



FIVE DEATHS AT DAMMASCH HOSPITAL

A Question of Responsibility

A Report Prepared by Oregon Advocacy Center

December 17, 1993

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INTRODUCTION

This report is the result of an investigation into the deaths of five patients at Dammasch State Hospital between June 25 and October 8, 1993. The investigation was begun in response to independent complaints about each death. The report is being released in the hope that it will bring attention to the conditions that contributed to these deaths and prevent future harm to Dammasch patients.

Oregon Advocacy Center (OAC) is a private, non-profit organization which advocates on behalf of people with disabilities. As Oregon's "Protection and Advocacy System", OAC is authorized by state and federal law to investigate complaints of abuse and neglect of patients in treatment facilities. In the course of this investigation, OAC reviewed the patients' treatment records, interviewed family members and spoke to any staff members who would agree to do so.

This report contains a separate section for each patient. Background information is supplied for each patient so that his or her death can be understood within the context of life at Dammasch. The details surrounding each death is then set forth, followed by questions that OAC believes still need to be answered and OAC recommendations.

OAC staff who prepared this report are investigators and attorneys. They are not formally trained in medicine or psychiatry. Many of the questions raised by this report regarding appropriate clinical practices need to be answered by qualified professionals who are not affiliated with Dammasch. These tragic deaths deserve expert objective review at state expense.

While the circumstances of the deaths differ, systemic deficiencies at Dammasch affect each one. Factors such as staff instability, budget reductions, inadequate physical plant, and poor training and oversight contribute to conditions that endanger patients who present special needs. These problems are not new to Dammasch, but the hospital's ongoing process of transitioning to a smaller institution has made them more acute and, in our opinion, contributed to the deaths of five patients.

This report was produced by OAC staff members Janice Perciano, Rick Vachio, Jonna Schuder, and Bob Joondeph.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

OAC's investigation of five recent deaths at Dammasch State Hospital finds that major deficiencies in the following areas contributed to the deaths of some or all of the patients. These deficiencies must be corrected while Dammasch remains open in order to assure the basic safety of its patients.

- * LACK OF ADEQUATE MEDICAL SERVICES FOR PATIENTS.
- * REPEATED FAILURE OF EMERGENCY MEDICAL RESPONSE.
- * FAILURE TO TRANSFER PATIENTS WITH SPECIAL MEDICAL AND BEHAVIORAL TREATMENT NEEDS.
- * INADEQUATE AND PROFESSIONALLY UNSUPERVISED SECLUSION AND RESTRAINT PRACTICES.
- * RELIANCE UPON MEDICATION AND RESTRAINT AS ALMOST EXCLUSIVE TREATMENT OPTIONS.
- * REPEATED FAILURE TO HONOR DUE PROCESS PROTECTIONS FOR PATIENTS BEING FORCED TO UNDERGO TREATMENT.
- * REPEATED FAILURES TO PROVIDE HUMANE, INDIVIDUALIZED TREATMENT AND LIVING ENVIRONMENTS.

In light of these deficiencies, OAC again calls on the Governor to take the following actions:

1. Request that the Emergency Board provide MHDDSD with supplemental funds to establish additional community-based mental health treatment services which can accept present and prospective Dammasch patients.
2. Direct the Mental Health and Developmental Disabilities Services Division to prepare a transition plan for moving all Dammasch patients into existing and newly created services before the end of this legislative biennium so that Dammasch, at that time, will be closed.
3. Direct MHDDSD to immediately facilitate the transfer of any Dammasch patient with serious physical health problems such as AIDS or seizure disorders and patients with Developmental Disabilities to facilities where they can receive knowledgeable and appropriate health and habilitation services.
4. Order a special investigation by State Police into the death of patient P.G. who was suffocated to death on October 8, 1993 while being restrained.

P.G.

P.G. was born on September 25, 1961. He died on October 8, 1993. He was thirty-two years old. The official cause of death was listed as clinical history of schizophrenia with agitation and positional asphyxia during restraint. He was a patient at Dammasch State Hospital (DSH) when he died.

Background

P.G. was admitted to DSH on August 3, 1992. He was placed at DSH on a police hold because he was threatening his mother, barking like a dog and, apparently, hallucinating. He was civilly committed several days after his initial admission. P.G. was diagnosed with schizophrenia, chronic paranoid type, and substance abuse. He had been admitted to DSH seven times.

P.G. was considered competent to give or refuse consent to medications. A variety of medications were tried on P.G.. At the time of his death, P.G. was being medicated with Tegretol, Artane, Prolixin and Imipramine.

According to the Physician's Desk Reference (PDR), Tegretol is primarily an anti-convulsant medication. Tegretol is also indicated for relief of neuralgia pain. Although this use is not mentioned in the PDR, psychiatric institutions also use Tegretol to control behavior. Artane is used to control parkinsonism. Parkinsonism is a chronic nervous disease characterized by tremors, muscular weakness and a peculiar gait. Specifically, Artane is given to counteract the side effects of neuroleptic drugs such as Prolixin. Prolixin is used to control psychotic disorders. Prolixin is a neuroleptic drug with the possibility of major serious side effects. According to the PDR, Imipramine is a medication used to treat depression. For P.G., it was used to control persistent adult attention deficit/hyperactivity.

By late September, 1993, P.G. was improving and was allowed to go home for overnight passes. Tentative discharge plans were being discussed. The medications seemed to be working fairly well for him.

Circumstances surrounding P.G.'s death

On October 8, 1993, P.G. died as a result of being placed in restraints. "Restraints" refers to a bed with leather straps used to strap the person's legs and arms to the bed. A waist strap may also be used.

About 11:15 a.m., P.G. became upset about something. A staff person took P.G. to the time-out room. The time-out room is used

to isolate a patient and give the patient an opportunity to calm down. Although time-out is voluntary, if a patient refuses to "go to time-out", then the patient often is put in seclusion by forcibly locking the patient in an empty room.

P.G. went into the time-out room without a struggle. He was removed from the time-out room a short time later when staff wanted to use the time-out room for another patient.

After leaving the time-out room, P.G. walked out onto the ward patio. According to staff, P.G. picked up a cigarette butt, removed the filter and began to eat the remainder. The record does not show that any staff person talked to him about how he felt or why he was eating the cigarette butt.

On his own or after being told to reentered the ward, P.G. did so. He banged on the window of the nurse's office and asked to be put in seclusion. Two mental health therapy technicians (MHTT) took P.G. into the seclusion room. Once in the seclusion room, the MHTT's asked P.G. to take his shoes off. P.G. refused. The MHTT's asked several times and P.G. continued to refuse. P.G. told the MHTT's they would have to get the shoes themselves.

The MHTT's then put "hands on" P.G.. Each MHTT grabbed one of P.G.'s arms. P.G. flailed his arms and hit at them. The MHTT's began to struggle against P.G. and tried to hold him down on the bed. They were holding him perpendicular to the bed and could not control him.

The registered nurse came to the room. She asked if they needed help. The MHTT's said they needed help, so the nurse left to call for another staff person, a Mental Health Therapist I (MHTI). After this man came, the staff still could not control P.G.. The nurse asked if she should call a code 33. The staff struggling with P.G. said yes. The nurse then left the room to call a code 33. Code 33 means staff needs help, usually to assert control over an uncontrollable person. A code 33 is broadcast throughout the hospital. Upon hearing a code 33, staff from each ward are expected to respond to the code 33 location. The code 33 was called at 11:27 a.m.

When people responded to the code 33, the scene in the small seclusion room became even more chaotic. In addition to the four staff already in the room, eight more arrived in response to the code 33. Those who responded included the nursing coordinator for the hospital, the director of social work for the hospital, the hospital safety officer, and another nurse, a certified nursing student and three MHTT's.

