Details On Deaths Of The Developmentally Disabled In State Care

By **Matthew Kauffman**

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From 2004 to 2010, state investigators cited abuse and neglect while investigating the deaths of 76 Connecticut men and women with developmental disabilities. This timeline provides information on the circumstances of each death, culled from summaries of investigations conducted by the state Department of Developmental Services. The summaries do not contain the names of individuals, but the Courant, through public records, was able to identify most of them.

The date listed with each case is the date of death for those individuals identified by the Courant, or the date on which the state's Office of Protection and Advocacy for Persons with Disabilities accepted the case or made a referral to the state Department of Public Health. The town listed with most of the cases is the town of residence identified on the individual's death certificate.

Sort By Year

Select Year

2004

JANUARY 21, 2004

Lorraine Beeman

› **Age:** 50
› **Type of Facility:** Private Group Home
› **Town:** Torrington
› **Cause of Death:** Did not receive care when in respiratory distress.

Beeman had a terminal illness and a "do not resuscitate" order on file instructing staff to provide palliative care but no heroic measures to keep her alive. Investigators found that there were no hospice services put in place for Beeman and that when she began having trouble breathing, staff at her group home did not provide medication or other appropriate end-of-life care.

FEBRUARY 10, 2004

Douglas Davis II

› **Age:** 41
› **Type of Facility:** Regional Center
› **Town:** Stratford
› **Cause of Death:** Suffered serious, unaddressed side effects from new medication.

Davis suffered unsteadiness and repeated falls after doctors switched his medication from Haldol to Seroquel. Despite injuries and calls by medical professionals to monitor his blood pressure, staff failed to properly address his medical condition.

MARCH 17, 2004

Rebecca Wojcik

› **Age:** 59
› **Type of Facility:** Private Group Home
› **Town:** Plainfield
› **Cause of Death:** Severely scalded in bathtub.

Wojcik, who was non-verbal, was placed in a bathtub with scalding hot water, which left her with peeling skin and burns over at least 40 percent of her body. Investigators found a problem with the thermostat on the group home's water heater, and the case led to a requirement for anti-scald devices in all group homes.

JUNE 13, 2004

Kenneth Anderson

› **Age:** 37
› **Type of Facility:** Private Group Home
› **Town:** Waterford
› **Cause of Death:** Suffered fatal head injury falling down stairs.

Anderson had fallen down a set of porch stairs at his group home, and his seizure activity had increased, but his group home did not put in place a protocol to keep him safe. He subsequently fell down the same set of stairs and died, due in part to head trauma from the fall.

JUNE 26, 2004

Judith Ferrell

› **Age:** 59
› **Type of Facility:** Private Group Home
› **Town:** Wethersfield
› **Cause of Death:** Did not receive follow-up care for serious intestinal problem.

Ferrell was treated in an emergency room for symptoms indicating possible intestinal blockage. When the symptoms remained days later, her doctor declined to order a further examination. The case was referred to the Department of Public Health, which found problems with documentation and pain assessment at the hospital, but dismissed cases against hospital practitioners.

JUNE 30, 2004

Richard Deprodocini

› **Age:** 43
› **Type of Facility:** Private Group Home
› **Town:** Torrington
› **Cause of Death:** Died following unapproved catheter technique.

Deprodocini's doctor had ordered the use of a straight catheter to obtain a urine culture, but a nurse at Deprodocini's group home instead used a different type of catheter, which was left in place for several hours. Deprodocini sustained a traumatic urethral injury and died of sepsis as a consequence of the injury. The nurse signed a consent order calling for re-education, but the state's Board of Examiners for Nurses denied the consent order and dismissed the case.

AUGUST 4, 2004

Tracy Hilliard

› **Age:** 30
› **Type of Facility:** Community Training Home
› **Town:** Meriden
› **Cause of Death:** Drowned at a campground.

Hilliard, who could not swim, was taken to a campground and allowed to swim without a life jacket. Overseer - who also could not swim - lost sight of Hilliard and she drowned.

AUGUST 5, 2004

Joshua Young

› **Age:** 25
› **Type of Facility:** State-operated apartment
› **Town:** New London
› **Cause of Death:** Was dead for several hours before staff found him.

Young, who suffered from a seizure disorder, was purple and unresponsive when he was discovered in the morning on the floor in his bed clothes. It appeared he had been dead for several hours, leading investigators to question whether staff completed bed checks as required.

AUGUST 13, 2004

Name unknown

› **Age:** 58
› **Type of Facility:** Nursing Home
› **Town:** Unknown
› **Cause of Death:** Did not receive prompt treatment for osteomyelitis.

Investigators suspected care provided to the client at his nursing home and by his physician was not appropriate, including delays in treatment when he was first diagnosed with osteomyelitis. State health department declined to accept the case, citing too many variables associated with care to single out any individual practitioner.

SEPTEMBER 21, 2004

Robert Anderson

› **Age:** 51
› **Type of Facility:** Private Group Home
› **Town:** Wethersfield

› **Cause of Death:** Choked on toilet paper.

Anderson was known to have a compulsion for eating inedible objects, but his group home had inadequate protocols in place to minimize the risk. He attempted to eat a wad of toilet paper, which became stuck in his throat.

SEPTEMBER 26, 2004

Carol Newton

› **Age:** 57
› **Type of Facility:** Private Group Home
› **Town:** Stamford
› **Cause of Death:** Health problems were not assessed in the weeks prior to her death.

