DANGEROUS
RERAINTS

Mistreatment and Harm
at
St. Elizabeths Hospital

July 31, 2019
DISABILITY RIGHTS DC

Since 1996, Disability Rights DC at University Legal Services, Inc. (“DRDC”), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. In addition, DRDC provides legal advocacy to protect the civil rights of District residents with disabilities.

DRDC staff directly serves hundreds of individual clients annually, with thousands more benefiting from the results of investigations, institutional reform litigation, outreach, education and group advocacy efforts. DRDC staff address client issues relating to, among other things, abuse and neglect, community integration, accessible housing, financial exploitation, access to health care services, discharge planning, special education, and the improper use of seclusion, restraint and medication.

For more information about this report or to request additional copies, please contact:

Jane Brown  
Executive Director  
University Legal Services, Inc.  
220 I Street, N.E  
Suite 130  
Washington, D.C. 20002  
202.547.0198 (voice)  
202.547.2657 (tty)  
Or visit our website at:

“The very first requirement in a hospital is that it should do the sick no harm.”

Florence Nightingale
I. EXECUTIVE SUMMARY

In the first four months of 2019, DRDC initiated investigations into allegations of abuse of three patients at St. Elizabeths Hospital. The investigations uncovered disturbing staff abuses and serious staff violations of federal regulations and D.C. laws during multiple incidents of restraints and seclusions. This report raises grave concerns about St. Elizabeths practices, where the use of restraint and seclusion has significantly increased, and legal protections are ignored.

In April 2019, staff violently restrained John Holmes, a newly admitted patient, causing him to suffer serious injuries, including a fractured hip and a fractured arm. Staff documentation indicates that a few days after his admission, at around midnight, Mr. Holmes was wandering around his unit, refused staff directions then made a threatening statement. He then returned to his room and “used his body” to block the door to his room. Staff then “used the aid of a shield to force the door open and took physical hold of him.” Staff “secured Mr. [Holmes] by the extremities” and “carried him into the restraint room,” where they strapped his four limbs to a bed and forcibly administered an injection of powerful antipsychotic medications against his will. Staff failed to adhere to multiple D.C. laws and regulations throughout the restraint. D.C. law requires that any use of restraint or seclusion must be implemented in accordance with safe and appropriate seclusion or restraint techniques. The St. Elizabeths staff training Safety Care Manual strictly prohibits lifting and/or carrying a patient as a method of physically moving a patient. Staffs’ actions of lifting Mr. Holmes by his arms and legs and carrying him could very well have exacerbated, or even been a cause of his fractures. In addition, the Safety Care Manual does not indicate that staff are permitted to force open or break down a patient’s door, which can clearly put a patient at risk.

After the restraint, Mr. Holmes’ repeatedly complained of pain and the inability to walk. Disturbingly, it appears medical staff did not adequately assess him for injuries for more than sixteen hours. When X-rays of Mr. Holmes leg and hip were finally ordered, they revealed that Mr. Holmes had sustained a fracture to his hip. Mr. Holmes was then transferred to George Washington Hospital, where staff discovered that in addition to his hip fracture, his arm was also fractured. On arrival to the emergency room, staff observed that Mr. Holmes’ left leg was “externally rotated, shortened and swollen,” and that he was suffering “severe” pain. He

---

1 Name changed to protect patient’s privacy.
2 Unusual Incident Report, UI DB #26527, dated 4/19/19.
3 Id.
4 Id.
5 RN Progress Note dated 4/19/19, timed at 6:48 a.m. According to Mr. Holmes, after staff forced his door open, staff knocked him to the floor and fell on top of him, which he believes caused the fracture to his arm and hip. DRDC interview with Mr. Holmes on 5/22/19.
6 D.C. Code § 7-1231.09(d)(2).
9 Nurse Practitioner Progress Note dated 4/19/19, timed at 4:46 p.m.
10 GMO Progress Note dated 4/19/19, timed at 10:39 p.m.
11 Nurse Practitioner Progress Note dated 4/25/19, timed at 5:50 p.m.
12 George Washington Hospital Trauma Flowsheet dated 4/19/19 at 4.
13 George Washington Hospital Emergency Department Physician Record, 4/20/19, timed at 2:40 a.m.
underwent surgery to repair his hip with permanent metal hardware inserted to stabilize the fracture, and his arm was placed in a cast.14

Patient Keith Carter15 was also abused by staff during a restraint.16 A review of a video footage of the restraint reveals very disturbing staff conduct, which culminated in an unnecessary and abusive physical, chemical, and four point restraint.17 The video footage reveals, that for at least fourteen minutes immediately prior to the restraint, Mr. Carter was either walking around the unit, speaking with or attempting to speak with staff or standing or sitting quietly.18 At no point during that time did he appear to be violent. Throughout most of the video, staff did not make meaningful attempts to engage with him. Methodical staff preparation culminated in an overwhelming scene, in which thirteen staff and security personnel surrounded Mr. Carter.19 Multiple security guards then grabbed him by the arms, dragged him down the hall and pushed him into a room.20 Records indicate staff then strapped his arms and legs to a bed and forcibly administered a chemical restraint.21

Patient Lisa Morgan,22 who reports a history of physical and sexual abuse23, was secluded and restrained multiple times,24 even though St. Elizabeths’ policy specifies that restraint and seclusion is clinically contradicted for individuals with a trauma history.25 The record contains little evidence that staff attempted to employ meaningful, less restrictive measures to avoid the restraints and seclusions.26 Staff also failed to release Ms. Morgan from restraints and seclusion at the earliest possible time, failed to conduct meaningful post-event debriefings,27 and failed to adjust treatment planning and behavioral approaches after the restraint and seclusions, all of which are required by D.C. law, D.C. regulations, and the hospital’s own policy.28

14 Id. The progress note indicates that Mr. Homes underwent “ORIF” surgery while at George Washington Hospital. An ORIF is an “open reduction internal fixation,” a surgery to fix severely broken bones. It is only used for serious fractures that cannot be treated with a cast or splint and fractures that are displaced, unstable, or those that involve the joint. “Open reduction” is when a surgeon makes an incision to re-align the bone. “Internal fixation” is when the bones are held together with hardware like metal pins, plates, rods, or screws. After the bone heals, this hardware is not typically removed. https://www.healthline.com/health/orif-surgery
15 Name changed to protect patient’s privacy.
16 See infra section V(2).
17 Videotape (St. Elizabeths Hospital January 19, 2019) (“Videotape”). See also Attachment A.
19 Videotape at 11:35:47 a.m.
20 Id.
21 Unusual Incident Report, UI DB #25944, dated 1/17/19.
22 Name changed to protect patient’s privacy.
24 See infra section V(3).
25 St. Elizabeths Policy, Restraint and Seclusion for Behavioral Reasons, Policy Number 103.00 (Revision Date 10/20/16.) (“SEH Policy103.00”). Section III(A)(3) states that “seclusion is contraindicated…for those individuals who have a trauma history, especially of a containment nature.”
26 See infra Section V(3).
27 Id.
28 Id.
In addition to the extensive physical injuries suffered by Mr. Holmes, all three patients report being markedly fearful and traumatized by the restraint incidents. Staff violated multiple D.C. laws, federal regulations, and St. Elizabeths’ own policies, all designed to protect patients from unnecessary, abusive and harmful restraint practices. Nothing indicates that staff involved in these restraints -- the psychiatrist who ordered the restraint, the RNs whose responsibility it was to supervise the restraint, the mental health technicians and security staff -- all reportedly trained on hospital policies for restraint and seclusion and Safety Care techniques, took steps to intervene to prevent the use of illegal and abusive restraints, and the trauma they caused.

When staff fail to adhere to the many legal and hospital policy restraint and seclusion restrictions and requirements, the frequency of the use of restraint and seclusion will inevitable increase. St. Elizabeths own data that tracks restraint and seclusion rates indicates that patients at the hospital are being restrained and secluded at alarming rates. In 2012, hospital staff used restraint only five times during the entire year. Restraint and seclusion rates have soared over the past six years. In 2018, the hospital staff employed physical or mechanical (four-point) restraints 782 times and patients spent 719 hours in restraints. In December 2018, St. Elizabeths restrained over 20 percent of the entire patient population.

Far from the care and treatment described in the St. Elizabeths’ vision statement that staff provide “a healing environment” and that “each person who comes through our doors is treated with respect, dignity, and sensitivity to spiritual and cultural norms and is empowered to be an active partner in recovery,” these abusive restraint and seclusion practices can cause irreparable physical and emotional trauma to patients.

II. METHODOLOGY

Under the Protection and Advocacy for Individuals with Mental Illness (“PAIMI”) statute, Disability Right DC at University Legal Services (“DRDC”) has the authority to

---

29 DRDC interview with Mr. Holmes on 5/22/19, DRDC interview with Mr. Carter on 2/1/2019, DRDC interview with Ms. Morgan on 5/21/19.
30 See St. Elizabeth’s Required Course List for clinical staff; Safety Care - Behavioral Safety Training Manual; SEH Policy 103.00.
31 Office of Statistics and Reporting, St. Elizabeths Hospital, Performance Related Information for Staff and Managers (“PRISM Report”) December 2012, PRISM Data Tables at # 4. The PRISM reports for 2012 and 2013 indicate the total number of “restraint events,” but do not specify the type of restraint used such as physical hold, or mechanical (four-point) restraint.
32 Restraint statistics in the current PRISM reports include physical and mechanical restraint only. Significantly, the hospital does not count many involuntary injections of drugs, which are used as a restraint as defined by D.C. law, thus the numbers of incidents of restraint are significantly undercounted. See infra Section III B.
33 PRISM Report December 2018, PRISM Data Tables at # 4. The hospital administration recently reported to DRDC that the current PRISM statistics regarding restraint may not be accurate and that some incidents of restraint may have been counted twice. We welcome a detailed description of what conduct is counted as a physical and mechanical restraint and why the current reported numbers are inaccurate.
34 Id.
35 https://dbh.dc.gov/page/saint-elizabeths-hospital
36 See infra Sections IV and V.
“investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to [DRDC] or if there is probable cause to believe that the incidents occurred.”