All of these people converged on P.G.. Some grabbed his legs or arms. Some watched. Someone called for a towel to prevent P.G.

from biting or spitting. One of the MHTT's snatched the towel. He wrapped it up and pulled it around P.G.'s mouth. With one hand, he held the towel ends behind P.G.'s head and used the towel to control the head, not unlike using the reins of a horse. With the other hand, the MHTT pushed down on P.G.'s left shoulder. On P.G.'s right side, the safety officer had his knee on P.G.'s right shoulder. To help restrain P.G.'s arm, the safety officer put his left knee on P.G.'s right wrist. Eventually, P.G. was restrained, with each arm and leg and his waist strapped to the table.

Although details differ, most of the persons in the seclusion room agreed that P.G. was fighting very hard. Then, prior to all the restraints being secured, P.G. became rigid and passive. The towel had been tightly wrapped around his mouth for two to three minutes.

As the restraint process seemed to be ending, people began leaving the room. Here, again, the exact details vary. The nursing coordinator removed the towel from P.G.'s mouth. She had to pull it very hard to get it from his mouth because his teeth were clenching it hard. Some blood was on the towel and on the sheet.

The nursing coordinator, the MHTT who had been holding the towel and the safety officer were the last to leave. According to the MHTT, after P.G. went from extremely combative to very calm, he checked P.G.'s pulse and breathing. The MHTT, "thought he felt a pulse" and "thought he saw a breath." No one else mentions these actions by the MHTT and no one else checked the pulse or breathing.

As the safety officer left the room, he mentioned that P.G.'s color did not look good. The ward nurse, who was entering the room, looked at P.G.. The nurse went to get the doctor who was in a meeting about twenty feet away. The doctor arrived and found P.G.'s face to be almost black.

The doctor did not find a pulse. He called to have the restraints removed and began mouth-to-mouth resuscitation. After mouth-to-mouth resuscitation was begun, a code 99 was called and the Tualatin Valley Fire and Rescue was called. A code 99 signifies a medical emergency and requires medical personnel to respond. The code 99 was called at 11:35 a.m.

After P.G. was removed from restraints, cardio-pulmonary resuscitation (CPR) was begun. Because of a concern that P.G. have blocked airways because of the cigarette butt he reportedly ate, the doctor intubated P.G.. No foreign objects were blocking the airway. The CPR continued.

The paramedic team from Tualatin Valley Fire and Rescue arrived at 11:45 a.m. The paramedics attempted to defibrillate P.G. but he did not respond. The paramedics administered five one milligram doses of epinephrine, three ampules of bicarbonate soda and a

milligram of atropine in attempts to get P.G.'s heart to function. The paramedics worked on P.G. for thirty-four minutes. P.G. was non responsive. The paramedics consulted a doctor at Meridian Park Hospital Emergency Room who concurred that resuscitative efforts should be stopped. The time was 12:19 p.m.

Questions raised by P.G.'s death

P.G. died because we was improperly physically restrained. Forcible restraint is a violent, intrusive and dangerous activity. In society, a person is not permitted to restrain another without specific legal authority. In Oregon's psychiatric facilities, doctors are authorized to order restraint in emergency situations. Because of the danger involved, strict protocols and procedures are to be followed by staff who are trained in their use. Even then, restraint is still potentially dangerous in nature and is to be used only as a last resort.

1. Why was P.G. subjected to forcible restraint? P.G.'s safety was put at risk because he refused to remove his shoes. The MHTT's were so intent on achieving the shoe removal that they created a power struggle in which they knew they had the trump card: the power to physically restrain. If they were not permitted such liberal authority to play this card, other means of resolving the dispute may have been used and the death may have been avoided.

First, the situation simply did not warrant a power struggle. P.G. volunteered to be isolated. He did not need to be forced into seclusion, he asked to go. He was not violent. He was not dangerous to himself or others. If he did not want to remove his shoes, why did it matter? If the shoes presented a genuine safety issue, P.G. could have been closely monitored while in seclusion. Instead, violent intervention was chosen by the staff.

Second, the MHTT's claim they had to remove the shoes because it was hospital policy to do so. Hospital policy does not require the immediate removal of shoes. According to the DSH Interdisciplinary Manual, the physician, RN or professional directing the team makes the decision about whether the patient can remain in street clothes. The removal of street clothes is discretionary, not mandatory. Here, the MHTT's escalated a minor incident by demanding compliance with a rule that was not mandatory.

Third, the rule requires a professional to make the determination about street clothes. In this case, the decision was not made by a professional. A professional was not present throughout the seclusion process and a

professional did not assess the need to remove the shoes. Instead, this decision was made by the least qualified and least trained members of the patient care staff, two MHTT's.

The MHTT position does not require even a high school diploma. The MHTT position does not require any prior training or knowledge of mental health treatment problems. After employment, the MHTT must become a certified nursing assistant (CNA). CNA training focuses on medical issues. The MHTT is not a professional and does not have the authority to make decisions regarding seclusion and/or restraint.

2. Was P.G. restrained in accordance with professional standards? People who are legally authorized to restrain others, such as police and mental hospital personnel, are governed by rules of conduct. These rules are supposed to assure professional oversight, safety and accountability.

In this case, a towel contributed to P.G.'s suffocation. Some staff said the towel was used to prevent biting and spitting. Some staff said the towel was used to control P.G.'s head. Most staff agreed that the use of a towel in this manner was standard procedure.

Our investigation showed, however, that towel use is not included in the IDM (DSH's procedures manual) as an accepted technique during restraint. The required staff trainings on behavior management do not teach the use of a towel. The use of a towel may have been standard procedure, but it was not hospital policy, it was not considered or approved by any professional review process and it was not taught as a behavior management technique.

It seems obvious that the use of a towel in the manner that it was applied to P.G. is inherently dangerous. Blocking a person's airway and forcibly manipulating his head and neck during a violent interaction creates great potential for injury. And yet, most DSH staff involved in this incident believed, even after the death, that this was regular procedure. Police investigation reports of this incident also accepted this as true.

Subsequent to P.G.'s death, DSH did make an explicit statement about the use of towels. The new policy allows the use of towels during restraints, but only by holding the towel at least three inches in front of the patient's face. This is the first official DSH policy on the use of towels during restraint.

Additionally, it appears that no leadership or professional oversight occurred during the restraint of P.G.. Although the

nursing coordinator, the director of social work and several nurses were in the room, none of them took command of the situation and none of them acted to control the participants. The professionals, who should have recognized the danger of the procedure and the need to intervene, did nothing.

3. Have adequate steps been taken to avoid a reoccurrence?

As stated above, DSH has created a policy for the use of towels during restraint. It has also prohibited the restraint of a patient on his or her stomach. They have not, however, addressed these issues:

A. Why did DSH staff believe that a procedure which is not written down and for which they have received no training is the official protocol for the hospital?

B. Why was restraint used to assert authority over a patient rather than as a last resort in an emergency situation?

C. Why was a patient violently and unsafely restrained in the presence of clinical professionals without their leadership and guidance? Why was P.G.'s medical condition given so little attention during the incident?

D. Why were county police investigators lead to believe that the restraint incident was performed in conformance with approved hospital protocols when this was not the case?

Recommendations

1. Additional investigation is needed of this incident. County sheriff reports presumed that DSH staff were applying hospital-approved techniques in restraining P.G.. OAC's findings indicate that either police were misled on this issue or that DSH has allowed inherently dangerous techniques to be used on patients as a matter of custom. The fact that trained mental health professionals were present at the killing of P.G. and made no effort to halt the use of the towel or to report it as patient abuse afterwards indicates that such activities are both common and accepted throughout the hospital.

Additional investigation is necessary to uncover whether this is true. Patients at DSH, those who may become patients and their families deserve some assurance that basic medical and safety standards are observed at DSH. This matter cannot be considered settled based upon a police report which excuses staff behavior and clinical management practices based upon

false assumptions.

2. Seclusion and restraint should be thoroughly reconsidered as appropriate techniques for use in DSH. Alternatives to these violent and coercive measures are available and effective. The state institution for persons with developmental disabilities, Fairview Training Center, has prohibited the use of seclusion and restraint. The difficult behaviors presented by residents at Fairview are no different than those at DSH, yet the residents are treated humanely, not strapped to a bed or locked in a tiny room.