After Newton's death, investigators raised issues about the quality of nursing oversight. There were indications that Newton was suffering a bowel obstruction, but there were no documented nursing assessments regarding her health in the weeks prior to her death. It was also unclear how much information was relayed to her doctor when Newton ultimately was taken to the hospital. The state health department declined to take the case, citing too many issues associated with the overall nursing services delivery system to single out one practitioner.

OCTOBER 4, 2004

Jeanne Zelinsky

› **Age:** 50
› **Type of Facility:** Hospital
› **Town:** Stamford
› **Cause of Death:** Died after 17 days in a hospital psychiatric unit.

Zelinsky was hospitalized after decompensating following the discontinuation of two of her medications. Despite hospital policies requiring a physical exam within 12 hours of admission, staff at the hospital never identified her condition or developed a personal treatment plan for Zelinsky from the day she arrived until she was found dead 17 days later.

OCTOBER 27, 2004

James D. Marshall

› **Age:** 46
› **Type of Facility:** Hospital
› **Town:** Bridgeport
› **Cause of Death:** Developed infection following extraction of all of his teeth.

Marshall, who lived in a nursing home, had all of his teeth removed at a hospital, without medical staff calculating his clotting time to assess whether the surgery should be performed over multiple days. Marshall, who also had a serious staph infection, suffered significant bleeding and days later was diagnosed with septic arthritis - a known complication. Marshall was sent back to his group home and belatedly given antibiotics through his IV line. He developed a high fever, was sent back to the hospital and died 13 hours later.

2005

JANUARY 25, 2005

Gerard Paul Gammons

- **Age:** 44
- **Type of Facility:** Community Training Home
- **Town:** Branford
- **Cause of Death:** Developed serious bedsore in hospital.

Gammons was hospitalized for pneumonia, and on discharge, had a serious ulcerous bedsore, despite having no skin breakdown prior to his hospitalization. The state health department cited the hospital for failing to implement protocols to prevent skin problems.

FEBRUARY 6, 2005

Kindale Engram

- **Age:** 21
- **Type of Facility:** Supported Living Arrangement
- **Town:** Manchester
- **Cause of Death:** Killed in a car crash.

Following a Courant story about Engram's death in a car accident, investigators determined that the contract agency hired to provide 35 hours a week of direct staff support hardly ever visited Engram, failed to enforce a curfew and failed to provide transportation to Narcotics Anonymous. Engram's live-in girlfriend said she never saw Engram's caseworker, and said Engram smoked marijuana daily, while agency claimed he was not involved with drugs.

FEBRUARY 28, 2005

Michael Gorman

- **Age:** 52
- **Type of Facility:** Private Group Home
- **Town:** Andover
- **Cause of Death:** Developed hypothermia following hospital procedure.

Gorman had a condition that can lead to an unusual reaction to certain medicines and anesthetics. During a hospital endoscopy, Gorman's blood pressure dropped and he was given various drugs and discharged to his group home. Soon after, he was taken back to the hospital and admitted to the ICU with a diagnosis of hypothermia and severe shock. The state health department cited the hospital for failing to assess Gorman for hypothermia, failing to ensure accurate medical records and failing to provide adequate communication on his discharge. Physician was issued an "advisory letter" pointing out areas where adequate care might not have been provided.

MARCH 9, 2005

Brian Francis Casey

- **Age:** 53

› **Type of Facility:** Private Group Home

› **Town:** Windsor

› **Cause of Death:** Weighed 55 pounds when investigators were called in.

Casey was sent to his day program despite having pneumonia that had not improved with medication. Three months later, investigators received a second report and discovered that Casey weight had dropped to 55 pounds. Investigation concluded that Department of Mental Retardation had failed to follow recommendations to protect Casey's health, including going to probate court if necessary to assure he received necessary medical care even if over the objection of his guardian.

APRIL 13, 2005

Nicholas Vazquez

› **Age:** 48

› **Type of Facility:** Supported Living Arrangement

› **Town:** Hartford

› **Cause of Death:** Jumped to his death from his fourth-floor balcony.

Vazquez committed suicide three days after a three-week inpatient hospitalization in psychiatric facility. He had been hospitalized after hallucinations and paranoid thinking, including voices telling him to kill himself. Discharge plan called for increased staffing and monitor to assure he was taking medication. He was provided staff from 8am to 1pm and 4pm to 10 p.m. He jumped off his balcony at 3:20 p.m.

MAY 9, 2005

Craig Dyson

› **Age:** 44

› **Type of Facility:** Private Group Home

› **Town:** East Haven

› **Cause of Death:** Did not receive medical care despite worsening illness.

Dyson, who came down with a high fever and cough, was prescribed antibiotics by a doctor who asked to be notified of any worsening of his condition. Dyson's fever climbed higher, but staff at his group home did not notify the doctor and did not have an on-call nurse system. Dyson's mother also resisted taking him to the hospital. Days later, he was seen by his primary physician, who immediately sent him to the hospital, where he was diagnosed with pneumonia and died two weeks later.

JUNE 12, 2005

Rosemary Hicock

› **Age:** 52

› **Type of Facility:** Southbury Training School

› **Town:** Southbury

› **Cause of Death:** Choked on a hamburger while caregivers went shopping.

Hicock had a history of stuffing large amounts of food in her mouth and had a plan requiring her food to be cut up and for her to be monitored while eating. But during an unauthorized outing, Hicock choked to death

when she was given a hamburger to eat alone in a van while staffers went shopping or sat in another van. Some staffers initially lied during the police investigation and several were arrested.