Following three complaints of abuse, DRDC obtained and reviewed St. Elizabeths Hospital’s Unusual Incident Reports, surveillance videos of the incidents, the patients’ medical records, hospital policies, and staff training information.

III. ALARMING INCREASE IN PATIENTS BEING SUBJECTED TO RESTRAINT AND SECLUSION AT ST. ELIZABETHS SINCE 2012


The Center for Medicare and Medicaid Services (“CMS”) regulations, D.C. law and D.C. regulations generally prohibit the use of restraint and seclusion, carving out narrowly tailored exceptions. CMS regulations allow for restraint only when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm. D.C. law imposes similar restrictions on the use of restraint and seclusion, allowing its use only in an emergency when necessary to prevent serious injury to the consumer or others and only when less restrictive alternatives have been considered and determined ineffective. D.C. law specifies that patients “have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.” D.C. law also requires that “any use of seclusion or restraint shall be: (1) implemented in the least restrictive manner possible; (2) implemented in accordance with safe and appropriate seclusion or restraint techniques; (3) continually assessed, monitored, and reevaluated; and (4) ended at the earliest possible time.”

St. Elizabeth’s own restraint and seclusion policy requires that staff only use restraints and seclusion as a last resort, stating “[i]t is the policy of Saint Elizabeths Hospital… to limit the use of restraint or seclusion for behavioral reasons to those emergencies when less intrusive

38 CMS and the District both define of seclusion and restraint. CMS defines restraint as “[a]ny manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely.” 42 C.F.R. § 482.13(e)(1)(i)(a). D.C. regulations note that “[r]estraints shall include devices and techniques designed and used to control a consumer’s behavior in an emergency.” Methods of restraint include: (a) Four-point restraints; (b) Five-point restraints; (c) Physical Holds; (d) Legally mandated restraints; (f) Medical restraints; and (g) Drugs used as a restraint. D.C. Mun. Regs. tit. 22A § 503. D.C. law defines seclusion as “any involuntary confinement of a consumer alone in a room or an area from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will.” D.C. Code § 7-1231.02(24).
39 42 C.F.R. § 482.13(e)(2).
40 D.C. Code § 7-1231.09(c).
41 D.C. Code § 7-1231.09(a). See also St. Elizabeths Restraint and Seclusion Policy, which also states, “Each individual has the right to be free from restraint or seclusion of any form, except as consistent with this policy, and at no time should restraint or seclusion be used as a means of coercion, discipline, convenience, or retaliation.” St. Elizabeths Policy 101.2 04 II(A)(1).
42 D.C. Code § 7-1231.09(d).
alternative interventions are not viable or have been ineffective. *Seclusion or restraint is not a therapeutic intervention,* but is an emergency safety measure for the protection of individuals and staff, to be used only when less restrictive interventions are not appropriate."\(^{43}\) The policy also recognizes how harmful and distressing restraint and seclusion can be for their patients, stating, “[b]ecause of the trauma inducing aspects of seclusion and restraint, as well as the potential for physical and psychological harm and loss of dignity, seclusion or restraint shall only be used in emergency situations that pose an immediate risk of an individual physically harming him/herself, staff or others, when less restrictive interventions are not viable or have been ineffective and when the individual's behavior at the time poses a greater risk to himself or others than the risk of using seclusion or restraint."\(^{44}\)

The policy requires staff to exhaust all less restrictive techniques prior to restraint and seclusion and provides examples of multiple interventions staff should employ before resorting to restraint or seclusion, such as that staff: (1) use non-physical crisis intervention techniques; (2) offer one to one verbal counseling; (3) remove stressors that contribute to negative mood and/or behavior; (4) offer sensory-based interventions; (5) allow or suggest that the individual spend time in his or her room or the comfort room; and (6) provide the opportunity for contact with family or significant others to de-escalate the situation.\(^{45}\)

D.C. regulations and St. Elizabeths policy dictate specific documentation requirements staff must follow, including that within one hour of the restraint, the registered nurse in charge document: (1) the justification for the use of restraints or seclusion; (2) alternative strategies which failed to manage the consumer's behavior or why other strategies were considered but deemed impractical or unsafe; (3) the consumer's current behaviors and mental and emotional status; and (4) the consumer's physical status.\(^{46}\)

These restrictions and requirements are essential to protect the safety and dignity of patients. CMS interpretive guidelines note that the intent of their regulations is to “identify patients’ basic rights, ensure patient safety, and eliminate the inappropriate use of restraint or seclusion.”\(^{47}\) D.C. regulations also specifically explain the reasons for the multiple legal requirements staff must follow prior to, during and after a restraint, noting that their purpose is: (1) to provide a safe and therapeutic environment to significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion; (2) to establish positive, trusting relationships among consumers and mental health provider staff; (3) to reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques; (4) to promote, facilitate, and implement initial and continuing education and training programs for mental health provider staff charged with applying, monitoring and

\(^{43}\) SEH Policy 103.00(I) (emphasis added).

\(^{44}\) SEH Policy 103.00(III)(A) (emphasis added).

\(^{45}\) SEH Policy 103.00(III)(E). Specific techniques in this section of the policy include maintaining a calm demeanor and voice, offering help and choices, distracting the individual, allowing the individual to vent and pace, encouraging the individual to use stress management or relaxation techniques such as breathing exercises, and removal of the trigger. Other ideas to consider include providing companionship and supportive supervision, offering diversionary and physical activities, and self-timeout.

\(^{46}\) D.C. Mun. Regs. tit. 22A § 506.2 (b). See also SEH Policy Number 101.01-4 (V)(B)(1).

\(^{47}\) CMS Interpretive Guidelines for 42 C.F.R. § 482.13(e), at p. 90 (emphasis added).

documenting the use of restraints and seclusion in an emergency; (5) to aid in the development of internal and external quality improvement processes to identify and implement ways in which the use of restraints and seclusion in an emergency may be reduced or eliminated in favor of more positive behavioral management techniques with less potential risk.48

B. Dramatic Rise in Restraint and Seclusion at St. Elizabeths

Despite the multiple federal and District protections that allow for restraint and seclusion in very limited circumstances, as the chart below illustrates, St. Elizabeths’ use of restraint and seclusion has been steadily increasing and are now at alarmingly high rates. According to their own published statistics, in 2012 and 2013, patients at St. Elizabeths were rarely restrained or secluded, with only five incidents of restraint for the entire 2012 year and four incidents of restraint for the entire 2013 year.49 Incidents of restraints have increased exponentially since then. In 2018, the hospital restrained patients 782 times and patients spent an astonishing 719 hours in restraints.50 The percent of patients that St. Elizabeths restrained was more than double the national average.51 In December 2018, St. Elizabeths restrained over 20 percent of all its patients.52 These disturbing trends are continuing into 2019. In the first four months of this year, the hospital restrained patients 242 times.53 In April 2019, the hospital restrained 15.9% of their patients.54

The hospital’s rate of placing patients in seclusion has also been increasing at equally disturbing rates. The number of hours patients at St. Elizabeths spent in seclusion increased from 49 hours in 201255 to almost 400 hours in 2018.56 In 2018, the hospital secluded patients 291 times, patients spent a total of 391 hours in seclusion, and the percent of patients secluded was more than double the national average.57

49 The PRISM reports for 2012 and 2013 indicate the total number of “restraint events,” but do not specify the type of restraint used such as physical hold, or mechanical (four-point) restraint. PRISM Report December 2012, PRISM Data Tables at # 4; December 2103, PRISM Data Tables at # 4.
50 PRISM Report December 2018, PRISM Data Tables at # 4. Restraint statistics in the PRISM reports include physical and mechanical restraint only. As discussed in this section of the report, the hospital does not count many involuntary injections of drugs, which are used as a restraint as defined by D.C. law, thus the numbers of incidents of restraint are significantly undercounted.
51 According to the PRISM Reports, the national average data is obtained from “National Public Rate, NASMHPD Research Institute, National Research Institute (NRI), Data as of June 2013, Published in November 2013.”
52 Id.
53 St. Elizabeths PRISM Report April 2019, PRISM Data Tables at # 4.
54 Id.
55 PRISM Report December 2012, PRISM Data Tables at # 4.
56 PRISM Report December 2018, PRISM Data Tables at # 4.
57 Id. We note that beginning in 2019, the hospital began to make use of a solitary confinement area but did not count patient time in this room as seclusion. Therefore, rates of seclusion could be substantially higher once these hours are included in the statistics. See DRDC report, Solitary Confinement at St. Elizabeths Hospital (January 28, 2019). http://www.uls-dc.org/media/1173/reportfinal12819.pdf
St. Elizabeths PRISM Report Rates of Restraint and Seclusion

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of restraint events</th>
<th>Number of hours patients were in restraints</th>
<th>Percent of patients restrained (National average of 5.8%)</th>
<th>Number of seclusion events</th>
<th>Number of hours patients were in seclusion</th>
<th>Percent of patients secluded (National average of 2.4%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>5</td>
<td>3 hours</td>
<td>0.1%</td>
<td>30</td>
<td>49 hours</td>
<td>0.5%</td>
</tr>
<tr>
<td>2013</td>
<td>4</td>
<td>8 hours</td>
<td>0.1%</td>
<td>74</td>
<td>98 hours</td>
<td>1.1%</td>
</tr>
<tr>
<td>2014</td>
<td>43</td>
<td>71 hours</td>
<td>0.5%</td>
<td>183</td>
<td>188 hours</td>
<td>2.6%</td>
</tr>
<tr>
<td>2015</td>
<td>402</td>
<td>109 hours</td>
<td>7.5%</td>
<td>239</td>
<td>246 hours</td>
<td>3.6%</td>
</tr>
<tr>
<td>2016</td>
<td>647</td>
<td>352 hours</td>
<td>8.2%</td>
<td>271</td>
<td>317 hours</td>
<td>4.2%</td>
</tr>
<tr>
<td>2017</td>
<td>640</td>
<td>487 hours</td>
<td>10.2%</td>
<td>328</td>
<td>452 hours</td>
<td>5.5%</td>
</tr>
<tr>
<td>2018</td>
<td>782</td>
<td>719 hours</td>
<td>13.1%</td>
<td>291</td>
<td>391 hours</td>
<td>5.9%</td>
</tr>
</tbody>
</table>

Equally disturbing is the high number of incidents of drugs being used as a restraint. St. Elizabeths statistics indicate that they routinely uses drugs as a restraint, which they refer to as “STAT events.” Since 2013, the hospital has significantly increased the use of drugs used as a restraint -- from 485 “STAT events” in 2013 to 768 “STAT events” in 2018. Each “STAT event” typically involves administering or injecting a patient with multiple psychotropic medications, thus according to the statistics, in 2018, St. Elizabeths doctors ordered 1,656 separate orders for psychotropic drugs, many of which were forcibly administered to patients. Forcibly administering a drug into a patient’s body against their will can also be very traumatic, not only because the patient often does not want to receive the medication, but also because staff often restrain the patients by physically holding them down and injecting medication to their arms, hip or buttocks.