The use of restraint as an assertion of authority rather than an emergency psychiatric intervention is not uncommon. In settings where there are an adequate number of staff who are familiar with the patients they serve, less drastic measures can be taken before an incident escalates. But in facilities where restraint is commonplace, a level of violence becomes tolerated which can lead to tragic consequences which occur outside of the public eye. People who must struggle with the devastating effects of major mental illnesses deserve better.

Even if seclusion and/or restraint are not entirely eliminated as control techniques, extensive retraining and extensive review and redevelopment of policy must occur. Staff need to have knowledge of a wide range of alternatives. Enough staff must be on the ward at all times to allow use of interventions that require more staff time and energy. The professional staff must provide more suggestions regarding treatment of individuals. In short, seclusion and restraint must be understood to be a very last resort and must be used only in that way.

J.W.

J.W. was born on November 10, 1940. He died on August 29, 1993. He was fifty-two years old. The official cause of death is listed as asphyxiation due to impacted food in airway. He was a patient at Dammasch State Hospital when he died.

Background

J.W. was admitted to DSH on December 3, 1992. According to the records it was either his fifth or ninth DSH admission. One of J.W.'s prior admissions had lasted thirteen years, from 1978-1991. At the time of his death, he was diagnosed as having schizo-affective disorder, bipolar type. He also had tardive dyskinesia (TD) and drug induced parkinsonism (DIP) as a result of his many years of drug therapy. TD is characterized by rhythmical involuntary movements. DIP is characterized tremors, muscular weakness and a peculiar walk.

During that period of hospitalization, and before, J.W. was treated with electro-convulsive therapy (ECT), also known as shock therapy. Prior to 1974, while a patient at DSH, J.W. was given 174 shock treatments. While he was out of the hospital, he was on maintenance shock treatments, receiving treatments once every two to four weeks. From 1978 to 1982, while again a patient at DSH, J.W. received 255 shock treatments. At that time, shock treatments were discontinued because J.W. had gone from "bad to worse." By June 30, 1982, when ECT was discontinued, J.W. had received 429 shock treatments at DSH and an undetermined additional number in the community.

J.W. also had been medicated with a variety of psychiatric drugs. As mentioned above, by the time he was admitted to DSH in 1992, J.W. was suffering several serious side effects from these medications. The admission notes recited the TD and DIP symptoms. J.W. fidgeted, gestured and pursed his lips. His lips quivered. His right arm and leg shook. He was stooped over and shuffled when he walked. J.W. was also severely constipated, a side effect of the medication he was given to prevent the side effects of the neuroleptic medications.

J.W. was out of DSH from August 14, 1991 until December 3, 1992. He managed to live in the community until September 29, 1992 when he was admitted to Oregon Health Science University (OHSU) for pneumonia and lithium toxicity. Apparently, even when he caught pneumonia he continued taking his prescribed lithium. But, because the pneumonia caused him to eat and drink less, the lithium was stronger. He stayed in OHSU for over a month and was discharged on November 12, 1992. He lived in a private group home. He began

to decompensate. He became shaky and delusional. His speech could not be understood. He thought he was George Bush. Eventually, on December 3, 1992, he was civilly committed and taken to DSH.

At admission, the social worker noted that J.W.'s space at the adult foster home would be available only until January 1, 1993. The social worker mentioned the hope that J.W. would be able to return to the adult foster home because it was a good setting. She continued that if J.W. stayed at the hospital too long and loses the bed, then the hospital would have to locate another one for him.

His life at DSH in the months before his death.

While in DSH, J.W. was determined unable to consent to the administration of medications. An outside physician concurred that J.W. lacked capacity to consent and also approved the administration of a number of medications. The consulting physician approved the use of antipsychotic agents, including Clozaril, Prolixin, Permitil, Haldol, Serentil, Trilafon and Narave. The consulting physician approved the use of thymoleptic agents, including Lithium, Tegretol, Klonopin and Depakote. He approved the use of anti anxiety agents, including Valium and Ativan. During the nine months before his death, many of these drugs were prescribed in varying combinations. Additionally, J.W. was medicated with Mellaril, a drug to which J.W. was incapable of giving consent and which was not on the approved list.

No combination of medications seemed to be very helpful to J.W. and the doctors constantly changed, increased, decreased, began and discontinued various drugs. When J.W. entered DSH, he was started on Lithium Citrate and Navane Concentrate with Ativan for anxiety. On December 18, 1992, J.W. was transferred to a different ward. The doctor on the new ward started him on Clozapine and began reducing the Navane. Clozapine was increased and Valproic Acid was added.

On January 27, 1993, the doctor discontinued Clozapine because J.W. was not benefitting from it. J.W. was then placed on low doses of Haldol with Valproic Acid continued. Although his psychosis improved, his Parkinsonism worsened. In mid March the Haldol dosage was increased. Haldol Decanoate was added in April 1993. In mid-May, Haldol was reduced and Trilafon was added. Valproic Acid was discontinued. In June, Trilafon was discontinued and Mellaril was begun. By July 1993, J.W. was taking Lithium Carbonate, Mellaril, Cogentin and Valium. In July, Haldol was prescribed in increasing amounts while Mellaril was decreased. By July 26, 1993, the Mellaril was stopped completely. On August 3, 1993, the doctor began to reverse this process by restarting Mellaril and decreasing the Haldol. On August 3, 1993, the Haldol was reduced and eventually stopped. Mellaril and, later, Lithium

were increased.

Although the doctors experimented frequently with the drugs they administered to J.W., none of the drugs were of great benefit to him. The major and long lasting effects of these drugs were to give J.W. tardive dyskinesia and drug induced parkinsonism. The lack of effectiveness did not cause the doctors to cease the prescriptions or consider alternatives to medications. Rather, the doctors just continued manipulating the doses and specific drugs.

On the ward, J.W. began his stay by being delusional and disorganized. He spoke with garbled speech. He spoke intensely on religious topics. By February 24, 1993, he had improved enough that discharge planning was initiated, On March 11, 1993, the social worker made a referral to Taft Home. Within three weeks, the discharge plans were discontinued. J.W. was deteriorating again. On March 14, 1993, J.W. was in seclusion for four hours. He was secluded because he was singing and preaching loudly to unseen others. Other patients were angry at him and threatening to hurt him.

A chart note on March 19, 1993, observed that J.W.'s medications had been adjusted several times to balance/decrease the adverse side effects such as constipation, and drug induced parkinsonism. J.W. displayed constant TD and DIP symptoms such as teeth grinding, shoulder shrugging, stiffness and an abnormal gait.

By July 1993, J.W. was still unresponsive to medications. He was delusional and suffering from tardive dyskinesia, drug induced parkinsonism and constipation. The constipation was a side effect of the medication used to control the side effects of the other medications. J.W. was not able to do even daily hygiene and activities of daily living (ADL). He needed help in shaving and dressing. He continued to be obsessed with religion and talked about religion constantly.

In August 1993, J.W.'s condition worsened. He often was found incontinent of urine and feces. He often refused to wear clothes. He would wander around the ward nude, until staff directed him to his room and helped him dress. He was not eating well and refused meals. On August 10, 1993, J.W. initially refused meals, but ate jello and pudding when staff fed him.

On August 11, 1993, a staff person wrote, "He appeared to have difficulties swallowing--Pt. drank milk--took 90 cc juice and ate cereal. Seemed to have difficulties with solid food and did not swallow any." On August 12, 1993, staff again fed J.W.. J.W. told the doctor he did not have an eating problem and swallowing was not painful. Concerning these statements, the doctor noted, "I cannot attest to the accuracy of this information as he was carrying on his own conversation at the time."

On August 13, 1993, J.W. again was hand fed. His speech was garbled and he continued to appear on the ward nude. In an August 19, 1993 note, the nurse stated J.W. was unable to eat or dress independently. He needed, "virtually total nursing care."