JUNE 24, 2005

Diana Lee McCullough

› **Age:** 43
› **Type of Facility:** Day Program
› **Town:** Simsbury
› **Cause of Death:** Choked on a sandwich while left unattended.

McCullough required line-of-sight supervision at all times. At her day program, the manager had that responsibility, but left without finding a replacement. McCullough, who was known to stuff food in her mouth, raided other clients' lunches and choked on a peanut butter sandwich. She died two days later.

AUGUST 8, 2005

Elizabeth Bennett

› **Age:** 30
› **Type of Facility:** Day Program
› **Town:** Orange
› **Cause of Death:** Choked on wallpaper sample.

Bennett, who was known to have a compulsion to eat inedible items, choked on a sample of wallpaper while attending her day program. A staff member told investigators she saw that Bennett had paper in her mouth for "a while," but didn't intervene until it was too late.

SEPTEMBER 7, 2005

Laura Mae O'Neil

› **Age:** 60
› **Type of Facility:** Nursing Home
› **Town:** Lebanon
› **Cause of Death:** Did not receive medical care after post-surgical problems.

After cataract surgery, O'Neil's group home was instructed to notify her doctor if she experience nausea. O'Neil subsequently experienced multiple episodes of vomiting, but five hours passed before staff called 911, after O'Neil began to have trouble breathing. Her heart stopped in the ambulance and she died 13 days later.

NOVEMBER 1, 2005

Elaine V. Anderson

› **Age:** 78
› **Type of Facility:** Private Group Home
› **Town:** Wethersfield
› **Cause of Death:** Died following fall at nursing home.

Anderson had a seizure disorder that required careful monitoring of medication dosages to avoid a complication that made her prone to falls. After falling at her apartment, she was transferred to a nursing home for short-term rehabilitation. Anderson fell at the nursing home, breaking her hip, and later died following post-operative complications. The state health department cited the nursing home for failing to develop a care and supervision plan for Anderson.

DECEMBER 4, 2005

Victor Carl Soderquist

- **Age:** 62
- **Type of Facility:** Private Group Home
- **Town:** Bethel
- **Cause of Death:** Did not receive emergency care after being found unresponsive.

Soderquist was found unresponsive at his group home, but no one on staff attempted life-saving procedures, with one reportedly saying it didn't occur to anyone to do CPR. Staff represented to investigators that Soderquist's body was cold, but first responders contradicted that assertion. Earlier in the day, a nurse had noticed low urine output, but took no action before her shift ended, and the nursing supervisor position for the following shift had been vacant for most of previous three years.

2006

JANUARY 2, 2006

Kallif P. Mysogland

- **Age:** 30
- **Type of Facility:** Regional Center
- **Town:** New Canaan
- **Cause of Death:** Suffered a heart attack while being restrained.

Mysogland, who was frequently agitated, was physically restrained three times in one night, and during the third restraint, he went limp and apparently suffered a heart attack. He also suffered a large laceration on his nose during the restraints, but received no medical assessment or care. Another resident told police he saw Mysogland wrapped in a rug with a staff member sitting on him, but police did not find the statement credible. But the investigation did find that the facility had not modified its restraint policy for Mysogland despite concerns, dating to 1995, about his high blood pressure.

FEBRUARY 21, 2006

Kathy Seleman

- **Age:** 46
- **Type of Facility:** Private Group Home
- **Town:** Bristol
- **Cause of Death:** Was not seen by nurse for two days despite serious symptoms.

Staff at Seleman's group home called the on-call nurse at 1 a.m. to report that Seleman was not feeling well, but the call was not returned and no contact was made for 3 1/2 hours. At that point, the nurse was told that Seleman had a fever and had vomited blood, but she was not told Seleman's hands were blue-tinged. The

nurse instructed the staff to monitor Seleman's condition, and later prescribed Tylenol, but did not examine Seleman over the next two days. Early in the morning of the third day, Seleman was found blue and unresponsive and she was pronounced dead on arrival at the emergency room.

MARCH 1, 2006

Michael J. Damicis

› **Age:** 45
› **Type of Facility:** Public Group Home
› **Town:** Hamden
› **Cause of Death:** Choked on a meatball, despite ground-food-only diet plan.

Damicis, who had a swallowing disorder, a ground-food-only diet and a history of taking food, choked on a meatball and was "semi-unconscious" when found. EMTs used forceps to remove too pieces of meatball from his throat. Damicis had had a choking episode a year earlier involving the same staff members at the group home, and investigators found that the group home manager who investigated that case could not provide specific infomation on the implementation of his own recommendations.

MARCH 28, 2006

Larry Mihalcik

› **Age:** 45
› **Type of Facility:** Private Group Home
› **Town:** New Milford
› **Cause of Death:** Choked on cookies, despite one-to-one monitoring plan.

Mihalcik, who was known to have insomnia and aggressive food-seeking tendencies, had a care plan requiring one-to-one staffing when he was awake. In addition, after a previous choking incident, all food was restricted from his room. After a staff member on the late shift returned from using the bathroom, Mihalcik was found unresponsive with cookie wrappers on or around his bed. Investigators found that the group home operator had cut third-shift staff from two to one, and that "third shift responsibilities were practically beyond the ability of one staff person to safely perform."

APRIL 27, 2006

Lillian Rutkowski

› **Age:** 52
› **Type of Facility:** Private Group Home
› **Town:** Danbury
› **Cause of Death:** Did not receive follow-up exam after abnormal pap test.