58 The D.C. Code refers to medication administered during an emergency as “drugs used as a restraint” -- "a medication that is used in addition to or in place of the consumer's regular, prescribed drug regimen to control extreme behavior during an emergency, but does not include medications that comprise the consumer's regular, prescribed medical regimen and that are part of the consumer's service plan, even if their purpose is to control ongoing behavior." D.C. Code § 7-1231.02 (9). Prior to 2010, the hospital’s policy addressing chemical restraints was consistent with the statutory definition. That policy correctly stated "[t]he emergency administration of involuntary medications shall be considered to be an incident of drugs as a restraint . . . and the requirements of that policy shall apply." SEH Policy Number 201-05(IV)(C)(1) (Nov. 15, 2007). Despite no change in the D.C. law definition of drugs as a restraint, in 2010, the hospital abruptly altered the definition of "drugs used as a restraint" as used within its policy regarding "Involuntary Medication Administration" and then stated that it now prohibits the use of drugs as a restraint. SEH Policy 103.00(II). The new definition, however, effectively allows the hospital to assert that its staff no longer administers drugs as a restraint, even though staff actions frequently meet the statutory definition of drugs as a restraint, denying the patients the protections D.C. law affords them.

59 PRISM Report December 2013, PRISM Data Tables at #3; PRISM Report December 2018, PRISM Data Tables at #3.

60 Id.

61 For example, Mr. Carter reports that staff “pulled down” his pants and injected him with medication in the buttocks. DRDC interview with Mr. Carter on 2/1/2019.
IV.  ST. ELIZABETHS MUST STOP ABUSIVE STAFF PRACTICES AND DRAMATICALLY REDUCE RESTRAINT AND SECLUSION RATES

The rise in the number of -- and staff abuses during -- restraints and seclusion of patients at St. Elizabeths are dramatic and dangerous. According to the National Association of State Mental Health Directors (“NASMHD”), “in light of the potential serious consequences, seclusion and restraint should be used only when there exists an imminent risk of danger to the individual or others and no other safe and effective intervention is possible,” with the goal to “prevent, reduce, and ultimately eliminate the use of seclusion and restraint and to ensure that, when such interventions are necessary, they are administered in as safe and humane a manner as possible by appropriately trained personnel.” NASMHD also notes that, “[t]he use of seclusion and restraint creates significant risks for people with psychiatric disabilities. These risks include serious injury or death, traumatization of people who have a history of trauma, and loss of dignity and other psychological harm.”

Studies have shown that adult patients in forensic hospitals who were restrained or secluded the most were 75 times more likely to be physically abused while in care compared to those who had little or no restraint or seclusion experience. Patients also experience damage to the therapeutic alliance and mistrust of the healthcare system and staff as a result of being restrained or secluded. Treatment is not provided while being restrained or secluded, and other patients are not receiving care while staff attention is diverted to manage a restraint or seclusion.

According to the NASMHD Research Institute, research shows seclusion and restraint are not effective and “can actually fuel violence,” creating a vicious cycle whereby restraint and seclusion “may cause, reinforce, and maintain aggression and violence on the ward.” Indeed, the dramatic increase in the use of restraint and seclusion at St. Elizabeths has coincided with an increase in patient injuries and physical assaults, which remain disturbingly high even though the patient census has remained steady. In 2013, there were 417 incidents of physical assaults, and 228 patients were injured and 19 patients were seriously injured. In 2018, the number of

---

62 See NASMHD Position on Seclusion and Restraint, Approved by the NASMHPD membership on July 13, 1999. (emphasis added). The position paper also notes, “This goal can best be achieved by: (1) early identification and assessment of individuals who may be at risk of receiving these interventions; (2) high quality, active treatment programs (including, for example, peer-delivered services) operated by trained and competent staff who effectively employ individualized alternative strategies to prevent and defuse escalating situations; (3) policies and procedures that clearly state that seclusion and restraint will be used only as emergency safety measures; and (4) effective quality assurance programs to ensure this goal is met and to provide a methodology for continuous quality improvement. These approaches help to maintain an environment and culture of caring that will minimize the need for the use of seclusion and restraint.” https://www.nasmhpd.org/content/position-statement-seclusion-and-restraint


64 Id.

65 Id.

66 Id.


68 St. Elizabeths PRISM Report December 2013, PRISM Data Tables at #3.
physical assaults jumped to 537, and 178 patients were injured with 21 patients suffering major injuries.69

Successful reductions and/or eliminations of restraint and seclusion practices have been achieved in other psychiatric facilities with patient populations that, like St. Elizabeths, house both civil and forensic patients. For example, in 2005, the state of Pennsylvania initiated a concerted effort to reduce the incidence of restraint and seclusion in all six of its state run psychiatric hospitals.70 The initiative proved highly successful, so much so that the hospital steadily reduced the amount of seclusion and restraint, and has not used seclusion or mechanical (“four point”) restraint in any of its facilities since at least 2015.71 The state achieved these impressive results by committing to and implementing six “core strategies” which included leadership and organizational change, intensive staff training on crisis prevention and therapeutic techniques, as well as employing crisis teams of experienced and skilled staff during events.72

Reducing or eliminating restraint and seclusion will markedly decrease the physical injuries and psychological trauma many St. Elizabeths patients are currently experiencing. The hospital will benefit as well. Restraint and seclusion impose significant costs to the hospital including: (1) the significant amount of staff time spent managing these procedures; (2) physical injuries to staff and patients during restraint and seclusion; and (3) workforce volatility including staff turnover and absenteeism and sick time.73 Reductions in restraint and seclusion have been shown to: (1) decrease staff injuries; (2) reduce costs associated with lost time because less staff members are taking leave; (3) decrease the number claims for workers compensation; (4) decrease liability insurance premiums; (5) increase in job satisfaction among workers; and (6) increase perceptions of safety amongst workers.74

69 St. Elizabeths PRISM Report December 2018, PRISM Data Tables at #3. From January to April 2019, there were 130 physical assaults, 55 patients were injured, and 5 patients suffered major injuries. St. Elizabeths PRISM Report April 2019, PRISM Data Tables at #2.

70 Other examples include: (1) Johns Hopkins Hospital reduced restraint and seclusion use by 75 percent with no increase in staff or consumer injuries; (2) A Florida State Hospital reduced its use by 54 percent and realized nearly $2.9 million in cost savings from reduced worker’s compensation, staff and consumer injuries, and length of stay costs; (3) Idaho State Hospital South reduced its use approximately 90 percent in less than 4 years; and (4) two State Hospitals in Massachusetts reduced restraint and seclusion use more than 90 percent. Janice LeBel, Ed.D., The Business Case for Preventing and Reducing Restraint and Seclusion Use, Substance Abuse and Mental Services Administration (“SAMHSA”), 2011. https://edsource.org/wp-content/iframe/seclusion-restraint/Businesscaseagainstrestraint.pdf


72 See Amanda Wik, MA, Elevating Patient/Staff Safety in State Psychiatric Hospitals, (January 2018). The strategies included: 1) Leadership movement toward organizational change; 2) Using data to inform hospital practices; 3) Developing the workforce to create a treatment environment; 4) Use of tools (e.g. risk assessment tools) to prevent the use of seclusion and restraint practices and lead to the development of individualized plans; 5) Giving consumers roles within all levels of the organization in order to allow them to provide their insights; and 6) Performing a debriefing after every seclusion and restraint event. https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf


74 Amanda Wik, MA, Elevating Patient/Staff Safety in State Psychiatric Hospitals, (January 2018). Grafton School in Virginia, which provides treatment services to individuals diagnosed with intellectual and mental health
V. PATIENTS HARMED BY ILLEGAL AND EXCESSIVE RESTRAINT

Compounding the serious concerns surrounding the alarmingly high number of patients subjected to seclusion and restraint, DRDC’s investigation into three recent incidents of seclusion and restraint demonstrate the harmful impact and potential for abuse that can result during the use of restraints and seclusion. The investigations confirmed illegal staff practices, each of which caused significant harm to the St. Elizabeths patients subjected to restraint and seclusion. Moreover, the investigations raise serious concerns that some, if not many, St. Elizabeths staff may be routinely disregarding the legal protections required when using restraint and seclusion.

1. Patient John Holmes

Mr. Holmes’ medical records indicate that he was sent to St. Elizabeths for a competency evaluation. On admission, he was exhibiting multiple symptoms of his mental illness diagnosis of disorganized schizophrenia. Shortly after his admission, staff restrained and secluded Mr. Holmes on three occasions. During the third restraint, Mr. Holmes suffered a fracture to his left hip and right arm.

Mr. Holmes reports that prior to the restraint, he was “paranoid” and thought that other patients and staff were trying to hurt him, so he blocked his door to prevent anyone from entering. He reports that staff broke down the door to his room and then fell on top of him, which he believes caused his arm and hip to fracture and one of his teeth to become knocked loose. He also recalls that staff twisted his arm during the process, which caused severe pain. The medical records confirm that Mr. Holmes suffered an arm and hip fracture, however, records do not indicate how the injuries occurred.

In addition to the obvious pain and suffering Mr. Holmes endured from a hip and arm fracture, he also reports that he experienced psychological trauma from the restraints. He reports that he did not understand why staff forced him into the seclusion room and restrained him to a bed, noting, “I didn’t want to hurt anyone – they were trying to hurt me and I was scared of being hurt.”

