

**ASSAULT IN THE VISITOR'S ROOM:  
Staff Abuse at St. Elizabeths Hospital**

September 26, 2016

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*The Protection and Advocacy Agency  
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## **UNIVERSITY LEGAL SERVICES, INC**

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.

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## I. EXECUTIVE SUMMARY

St. Elizabeths Hospital is a dangerous place. During the year following the incident described below, there were 632 physical assaults, 384 injuries, and 524 incidents of physical and mechanical restraint. Multiple reasons may exist for these numbers; however, a significant reason for large numbers of acts of aggression may be the result of staff conduct – either because of staff conduct that escalates behaviors or staff’s failure to use techniques that deescalate behaviors. The following report details a specific instance of substantiated staff abuse resulting from (1) a staff member’s conduct that escalated the behavior of an individual in care, (2) his failure to use deescalating techniques, and then (3) his use of unsafe restraint techniques that might have resulted in very serious injuries.

During a mother’s visit with her son, a staff member abused her son in the visitor’s room while she was present. Even prior to arriving at the visitor’s room for the meeting, the staff member nagged the consumer to walk more quickly and expressed his anger at having to take the consumer to the visitor’s room during the time the staff member was supposed to be eating his dinner. In the visitor’s room and now agitated, the individual in care responded to his mother’s conversation angrily, reaching his hand toward her face. The staff member reacted explosively trying to grab the consumer, “shoving” “squaring off” and “lunging” at him.<sup>1</sup> The consumer responded aggressively, and the staff member threw his arm around the consumer’s neck and tried to force him down then grabbed his waist and pushed him backwards into a table, both falling onto the floor. After they fell, the staff member continued to hold the consumer down on the floor, applying his body weight to sit on or straddle his stomach, while the consumer was struggling on the floor. The staff member’s conduct was not simply abusive, it was extremely dangerous for the consumer and all involved. It could have easily resulted in very serious injury. Accordingly, St. Elizabeths’ own investigation found staff abuse. Nevertheless, it failed to recommend adequate corrective action in response.

Furthermore, such a serious instance of staff abuse by a staff member at St. Elizabeths Hospital should have triggered a separate secondary investigation by the Department of Behavioral Health (“DBH”) to review St. Elizabeths’ investigation and response. DBH should have provided its own recommendations and corrective actions to ensure that such an incident would not occur again. Such an investigation was not done, or, if done, not provided to DRDC upon request.

Moreover, since the incident, the hospital has continued to have significant instances of physical assaults and injuries as described above. The hospital has noted in its risk management reporting: “In April 2016, the number of incidents involving aggressive behaviors with non-physical contact increased only marginally but physical assaults, psychiatric emergencies, patient falls and incidents that triggered injuries noticeably increased.”<sup>2</sup>

DRDC reviewed unusual incident reports for the months of December, 2015 through February, 2016, and noted significant concerns both with the reporting of instances of patient injury and the failure to describe attempts to deescalate individuals in care who became

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<sup>1</sup> See *Investigation of Unusual Incident Report Regarding Mr. Mann and Staff One* (dated June 25, 2015) (“SEH Investigation Report”) at 15.

<sup>2</sup> Office of Statistics and Reporting, St. Elizabeths Hospital, *Performance Related Information for Staff and Managers* (dated May 12, 2016) at 3.

agitated. Like the incident described above, these incidents should be evaluated for systemic flaws in an effort to determine how to prevent future dangerous incidents.

Given the serious problem with safety at Saint Elizabeths, the Department of Behavioral Health should perform its own investigation of the problem. One important part of that review should be an analysis of the past incidents to (1) identify staff members who have failed to use appropriate methods to deescalate individuals in care and (2) identify staff involved in multiple incidents where individuals in care have exhibited aggressive behavior. Those staff members should receive additional trainings and competency-based assessments along with additional support to ensure they are responding appropriately to agitated or aggressive consumers; thereby improving the safety of the hospital for both the individuals in care and the staff.

## **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 “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.”<sup>3</sup>

Following a complaint of abuse, DRDC obtained and reviewed patient’s records from the District’s Department of Behavioral Health (“DBH”) and St. Elizabeths Hospital. DRDC’s review included St. Elizabeths Hospital’s “Investigation of Unusual Incident Report” regarding the individual in care and the staff involved, the surveillance video of the incident, relevant law and regulations, and DBH policy. DRDC interviewed multiple witnesses. DRDC also reviewed 176 Unusual Incidents involving chemical restraint (emergency involuntary medication), physical assault and physical injury, physical restraint (including physical holds), mechanical restraint, and seclusion from December 1, 2015, to March 1, 2016.