Rutkowski had an abnormal pap test in November 2004, and after a follow-up biopsy produced too few cells for a diagnosis, her group home failed to schedule a second follow-up exam. Nearly a year later, after new problems arose, an ultrasound exam suggested she had an enlarged prostate - an obviously erroneous finding for a female patient, but again there was no follow-up. After another year passed, Rutkowski was diagnosed with inoperable cervical cancer, from which she died.

MAY 22, 2006

Name unknown

› **Age:** 74
› **Type of Facility:** Private Group Home
› **Town:** Unknown
› **Cause of Death:** Did not received timely diagnosis in the emergency room.

Investigators found numerous discrepancies in client's hospital medical records and had concerns about lack of timely diagnosis and intervention for a serious medical condition. The state health department cited the hospital for failing to ensure a comprehensive assessment of symptoms was performed when client was seen in the emergency room.

JUNE 14, 2006

Jennie Pawlicki

› **Age:** 84
› **Type of Facility:** Private Group Home
› **Town:** Avon
› **Cause of Death:** Did not receive prompt care after suffering apparent heart attack.

Pawlicki underwent angioplasty for two blockages, only one of which was successfully cleared. At the hospital an EKG revealed evidence of a possible heart attack, but Pawlicki was sent back to her group home without further assessment by the hospital's cardiac team and with no notification to the group home of either the angioplasty or EKG results. Pawlicki became dizzy, nauseous, pale and clammy and was taken by ambulance back to the hospital, where the heart attack was diagnosed. She died six days later. The state health department issued a consent order against a physician for misreading the EKG, but the hospital was not cited.

JULY 21, 2006

George D. Birkbeck Jr.

› **Age:** 36
› **Type of Facility:** Family Home
› **Town:** Groton
› **Cause of Death:** Died while living in family's squalid home while mother refused state services.

Birkbeck, an overweight man with diabetes, lived in his family's filthy house, watching cartoons all night and sleeping on the floor of a room with no furniture. The home was rundown and a police report described the residence as a "bio hazard." The family repeatedly refused assistance and Birkbeck's mother insisted her son was not diabetic. Despite occasional checks with family dating to 2001, state officials never reported suspected neglect to the Office of Protection and Advocacy for Persons with Disabilities

AUGUST 21, 2006

Cathleen Carrignan

› **Age:** 49
› **Type of Facility:** Private Group Home
› **Town:** New Haven

› **Cause of Death:** Choked on Mucinex tablets, despite ground-food-only diet plan.

Carrignan, who could consume only ground food, was given two full Mucinex cold tablets, which became lodged in her lung and throat. Staff at group home gave conflicting reports on what happened the morning Carrignan choked, and investigators found that paperwork had been completed in advance by two workers, with one indicating the cold tablets had had the desired effect, and the other indicating Carrignan had a good morning and had gone to her day program.

SEPTEMBER 1, 2006

Steven Chandler

› **Age:** 54
› **Type of Facility:** Private Group Home
› **Town:** Killingly
› **Cause of Death:** Choked on uncooked piece of chicken.

Chandler had swallowing problems and was known to aggressively seek food, but staff at his group home did not have a clear protocol for keeping him safe, and instead followed an informal and poorly explained policy of not leaving him alone in the kitchen when food was out. While staff members were out of the kitchen, Chandler was able to obtain a piece of uncooked chicken and he choked on it and died.

SEPTEMBER 24, 2006

Linda June Bowden

› **Age:** 36
› **Type of Facility:** Family Home
› **Town:** Thomaston
› **Cause of Death:** Developed bedsores so severe, her hip bone was visible.

Bowden, who had a history of bedsores, had a protocol requiring home care agency nurse to visit every week and coordinate bedsore care if necessary. Two months prior to her death, Bowden was admitted to hospital with bedsores so severe, her bone was visible, which necessitated a partial hip removal.

OCTOBER 24, 2006

Lindsey J. Haile

› **Age:** 25
› **Type of Facility:** Private Group Home
› **Town:** Wallingford
› **Cause of Death:** Faced delays in treatment of medical issues.

Haile spent the last eight months of her life shuttling seven times between four different hospitals. Broad investigation found delays in treating Haile's conditions, as well as the use of pain medication that may have masked the severity of her medical condition.

NOVEMBER 26, 2006

Charles Sullivan

› **Age:** 58
› **Type of Facility:** Supported Living Arrangement
› **Town:** Manchester
› **Cause of Death:** Was found unresponsive, but staff failed to perform CPR.

Sullivan was found unresponsive in the morning, after a day of frequent vomiting. But a caregiver made no attempt at CPR and did not immediately call 911, concluding that Sullivan was already dead. The same staff member ordered Sullivan a pizza and a grinder sandwich two days earlier, despite Sullivan's low-cholesterol and no-added-salt diet. Sullivan also vomited twice that night.

2007

FEBRUARY 6, 2007

Kathleen Bentze

› **Age:** 77
› **Type of Facility:** Southbury Training School
› **Town:** Southbury
› **Cause of Death:** Questions raised about use of restraints and failure of hospital to review patient's death.

Bentze died unexpectedly, a day after she was found alone in a hospital hallway with a bleeding neck injury. Investigation raised questions about the use of wrist restraints at the hospital, and about how Bentze was able to get out of bed. Investigation also found the hospital conducted no review after Bentze was discovered in the hallway, and no review surrounding her death.

FEBRUARY 9, 2007

Joanne DeCarli

› **Age:** 49
› **Type of Facility:** Nursing Home
› **Town:** Milford
› **Cause of Death:** Was not properly diagnosed despite obvious health changes.