The school estimates that it has saved over 2 million dollars with the reductions in staff turnover, liability premiums, and worker’s compensation claims. https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf

---

75 RN Progress Note dated 4/15/19, timed at 11:53 a.m. These symptoms included behaviors such as being hostile, suspicious, anxious, manic, irritable, angry and disorganized with loud pressured speech.
76 DRDC interview with Mr. Holmes on 5/22/19.
77 Id.
78 Id.
79 DRDC requested the hospital’s and/or the Department of Behavioral Health’s investigation report of the incident, however, to date, the hospital has indicated that the report not been finalized.
80 DRDC interview with Mr. Holmes on 5/22/19.
81 Id.
rehabilitation process after his hip fracture has been, and continues to be, difficult and quite painful, especially during and after physical therapy.82

A. Restraint on April 19, 2019

Within days of Mr. Holmes being admitted to St. Elizabeths, staff restrained him twice and placed him in seclusion.83 Staff restrained Mr. Holmes a third time four days later. Progress notes describe the events leading up the third restraint, and indicate that in the middle of the night, Mr. Holmes walked into the bedroom of another patient then walked into the bathroom, did not following staff instructions to leave the bathroom and then threatened to “mess a staff up.”84 Staff then called a “Code 13,” at which time Mr. Holmes went into his room, disrobed and used his body to block his door.85 Staff noted that his floor was wet with urine, that Mr. Holmes had a milk carton he claimed contained urine and threatened to throw urine on the staff.86 According to the progress note, Mr. Holmes did not comply with staffs’ requests to put the container down, so “staff used the aid of a shield to force the door open and took physical hold of him.”87 The note indicates that staff “secured [Mr. Holmes] by the extremities and carried him into the restraint room.”88 Staff then forced Mr. Holmes into four-point restraints and administered an injection of two psychotropic medications.89

82 DRDC interview with Mr. Holmes on 6/26/19.
83 Prior to the incident, an RN progress note dated 4/15/19, timed at 10:05 p.m. indicates that Mr. Holmes was “uncooperative” and “demonstrated aggressive behavior” during the admission process. The note indicates he refused medication that was ordered for agitation, then was “escorted to the unit and to his bedroom” where he “received the IM injections no problem.” The note indicates that “a few minutes later” staff heard banging and called a “Code 13” in response to Mr. Holmes’ behavior of barricading himself in his room and damaging the furniture, that staff were “finally able to get him out,” and that staff “escorted” him to the restraint room and placed him in four-point restraints. The note indicates he was released from restraints approximately one hour and forty minutes later, at 7:40 p.m., because he was sleeping. According to another Unusual Incident Report, Mr. Holmes was placed in the seclusion room less than an hour later, at 8:05 p.m. While in seclusion, he began to disrobe and barricade himself in the room. Staff entered and placed him in a two-man safety hold. The nurse then attempted to administer an injection, Mr. Holmes broke free and grabbed the syringe. Staff then applied a physical hold, secured the syringe and “escorted” him to the restraint room and placed him in four-point restraints. Mr. Holmes remained in restraints for approximately five hours before he was released. Unusual Incident Report # UI/DB # 26503, dated 4/16/19. A subsequent medical doctor progress note dated 4/15/19, timed at 10:16 p.m., indicates that Mr. Holmes sustained “abrasions to his right side after [two] code 13s.” Prior to the restraints and seclusion, staff failed to employ adequate, meaningful less restrictive alternatives. The Initiation of Seclusion and Restraint: RN Assessment, dated 4/15/19, timed at 8:04 p.m., indicates, by checked choices, that the less restrictive measures employed included “talked with individual in care,” “redirected verbally,” and “set limits.” The narrative portion of the form indicates that the less restrictive measures included physical hold, counselling, verbal redirection and de-escalation. However, neither the progress notes nor the unusual incident report refers to staff employing these techniques. D.C. regulations require that the RN document meaningful alternative strategies which failed to manage the behavior and to document why other strategies were considered but deemed impractical or unsafe. D.C. Mun. Regs. tit. 22A § 506.2 (b). For the reasons set forth in this report, vague, generic descriptions are not sufficient. These incidents demonstrate further violations of policies and laws.
84 RN Progress Note dated 4/19/19, timed at 6:48 a.m.
85 Id.
86 Id.
87 Id.
88 Id. Mr. Holmes reports that after staff knocked him to the ground and fell on top of him, staff placed him in a sheet and carried him in the sheet to the restraint room. DRDC interview with Mr. Holmes on 5/22/19.
89 RN Progress Note dated 4/19/19, timed at 6:48 a.m.
B. Staff Response after the April 19\textsuperscript{th} Restraint

Progress notes indicate that about an hour and a half after staff placed Mr. Holmes in four-point restraint, staff released the arm restraints.\textsuperscript{90} The nurse obtained vital signs and noted that Mr. Holmes’ blood pressure was highly elevated. After sitting up in bed, Mr. Holmes vomited.\textsuperscript{91} Staff then released the leg restraints, and Mr. Holmes was “cleaned up, assisted to put clothes on and wheeled to the day room.”\textsuperscript{92} (The note does not explain why Mr. Holmes needed to be placed in a wheelchair as records indicate he had been independent with ambulation prior to the restraint and make no mention of a wheelchair.)\textsuperscript{93}

It was not until almost 5:00 p.m. the next day, \textit{over sixteen hours after the restraint}, that a nurse practitioner finally saw Mr. Holmes to evaluate him for his complaints of pain and inability to bear weight. A very brief nurse practitioner note, timed at 4:46 p.m., indicates that Mr. Holmes was sitting in a wheelchair and complaining of leg pain “since the morning” and that “STAT” x-rays were ordered.\textsuperscript{94} The note contains no further details or evidence of a physical assessment by the nurse practitioner, such as a description of his injury, whether his leg was swollen or bruised, etc.\textsuperscript{95} It was not until approximately 10:30 p.m., that a medical doctor first noted that Mr. Holmes was complaining of pain, his left thigh was swollen and that the x-rays showed an acute left hip fracture.\textsuperscript{96} Finally, at 11:00 p.m., almost 24 hours after Mr. Holmes sustained a hip and arm fracture, Mr. Holmes was transferred via 911 to George Washington Hospital,\textsuperscript{97} where his arm was noted to also be fractured and was placed in a cast, and he underwent surgery for his hip.\textsuperscript{98} On arrival to the emergency room, staff observed that Mr. Holmes’ left leg was “externally rotated, shortened and swollen,”\textsuperscript{99} and that he was suffering “severe” pain.\textsuperscript{100}

C. Staff Violations of CMS Regulations, D.C. Laws, D.C. Regulations and St. Elizabeths’ Policies

Prior to and during the restraints, St. Elizabeths staff violated multiple District and federal laws, including that staff failed to (1) document or implement meaningful less restrictive alternatives to restraint; (2) employ safe techniques prior to and during the restraints; and (3) provide adequate medical care to Mr. Holmes after he sustained serious injuries.

First, staff’s’ actions of breaking down Mr. Holmes’ door, lifting, and carrying him to the restraint room were NOT approved safety care transport techniques and thus prohibited by D.C. law, which requires that restraint and seclusion must be implemented in accordance with safe

\textsuperscript{90 Id.}
\textsuperscript{91 Id.}
\textsuperscript{92 Id.}
\textsuperscript{93 Id.}
\textsuperscript{94 Nurse Practitioner Progress Note dated 4/19/19, timed at 4:46 p.m.}
\textsuperscript{95 Id.}
\textsuperscript{96 GMO Progress Notes dated 4/19/19, timed at 10:39 p.m.}
\textsuperscript{97 RN Progress Note dated 4/19/19, timed at 11:57 p.m.}
\textsuperscript{98 Nurse Practitioner Progress Note dated 4/25/19, timed at 5:50 p.m.}
\textsuperscript{99 George Washington Hospital Trauma Flowsheet dated 4/19/19.}
\textsuperscript{100 George Washington Hospital Discharge Summary dated 4/25/19.}
and appropriate seclusion or restraint techniques. The Safety Care Training Manual (“the Manual”) used for the training of all St. Elizabeths clinical staff does not include allowing staff to break down or force open a door with a patient behind it -- clearly a dangerous practice. Moreover, the Manual specifically states that staff should never carry a patient. Staff’s actions of lifting Mr. Holmes by his arms and legs and carrying him to the restraint room could very well have exacerbated, or even been a cause of, his fractures. Their actions caused psychological trauma as well. Mr. Holmes reports that after staff injured him and placed him in restraints, he felt very drowsy from the injections, his hip and arm hurt badly, and he thought he that he was going to die during the night.

Second, although Mr. Holmes’ documented behaviors may have required staff intervention, staff can only use seclusion and restraint as a last resort. Staff are legally required to try or consider less restrictive alternatives and determine that they are ineffective before they force a patient into restraints. D.C. regulations require that the RN document meaningful alternative strategies which failed to manage the behavior and to document why other strategies were considered but deemed impractical or unsafe. Prior to this restraint and serious injury, the RN progress note indicates that that staff “instructed” Mr. Holmes not to walk into another patient’s room, “instructed” Mr. Holmes not to walk into the bathroom and that staff “instructed” Mr. Holmes to put down the container which allegedly contained urine. “Instructing” a patient, especially a patient in an acute mental health crisis, is not a de-escalation technique and was clearly ineffective. Although the RN indicates that Mr. Holmes “did not follow verbal redirection from staff,” it is not clear what specific type of statements were used as “verbal redirection.” A vague reference to “redirection” does not evidence a meaningful attempt to use less restrictive measures, such as those on which the RN and all staff should have been trained. The records provided contain no evidence that the RN or other staff employed the de-escalation techniques contained in the Manual, which are designed to avoid the use of restraint and seclusion. For example, one strategy staff could have employed was the “help” strategy to assist Mr. Holmes to communicate his needs. Or staff could have employed the “wait strategy” and monitored Mr. Holmes until he calmed down and moved away from the door.

