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Connecticut Examines Use of Restraint Holds on Psychiatric Patients After Death of Boy, 11

Four days into his stay at a psychiatric hospital in Portland, Conn., 11-year-old Andrew McClain, a mildly retarded child in foster care, was brought to a padded "time-out" room.

He had been demonstrating "inappropriate behavior," the authorities said, and two health workers were restraining him. A few minutes later he was dead.

The State Medical Examiner said Andrew died of traumatic asphyxiation and chest compression. But now the police and several state agencies are seeking answers to these larger questions: whether it was necessary to restrain Andrew, whether the restraint method was properly applied and whether the state should prohibit the restraint hold that was used.

Vincent J. Trantolo, a lawyer for Andrew's mother, Lucinda McClain, puts it more simply. He wants to know why Andrew died.

"My client asked me to do two things: find out what happened to her child and make sure this doesn't happen again," Mr. Trantolo said.

Andrew's death on March 22 has already prompted the State Department of Children and Families to look at whether the hold applied to Andrew should be banned. Mr. Trantolo said the hold involved crossing a patient's arms in front of him and holding his wrists from behind.

"It's very clear in this case that something went terribly wrong," Linda Pearce Prestley, the state's Child Advocate, said.

Mr. Trantolo said he wonders if Andrew, who was 4 feet 6 inches tall and weighed 90 pounds, should have been restrained to begin with. He said that the Portland police, who are conducting the criminal investigation, told him that Andrew was screaming and disobeying orders when he was restrained, but that he was not kicking or biting or slapping.

"I got the absolute impression that there was no violent behavior at the time," Mr. Trantolo said.

The Portland police are not commenting on their investigation.

Advocates for the mentally retarded and the mentally ill say that physically restraining patients is becoming less common, but still sometimes ends in injury or even death. Within the last few months, a boy in Arizona died of oxygen deprivation after being held to the floor by psychiatric workers, and a man died in Cleveland when he was sandwiched between two boards while being transported to a psychiatric hospital, said Ronald S. Honberg, director of legal affairs for the National Alliance for the Mentally Ill.

Kristine Ragaglia, Commissioner of the State Department of Children and Families, said she is setting up a task force to look at whether Connecticut should establish a higher standard on physical restraints.

Officials at Elmcrest Hospital, where Andrew died, are not commenting on this case, but said that the hospital's protocols for restraining patients were followed. The two mental health workers involved in restraining Andrew have been suspended pending the results of the investigation into the boy's death.

But the Department of Children and Families does not have its own regulations on physical restraints. Margaret H. Dignoti, executive director of Arc of Connecticut, an advocacy group for the mentally retarded, said she may fight to get that changed.

Ms. Dignoti said her group lobbied hard for a law, passed in 1994, that required the State Department of Mental Retardation to set strict regulations on which restraints may be used on clients. She said her group may work to have those regulations expanded to other state agencies.

"I'm heartbroken," she said. "This is a little boy. These kinds of things shouldn't still be happening."

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