Was not properly diagnosed despite obvious health changesDeCarli's behavior and level of functioning changed noticeably, but investigators found that caregivers at her nursing home failed to evaluate her condition or have her properly examined and diagnosed, and failed to coordinate care among her doctor and other healthcare workers.

FEBRUARY 19, 2007

Jean Ann Mulready

› **Age:** 63
› **Type of Facility:** Private Group Home
› **Town:** Manchester
› **Cause of Death:** Received no medical intervention despite vomiting "all day".

On the day she died, Mulready had been vomiting "all day" and "pretty much continuously," according to staff at her group home, but she received no intervention other than fluids and the agency nurse was not called. Mulready was later found unresponsive, but a worker "freaked out" and was unable to perform CPR.

MAY 26, 2007

Jason W. Schools

› **Age:** 24

› **Type of Facility:** Private Group Home

› **Town:** Enfield

› **Cause of Death:** Drowned in a pond.

Schools had autism, an unsteady gait and a seizure disorder that required staff to remain within an arm's length when he was walking. He also could not swim, but was allowed to enter a pond at a public park by himself. While wading in the pond, he suddenly went under and drowned before he was located and pulled from the water.

JUNE 8, 2007

Name unknown

› **Age:** 71

› **Type of Facility:** Nursing Home

› **Town:** Unknown

› **Cause of Death:** Choked to death.

Following choking death, the client's guardian was told that she died from an accumulation of food in both lungs, and one nursing home staff member told investigators the client had been "force-fed" because she did not want to eat or get out of bed to go to the dining area. The case was referred to the Department of Public Health, which dismissed for lack of evidence. Investigators for the Department of Developmental Disabilities reported that the health department did not pursue a case against the nurse assistant who fed the patient, even though she was "completely unable to recall the incident" when interviewed by three different agencies. The case was later referred to the chief state's attorney's office, which concluded there was no criminal aspect to case.

JULY 20, 2007

Mary E. Schroeder

› **Age:** 63

› **Type of Facility:** Southbury Training School

› **Town:** Southbury

› **Cause of Death:** Was not tended to after she removed her tracheostomy tube.

Schroeder, who had a tracheostomy tube, was battling pneumonia and was known to remove the tube to improve her breathing when she wasn't feeling well. After two staff members discovered the tube had been removed, they said they paged the on-call nurse and attended to another client, who had vomited. When the staffers returned, Schroeder was blue. The nurse later claimed she never received the page, but investigators cast doubt on that claim. Investigators also concluded that the staff members left Schroeder unattended for about 30 minutes, despite paperwork claiming she was seen every 15 minutes, as her care plan required.

SEPTEMBER 28, 2007

Name unknown

› **Age:** 73
› **Type of Facility:** Nursing Home
› **Town:** Unknown
› **Cause of Death:** Received inadequate pain management in final weeks of life.

Client, who had terminal cancer of the thoracic cavity, cried out in pain in the final weeks of his life. But investigators found his nursing home failed to conduct comprehensive assessments of the client's pain, failed to use alternative pain-management measures such as ice packs, and failed to promptly follow up on a nurse's recommendation for a hospice evaluation.

2008

FEBRUARY 11, 2008

Pamela Buzon

› **Age:** 64
› **Type of Facility:** Community Training Home
› **Town:** Cheshire
› **Cause of Death:** Choked on a corn muffin.

Buzon, who was blind and had no teeth, had a care plan calling for her food to be cut up into dime-sized pieces and for her eating to be monitored. But she was served a whole corn muffin and choked, dying six days later. Two years earlier, Buzon's facility had been cited by state regulators for deficiencies in Buzon's food plan.

MARCH 6, 2008

Chavis R. Chappell

› **Age:** 27
› **Type of Facility:** Independent Living
› **Town:** Hartford
› **Cause of Death:** Did not receive proper medical referral due to misread CT scan.

A few months before his death, Chappell went to a hospital emergency room complaining of headache and nausea and asking that his shunt be checked. A CT scan was ruled inconclusive and Chappell was discharged with instructions to follow up with neurosurgery. A subsequent review of the scan showed that Chappell had moderate hydrocephalus, which may have explained his symptoms. The hospital was cited for failing to arrange a consultation with the neurology department.

APRIL 16, 2008

Carolyn Elizabeth Cormier

› **Age:** 48
› **Type of Facility:** Private Group Home
› **Town:** Windsor
› **Cause of Death:** Suffered a seizure, but EMS not called for 27 minutes.

Cormier had a protocol requiring a 911 call in response to any seizure lasting more than 10 minutes. Two days before death, she had a seizure, and after more than 15 minutes, staff telephone the agency's on-call nurse, rather than 911. The nurse did not seek emergency help and instead drove from a nearby office to assesss the client. At least 27 minutes passed from the onset of the seizure before 911 was called. At the hospital, brain damage was noted, and Cormier died two days later.

MAY 7, 2008

Maureen H. Quinn

› **Age:** 57

› **Type of Facility:** Private Group Home

› **Town:** Preston

› **Cause of Death:** Did not receive coordinated care for several ailments and injuries.

Quinn collapsed while shopping and was diagnosed with possible hydration. The next day, doctors at a different hospital determined she had broken two bones in her ankle when she collapsed. One day later, she developed a fever and a doctor ultimately diagnosed an upper respiratory infection. One more day later, she became pale and her breating was labored and she was deemed to have acute respiratory failure and pneumonia, and she died three weeks later. Investigation concluded she received appropriate medical care at each step, but that there was a lack of coordinated care and a failure to follow accepted nursing standards.