103 DRDC interview with Mr. Holmes on 5/22/19.
104 D.C. Mun. Regs. tit. 22A § 501.2(b).
105 D.C. Mun. Regs. tit. 22A § 506.2 (b). See also SEH Policy103.00(III)(M)(1)(b).
106 DRDC interview with Mr. Holmes on 5/22/19.
106 D.C. Mun. Regs. tit. 22A § 506.2 (b). See also SEH Policy103.00(III)(M)(1)(b).
106 RN m.
107 Initiation of Seclusion and Restraint: RN Assessment, dated 4/19/19, timed at 12:35 a.m.
108 Safety Care Training is a mandatory training for all clinical staff at St. Elizabeths. The training manual requires that staff attempt to employ various de-escalation methods prior to resorting to restraint. These include: (1) the “help strategy” in which staff assist the patient to communicate; (2) the “prompt strategy” in which staff ask the patient to engage in behavior that is incompatible with the challenging behavior; and (3) the “wait strategy” in which staff monitors the patient and gives the patient time for the challenging behavior to improve. Safety Care - Behavioral Safety Training Manual at pages 25 - 34.
109 Id.
110 Id.
111 Id.
Mr. Holmes reports that he blocked the door to his room because he was experiencing a mental health crisis and was afraid.  He does not recall that staff attempted to allay his fears, reassure him or offer him time to calm down. Furthermore, staff documentation does not explain how Mr. Holmes was an imminent threat by blocking the door with his body, nor why staff deemed it was necessary to force open the door, which also could have been the cause of his injuries.

Third, and equally disturbing, the nurses and medical staff failed to provide timely medical care and treatment; they failed to adequately assess Mr. Holmes both after the restraint itself and inexplicably, when he was complaining of pain and needed to be placed in a wheelchair. Hospital policy notes that “[t]he health and safety of the individual are of paramount importance at all times. If an individual needs medical attention in the course of an episode of restraint or seclusion, the use of restraints or seclusion shall be terminated immediately, and the individual shall receive immediate medical attention.” Although the record indicates that after the restraint, a medical doctor evaluated Mr. Homes for elevated blood pressure and vomiting, the record contains no evidence that the medical doctor assessed whether Mr. Holmes was in pain or injured during the restraint, nor did a physician assess why he was unable to walk or bear weight. In addition, D.C. law requires that an attending or treating physician must see a patient within one hour after the initiation of the seclusion or restraint. Although a psychiatric resident note written approximately two hours after the initiation of the restraint indicates “I have personally responded to code 13 on 1D and evaluated the patient face to face,” the note contains no description of a physical evaluation.

St. Elizabeth’s Nursing Procedure Manual requires the nurses to conduct timely assessments, which should include vital signs and an assessment of all relevant systems, and to document a narrative progress note at least every shift for 72 hours following a change in physical status to reflect continued nursing observations and reassessments and the individual’s response to the interventions. However, nursing progress notes contain no evidence that the nurses adhered to these requirements. The single nursing progress note describing Mr. Holmes’ injuries was timed seven hours after the release from restraints, when an RN noted that Mr. Holmes “complained he could not stand on his [left] limb this shift” and that he could “wiggle his toes but could not lift his limb.” This description is not an “assessment of all

---

112 DRDC interview with Mr. Holmes on 5/22/19.
113 Id.
114 SEH Policy 103.00(III)(A)(20) (emphasis added).
115 The records contain two very brief GMO notes which also contain no evidence of an adequate assessment nor that the GMO was aware that Mr. Holmes had been injured during the restraint. A note dated 4/19/19, timed at 2:04 a.m., states, “Patient coming out of four-point restraints has blood pressure of 185/106 P 80…Lisinopril was reordered.” A note dated 4/19/19 timed at 6:47 a.m. states, “Patient had episode of vomiting large volume of undigested food after coming out of seclusion. Patient is clinically stable, no stomach pain feels better.”
116 Id.
117 D.C. Code §7-1231.09(f).
118 Psychiatry Resident Progress note dated 4/19/19, timed at 12:17 a.m.
120 Nursing assessment failures have been an ongoing deficiency at St. Elizabeths. For example, in 2018, DRDC investigated the death of a St. Elizabeths patient and uncovered serious nursing neglect, including failures to conduct timely and adequate assessments. A Patient’s Suffering and Death at St. Elizabeths Hospital (October 1, 2018).
http://www.uls-dc.org/media/1166/investigationfinalpublic.pdf
121 RN Progress Note dated 4/19/19, timed at 6:47 p.m.
relevant systems” and failed to include vital information such as the location and intensity of pain, and whether his leg or arm were swollen or bruised.122

It appears that the nurses did not consider an acute injury after a restraint, one in which a patient could no longer stand or bear weight, an emergency condition which needed immediate medical attention. Nor do the progress notes explain how the nurses and physicians could be unaware that Mr. Holmes’ arm was also fractured. Mr. Holmes reports that after the restraint, he experienced significant pain in his hip and arm, which he repeatedly reported to staff throughout the day, but that “a doctor did not see me until the evening.”123

2. Patient Keith Carter

On January 19, 2019, St. Elizabeths’ staff initiated and implemented a coordinated, planned restraint of patient Keith Carter.124 A review of the medical records and videotape footage reveals an alarming series of events that occurred over a twenty-one minute period of time, which culminated in multiple staff restraining Mr. Carter in a physical hold, physically forcing him down a hallway, pushing him into a room, applying four-point restraints and injecting him with psychotropic medications against his will.125 Prior to and during the restraint, staff violated multiple federal regulations, D.C. laws and hospital policies designed to protect patients from unnecessary and abusive restraints.

Understandably, Mr. Carter reports that he suffered significant psychological trauma because of the restraints.126 Mr. Carter recalls being very frightened and frustrated throughout the incident, and especially when “all those people surrounded me, came towards me and dragged me into the restraint room.”127 Mr. Carter reported that during the restraint “no one would listen to what I was saying” and that “it felt like staff had a mob mentality.”128 He was equally frightened and humiliated when staff forcibly administered the chemical restraint. Mr. Carter relayed that staff “wrestled me over, pulled down my pants and exposed my buttocks” and then gave him the injection. He reported that throughout the restraint, he pleaded with staff not to restrain him and not to inject him with medication.129 Months after the incident and after his discharge from St. Elizabeths, Mr. Carter reports lingering psychological trauma and frustration with staffs’ treatment of him.130 He also reports that he is concerned for the patients on his former unit, stating that “I don’t want them experience the abuse that I did.”131

---

122 Id.
123 DRDC interview with Mr. Holmes on 5/22/19.
124 DRDC requested the hospital’s and/or the Department of Behavioral Health’s investigation report of the incident, however, to date, the hospital has indicated that the report not been finalized.
125 Videotape at 11:21:32 to 11:36:09. Each unit at the hospital has a revolving camera mounted on the ceiling, which scans the day rooms and hallways if each unit.
126 DRDC interview with Mr. Carter on 2/1/19.
127 Id.
128 Id.
129 DRDC interview with Mr. Carter on 2/1/19.
130 DRDC interview with Mr. Carter on 6/24/19.
131 Id.
Mr. Carter also reports that staff would not explain why it was necessary to inject him with such a powerful medication against his will, and that he suffered multiple physical side effects after the injection. Indeed, a psychiatry resident progress note indicates that Mr. Carter reported multiple side effects from the injection, including a rash on his buttocks, shortness of breath, chest tightness and difficulty sleeping. The psychiatry resident notes that Mr. Carter “asked for an explanation of why his [injection of] medication was given and what the procedure is to choosing a medication.” The psychiatry resident simply noted, “[p]atient counseled and encouraged to speak with the primary team about the specifics of his treatment.”

A. Summary of Videotape Footage – See Attachment A for Videotape Tracings

Videotape footage of the restraint incident begins at about 11:15 a.m. Initially, the ward appears calm, patients and staff sit in chairs or lean leisurely against walls in the dayroom. A few minutes later, a patient (not Mr. Carter) flips a table into the middle of the room, then three male staff escort that patient down one of the adjoining hallways.

At approximately 11:21 a.m., Mr. Carter is standing against a column adjacent to the dayroom. Mr. Carter’s posture is non-threatening, his hands are behind his back as he leans against the wall. Approximately one minute later, a female staff person engages with Mr. Carter. Mr. Carter moves to a chair squarely facing the nurses’ station. For less than a minute, Mr. Carter stands, puts his hands in the air and pumps his arms in the air as if cheering. (This act of placing his hands in the air is the most energetic action Mr. Carter takes during the entire twenty-one minutes of footage.) One male staff member a few feet away continues to calmly sip a beverage. By approximately 11:25 a.m., Mr. Carter’s arms are by his side as he stands by the nurse’s station. Staff nearby do not react, and one staff person continues to sip a beverage. Approximately three minutes later, Mr. Carter meanders towards the middle of the main dayroom. There, his fellow patients relax in armchairs with their legs outstretched. One lies across a couch napping. Another sits at a round table with something in front of him. Mr. Carter appears calm. Nothing unexpected or out of the ordinary occurs until the security guards begin to stream in.