On August 20, 1993, J.W. was found in his room, with feces on his body and his bedding. J.W. was disoriented. He could not hold a conversation. He could not follow extremely simple directions. He had to be fed and ate only with much persuasion. He had scaling skin on his head and face. His lithium level was above the acceptable level. At one meal, J.W. chewed the food and then spit it back onto the tray without eating it. J.W. needed almost total nursing care assistance.

On August 23, 1993, J.W. spent most of the day nude. He told staff that he couldn't swallow. He said his throat did not hurt but he insisted he could not swallow. He asked for jello and ice cream. The doctor found J.W. huddled under his blankets. His answers to the doctor's questions were nonsensical. The doctor noted that standard drug therapy had not worked and wondered if ECT should be considered.

On August 25, 1993, J.W. was incontinent of urine. He was given clean pajamas. He took his clean pajamas into his room and crawled into his wet bed. He was able to eat dinner without assistance but was again incontinent of urine and feces. Still, he appeared to be feeling better.

By August 27, 1993, J.W. was again doing poorly. He was loud and confused. He wore a T-shirt as a pair of pants. He was incontinent of urine and feces. He ran naked out of the shower twice. The second time he fell and hit his head on the floor.

Circumstances surrounding J.W.'s death

On August 29, 1993, at 8:00 a.m. he was put in time-out in his room because he was intrusive and bothering another patient. He was given a breakfast of pancakes to eat in his room. At 12:15 p.m., a staff person checked on J.W.. He was cool to the touch, cyanotic and unresponsive. A code 99 was called. The doctor examined J.W. and found no respirations, fixed pupils and cold extremities. J.W. was declared dead at 12:25 p.m.

A note written in the chart after J.W. was declared dead, but before the cause of death was known, claims, "Pt had been singing hymns while in time out on bed. Took meds. Ate 100% of breakfast. Had been up to nurse's office as usual after that." Since J.W. choked on the breakfast pancakes and since the medical examiner found uneaten pancakes on the plate in his room, at least some parts of this note are untrue.

This incident was never reported to or investigated by the Office of Client Rights. This is the office within the Mental Health and Developmental Disabilities Services Division which is charged with investigating patient abuse and neglect.

Questions raised by J.W.'s death

1. Use of medications and lack of alternative treatments. J.W. was not responding well to medications, yet he was medicated as the sole treatment. The doctors were well aware that the medications were not effective and they changed the medications frequently, but to no avail. The only substantial impact on J.W. was to cause him to suffer the severe side effects of tardive dyskinesia and drug induced parkinsonism. Further, he suffered extreme constipation as a side effect of the medication given him to reduce the side effects of the other medications.

J.W. had received medications and electroconvulsive treatment for over thirty years. Neither of these approaches brought lasting relief. Still, the doctors persisted. In August 1993, when the medications were failing, the doctor even suggested a return to the shock treatment. Nowhere are any alternative therapies mentioned. J.W. did not appear to be receiving any kind of nonmedication therapy on the ward. His life consisted of taking medications, eating meals and waiting. Was this adequate treatment?

2. Use of the override procedure. The override procedure allows a doctor to medicate someone who is incapable of deciding whether to consent to medications. It is designed to protect a patient's right to be free of from unwarranted treatment. The use of the override procedure includes the consultation by a outside physician to consider the patient's capacity and whether certain medications should be approved. At DSH, this procedure has become a pro forma process with little meaning. In J.W.'s case, almost all possible medications were approved. One medication that was not specifically approved was Mellaril. The DSH doctor, acting without any reference to the outside consult, prescribed Mellaril even though it was not on the approved list. Given this level of attention to the process and the outcome, the override procedure provides virtually no protection for patients.

3. Lack of available medical and nursing care. According to the progress notes, J.W. deteriorated to the point where he needed virtually full time nursing care. The chart also indicates that J.W. was not a danger to himself or others. DSH was not equipped to provide the level of care J.W. needed. Why was J.W. kept at DSH? He should have been transferred to a facility which could meet his increasing basic care needs.

4. Failure to monitor at time of death. On the day he died, J.W.

was required to go to his room for time-out. This occurred at 8:00 am. He was given pancakes to eat in his room. He was not watched while eating. At 12:15 pm, over four hours later, J.W. was found unresponsive and pulseless in his room. Why was J.W. allowed to eat alone in his room? Only six days earlier, the chart noted J.W. complained he could not swallow. He ate only when fed. He chewed his food and then spit it out. Although his eating ability improved some over the next few days, he was still having extreme problems with basic living skills, was disorganized and incontinent. Clearly, he needed constant monitoring. Therefore, these questions should be answered:

- A. Was he not monitored because of lack of staff?
- B. Was the staff on duty not familiar with his needs because they were temporary or float staff not usually assigned to that ward?
- C. Why was he given pancakes to eat while unsupervised when he had problems swallowing?
- D. Why was such a clear case of neglect never reported to the Office of Client Rights or other oversight body?

RECOMMENDATIONS

1. Patient treatment should not be limited to medications.
2. The medical override procedure should be reviewed, revised and adequately enforced.
3. Unless DSH is funded and staffed to provide skilled nursing care, patients who need it should be transferred immediately to a place where they can receive adequate care.
4. Incidences of neglect such as this must be reported and investigated as patient abuse. It is outrageous that this death was not reviewed by State officials from outside DSH.

L.L.

L.L. was born on December 9, 1926. She died on August 29, 1993. She was sixty-six years old. The official cause of death is listed as asphyxia due to aspiration of breakfast pancake. She was a patient at Dammasch State Hospital (DSH) when she died.

Background

L.L. was admitted to DSH on March 12, 1990. It was the twenty-fifth time she had been admitted. Just prior to her admission, she had been living in a community facility. At the community facility, she had been violating the smoking regulations, wandering around the city and staying out all night. She was taken to Portland Adventist Medical Center where she was held on a commitment hold. While at Portland Adventist, she was given Lithium and Haldol and she stabilized. She was committed to DSH anyway. Her record noted she had stabilized and then stated, "However, recommitment to DSH became necessary because there was no community placement available".

The DSH social worker wrote a report on March 12, 1990. He stated, "It is anticipated that a request for residential placement for her will be submitted to Multnomah County with the hopes that a suitable living situation will be located for her." For whatever reasons, L.L. never left the hospital again before her death, three and one half years after this admission.

L.L. had a diagnosis of bipolar disorder. Bipolar disorder, formerly referred to as manic-depressive disorder, is characterized by cycling into manic phases and depressive phases. Her chart noted a history of alcohol abuse. At times, she carried an axis II diagnosis of passive/aggressive personality. L.L. also had some major physical problems. She had diabetes mellitus which required constant monitoring and treatment. She had osteoarthritis of the right knee. This caused pain and impaired her ability to walk. She sometimes used a walker. She also had severe dental problems and needed dentures. Because of the lack of dentures, she was placed on soft diet. L.L. also had some signs of tardive dyskinesia, the slow, rhythmical involuntary movements which are side effects of psychotropic drugs such as Haldol.

L.L. was not considered a danger to others. She was not considered suicidal. She was not considered a security risk. She was not a fire setter. She was considered unable to care for herself.

Her life at DSH in the months before her death.

In the months just prior to her death, L.L. lived on ward M at DSH.

She had been transferred to that ward in December 1992. Ward M is on the second floor of the hospital. It has no access to the outside and fresh air. It is a ward designed to hold women who are long term patients. Some of the women wear protective helmets. Most of the women wear old, stained and out of fashion clothing. They shuffle around the ward with no apparent destination. The television drones in the background. No one seems to be doing anything. Most of the patients anxiously await smoke breaks because smoking is the only form of entertainment available.

