Western State File

Allegheny County Chapter
OF THE PENNSYLVANIA ASSOCIATION FOR RETARDED CHILDREN, INC.

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REPORT ON VISIT TO WESTERN STATE SCHOOL AND HOSPITAL, JULY 5, 1972

This report will deal generally with the program and supervision of children in two of the Units at Western State School and Hospital, Pine #2 and #3. This report was initiated because of a complaint by the parents of one of Pine's summer residents. The report is made after a personal visit by this staff member. During that visit (2 1/2 hours) I had a discussion with the doctor, nurse, social worker and unit attendants for Pines #2 and #3.

Various indications lead to the conclusion that these Units are under-staffed, over-crowded and under-programmed. There are grave consequences. One is that the institution's program is less rehabilitative. Western State becomes a human warehouse. Another consequence, of our immediate concern, is that the children and teenagers are more frequently bruised and injured.

As the parents said, the child was black and blue all over his body. The injuries and bruises were, as the parents indicated, bruises of the nose, ear lobes, right kneecap, left forearm; cuts, scratches or laceration of lower lip, upper left arm, under left forearm, back of neck; mucus and/or blood on nose, chin, back of hands; dirty face; dehydration; no socks or shoes; pants drying on him from previously being wet. In addition, I saw a new four-inch scratch across his face. It was bleeding.

Staffing

When we went to see Mike on Pine #3 (School Boys' Unit) there was no supervisor in the day-room where Mike was sleeping on a gym mat. There were several other children playing or rocking on chairs. Two summer volunteers were in the bathroom, busily toiletting and changing residents. Dr. Eldridge instructed them to supervise the day-room while there were children around. I presume that the regular attendant was in the sleeping area or dining hall with other Pine #3 residents.

The doctor, the nurse and the social worker indicated that the major problem on Pine #2 (the Lincoln Unit) is under-staffing. At the time the incident occurred, there were two attendants for the whole unit. When we visited the Unit today, there were three attendants. The staff indicated that this is an inadequate staffing for any unit, and particularly inadequate to supervise 43 profoundly/severely retarded and hyper-active adolescent males.

Dr. Eldridge claimed that the present attendant staff is "good" -- in some cases, "excellent".

It appears that these two units are inadequately staffed. "Could such an incident re-occur?" Children are always pushing, shoving, hitting and kicking other children. Does this environment encourage children being hurt? One staff person indicated that 43 hyper-active children are too many to have in any area. "You could have a staff person spaced every five feet and not be able to prevent children from attacking others." Preventive action is taken in extreme cases.

One young man, who constantly bites other residents, was segregated in another room for others' safety. One young fellow had his hands tied behind his back for his own safety. All the others were allowed to freely move around the room. The nurse claimed "Mike's 'battle scars' were minimal compared to what other children have incurred."

Programming

The majority of the young men on Pine #2 (Lincoln Unit) were inactive. Several individuals were sleeping, several were masturbating. Several were wandering around the day-room. All the others were sitting or lying quietly. No two residents were playing, talking, or otherwise interacting. Periodically one of the attendants played with one of the residents.

The Unit attendants and social worker said all the children are involved in some program at least once during the week. None of the children on the Unit are involved in a daily program;(i.e., school, training, recreation, jobs). Only one worker is assigned to teach eating, dressing, and other daily skills. It was not possible to determine exactly how much programming each of these children gets and whether it meets their needs.

While I was on the Unit, there was only a trace of constructive activity -- no programming at all.

Conclusion

The visit revealed nothing new or surprising. Needless to say, the situation screams for corrective action. More staff! More programming! Fewer residents!

This one incident alone is distressing. Both parents and staff indicate there are many more. Many cause more serious harm.

ACC-PARC Action Options

The staff hope and pray for citizen action. Weary of poor citizen success in the past, employees expect no relief.

The parents, WSSH parents group in particular, are growing more militant. They want more for their kids and are beginning to make demands of WSSH trustees and D.P.W. They could use a boost from a third party.

This leads us to the options available:

Option I - Do nothing. Wait for others to act. State PARC or DPW.

Option II - Tour of VIP's - Governor, legislators, welfare administrators

Option III - Discussion w/ WSSH administration. Internal remedy.

Option IV - Media expose' - Similar to Willowbrook, Pennhurst

Option V - Immediate legal action - injunction

I don't think we can wait for Option I. VIP visits and media exposés seem to have no lasting effect. The WSSH administration doesn't have the authority to increase number of staff. This all leads to Option V.

Recently much legal action has been initiated on behalf of inmates. It has been successful. Now five states have filed right to treatment suits for the institutionalized retarded. They are successful. It seems like our only hopeful action.

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