At first, four security officers or hospital staff enter the ward. One of the officers puts gloves on. At this point, Mr. Carter has moved to and stands by the nurse’s station. He leans

---

132 Id.
133 Psychiatry resident Progress Note dated 1/21/19, timed at 1:26 a.m.
134 Id.
135 Id.
136 Videotape at 11:15:12 a.m. See Tracing 1.
137 Id. at 11:17 - 11:18 a.m.
138 Id. at 11:21:34 a.m.
139 Id. at 11:22:05 a.m.
140 Id. at 11:23:34 a.m.
141 Id. at 11:24:16 a.m. See Tracing 2.
142 Id. at 11:24:25 a.m.
143 Id. at 11:25:32 a.m.
144 Id. at 11:28:18 a.m.
145 Id. at 11:28:21 a.m.
146 Id. at 11:29:42 a.m.
slightly over the counter, holding a paper with both hands. A staff member, standing a few feet from him appears calm and ignores Mr. Carter.\textsuperscript{147} At approximately 11:31 a.m., Mr. Carter approaches a few of the assembled officers and staff. The officers and staff seem uninterested in conversing, but the situation appears calm. One staff member waves Mr. Carter away, while intermittently taking sips from his drink.\textsuperscript{148} Just one minute later, more staff and security arrive. One staff member stands with his hands in his pockets, two of the staff face each other talking, and a third holds a large plastic shield.\textsuperscript{149}

Mr. Carter walks down the hallway towards these staff members.\textsuperscript{150} One of the security officers is holding a shield and gestures toward Mr. Carter as he walks down the hall. Mr. Carter responds with a shrug.\textsuperscript{151} Another security officer faces Mr. Carter but looks down. Mr. Carter walks into the dayroom, where his peers continue to nap and sit. His hands are behind his back, and he does not seem threatening.\textsuperscript{152} None of the other unit staff or security officers make any effort to interact with Mr. Carter. They congregate to the side, leisurely leaning against the nurses’ station or hovering near one another, while Mr. Carter stands passively in the center of the dayroom.\textsuperscript{153}

Two staff members gesture toward the dayroom and seconds later the other patients leave the dayroom, walking somewhat single-file down the hall.\textsuperscript{154} Mr. Carter sits calmly and quietly perched atop a chair in the dayroom. His back is against the wall, and his body is curled forward slightly and he continues to show no signs of threatening or aggressive behavior.\textsuperscript{155} To his left, stand three staff. They do not appear to make any effort to engage Mr. Carter in any conversation. Another staff member speaks to the final patient in the room, who then exits the dayroom.\textsuperscript{156}

By approximately 11:35 a.m., the only people in the dayroom are Mr. Carter and the many St. Elizabeths staff who will soon restrain him. Mr. Carter remains perched on the chair, his hand to his chin. One security guard faces him, his foot forward to approach closer. Another hospital staff worker stands a couple of feet behind this officer, her arms crossed across her chest and her legs spread out.\textsuperscript{157} The assembled staff continue to make no effort to interact with Mr. Carter. At approximately the same time, in the hallway adjacent to the dayroom, security officers escort a different patient from the room where they will soon drag Mr. Carter.\textsuperscript{158} Two security officers, one on each side of the other patient, grip his arms and walk with him down the hall, where three additional security guards stand.\textsuperscript{159} By now, all of the security officers and staff workers wear blue gloves.

\textsuperscript{147} Id. at 11:30:39 a.m.
\textsuperscript{148} Id. at 11:31:15 a.m.
\textsuperscript{149} Id. at 11:31:58 a.m.
\textsuperscript{150} Id. at 11:32:00 a.m.
\textsuperscript{151} Id. at 11:32:07 a.m.
\textsuperscript{152} Id. at 11:32:15 a.m.
\textsuperscript{153} Id. at 11:32:30 a.m.
\textsuperscript{154} Id. at 11:32:58 a.m. to 11:33:40 a.m.
\textsuperscript{155} Id. at 11:33:56 a.m.
\textsuperscript{156} Id. at 11:34:28 a.m.
\textsuperscript{157} Id. at 11:34:35 a.m. \textit{See} Tracing 3.
\textsuperscript{158} Id. at 11:35:10 a.m.
\textsuperscript{159} Id. at 11:35:11 a.m.
In an extremely intimidating and disturbing show of force, thirteen staff and security guards then descend upon Mr. Carter. At first, one security person places his hand on Mr. Carter’s right shoulder, as Mr. Carter stands with his back against a wall and his hands behind his back. Three male security officers move towards Mr. Carter. Seconds later, five male staff approach Mr. Carter. One female staff remains farther away watching, her hands still crossing her chest. There are now eight hospital staff and security involved in the restraint. A few seconds later, three more staff join in.

Thirteen staff now surround Mr. Carter in a circle, all facing him. Three security officers grip Mr. Carter’s arms. Approximately nine seconds later, two more security officers each grab Mr. Carter’s arms. Mr. Carter passively resists. The two security officers begin to drag Mr. Carter, with another pushing him forward from behind. The other men close in tightly, and the men holding Mr. Carter begin to pull him away. Mr. Carter stumbles as the men drag him away.

Mr. Carter looks reluctant and terrified. One of his legs is pushed forward while the other drags behind his body. There are nine people surrounding Mr. Carter, with a tenth watching from further way. Four more of the staff persons appear to lunge towards Mr. Carter and place their hands on him, some pushing him as he is dragged down the hallway. As the group turns the corner, Mr. Carter is pushed and pulled as thirteen hospital staff persons assist, follow, or watch — all within feet of him. Staff then push Mr. Carter into a room. Two additional staff persons, holding large plastic shields, walk down the hallway and into the room.

After he was pushed into the room, Mr. Carter reports, and records confirm, that staff restrained his arms and legs to the bed and forcibly injected him with a chemical restraint of antipsychotic medications. The same thirteen individuals who followed Mr. Carter as he was pushed down the hallway begin to dissipate. They chat with each other as they walk away from the room where Mr. Carter is restrained to the bed. They take off their blue gloves and casually drop them in the large paper bag. More staff members — including some who were apparently on the ward but not directly involved in the restraint — gather to chat with one another.

---

160 Id. at 11:35:45. See Tracing 4.
161 Id. at 11:35:47 a.m. See Tracing 5.
162 Id. at 11:35:48 a.m. See Tracing 6 and 7.
163 Id. at 11:36:09 a.m.
164 Id. at 11:36:12 a.m. See Tracing 8.
165 Id. at 11:36:17 a.m. See Tracing 9 and 10.
166 Id. at 11:36:18 a.m.
167 Id. at 11:36:19 a.m. See Tracing 11.
168 Id. at 11:36:19 a.m.
169 Id. at 11:36:19 a.m.
170 Id. at 11:36:20 a.m. See Tracing 12.
171 Id. at 11:36:22 a.m. See Tracing 13 and 14.
172 Id. at 11:36:25 a.m. See Tracing 15 and 16.
173 Id. at 11:36:36 a.m.
174 See Psychiatry Resident Progress Note dated 1/17/2019, timed at 11:57 a.m.
175 Videotape at 11:38:28 a.m. See Tracing 17.
176 Id. at 11:38:39 a.m.
as well. 177 By approximately 11:43 a.m., the remaining security and additional staff leave the unit. 178

B. Summary of Hospital Documentation

Staff documentation of the events leading to the restraint contain minimal information and are not consistent with the video tape footage. The records contain no RN progress notes referencing the incident. The “Initiation of Seclusion and Restraint: RN Assessment” states that Mr. Carter was “sexually inappropriate and verbally threaten[ed] two female staff,” and that when staff “attempted to redirect” Mr. Carter, he “escalated, started yelling and cursing out staff.” 179 The “RN Update” portion of the Unusual Incident Report indicates that at “about 12:00 p.m., Mr. Carter was standing by the nurse’s station and began making sexually inappropriate comments towards two female staff members,” and that in response, the staff at whom he directed most of his remarks was asked to leave the nurses area. 180 According to the incident report, Mr. Carter was observed to have a toothbrush in his pocket and staff thought he might use it as a weapon. 181 The report states that after Mr. Carter was offered voluntary emergency medication, which he refused to take, a “Code 13” was initiated, Mr. Carter was physically escorted to seclusion, placed in a four-point restraint, and involuntarily injected with medication. 182 No other staff documentation references that Mr. Carter was holding a toothbrush, and the video tape shows no evidence that Mr. Carter was holding a toothbrush or any other object, nor that he was threatening to use any object as a weapon. 183 In fact, the Initiation of Seclusion and Restraint form asks for a list of personal and dangerous objects removed, and the form states “N/A.” 184 Records indicate that Mr. Carter remained in restraints for approximately 1 hour and 45 minutes. 185

C. Staff Violations of CMS regulations, D.C. law and Hospital Policy

Staffs’ actions were not only extremely disturbing, they were clearly illegal. If St. Elizabeths staff had adhered to the legal and hospital policy requirements, the physical, four point and chemical restraint of Mr. Carter would likely have been avoided. At no point during the twenty-one-minute video tape footage does Mr. Carter appear physically to be an imminent threat to anyone’s safety. 186 The video tape footage shows that for at least fourteen minutes prior to the restraint, as twelve staff and security guards were slowly, methodically, and calmly gathering for the planned restraint, Mr. Carter was not overtly exhibiting threatening or dangerous behavior. 187 Staff appear casual and do not appear threatened by Mr. Carter. 188

177 Id. at 11:40:08 a.m.
178 Id. at 11:43:10 a.m.
179 Initiation of Seclusion and Restraint: RN Assessment, dated 1/17/19.
180 St. Elizabeths Unusual Incident Report, UI DB #25944 dated 1/17/19. The quoted comments were offensive.
181 Id.
182 Id.
184 RN Assessment of Individual in Seclusion or Restraint, dated 1/17/19.
185 Id.
188 Id.
Though Mr. Carter’s comments initiating the chain of events may have been offensive, offensive remarks do NOT give staff the legal authority to plan and employ a physical, four point and chemical restraint in a seclusion room. The documentation provides no credible explanation as to how Mr. Carter was an imminent threat, especially because the two staff to whom he had directed the comments had moved away from Mr. Carter and/or left the unit. While offensive remarks may call for staff intervention, hospital policy requires staff to provide therapeutic, positive behavioral approaches and de-escalation techniques when incidents occur.189 Although the RN documentation indicates that staff attempted multiple times to redirect Mr. Carter verbally, but were unsuccessful,190 the nurse fails to explain what staff meant by “redirect” nor how the supposed “redirection” was not successful. Importantly, staffs’ documentation is contradicted by the video tape, showing that staff made little meaningful attempt to redirect or speak with Mr. Carter during the timeframe of the video. D.C. regulations require that the RN document meaningful alternative strategies which failed to manage his behavior and why other strategies were considered but deemed impractical or unsafe.191 Vague references to “redirection” are not sufficient.192

Alarmingly, while Mr. Carter was restrained, the psychiatrist ordered an antipsychotic medication, Zyprexa 10 mg, combined with an additional medication, Benadryl 50 mg., “four times a day “as needed.” The order states, “please offer [by mouth] first, if refused give IM [injection] for safety.” However, D.C. law specifically prohibits the use of drugs as a restraint/emergency medication on as “as needed” basis, requiring that the attending physician provide a separate written order for each restraint and that the orders “shall never be written as a standing order or on an as-needed basis.”194