JUNE 19, 2008

Thomas Barkley

› **Age:** 44

› **Type of Facility:** Private Group Home

› **Town:** Naugatuck

› **Cause of Death:** Did not receive appropriate care when fluids were secreting from his tracheostomy tube.

Staff at Barkley's group home called for ambulance, reporting that Barkley had low oxygen saturation levels and fluids coming out of his tracheostomy tube. Agency nurse said she did not suction the tube, despite physician's order, so as not to block Barkley's airway. Investigators concluded that was not the medically appropriate decision.

AUGUST 20, 2008

Sharon Spiegel

› **Age:** 64

› **Type of Facility:** Nursing Home

› **Town:** New London

› **Cause of Death:** Blood sugar levels were not properly monitored.

Spiegel had hypoglycemia - dangerously low blood sugar, which can lead to seizures or coma - but investigators found that her nursing home failed to properly monitor or treat her condition.

SEPTEMBER 11, 2008

Susan Plourde

› **Age:** 49
› **Type of Facility:** Public Group Home
› **Town:** Newington
› **Cause of Death:** Fell down basement stairs.

Plourde, whose care plan required line-of-sight supervision and who was not to be on stairs without staff assistance, fell down basement stairs at her state-run group home and suffered multiple fractures to her head and face. She also suffered swelling inside her skull and died as a result of the injuries. Neglect was substantiated against the state agency running the home, but not against Plourde's direct caregiver at the time, who had not been informed of Plourde's specific needs.

OCTOBER 26, 2008

Richard Porter

› **Age:** 86
› **Type of Facility:** Nursing Home
› **Town:** West Haven
› **Cause of Death:** Was not taken immediately to emergency room despite doctor's instruction.

X-rays showed that Porter had a potentially serious colon problem, prompting a urology surgeon to contact Porter's nursing home with instructions to bring him to an emergency room for further evaluation. Investigators found that the urgency of that instruction was never relayed to the nursing home physician. The state health department cited the nursing home, but took no action against the surgeon for failing to assure that his instructions were relayed and followed.

NOVEMBER 15, 2008

Ronald David Bentch

› **Age:** 52
› **Type of Facility:** Private Group Home
› **Town:** Milford
› **Cause of Death:** Repeated hospitalizations brought questions about quality of care.

Bentch's guardian brought concerns to the state health department, following a series of hospitalizations for ailments, including C-difficile - a bacterial infection often acquired in hospitals and nursing homes. The health department cited the nursing home for failing to document that Bentch's condition was monitored or that certain appropriate medical steps were taken.

DECEMBER 12, 2008

Name unknown

› **Age:** 74
› **Type of Facility:** Private Group Home
› **Town:** Unknown
› **Cause of Death:** Did not receive prompt medical care in response to declining health.

This client exhibited signs of illness early one morning, but staff at her group home responded by attempting to reach the group home's manager, rather than contacting the on-call nurse. A number of hours passed

before an ambulance was called, and the client died 10 days later. Investigators also found that written records appeared to have been altered to change times listed on reports.

2009

JANUARY 18, 2009

David J. Thompson

› **Age:** 52
› **Type of Facility:** Nursing Home
› **Town:** East Hartford
› **Cause of Death:** Gained 33 pounds in 69 days from rare disorder.

Thompson, who had Prader-Willi Syndrome - a rare disorder that causes constant hunger - was found to have gained 33 pounds in the 69 days before his death, rising from 282 to 315 pounds. A physician was eventually called, but Thompson died six days later. Investigators found that the nursing home failed to adequately oversee Thompson's food intake.

JANUARY 28, 2009

Samuel Morales

› **Age:** 70
› **Type of Facility:** Nursing Home
› **Town:** Hartford
› **Cause of Death:** Died of head injuries from a fall.

Morales died in January 2009 from head injuries caused by a fall, but his case manager was not notified by the nursing home until March. State health department investigators cited the nursing home for failing to assess Morales' condition before discontinuing 15-minute checks, given that Morales had a seizure disorder and had received head injuries from falls in the past.

FEBRUARY 27, 2009

Barbara Libbey

› **Age:** 59
› **Type of Facility:** Private Group Home
› **Town:** Vernon
› **Cause of Death:** Received inadequate hydration due to miscommunication.

Received inadequate hydration due to miscommunicationLibbey came down with diarrhea while the nurse assigned to her group home was on vacation, and there was only an agency-wide on-call system for nursing services. Due to poor communication, an instruction to increase liquids for Libbey by giving her Jell-O was misinterpreted as an instruction to give her only Jell-O, with no additional liquids. After three days, Libbey was admitted to the hospital with signs of dehydration that may have contributed to renal failure and death.

APRIL 3, 2009

Name unknown

› **Age:** 24
› **Type of Facility:** Family Home
› **Town:** Unknown
› **Cause of Death:** Remained in filthy home despite emergency status.

In 2007, state investigators substantiated claims of neglect against the parents of this client after she was found to be sleeping on a urine-soaked mattress at home and was unclean ... with blackened feet and greasy hair." The woman was given "emergency" status by the Department of Developmental Services, placing her on a priority list to receive residential placement support services. But two years later, an investigation found the client was sleeping on a stained mattress that smelled of urine and that the family house was unclean and smelled of cigarette smoke and urine. Investigators also found client had not received necessary dental and medical care, and that her parent refused a state offer for in-home services. Following second investigation, state officials reported there were no available group home openings and that the client would remain on the emergency waiting list for placement. The client later died, but the circumstances of her death are unclear.