## **III. SUMMARY OF FACTS**

### **a. Incident in the Visitor’s Room**

Mr. Bill Mann<sup>4</sup> was an individual in care at St. Elizabeths Hospital (“St. Elizabeths”). On May 7, 2015, Mr. Mann’s mother visited him in the St. Elizabeths Visitor’s Room. Before arriving in the Visitor’s Room, Mr. Mann was escorted down a hallway by Recovery Assistant Staff One (“Staff One”). Video footage from the hallway was reviewed by St. Elizabeths in its own investigation, but only a few still screenshots from St. Elizabeths’ investigation were provided to DRDC. A screenshot of 6:56:05 PM showed Mr. Mann standing face to face talking to Staff One in the hallway.<sup>5</sup> At 6:56:07 PM, another screenshot showed Mr. Mann, a few feet away from Staff One, holding up one hand. St. Elizabeths, after reviewing the video footage, wrote in its report that Mr. Mann seemed to signal “stop” with his hand up, appearing to be a response to something Staff One had likely said.<sup>6</sup> A few seconds later, another screenshot showed that Staff One moved very close to Mr. Mann’s face and appeared to be talking to him.<sup>7</sup> St. Elizabeths further analyzed the video footage, reporting that Mr. Mann’s “body language indicates that he is shielding himself from [Staff

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<sup>3</sup> 42 U.S.C. 10805(a)(1)(A).

<sup>4</sup> Name changed to protect patient’s privacy.

<sup>5</sup> See SEH Investigation Report at 6.

<sup>6</sup> See *id.*

<sup>7</sup> See *id.*

One's] actions which can be perceived as threatening or intimidating.”<sup>8</sup> According to Mr. Mann, when he and Staff One exited his residential house Unit 1C into the hallway he was abruptly told by Staff One, “You better walk fast.”<sup>9</sup> Mr. Mann also stated that Staff One “acted very aggressive and made a comment about wanting to [eat] his dinner instead of having to accompany Mr. Mann to the Visitation Room.”<sup>10</sup>

According to DRDC’s own review of the full video of the incident in the Visitor’s Room, Mr. Mann entered the Visitor’s Room with Staff One at about 6:59:38 PM. Staff One watched Mr. Mann sit down at a table with his mother<sup>11</sup> and then walked toward the other end of the Visitor’s Room and sat down by himself. Mr. Mann started to talk with his mother, but stood up again at about 7:00:47 PM. Mr. Mann appeared to be concerned that staff open the door near him so that someone trying to come into the Visitor’s Room could enter. Mr. Mann remained standing while his mother seemed to be speaking to him. During an interview following the incident, his mother stated that she realized he was upset.<sup>12</sup>

Between 7:01:41 PM and 7:01:44 PM, Mr. Mann turned to his mother, reached over the table, and touched his mother on the face. His mother dodged and brushed him away with her hand. It is unclear from the video in what manner Mr. Mann touched his mother,<sup>13</sup> but Mr. Mann’s mother later explained that the contact was not painful or an attempt to injure her.<sup>14</sup> Mr. Mann, who was on the opposite side of the table from his mother, continued to stand.

Staff One then rushed toward Mr. Mann from behind and pulled his chair away.<sup>15</sup> Staff One then pushed Mr. Mann on his left side.<sup>16</sup> Mr. Mann and Staff One then squared off as if they were about to fight. Mr. Mann attempted to hit Staff One but missed.<sup>17</sup> At 7:02:01 PM, another staff (“Staff Two”) came over and attempted to pull Staff One away from the fight by grabbing his arm, but Staff One resisted. At the same time Recovery Assistant Staff Three (“Staff Three”) tried to redirect Mr. Mann, but he shook her off.

At 7:02:07 PM, Staff Three and Mr. Mann’s mother went to the exit door near the guardroom and tried to get the attention of someone outside in an urgent attempt to get out. The door remained locked.

At 7:02:09 PM, Staff Two attempted to pull Staff One away again, and Staff One resisted. Mr. Mann and Staff One pushed each other.<sup>18</sup> Again, Staff Two attempted to pull Staff One away.