3. Patient Lisa Morgan

A. Multiple Incidents of Restraint and Seclusion in April and May 2019

Lisa Morgan is longtime patient at St. Elizabeths hospital with a trauma history.195 A review of the medical records revealed a disturbing pattern of staff using restraint and seclusion to address Ms. Morgan’s ongoing conflict with two patients. During just two months, in April

---

189 See SEH Policy 103.00(III)(E).
190 Initiation of Seclusion and Restraint: RN Assessment, dated 1/17/19.
191 D.C. Mun. Regs. tit. 22A § 506.2 (b). See also SEH Policy103.00 (III)(M)(1)(b).
192 Staff failed to employ techniques in St. Elizabetht's policy, such as offering help and choices, allowing Mr. Carter to vent and pace, or encouraging Mr. Carter to use stress management or relaxation techniques. In addition, the policy requires that staff attempt to implement the de-escalation strategies in a patient’s treatment planning or “comfort plan” prior to initiating a restraint. SEH Policy 103.00(III)(A)(10). However, staff failed to follow the recommended calming strategies listed in Mr. Carter’s treatment plan, which included doing artwork, being offered a cold face cloth, and being given a chance to exercise or lie down.
193 Client Doctors orders dated 1/24/19, timed at 10:29 a.m.
194 D.C. Code §7-1231.09(c)(3). See also, SEH Policy 201-05 III(C)(2)(c), which states, “[t]he use of PRN orders for oral or injectable psychotropic medication for emergency purposes shall be prohibited.”
195 A Social Work Initial Assessment, dated 10/9/15, states “that Ms. Morgan “previously reported a history of sexual, physical and emotional abuse beginning at a young age.”
and May of 2019, St. Elizabeths staff restrained and/or secluded Ms. Morgan seven times. She spent almost twelve hours either being physically held by staff, strapped to a bed or secluded alone in a room. Staff also injected her with psychotropic medication against her will five times.

The repeated restraints and seclusions caused significant psychological harm to Ms. Morgan. She reports that the restraints and seclusion were very frightening and traumatizing, and that she “was very scared and hated being locked in a room and tied down to the bed.” She reported that other patients were threatening and trying to hurt her and that she needed to protect herself. Ms. Morgan also reports that she felt humiliated when staff pulled down her pants and exposed her buttocks in front of male staff when they administered the injections. Certainly, in addition to the legal violations related to this incident as discussed below, staff conduct did not reflect “respect, dignity and sensitivity.”

A. Staff Violations of CMS Regulations, D.C. law, and Hospital Policy

In addition to restraining and secluding Ms. Morgan even though clearly contradicted due to her trauma history, staff failed to adhere to multiple legal and hospital policy requirements, including failure to: (1) implement meaningful less restrictive alternatives which were available; (2) release Ms. Morgan from restraints at the earliest possible time; (3) conduct meaningful debriefings after the restraints and seclusions; and (4) reference her comfort plan and adjust treatment planning.

First, the record indicates that Ms. Morgan reported a history of physical and sexual abuse. According to St. Elizabeths policy, seclusion is clinically contradicted for individuals with a trauma history. Many, if not most, patients at St. Elizabeths hospital have a history of trauma. Since these patients are particularly vulnerable to psychological harm from restraint and

---

197 Id.
198 Id.
199 DRDC interview with Ms. Morgan on 5/21/19.
200 Id. See also Recovery Team Debriefing Form dated 5/28/19, which indicates that Ms. Morgan reported that another patient “was calling me names and attacked me first,” and that “I was still upset from the last time someone beat me up.” In fact, Ms. Morgan was assessed by a medical doctor after one incident of seclusion, who noted that Ms. Morgan “sustained (L) upper lip swelling after an altercation with another patient... .” GMO Progress note dated 4/28/19, timed at 8:02 a.m.
201 DRDC interview with Ms. Morgan on 5/21/19.
202 As previously noted, St. Elizabeths’ vision statement that staff provide “a healing environment” and that “each person who comes through our doors is treated with respect, dignity, and sensitivity to spiritual and cultural norms and is empowered to be an active partner in recovery.” https://dbh.dc.gov/page/saint-elizabeths-hospital
203 A Social Work Initial Assessment, dated 10/9/15, states “that Ms. Morgan “previously reported a history of sexual, physical and emotional abuse beginning at a young age.” Ms. Morgan also reported that she had been raped in the past. See GMO note dated 5/6/19, timed at 8:24 a.m. Ms. Morgan also reported to DRDC that she was raped at age 14. DCDC interview with Ms. Morgan on 5/21/19.
204 SEH Policy 103.00(III)(A)(3) states that seclusion is contraindicated for individuals with suicidal ideation, self-injurious behaviors, medical conditions that preclude seclusion and for individuals with a trauma history. (Emphasis added).
seclusion, D.C. regulations require that staff employ restraints or seclusion that is “appropriate for the severity of the consumer's condition or behavior, as well as the consumer's … physical, mental, and emotional condition, and personal history, including any history of trauma, physical, sexual or mental abuse.” 205 As such, the psychiatrist should not have ordered that Ms. Morgan be placed in restraints or seclusion. The restraint and seclusion regulations also state that the physician shall document a note separate from the doctor's order that includes “whether the consumer has a history of trauma, sexual, or physical abuse that would place the consumer at greater psychological risk during the use of restraints or seclusion.” 206 Despite Ms. Morgan documented history of physical and sexual abuse, the record contains no such documentation by the psychiatrist.

Second, records indicate that staff failed to employ viable and available less restrictive alternatives to restraint and seclusion when Ms. Morgan was involved in altercations with two other patients. Staff applied a physical hold and/or “escorted” Ms. Morgan to the restraint or seclusion room and injected her with a emergency medications on multiple occasions, even though separating her from the other patient may have been equally effective. For example, records indicate that in one incident, Ms. Morgan was exhibiting aggressive behavior towards another patient and that staff were able to effectively separate the two patients. 207 Even after the patients were successfully separated, staff implemented a physical hold, injected an emergency medication and placed Ms. Morgan in seclusion for four hours. 208 Progress notes indicate that Ms. Morgan and the other patient were “antagonist towards each other for most of the day,” that Ms. Morgan “charged towards” the patient, and that “staff and security intervened and guided Ms. Morgan to the seclusion room.” 209 Staff do not explain how Ms. Morgan was an imminent threat nor why it was necessary to place Ms. Morgan in seclusion after she was physically separated from the other patient instead of keeping the two individuals away from each other. (In fact, staff did employ close monitoring on at least one occasion when Ms. Morgan and the other patient were involved in an altercation. Staff note that they “intervened and separated the two patients,” and, as such, neither restraint nor seclusion was used on Ms. Morgan at that time. 210) Additionally, the doctor’s order for the seclusion states that the less restrictive methods employed were “counseling and redirection,” both were deemed “ineffective,” without noting more details about how the counseling and redirections were approached, why they were not effective and what continued behavior Ms. Morgan was exhibiting to justify the seclusion. 211 Such reflection is critical to avoid future incidents, especially where there is a pattern of behavior as here.

The next day, and again in response to an altercation with the same patient, staff, “led [Ms. Morgan] to the restraint room with a stability hold” injected her with psychotropic medication and placed her in four-point restraints for two hours. 212 Again, the staff

205 D.C. Mun. Regs. tit. 22A § 501.3(b)(2). See also St. Elizabeths Policy 103.00 III(A)(27).
206 D.C. Mun. Regs. tit. 22A § 506.10(c).
207 Psychiatry Resident Note dated 4/27/19, timed at 9:17 p.m. See also RN Assessment of Individual in Seclusion or Restraint dated 4/27/19.
208 Id.
209 Psychiatry Resident Progress Note dated 4/27/19, timed at 9:17 p.m.
210 Psychiatry Resident Progress Note dated 5/26/19, timed at 8:27 p.m.
211 Restraint and Seclusion Doctor’s Order dated 4/27/19, timed at 6:56 p.m.
212 Psychiatry Resident Note dated 4/28/19 timed at 3:29 p.m.
documentation fails to explain why separating the patients was not a viable alternative to restraints.\textsuperscript{213} Staff note that the less restrictive alternatives employed prior to the restraints included “redirection,” “verbal counseling,” and “oral medications.”\textsuperscript{214} These generic and vague descriptions of staff attempts to avoid restraint and seclusion are not sufficient. As was the case with Mr. Holmes, Ms. Morgan was exhibiting an exacerbation of her mental health symptoms. More meaningful and effective staff interventions, such as those outlined in the hospital’s policy and Safety Care Training Manual,\textsuperscript{215} were indicated and required.

Moreover, the Restraint and Seclusion Doctor’s Order for the restraint indicates that Ms. Morgan was “relocated to the restraint room,” “released from the stability hold” and “[a]t that time she allowed the application of restraint.”\textsuperscript{216} Although the order notes that Ms. Morgan was making verbal threats prior to the stability hold, staff do not explain how a patient who willingly lays down on a restraint table and willingly places her extremities in position to be restrained, continues to be an imminent threat to safety, and why less restrictive alternatives were not pursued at the time when Ms. Morgan was obviously cooperating with a restraint.

Third, St. Elizabeths staff failed to release Ms. Morgan from restraint and/or seclusion at the earliest possible time, as is required by CMS regulations and D.C. law.\textsuperscript{217} D.C. regulations state “[t]he criterion for release of a consumer from restraints or seclusion is that the consumer no longer presents an imminent risk of serious injury to self or others, rather than that a period of time has passed.”\textsuperscript{218} However, nursing documentation often failed to justify continued restraint and seclusion. For example, during a two hour seclusion of Ms. Morgan, the RN assessment notes that Ms. Morgan was “resting and quiet” and “lying or sitting on the bed” throughout the seclusion.\textsuperscript{219} The nurse comments are identical and cursory, with phrases such as “uncooperative,” “not responding,” and “did not contract for safety.”\textsuperscript{220} None of these behaviors demonstrates a continuing imminent risk of serious injury.