Like most of the women on the ward, L.L. was administered a variety of medications. L.L. was considered unable to make decisions about whether to take these drugs. Consequently, another doctor was brought into DSH to review her records and talk to her. In November 1990, the consulting doctor determined taking medications was in the best interest of L.L.. From then on, she received medications. The doctor approved of the administration of antipsychotic agents, including Haloperidol, Perphenazine and Thiothixine. He approved the administration of thymoleptic agents for treating the manic episodes, including Lithium and Carbamazepine. He approved the use of an antianxiety agent, Lorazepam.

In June 1992, another outside consultant reviewed the medication issue. This doctor approved of the administration of antipsychotic agents, including Haloperidol, Clozapine and Thiothixine. The doctor also approved the administration of thymoleptic agents, including Lithium, Carbamazepine, Clonazepam and Divalproex. He approved the administration of an antidepressant agent, Nortriptyline. The doctor approved the use of an antianxiety agent, Lorazepam.

The specific medications prescribed for L.L. varied as the doctors continued to experiment with different combinations. In the week before her death, L.L. was taking a variety of medications for her physical problems, including insulin. In addition, for her psychiatric and emotional problems, she was taking Trilafon, Depakene and Klonopin. Because L.L. was considered unable to consent to these medications, authority to medicate her without her consent was based on the report of an outside consulting physician and chief medical officer approval. The Trilafon was not approved by the consulting doctor or the chief medical officer, but was being administered anyway.

According to the Physician's Desk Reference (PDR), Trilafon is used for the management of major psychotic disorders. The PDR notes that among other serious adverse effects, Trilafon can cause tardive dyskinesia (TD). TD is characterized by rhythmical, involuntary movements of the tongue, face, mouth or jaw, such as tongue thrusting, cheek puffing, mouth puckering and chewing. The hands, arms, feet and legs may also show involuntary, rhythmical

movements.

TD is highest among elderly women. The risk of developing TD and the risk of it being irreversible increase as the duration and cumulative dose increase. The PDR states that chronic neuroleptic treatment should be reserved for patients who are known to respond and for whom equally effective alternative treatments are not available. The PDR suggests discontinuation of Trilafon be considered if signs of TD develop. L.L. showed signs of TD and Trilafon and the other neuroleptics were not effective for her. Yet, she continued to be administered these drugs.

Other adverse reactions to Trilafon include dry mouth. Cases have been reported of sudden death among patients taking Trilafon. These sudden deaths have apparently been caused by asphyxia due to failure of the cough reflex.

Depakene (valproic acid) and Klonopin are anticonvulsant drugs used to treat seizures. Although the PDR does not mention this use, DSH appears to use these drugs to control manic phases and to control behavior. Dry mouth and coated tongue are mentioned as possible side effects.

L.L. had a treatment plan. The first problem on the treatment plan stated that L.L. displayed loud, threatening, verbally abusive and disruptive behavior. The most recent treatment plan stated that L.L. was physically assaultive to staff and peers. The treatment plan noted the difficulty in placing L.L.. The treatment plan listed her physical problems, including the diabetes, the arthritis and the dental problems.

The treatment plan also listed the "interventions" to be used with regard to the different problems. In March 1990, the interventions were medications and a one to one meeting with staff three times a shift to redirect L.L. to a reality based conversation. Nothing in the chart indicated how this actually would be accomplished. In December 1991, the treatment plan called for L.L. to be encouraged to complete the activities of daily living (ADLs) such as combing her hair, dressing, brushing her teeth etc. She was to be praised for completing these activities. She was to be rewarded according to the hospital privilege system for following rules and attending scheduled activities. She was to be restricted for sarcastic and irritable behavior. A staff person was directed to educate L.L. on the need for medication compliance and mental illness. In August 1992, L.L. was restricted in cigarette use to one cigarette per half hour. Later she was restricted to one cigarette every hour. The treatment plan did not mention any therapy.

The treatment plan discussed L.L.'s physical problems. L.L. had diabetes that required diet change, monitoring and medication. The

need for dentures was noted but she had not received dentures by the time she died. As a result, she was on a soft diet.

L.L.'s life on ward M appears to have been a constant struggle for cigarettes and trips off the ward. Since these small pleasures often were denied, L.L. lived a life of frustration, anger and hopelessness.

In the twenty day period from June 10, 1993, to June 30, 1993, L.L. was in forced seclusion and/or restraints twenty-three times. The length of time she was secluded and/or restrained ranged from one hour and forty-five minutes to thirty-two hours and forty-five minutes. Almost every one of these episodes began with L.L. asking for cigarettes or asking to be let off the ward. When she did not receive a positive response, she would become agitated and pound on the nurse's office window. She would scream and make threats. On some occasions she tried to hit or kick others. Inevitably, L.L. would be secluded and sometimes restrained. She would be physically escorted or dragged to the seclusion room. While in the seclusion room, she would cry out for cigarettes and candy bars. She would plead for release. This virtually identical scenario played over and over and over again.

Occasionally, when L.L. asked for a cigarette or to go off the ward, a staff person would respond. On June 25, 1993, for example, the chart notes that L.L. demanded to be off unit and became loud and agitated when the response was delayed. But, according to the record, she calmed down when escorted off the unit. Similarly, the hairdresser noted that L.L. would focus on negative things and become upset but that she would settle down when talked to. The monthly nursing evaluation for July, 1993 noted that L.L. was extremely appreciative whenever she got to go off ward with staff. The chart notes contain several references to L.L.'s appreciation and gratefulness for being allowed off the ward. The notes indicate how pleasant and cooperative she was with ward routines after she was taken off the ward and/or given a cigarette.

L.L.'s physical problems continued to worsen during the months before her death. Although denture evaluations were made, she had not received the dentures at the time of her death. Her diabetic condition worsened. She made several reports that her whole body ached. She had trouble walking and was considered at great risk for falling. A couple of times she was found on the floor where she had urinated and fallen in the urine. One time she was injured when a closet fell on her as she was trying to remove something. On June 21, 1993, her doctor noted that L.L. might need to be transferred due to a need for more intensive care. He mentioned that the physical therapist would no longer be available after the end of the month.

L.L. had a better month in July. She was not restrained or

secluded at all. The social worker recommended her transfer to a community facility. He referred her to Sunshine Care in Portland. According to the note, however, she could not go until a ground floor bed was available.

The circumstances surrounding L.L.'s death

L.L.'s death arose from her struggle for cigarettes. Her death was previewed by an incident that happened on August 20, 1993. On August 20, 1993, at 7:40 am, L.L. was at the nurse's office window demanding a cigarette. She was told she could not smoke until after breakfast because the smoke room did not open until after breakfast. L.L. said she did not eat breakfast. When her cigarette was still denied, she became sarcastic and hit the window with her fist. The staff then told L.L. her breakfast cigarette was being denied because she demanded it inappropriately. Nine days later, a similar encounter over a breakfast cigarette led to L.L.'s death.

On August 29, 1993, L.L. was eating pancakes for breakfast. She indicated she wanted to go to the smoke room. The staff person directed L.L. to finish her breakfast. L.L. said she was finished. The staff person insisted L.L. was not finished. L.L. grabbed the pancake from her plate, shoved it into her mouth and headed for the smoke room. Suddenly L.L. stopped and began to fall. Another patient caught her before she hit the floor.

The staff, including a nurse, gathered around L.L.. A staff person from the connecting ward was instructed to call a code 99 for emergency medical help. Instead of calling a code 99, the staff person pressed the button for a code 33. A code 33 is a call for assistance for controlling combative patients. A code 33 does not result in the arrival of medical personnel.

According to reliable observers, the mistake in calling the wrong code caused a delay of four or five minutes in the arrival of medical personnel. The Heimlich maneuver and suction were attempted. Ms. L.L. was not intubated and no airway was manually cut. Tualitin Fire and Rescue arrived but could not revive her. According to some sources, Tualitin Valley Fire and Rescue did not respond quickly and adequately because the initial caller failed to notify the emergency personnel of the nature of the emergency.