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<sup>8</sup> *See id.*

<sup>9</sup> *Id.* at 12 (St. Elizabeths’ interview of Mr. Mann regarding the incident).

<sup>10</sup> *Id.*

<sup>11</sup> Videotape (St. Elizabeths Hospital May 7, 2015) (“Videotape”) at 7:00:13 PM.

<sup>12</sup> Notes of DRDC’s interview of Mr. Mann’s mother, dated May 11, 2015.

<sup>13</sup> Videotape at 7:01:44 PM.

<sup>14</sup> Notes of DRDC’s interview of Mr. Mann’s mother, dated May 11, 2015.

<sup>15</sup> Videotape at 7:01:48 PM.

<sup>16</sup> *Id.* at 7:01:51 PM. In St. Elizabeths’ report, both Staff Three and Staff One alleged that Staff One was attempting to redirect Mr. Mann to go back to the unit, and Mr. Mann refused. *See SEH Investigation Report* at 3, 5. However, Staff One pulled the chair away and pushed Mr. Mann coming from behind, immediately after he walked from the other side of the room. The whole process happened less than ten seconds after Mr. Mann touched his mother. There does not seem to be any non-physical interaction or attempt to de-escalate.

<sup>17</sup> *Id.* at 7:01:59 PM.

<sup>18</sup> *Id.* at 7:02:11 PM.

At 7:02:19 PM, Mr. Mann and Staff One continued to move toward each other. Mr. Mann then attempted to slap Staff Two, who was trying to restrict him, but she moved out of the way and dodged his hand.<sup>19</sup> Seeing this, Staff One threw his arm around Mr. Mann's neck and attempted to throw Mr. Mann down, but Mr. Mann did not fall and pulled away.

At 7:02:24 PM, Mr. Mann's mother walked towards Mr. Mann; it appeared she was urging them to stop while Staff Three was still trying get the exit door opened. Mr. Mann's mother attempted to split up Mr. Mann and Staff One, but could not;<sup>20</sup> at 7:02:28 PM, Staff Three held Mr. Mann's mother back.

Staff One then lunged toward Mr. Mann, grabbing his waist, and pushed Mr. Mann backward.<sup>21</sup> Both men grappled with each other, and Staff One pushed Mr. Mann toward the back of the room between two glass tables.

At 7:02:31 PM, Staff One shoved Mr. Mann into a table and they both crashed to the floor.<sup>22</sup> Mr. Mann and Staff One were both on the floor, and Staff One held Mr. Mann down while Mr. Mann struggled. At the same time, Mr. Mann's mother, Staff Two and Staff Three walked towards them. Staff One pushed Mr. Mann's shoulders to the floor and climbed on top of Mr. Mann to restrain him.<sup>23</sup> Staff Three pulled Mr. Mann's mother away while Staff Two and another staff member ("Staff Four") bent over Staff One and Mr. Mann. At this point until he gets up off the floor, it appears that Staff One is straddling or sitting on Mr. Mann, holding his arms down.<sup>24</sup> At about 7:02:39 PM, Staff Two and Staff Four started to help Staff One by pulling Mr. Mann's arms away and holding Mr. Mann's arms down. Next, Staff Four pulled another table away and then re-joined Staff Two in holding Mr. Mann.<sup>25</sup>

At about the same time, Mr. Mann's mother and Staff Three appeared to have a brief argument, then Mr. Mann's mother seemed to follow the instruction of Staff Three and remained close to the exit door.

A little more than two minutes after the incident began, Safety Officers finally arrived at the Visitor's Room.<sup>26</sup> Staff Two and Staff Four stepped aside from Staff One and Mr. Mann, who were still on the floor struggling.<sup>27</sup> From 7:03:06 to 7:03:15 PM, the Safety Officers appeared to discuss the situation with other staff. During the same time, Mr. Mann's mother appears extremely agitated.

Staff Two and one Safety Officer then pulled a table further away while another two staff members came into the Visitor's Room.<sup>28</sup> One Safety Officer and Staff Four stayed close to Mr. Mann and Staff One while others<sup>29</sup> pulled all adjacent tables and chairs away. During the entire time, Mr. Mann remained under Staff One, who appears to be either

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<sup>19</sup> *Id.* two seconds later.

<sup>20</sup> *Id.* at 7:02:26 PM.

