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Lethal Restraint at Western State Hospital

A young woman was subjected to abusive restraint while involuntarily committed to Western State Hospital in Staunton, Virginia. She died as a result of those restraints, according to the investigative report released today by the disAbility Law Center of Virginia (dLCV). The report, *Lesson Never Learned: Lethal Restraint at Western State Hospital*, shines a light on the facility's long history of dangerous seclusion and restraint practices. The report notes that the Office of the Chief Medical Examiner concluded that Western State's use of restraint contributed to the embolism that killed the young woman.

dLCV found that Western State Hospital (WSH) allowed the woman, identified as "EB," to deteriorate both medically and psychiatrically over a twenty-six day period preceding her death. She spent her final 26 days in restraints, clearly in pain and clearly suffering. Moreover, the facility's top administrators and clinicians knew about the restraint use. Dr. Jack Barber was the director of WSH at that time; he served on the Behavior Management Committee that approved EB's treatment.

According to a review of EB's records, staff were directed to restrain EB, even in non-emergency situations, and even while sleeping, for unconscionably long periods of time. Most disturbing, the report notes, is that after EB's death, neither the hospital nor the Department of Behavioral Health and Developmental Services did a meaningful investigation of the death, nor did they implement any relevant corrective actions in response.

"Western State Hospital has long history of misusing restraints instead of providing active treatment," said Colleen Miller, the executive director of the disAbility Law Center of Virginia. "It is a history of serious harm, sometimes fatal harm, as we now know."

The report urges Western State Hospital to implement immediate reforms, including use of well established trauma-informed responses rather than outmoded restraint techniques. "Trauma informed care works." Miller stated, "It is clear that the techniques used by Western State do not. This was a preventable and tragic death. Virginia must take immediate steps to prevent similar tragedies."

dLCV is a nonprofit organization that serves as the Commonwealth's designated protection and advocacy system. dLCV's mission is to fight abuse and neglect and to encourage people with disabilities to have choice, independence, and inclusion in all aspect of life.

To read the full report and the Department's reply, visit www.dLCV.org.

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