Questions raised by L.L.'s death

1. Medications. Why was L.L. continued on so many medications? The record is clear that the medications were not effective, but they did have serious side effects. Also, during her hospital stay, L.L. was being given Haldol, Navane and Trilafon. These are antipsychotic drugs which are indicated for control of the

manifestations of psychotic disorders. L.L. never carried a diagnosis psychotic disorder. Why did outside doctors agree to the broad use of drugs? Why were the outside consultations, required at least every year, not conducted for almost two years? Did the antipsychotic drugs create a dry mouth condition or a cough reflex failure which contributed to the likelihood of choking on foods such as pancakes?

These concerns raise the general issues regarding medication practices at DSH. Medications are prescribed and forced upon persons even when they don't seem to help their mental disorder. Outside consulting doctors approve of broad ranges of medications while paying little attention to the individual patient. Even these minimal outside consultations are not conducted on the mandated time frame. In L.L.'s case, the treating doctor did not limit her medications to those on the broad list approved by the consultant. At the time of her death, L.L. was being administered Trilafon, even though it was not approved by the consulting physician. These important checks and balances are, we believe, routinely ignored.

2. Medical treatment. L.L. was a frail, unsteady, sick woman. She had serious medical problems. DSH closed its medical ward. Did L.L. need to be in a setting which was equipped to deal with her medical needs? Was she kept at DSH because there was no place else for her to go?

L.L. also needed dental treatment. At the time of her death she did not have the dentures she had needed for a long time. At one point, her chart mentions that she had dentures but they had been lost by staff during a seclusion and restraint episode. Whether this is true or whether she never had them, it is clear that she was restricted to a soft diet because she did not have enough teeth to eat. This is inhumane.

3. Psychiatric treatment. L.L. had been at DSH twenty-five times before she died. During her final stay, her treatment consisted solely of medications that did not work. Her chart shows that she received no individual therapy or group therapy.

At the end of June 1993, the nurse noted that L.L. had been in seclusion and/or restraints twenty-five times during the month. Despite this obviously terrible situation, the treatment plan did not contain a strategy for decreasing the need for this intervention. Nothing was ever done to give L.L. alternatives to avoid seclusion and restraint. L.L. told a staff person that she was aware of her problem of screaming and becoming agitated. She said it was the only way she had to deal with being at DSH and that it allowed her to let off steam. The record does not show that anyone ever helped L.L. find other ways to react.

4. Use of seclusion and restraint. The constant use of seclusion and restraint on L.L. is simply appalling. Secluding and/or restraining a person is a severe attack on her dignity and self esteem. If it is used at all, it must be used after all other methods have been tried. It must be a last resort. In L.L.'s situation, seclusion and/or restraint were very quickly used. The chart reflects that L.L. usually became upset because she was denied a cigarette or was denied the opportunity to go off the ward. L.L. often calmed down and was cooperative if these requests were met.

Why did the staff ignore L.L.'s requests until she was so agitated they secluded and/or restrained her? If this was part of some organized behavior modification treatment plan, it would have to have been included in L.L.'s treatment plan. Since it was not, one must assume that restraint was used for staff convenience and as a substitute for active treatment. This is how things used to be done in institutions for people with mental retardation. It was changed because it was ineffective and scandalous. But it continues to happen today at DSH.

4. Lack of community treatment. When L.L. entered the hospital in March 1990, she had been stabilized and was not in need of hospital care. But, according to the notes, she was committed anyway because there was no community placement available. Similarly, in July, 1993, when she was ready to move out into the community, her move to Sunshine Care was delayed because no ground floor room was available. Why were no appropriate community facilities available when needed?

5. Failure to properly handle the emergency. The medical emergency that caused L.L.'s death was not complicated. Nevertheless, staff lost essential time by calling the wrong emergency code and by failing to provide essential information to the ambulance dispatcher. Further, no one took the responsibility for taking the emergency steps, such as cutting into her throat to open an airway. In a hospital full of trained medical personnel, why was there no emergency medical response?

RECOMMENDATIONS

1. Medical issues--DSH must have the ability to identify and transfer persons who have significant medical treatment needs. Dental treatment should also be available when needed. DSH must develop an medical emergency response that actually responds effectively and efficiently to medical emergencies. If this cannot be accomplished, DSH must close.

2. Community services--State resources should be shifted away from large state hospitals to smaller community facilities where

individualized treatment can better be conducted.

3. Seclusion and restraint use and policies--In both policy and practice, the approach to seclusion and restraint use must be reviewed and altered. Seclusion and restraint are being used too frequently and too readily.

4. Psychiatric treatment and medication use--Medication is clearly used as the primary, and often only, form of treatment at DSH. DSH should not be used for patients with more extensive treatment needs.

Further, the procedures used to medicate persons who cannot consent need to be revised. The due process protection for individuals should no longer be ignored.

5. Physical structure of DSH--The physical structure of DSH prevents some patients from having any access to fresh air and forces imposition of arbitrary smoking rules. This alone requires DSH closure or major alteration. For now, all wards should be on the first floor so that all persons have access to patios for fresh air whenever they want.

D.C.

D.C. was born on February 8, 1961. He died on June 25, 1993. He was thirty-two years old. The official cause of death is listed as acquired immunodeficiency syndrome. He was a patient at Dammasch State Hospital (DSH) when he died.

Background

D.C. entered DSH on February 23, 1993. It was his sixth admission to DSH. D.C. had a long history of emotional and psychiatric difficulties and had been in several institutions in addition to DSH. He was diagnosed as having chronic schizophrenia with a history of alcohol and marijuana abuse. He had been discharged from DSH in October 1990. In early 1991, he began living at Ruby House in Winston, Oregon. Ruby House was a home for persons suffering from AIDS related problems. According to recent records, D.C. had been diagnosed as HIV positive in 1986. The records are unclear as to who made this diagnosis and the basis for the diagnosis.

D.C. seemed to do well at Ruby House. But, in late 1992, the Ruby House closed because of lack of funding. D.C. moved to another home for persons with AIDS related problems, but he did not like this place and left. For the next few months, D.C. was homeless. He wandered up to Portland and lived in the Burnside area. He slept under bridges and at the missions. He did not have much money and was unable to keep taking the medications prescribed for his mental illness or the AIDS.

In late January or early February, 1993, D.C. was treated at Oregon Health Sciences University (OHSU) for pneumonia. He was discharged and initially went to live in a single room occupancy hotel, paying ten dollars a night. Eventually, he again became homeless. He continued seeking free meals in the Burnside area. One day, while standing in line for a meal, he found himself weak and exhausted. He felt he could not stand up. He was picked up by paramedics who took him to Portland Adventist Medical Center. At Portland Adventist, he was placed on a civil commitment hold. Subsequently, he was committed and sent to DSH.

At admission to DSH, he was friendly and cooperative. He was disheveled and poorly groomed. He said he was in a good mood because he felt he needed to be at DSH. D.C. felt he was unable to take care of himself and that he would be cared for on at DSH. The admission screening note noted an anticipated length of stay of one to two months, depending on the length of time he took to stabilize on medications and the length of time needed to find a new placement for him.

The admission medical exam did not show him to be suffering any acute problems. He showed no evidence of skin complications associated with HIV positive condition. His lungs were clear. He had no lesions. He had no chest or abdominal pain or gastrointestinal problems. He reported no weakness, fever, fatigue or chills. D.C. had a splenectomy earlier and this was noted. He had lost twenty pounds recently and monitoring of weight was necessary. He had a history of absence seizures in which he would lose consciousness for several seconds. The medical report stated the significant medical finds as AIDS, history of alcohol and marijuana abuse, history of severe extra pyramidal symptoms (EPS) on Haldol, prior splenectomy and poor dental hygiene.

D.C. was considered able to consent to medications. He agreed to Thorazine, for the control of the manifestations of psychotic disorder, and Cogentin to control the side effects of the Thorazine. He also consented to the use of valproic acid, an anticonvulsant medication. At times during his hospitalization, he was administered Haldol instead of Thorazine, but he preferred Thorazine and that was the more often used neuroleptic. D.C. insisted at times that his medication be increased. On May 3, 1993, he also began receiving AZT, a medication used to treat persons who are HIV positive.