Significantly, the documented staff criteria for release violated the legal requirement for releasing a patient from restraint or seclusion. For example, a doctor’s order notes that the criteria for release from the above described seclusion was that Ms. Morgan needed to be able to “demonstrate calm behavior,” “discuss the behaviors that led to the restraint,” and “convincingly contract for safety.”\textsuperscript{221} Requiring Ms. Morgan -- a patient exhibiting symptoms of a mental health crisis and a victim of sexual abuse -- to accomplish all of these before she could be released from four-point restraints demonstrates the psychiatrist’s lack of knowledge regarding the legal and hospital policy requirements for continuing restraint, as well as the serious potential detrimental effects of restraint.

\textsuperscript{213} Restraint and Seclusion Doctor’s Order dated 4/27/19, timed at 2:30 p.m.
\textsuperscript{214} Initiation of Seclusion or Restraint: RN Assessment 4/29/17, timed at 2:30 p.m.
\textsuperscript{215} Safety Care - Behavioral Safety Training Manual.
\textsuperscript{216} Psychiatry Resident Progress Note dated 4/28/19 timed at 2:30 p.m.
\textsuperscript{217} 42 C.F.R. § 482.13 (e)(9). D.C. Code § 7-1231.09(d)(4).
\textsuperscript{218} D.C. Mun. Regs. tit. 22A § 506.11.
\textsuperscript{219} RN Assessment of Individual in Seclusion or Restraint, dated 5/27/19.
\textsuperscript{220} Id.
\textsuperscript{221} Restraint and Seclusion Doctor’s Order, dated 4/27/19, timed at 5:50 p.m.
Fourth, D.C. law and St. Elizabeths policy require staff to employ a post event debriefing after each incident of restraint and seclusion, which includes “debriefings with the consumer, the consumer’s family members or personal representatives if the consumer so consents, and staff about the events giving rise to the incident and how collection of that information will help prevent recurrences. The process shall include counseling for the consumer and staff for any trauma that may have resulted from the use of seclusion or restraint.” Ms. Morgan’s records contain three debriefing forms though she experienced seven incidents of restraint and seclusion. The forms do not evidence meaningful attempts to gather the information and then utilize that information to prevent further occurrences. A debriefing form dated April 29, 2019, states only “Ms. [Morgan] was in restraints this morning, so unable to complete a debriefing,” so it was not held. A debriefing form dated May 1, 2019, indicates that Ms. Morgan refused to meet with the treatment team and that one staff person was able to meet with her later in the day. Ms. Morgan reported that the “staff are not treating me right,” and “the doctor gave me shots and that’s not right.” A debriefing form dated May 28, 2019 notes that the treatment team met with Ms. Morgan to debrief two episodes of seclusion that occurred the previous day. The form notes that Ms. Morgan reported that the other patient “was calling me names and attacked me first,” and that “I was still upset from the last time someone beat me.” When asked what would have been helpful that was not done, Ms. Morgan reported, “I need to go to another unit.”

The forms contain no meaningful information beyond Ms. Morgan’s quotes such as whether consideration was given to moving Ms. Morgan to another unit. Inexplicably, the forms did not indicate what, if any, measures staff implemented in response to Ms. Morgan’s input, and disturbingly, state that Ms. Morgan’s recovery plan was not updated. Debriefings are a necessary tool to avoid continued restraint and seclusion. Given Ms. Morgan’s trauma and abuse history, staff should have been diligent about completing meaningful post event debriefings after each episode of restraint and seclusion in order to avoid future episodes and to address any additional trauma Ms. Morgan may be experiencing because of the restraint and seclusion incidents themselves.

Fifth, St. Elizabeths policy states that when an individual is exhibiting symptoms of agitation or escalation, staff shall refer to the individual’s personal comfort plan to inform decisions about less restrictive interventions to be employed. However, the record contains no evidence that staff employed any of the strategies in Ms. Morgan’s comfort plan. Although the May 2019 monthly assessment includes a summary of the multiple seclusions and restraints

---

222 D.C. Code § 7-1231.09(j)(3) (emphasis added).
223 Recovery Team Debriefing Form dated 4/29/19.
224 Recovery Team Debriefing Form dated 5/1/19.
225 Recovery Team Debriefing Form dated 5/28/19
226 Id.
227 Id.
228 Recovery Team Debriefing Form dated 4/29/19, 5/1/19 and 5/28/19.
229 SEH Policy 103.00(l)(A)(10).
230 Ms. Morgan’s comfort plan indicates that staff actions to assist her when she is “losing control” include offering her music to listen to and allowing her to spend time by herself. Advanced Instruction/Comfort Planning Report dated 4/9/19.
during April 2019, the section for staff to describe how her personal comfort plan was utilized during the assessment period is left blank.\textsuperscript{231}

Importantly, St. Elizabeths policy requires the treatment team, with participation of the patient, to review and update the comfort plan and IRP (Individual Recovery Plan) \textit{within 24 hours} if a patient (1) experiences two or more episodes of restraint and/or seclusion in a 24-hour period; or (2) experiences three or more episodes of restraint or seclusion within a 30-day period.\textsuperscript{232} Ms. Morgan experienced restraint and seclusion that met these criteria;\textsuperscript{233} however, the record contains no evidence that the treatment team formally met with Ms. Morgan, nor did they make meaningful updates to her IRP or update her comfort plan.

\section{VI. Conclusion}

St. Elizabeths is not effectively addressing the significant risk of harm caused by the use of restraint and seclusion. These three incidents illustrate a lack of training and insufficient oversight to ensure patient protections, and -- ultimately -- patient and staff safety. Locking a patient alone in a room, strapping a patient’s arms and legs to a bed, and/or forcibly injecting a patient with medications are all treatment failures. These extreme measures have no therapeutic value, cause suffering, may trigger severe emotional pain from past trauma, and frequently result in emotional and physical harm and even death. As discussed throughout this report, it is widely accepted that psychiatric facilities should avoid the use of restraint and seclusion as much as possible. It is also a legal requirement.

St. Elizabeths has much to improve. Rather than employing therapeutic, meaningful less restrictive techniques, records show that hospital staff often vaguely describe “redirection” or “counseling” as the only less restrictive intervention attempted prior to restraint and seclusion. Instead of employing a behavioral team specially trained in therapeutic techniques to de-escalate situations, the hospital “Code 13” responses include deploying multiple security guards and staff to intimidate and frighten patients -- often escalating dangerous situations.

Meaningful change must start with hospital leadership. The hospital administration must initiate a meaningful, concerted effort to significantly reduce, and ultimately eliminate, the need for seclusion and restraint.

\section{VII. Recommendations}

1. Within 30 days of the release of this report, and in collaboration with DRDC, St. Elizabeths and the Department of Behavioral Health should develop a strategic plan with the goal of significantly reducing and ultimately eliminating the use of restraint and seclusion.

\textsuperscript{231} Monthly Assessment Section II, dated 5/15/19.
\textsuperscript{232} SEH Policy 103.00(III)(N)(2).
\textsuperscript{233} Ms. Morgan was secluded twice on April 28, 2019, and twice on May 27, 2019, and was restrained or secluded four times in April 2019. See Clinical Progress notes dated 4/28/19, 4/29/19 and 5/27/19; Initiation of Seclusion or Restraint: RN Assessments dated 4/28/17, 4/29/19, and 5/27/129.
2. The plan should include hiring an independent consultant, chosen in collaboration with DRDC, to: (1) determine and analyze the specific causes of, and reasons for, the dramatic rise in restraint and seclusion practices at the hospital; (2) develop specific strategies to reduce and ultimately eliminate restraint and seclusion; and (3) oversee implementation of the strategies.

3. The Department of Health should investigate the allegations of abuse contained in this report.

4. The hospital should reinstitute its 2010 policy definition of “drugs as a restraint,” and the protections it provided, which are in accordance with D.C. laws and D.C. regulations.\(^\text{234}\)

\(^{234}\) See D.C. Code § 7-1231.02(9); D.C. Mun. Regs. tit. 22A § 503.8, and discussion in Section III B of this report.
On January 17, 2019, in the course of twenty-one minutes, a St. Elizabeths ward transformed from a relatively calm setting -- with patients sitting in armchairs and napping on couches, and hospital staff walking from room-to-room, occasionally talking to patients or each other while sipping drinks from disposable cups -- to the scene of a planned, coordinated and unjustified restraint by thirteen St. Elizabeths staff members. The following tracings of security footage document the restraint.

---

235 DRDC took screen shots of the video tape footage frames and manually traced them.
At 11:24:17, Mr. Carter stands and puts his hands in the air. His arms pump in the air as if cheering. He keeps his hands in the air for no more than 36 seconds; by 11:24:53, Mr. Carter’s arms are by his side as he stands by the nurse’s station. This act -- placing his hands in the air for less than 36 seconds -- is the most energetic action Mr. Carter takes during the entire 21 minutes of footage. Staff nearby did not react, and one male staff member a few feet away continues to calmly sip a beverage.
Mr. Carter seated calmly on top of a chair, staff in dayroom.

The following images document the disturbing restraint, beginning with Mr. Carter sitting atop a chair in a vulnerable position. Mr. Carter later told DRDC that he was terrified by staff's actions, confused as to why they were restraining him and felt as though staff had a “mob mentality.”
Tracing #4

One staff person places his arm on Mr. Carter’s shoulder. Other staff stand nearby.

Tracing #5

Staff begin to surround Mr. Carter.
Tracing # 6

Staff continue to surround Mr. Carter.

Tracing # 7

More staff surround Mr. Carter.
Staff begin to physically pull Mr. Carter.
Staff continue to physically pull Mr. Carter as he passively resists.

Staff continue to physically pull Mr. Carter as he passively resists.

Staff continue to physically push and pull Mr. Carter as he passively resist.
Tracing # 12

Staff continue to physically push and pull Mr. Carter as he passively resists

Tracing # 13

Staff continue to physically force Mr. Carter down the hallway.
Tracing # 14

Staff continue to physically force Mr. Carter down the hallway.

Tracing # 15

Staff continue to physically force Mr. Carter down the hallway.
Tracing # 16

Staff gathered outside of the seclusion room.

Tracing # 17

Staff walking up the hallway after the restraint.