JUNE 1, 2009

Arlene Mary Fiyalka

› **Age:** 57
› **Type of Facility:** Private Group Home
› **Town:** Easton
› **Cause of Death:** Did not receive medical care despite days of distress and calls to nurse.

The on-call nurse at Fiyalka's group home was notified at least four times over two days that Fiyalka was experiencing vomiting, a fever over 100 degrees, low blood pressure, high respiration, pursed-lip breathing and agitation. But Fiyalka's health was not assessed and by the time she was sent to the hospital, her oxygen saturation was 84, her respiration was 40 and her blood pressure was difficult to obtain. She died the same day.

AUGUST 3, 2009

Katherine Howes

› **Age:** 81
› **Type of Facility:** Hospital
› **Town:** Manchester
› **Cause of Death:** Fell off x-ray table at hospital.

Howes, who was non-verbal, was taken to the hospital for an x-ray as part of a feeding-tube replacement procedure. Radiology staff did not use straps available on the x-ray machine, and while unattended, Howes slid off the table and fell to the floor, breaking both legs and a vertebra. Howes was placed back on x-ray table without assessment by a nurse, as required by hospital policy, and the hospital would not x-ray or scan her legs and turned down a request for an overnight observation. Back at her group home, Howes developed a high fever and was taken back to the hospital emergency room the next day with low blood pressure, bruising to her face and flaccid lower extremities. No assessment was done on her legs and Howes was discharged with diagnosis of a urinary-tract infection, which later tests indicated was erroneous. Two days later, Howes was taken by ambulance again, and a diagnosis of severe anemia led to blood transfusions. X-rays for the first time revealed the fractures to both of Howes' femurs and to her right tibia. A week after the fall, a full body bone scan revealed the spine fracture for the first time. Later, leg splints led to skin problems and made it difficult

for Howes to remain upright in bed, which was important for her feeding and breathing. She developed pneumonia and died 18 days after the fall.

SEPTEMBER 5, 2009

Raymond Durga

› **Age:** 72
› **Type of Facility:** Nursing Home
› **Town:** Windsor
› **Cause of Death:** Chest pain and other medical changes were not reported to cardiologist.

A month before he died, Durga complained of chest pains and heartburn. and his medications were changed. But none of that information was included on paperwork that accompanied Durga to an appointment with his cardiologist.

OCTOBER 17, 2009

Audrey L. Bell

› **Age:** 57
› **Type of Facility:** Private Group Home
› **Town:** Beacon Falls
› **Cause of Death:** Did not receive prompt care when in medical distress.

Bell, whose care plan required bed checks every 15 minutes, was found unresponsive at a 5 a.m. check. But the group home staff member on duty was unable to explain a delay of more than an hour before she woke a second, sleeping staffer, at which time the pair performed CPR and called 911. Bell died at the hospital. Investigators also found that staff routinely marked 15-minute checks by drawing a line through an entire night of checks, rather than signing to confirm each check was made.

NOVEMBER 22, 2009

Marilyn Havelka

› **Age:** 73
› **Type of Facility:** Southbury Training School
› **Town:** Southbury
› **Cause of Death:** Was seriously injured falling from a device used to lift her.

Havelka broke her hip when a Hoyer lift tipped over as a result of staffers failing to properly open the lift's spreader bars. A hip replacement was ruled out and she died at her cottage two months later of cardio-pulmonary arrest, pulmonary fibrosis, recurrent aspiration pneumonias and COPD/emphysema. An autopsy did not directly link the fall to her death.

NOVEMBER 24, 2009

John J. DeFranco Jr.

› **Age:** 62
› **Type of Facility:** Southbury Training School
› **Town:** Southbury

› **Cause of Death:** Was fatally injured falling from a device used to lift him.

Two months after Marilyn Havelka fell from a Hoyer lift, DeFranco, who also lived at Southbury Training School, fell from a lift and struck his head on the floor. Despite a protocol requiring two staff members when using a Hoyer lift, a single staffer had attempted to DeFranco. After the fall, DeFranco was not breathing and had no pulse. First responders were able to restore a weak pulse and respiration, but he died four days later.

NOVEMBER 30, 2009

Elizabeth Jean Porter

› **Age:** 49
› **Type of Facility:** Private Group Home
› **Town:** Farmington
› **Cause of Death:** Did not receive prompt medical care despite breathing problem and blue lips.

Porter, who had Down syndrome and a history of heart problems, was observed to have a "bad cold" in last 10 to 14 days of her life. On Thanksgiving 2009, she had a persistent cough and later, while visiting a staff member's home, she had blue lips and breathing problems. An on-call nurse was called, but the nurse - who said she was not told that Porter's lips were blue - did not arrange an assessment of Porter's health or send her to the hospital. Two days later, Porter refused to eat breakfast and her lips were black. Staff attempted to take her to a walk-in clinic, but Porter refused and began screaming. Ultimately, 911 was called and Porter was taken to a hospital, where she died two days later.

JANUARY 15, 2010

Holly Anna Weiss

› **Age:** 49
› **Type of Facility:** Nursing Home
› **Town:** Southbury
› **Cause of Death:** Questions raised about quality of health monitoring.

Two weeks prior to her death from pneumonia, Weiss was hospitalized with sepsis. Subsequently, investigators with the Department of Developmental Service's Fatality Review Board reviewed her records and were concerned with the level of monitoring she was provided after she suffered a grand mal seizure. The case was referred to the state health department, which was "not able to validate non-compliance" with health care laws.

JANUARY 27, 2010

Carolyn Jackson

› **Age:** 71
› **Type of Facility:** Private Group Home
› **Town:** Terryville
› **Cause of Death:** Did not receive CPR when in distress.