Generally, D.C. was pleasant and cooperative on the ward. On May 6, 1993, D.C. was transferred to the long term care ward. He was happy to be on the long term care ward because he felt he was going to need to be at DSH for a long time and that he was unable to care for himself. A transfer note stated that the treatment plan called for indefinite hospitalization. The transfer note also mentioned that D.C. easily became agitated but that he also easily calmed with verbal interventions and time-outs on his bed.

On May 11, 1993, D.C. was placed in seclusion and restraint and on May 13, 1993, he was described as angry, agitated and delusional. On May 14, 1993, the chart indicated D.C. seemed to be settling down on the ward. D.C. was alert and well oriented. He requested to be discharged. A note added that there were no physical issues.

On May 24 and 25, 1993, D.C. was growling, slamming doors, pacing, threatening and making bizarre statements. He was secluded and restrained, released and secluded again when he asked to be placed in locked seclusion.

On June 3, 1993, D.C. complained of dyspnea (difficult labored breathing, insufficient oxygen intake) and chest tightness. He was examined but no action was considered necessary. He was seen by the doctor. The doctor prescribed valium.

Discharge planning continued for D.C.. The social worker from

Mental Health Services West, a Multnomah County provider, visited him and made plans for his move into the community. A tentative appointment was made for D.C. to visit the Bridgeview program in Portland.

On June 18, 1993, a staff person noted that for the past two weeks D.C. had been sleeping for six out of the eight hours on the staff person's shift. The note was written during swing shift. This excessive sleeping was not recorded elsewhere and apparently the doctor was not made aware of the problem.

On June 23, 1993, D.C., accompanied by his community case manager, went to Portland to visit the Bridgeview program. D.C. liked the program. According to the case manager, D.C.'s interactions while on pass were pleasant although he made occasional delusional statements.

In the evening of June 24, 1993, at 9:15 pm, D.C. was shaking. He said he felt sick and was going to bed.

On June 25, 1993, in the morning, a doctor evaluated D.C.. D.C. was acutely agitated and had panic-like feelings. He was unable to verbalize his thoughts coherently. He was hyperventilating and thirsty. He was trembling. He complained of abdominal pain. The treatment plan called for giving him Klonopin for the anxiety, monitoring him every twelve hours and conducting a chemical screening.

By 1:30 that afternoon, D.C. had deteriorated significantly. He was incontinent of feces. He was very confused. He was paranoid, hallucinating and nonsensical. He was placed in time-out, with a staff person outside the room, to see if he could calm down. D.C.'s skin was turning blue and his breathing was rapid and shallow. The nurse could not get D.C. to sit still long enough to take his vital signs. The nurse could not find his pulse in the wrist.

At 2:20 pm, the doctor recorded that D.C. was delirious with general diffuse cyanosis. The doctor believed D.C.'s condition might be terminal. The doctor wrote, "Will ask administration re procedure in view of lack of Ward F". Ward F had been the medical ward at DSH and it had been closed.

At 3:00 pm, the social worker called D.C.'s sister to tell her of his medical condition and the plan to transfer D.C. to the emergency room of Meridian Park Hospital. At 3:30 pm, D.C. collapsed as the paramedics arrived. He was not resuscitated. He was hemorrhaging internally, with blood in the mucous membranes and blood in his vomit. The DSH doctor determined death was from sudden circulatory failure possibly related to his HIV positive status.

The doctor contacted the chief medical officer of DSH and D.C.'s family. The doctor arranged for the body to be transferred to a funeral home, chosen by the family, in Gold Beach, Oregon. The medical examiner, in his report, stated that DSH had an obligation to notify the state medical examiner of any death at DSH, but that neither the treating doctor nor the chief medical officer contacted the medical examiner immediately. The medical examiner was not notified until four and one half hours after the death. By the time he was notified, D.C.'s body had been removed from DSH. As a result, the medical examiner was unable to conduct an examination.

Questions raised by D.C.'s death

1. Medical care. Did D.C. receive adequate medical care? Clearly, the doctors at DSH were not experts in the medical care of persons who were HIV positive or had AIDS. A person who is HIV positive needs specialized care and specialized medical knowledge. DSH did not even have a medical ward.

2. Emergency response. In addition to the inadequacy of the daily medical care, the question of adequacy of the emergency care arises. Was D.C. placed in time-out when he was experiencing a soon-to-be fatal internal hemorrhage? Why wasn't he transferred to a medical-surgical hospital earlier? Could he have been saved if he had received treatment earlier?

3. Cause of death. What was the cause of D.C.'s death? His sudden and abrupt deterioration into death was not typical of the course of an AIDS-related death. He had been well enough just two days earlier to go out on a pass to Portland. What happened to cause this sudden deterioration? Was the combination of AZT with neuroleptics dangerous or deadly? Did D.C.'s identity as an AIDS carrier affect the level of treatment he received? Why did DSH fail to contact the medical examiner in a timely fashion so that the cause of death could have been officially determined?

RECOMMENDATIONS

1. Medical treatment. Again, DSH must be able to assure that the medical health needs of its patients are met. This includes on-going medical treatment as well as emergency treatment.

2. AIDS related issues. Given the increase of the AIDS epidemic, DSH must be trained and knowledgeable about this disease and how it interacts with psychoactive medications.

3. Accountability. The facts of this death raise many questions about medical treatment received by D.C. and yet there has been no medical examiner's report, coroner's report, office of client

rights investigation or other outside look at the situation. DSH and MHDDSD must assure this incident does not go unreviewed by independent medical experts.

K.M.

K.M. was born on May 5, 1955. She died on September 19, 1993. She was thirty-eight years old. The official cause of death is listed as coronary arteriosclerosis. She was a patient at Dammasch State Hospital (DSH) when she died.

Background

K.M. was admitted to DSH on June 7, 1993. She was admitted under a civil commitment order from Multnomah County. K.M. never before had been admitted to a psychiatric facility.

Prior to her commitment, K.M. had been living with her aunt in Portland. K.M. had attended special education classes until the age of sixteen. At sixteen she quit attending school and stayed home. She had some difficulties getting along with her mother and moved in with her aunt. K.M. lived with her aunt, a cannery worker, for the next twenty years. After her aunt retired, K.M. rarely left the house. The two of them isolated themselves, spending a lot of time watching television, particularly soap operas.

In late May, 1993, K.M.'s aunt died. K.M. had no idea how to respond to the death. She did not know how to use the telephone. She did not have anyone to contact. She simply stayed in the house with the dead body. Eventually, neighbors called the police because they thought something had gone wrong. The police arrived to find the decaying body and the distraught K.M.. K.M.'s mother arrived. K.M. and her mother argued and K.M. tried to hit her mother. The mother did not feel endangered and understood her daughter's distress and anger.

K.M. was taken to the hospital. Her mother thought she needed to go to the hospital for a physical check. Instead, K.M. was held on a psychiatric ward and later committed to the Mental Health and Developmental Disabilities Division. She was transported to DSH.

While at DSH, K.M. was given many medical, psychological and mental tests. Her physical tests revealed an obese woman with thyroid and cholesterol problems. She had skin problems and hemorrhoids. Shortly before her death, K.M. developed a severe rash which did not respond to routine treatment. She was scheduled to go to a specialist, but died before the appointment date.

K.M.'s psychological and mental tests revealed a person with mild to moderate mental retardation. While in the hospital, testing showed her to have a full scale IQ of 54. This IQ put her well below the average range. Additionally, she had very little

knowledge of her surroundings. She thought the shape of a ball was square. She thought there were four months in a year. She could not repeat two digits in reverse order. She thought a penny was equal to almost a dollar. She had never purchased anything. She could tell time, but only to the nearest hour. She could not accurately state her age. She thought there were eighty states in the United States and the capital of Oregon was Tumwater, Washington. She added five plus seven and got eight. On June 7, 1993, she thought the date was July 1, 1987.

