies, such as DRCT, is an important one as they provide an external review of government, industry and organizations in the public realm," Diana Shaw, a spokeswoman for DMHAS, said. "We are eager to work with DRCT on ways in which we can continue to improve the quality care and services we provide to the over 100,000 individuals we serve every year."

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