Jackson, wheelchair-bound and developmentally disabled, was preparing for a colonoscopy when she began vomiting profusely and became unresponsive. Two staff members assisting her failed to perform CPR or move her from the wheelchair to the ground. Investigators also

found fault with her group home's oversight and care during a special five-day colonoscopy preparation and with a delay in calling 911 when Jackson became ill. She died in the hospital three days later.

2010

FEBRUARY 7, 2010

Sandra L. Codding

- **Age:** 66
- **Type of Facility:** Private Group Home
- **Town:** Manchester
- **Cause of Death:** Died of undiagnosed septic shock following days of untreated vomiting.

Codding was taken to the hospital by ambulance after vomiting and fainting. An emergency room physician diagnosed a urinary tract infection and discharged her with instructions to rest and follow up with her doctor. Hours later, Codding vomited a green substance and had abdominal distension. She was sent back to hospital, admitted in critical condition and died the next day of septic shock. The state health department cited the hospital for failing to re-assess Codding's vital signs before discharging her.

MARCH 12, 2010

Matthew Brian Thorp

- **Age:** 29
- **Type of Facility:** Hospital
- **Town:** Salem
- **Cause of Death:** Died after five days in four-point restraints.

Thorp, who had psychiatric problems including a propensity for aggressive behavior, died of a pulmonary embolism shortly after his transfer from an acute-care hospital to an inpatient psychiatric facility. Investigation found he had spent five days in four-point restraints at one hospital before his transfer. After arriving at the second hospital, Thorp's restraints were removed and he began to walk, but immediately stooped over and had to be helped into a wheelchair. He died less than an hour later. Investigators concluded the first hospital did not adequately assess the potential for deep-vein thrombosis and pulmonary embolism - both known risks when patients are immobilized by restraints.

JULY 19, 2010

Name unknown

- **Age:** 76
- **Type of Facility:** Private Group Home
- **Town:** Unknown
- **Cause of Death:** Died after developing several ailments in the hospital.

This client was admitted to the hospital for treatment of cellulitis with a MRSA infection, and while in the hospital he developed aspiration pneumonia, sepsis, hypotension and respiratory failure. Questions were raised as to whether the client received the proper food consistency in the hospital and whether that contributed to his pneumonia and death. An investigation by the state Department of Public Health found

insufficient evidence that he had been provided food with the wrong consistency, but cited the hospital for failing to assure that a comprehensive health assessment was completed following the diagnosis of aspiration pneumonia.

AUGUST 26, 2010

Joan Desrochers

› **Age:** 63

› **Type of Facility:** Private Group Home

› **Town:** Torrington

› **Cause of Death:** Despite order for 15-minute bed checks, rigor mortis had set in before client was found to have died.

Desrocher's care plan called for staff to check on her every 15 minutes. But after staff found Desrocher unresponsive and called 911, first responders reported that rigor mortis had set in, suggesting that a significant period of time passed before they were called. Investigators found that the two staff members on duty gave timeline reports that were "inconsistent, conflicting and ever evolving." Documentation was "purposefully falsely recorded," and "neither staff ever undertook to correct the record ... unless or until they were confronted with evidence which demonstrated the false nature of their previous representations."

SEPTEMBER 15, 2010

Name unknown

› **Age:** 76

› **Type of Facility:** Private Group Home

› **Town:** Unknown

› **Cause of Death:** Received poor pain management after breaking her hip.

The client fell at her group home and broke her hip, then declined medically and died. Investigation found no evidence of neglect on the part of the home, which had provided a walker and counseling, as well as an accessible bathroom and a bell to use if the client wished to move without her walker. But investigators did cite the hospital where the client was treated for failing to ensure appropriate pain management after the client's admission.

OCTOBER 1, 2010

Name unknown

› **Age:** 69

› **Type of Facility:** Nursing Home

› **Town:** Unknown

› **Cause of Death:** Was not sent to hospital for three days, despite vomiting blood and medical issues.

This client experienced a variety of acute medical issues at his nursing home - including vomiting blood, abdominal distension and grimacing in pain - for three days before being sent to the hospital. Investigators found that the nursing home physician was aware of the issues from the first day, but did not promptly refer the client for an outside evaluation. The case was referred to the state Department of Public Health, which took no action against the nursing home. The doctor was referred to the department's Practioner's Unit, which dismissed the complaint.

NOVEMBER 25, 2010

Carolyn McFadden

› **Age:** 50
› **Type of Facility:** Private Group Home
› **Town:** East Haven
› **Cause of Death:** Choked on food.

After a choking incident, McFadden's group home developed food consistency guidelines, including cutting her food into small pieces. But the home never told McFadden's day vocational program about the choking episode or the new food-preparation protocol. A month after the first incident, McFadden choked on food at the day program and died.

NOVEMBER 25, 2010

Francis F. Fedor

› **Age:** 76
› **Type of Facility:** Private Group Home
› **Town:** Torrington
› **Cause of Death:** Did not receive appropriate medical care after heart attack.

Fedor began complaining of pain at 7:30 one morning and was intermittently agitated and in pain throughout day. Although staff members at the group home occasionally gave him Tylenol, nearly 10 hours passed before the agency's nurse was called. At that time, Fedor was complaining of head ache and was reported as feeling "ice cold" with a temperature of 95.2. The nurse ordered an immediately call to 911, and at the hospital, doctors determined Fedor had suffered a heart attack. His heart stopped twice in the emergency room and resuscitation measures were deemed futile.

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