On the ward, K.M. was not able to do very much for herself. She needed help with every aspect of bathing and required constant staff assistance to complete bathing. She did not know how to make her bed. She was incontinent of urine frequently and, eventually, was dressed in diapers. She spent much of her time in bed and did not socialize much. She several times asked staff members to adopt her, promising she would be really good. She sometimes tried to get more help than she really needed, but even at her best she was not capable of much.

K.M. did not have any history of mental illness. When she was admitted to DSH, the admission note said she was not overtly psychotic. Her thought processes were coherent, relevant and without loosening of association or content. She did not have paranoid delusions and did not have hallucinations. She did not appear to be responding to internal stimuli. K.M. said she was depressed, but was unable to give much more information. She was not considered dangerous to herself or others except that she was extremely unable to care for herself. Later notes indicated she talked to herself and had bizarre thoughts. The only bizarre thought mentioned was her belief that her aunt was not dead.

When K.M. was admitted to DSH on June 7, 1993, the admitting doctor stated, regarding the expected length of hospitalization, "Hopefully, she will be transferred to appropriate facilities in two to four weeks." Over three months later, K.M. was still at DSH. A note written by the social worker on July 30, 1993, stated that the developmental disabilities division had not yet decided whether to take her. Nothing further is mentioned about this and the file contains no evidence of referral to community facilities.

While at DSH, K.M. was medicated with Synthroid, Ativan, Haldol and Cogentin. Synthroid was prescribed for the thyroid problem. She had not taken this medication previously. Ativan was prescribed to reduce agitation. Cogentin was prescribed to alleviate the side effects of the Haldol.

Haldol is a neuroleptic, psychotropic drug. According to the Physician's Desk Reference (PDR), Haldol is used for the control of the manifestation of psychotic disorders. How Haldol works is not known. Haldol has many possible serious side effects,

including tardive dyskinesia and parkinsonism. In the PDR, both Haldol and Synthroid carry precautions about their uses with persons who have cardiovascular problems.

K.M. did not consent to these drugs. The treating psychiatrist did not believe K.M. had the mental capacity to make decisions about whether to take the drugs. In accordance with the applicable Oregon Administrative Rules (OARs), the doctor requested an outside consultant to determine whether K.M. should receive Ativan and Haldol. In completing the forms, the DSH doctor stated that the benefit of the Haldol would be "improved thinking and functioning." As alternatives to procedure, the doctor listed "None(time?)".

The independent psychiatric consultant approved the proposed medications. He noted that K.M.'s problems seemed most consistent with a diagnosis of mental retardation. He found she was an immediate danger. Apparently, this determination was based on one incident where K.M. hit another patient. He also stated she lacked the insight and judgement to participate in the mental health therapy.

K.M.'s mother visited her while she was in the hospital. The mother expressed concern to the staff that her daughter was having a hard time breathing. This was shortly before her death. The mother also was concerned because K.M. was taking a thyroid medicine. K.M. had not previously taken this medicine and the mother felt the dose was too large. The mother asked if her daughter was being sedated and was told no. The mother was not told the her daughter was being medicated with Haldol. According to the mother, K.M. had never taken Haldol or anything like it. The mother also noticed the rash covering K.M.'s body.

Circumstances surrounding K.M.'s death

K.M. made several complaints, beginning in early August, about how her body hurt all over. On September 2, she said she felt miserable. On September 8, she reiterated that she hurt all over. On September 11, 1993, a staff person recorded noticing that K.M.'s skin was bluish and mottled. A note from the nurse on September 13 repeated the observation about the blue skin. The nurse wrote "circ" and followed this with a question mark. On September 16 another reference is made to possible circulation problems.

According to the records, K.M. was seen alive at 2:45 pm on September 19, 1993. She was lying on the bed in her cubicle at DSH. A staff person spoke to her and asked if she wanted to come into the day room. K.M. said she did not want to go into the day room. At 3:10 pm a staff person found K.M. lying on her back with her eyes and mouth partially open. She did not have a pulse and was not breathing. The staff person notified the nurse at 3:10 pm and the nurse checked her. The nurse found K.M. had no pulse.

Her skin was warm and her joints were soft and pliable. A code 99 emergency call for medical personnel was made. Thirteen minutes later a doctor arrived. The doctor pronounced her dead at 3:25 pm. The record does not mention the use of any resuscitative measures or emergency life saving actions.

Questions raised by K.M.'s death

1. Commitment of a person with mental retardation to a mental hospital. Why was K.M. was placed at DSH hospital? K.M. did not have a history of mental illness. She had not taken psychiatric drugs. She had never received mental health treatment. At admission, she had not done anything dangerous to anyone except be incapable of caring for herself.

Placing K.M. in DSH was cruel. K.M. was suffering from an extreme trauma. She had just lost the only companion and caretaker she had known for twenty years. She was unable to understand the death and had no concept of how to respond to the death. Consequently, in addition to the loss of her aunt, she spent two or three weeks inside the house with the dead body and without anyone to help her with her daily needs. She could not benefit from mental health treatment because she could not understand it. She needed help in dealing with this tragedy and help in creating a future. If she demonstrated behavioral problems, it would hardly be surprising given the trauma of her life and the lack of understanding of what was happening to her.

K.M. should not have been institutionalized at all. She should have been placed in an appropriate community facility or group home. If temporarily placed in an institution, she should have been at Fairview, not DSH. At least Fairview is staffed with persons who are trained and knowledgeable in assisting persons with mental retardation.

Instead, K.M. was placed in a mental institution and treated with psychiatric drugs as though she had a mental illness. She was treated with Haldol, a drug with serious side effects and a drug that should be used with great caution with persons with cardiovascular problems. Although DSH staff was unaware of K.M.'s cardiovascular problems, the administration of Haldol put her at risk.

DSH did not even consult with experts concerning the mental retardation issues. DSH did nothing to find appropriate training and treatment geared to her cognitive functioning.

Additionally, DSH did not get her out into the community quickly. K.M. should have been out in two to four weeks, according to the admission note. She was still in DSH three months later. The record does not reflect any efforts to relocate her. According to

K.M.'s mother, she talked to the social worker at DSH about having her daughter live with her but he told the mother that DSH would find a place for her. DSH did not find a place for her.

2. Lack of emergency response. When K.M. was first found at 3:10, she was unresponsive. The mental health therapist who found K.M. did not take any emergency life-saving actions. The mental health therapist notified the nurse. The nurse checked K.M.. The nurse did take any emergency life-saving actions. The nurse called the doctor. The doctor did not arrive for thirteen minutes. During this thirteen minutes, nothing was done to try to resuscitate K.M..

This failure to try life-saving techniques is appalling and outrageous. Each staff person is trained in basic CPR, yet the medical chart indicates that the mental health therapist did not provide CPR. The nurse, obviously, had more extensive medical training. Yet, the medical chart indicates that the nurse did nothing. Then, there is a delay of thirteen minutes. Why was there no immediate response? Why did the other staff do nothing while waiting? Did the fact that K.M. was a person with mental retardation have anything to do with these failures to act?

RECOMMENDATIONS

1. Treatment of persons with mental retardation and/or developmental disabilities. DSH clearly is unequipped to treat persons with special needs such as mental retardation or developmental disabilities. Instead, DSH forces persons with these needs into the mental health treatment mode consisting primarily of medications. Persons with mental retardation and/or developmental disabilities should not be placed at DSH. If a person with these treatment needs is placed at DSH, s/he should immediately be transferred to a facility where the staff has expertise in these issues. DSH must assure, through appropriate training and review, that its staff value the lives of all its patients equally.

2. Lack of emergency response. All staff need to be retrained on basic emergency measures and the circumstances under which such techniques should be used. Staff should be required to immediately initiate these techniques rather than allow delay. An emergency response team must be created that will respond to emergencies quickly and efficiently.

3. Medical care. An independent physician should review M.K.'s chart to determine whether the reports of circulation problems on September 13 and 16 should have prompted more medical attention.