<sup>21</sup> St. Elizabeths' report said Mr. Mann punched Staff One on the head at 7:02:28. *See SEH Investigation Report* at 10; Videotape at 7:02:28 PM.

<sup>22</sup> St. Elizabeths' report said "**their** momentum causes them to move toward the tables." *See SEH Investigation Report* at 10 (emphasis added). However, Staff One pushed Mr. Mann into the table; the movement is caused by Staff One's force.

<sup>23</sup> *Id.* at 7:02:35 PM.

<sup>24</sup> *Id.* at 7:02:37 PM.

<sup>25</sup> *Id.* at 7:02:47 PM.

<sup>26</sup> *Id.* at 7:02:58 PM.

<sup>27</sup> *SEH Investigation Report* at 7:03:05 PM.

<sup>28</sup> Videotape at 7:03:16 PM.

<sup>29</sup> Staff Two, Staff Three, another Safety Officer, and two additional staff members who had just arrived.

straddled or sitting on top of him. Mr. Mann seemed to have stopped struggling soon after the Safety Officers arrived.

At 7:03:27 PM, the exit door was finally opened, and Mr. Mann's mother followed Staff Three out of the Visitor's Room after some persuasion.<sup>30</sup> At the same time, the two Safety Officers and other staff gathered around Mr. Mann and Staff One. At this point, it is unclear from the video what was occurring between Mr. Mann and Staff One. At 7:03:47 PM, Staff One got up from the floor. He went to retrieve his badge and then returned to where Mr. Mann lay on the floor. Another staff member then pulled Staff One out of the room. All the other staff members then stood up, and Mr. Mann got up from the floor himself.<sup>31</sup> About a minute later, Mr. Mann cooperatively left the Visitor's Room escorted by security officers and other staff without any physical holds or restraints.

There were two other people in a back corner of the Visitor's Room – appearing to hide there – from the beginning of the incident. They seemed to be an individual in care and his visitor. The consumer tried to cover the visitor with a jacket in an effort to protect her from the sight. At 7:03:48 PM, Staff Three came back from the exit door and waved to the two persons in the corner, asking them to leave the room with her. Staff Two walked toward them. Eventually, the visitor exited through the exit door near the guard room, and the individual in care went with Staff Two. During the event, two public defender service attorneys remained in the separate meeting rooms on the side. These rooms have glass walls, and the attorneys observed the entire incident.

An interview with Mr. Mann one day after the incident revealed scratches on his knee and fingers as a result of the physical assault.<sup>32</sup> Mr. Mann's mother said that she was very disturbed by the incident and that she continued to fear for Mr. Mann's safety in the hospital afterwards.<sup>33</sup>

#### **b. St. Elizabeths' Investigation of the Incident**

On June 25, 2015, St. Elizabeths issued an investigation report regarding the May 7th incident and substantiated abuse.<sup>34</sup> St. Elizabeths' Report reviewed the unusual incident history of both Staff One and Mr. Mann during the time frame of May 7, 2014, through May 7, 2015. The record showed that Staff One was involved in six incidents in which he was allegedly the victim of physical assaults by individuals in care.<sup>35</sup> Mr. Mann was involved in one other incident in which he was the victim of physical assault by another individual in

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<sup>30</sup> Videotape at 7:03:33 PM.

<sup>31</sup> *Id.* at 7:04:54 PM.

<sup>32</sup> Notes of DRDC's interview with Mr. Mann dated May 8, 2015.

<sup>33</sup> Notes of DRDC's interview of Mr. Mann's mother, dated May 8, 2015. After reviewing DRDC's description of the event, Mr. Mann's mother also stated that she experienced Staff One push her in a threatening manner when she tried to stop him from provoking her son to fight. She added that when Mr. Mann and Staff One fell down, a steel armchair was thrown off at their feet and she rushed to move it away, fearing that Staff One would try to hit her son with it. Moreover, though not visible from in the video because of the number of people surrounding the two on the floor, she witnessed the St. Elizabeths' security guard pull Staff One off of her son to stop his abusive behavior.

<sup>34</sup> St. Elizabeths' Report summarized interviews of six witnesses' accounts: Mr. Mann, his mother, Staff One, Two, Three, and a public defender who was an eye-witness while in one of two glass enclosed meeting rooms on the side. Deputy Chief Nurse Executive and a Supervisory Psychiatric Nurse provided description of relevant follow-up events. It also reviewed the surveillance video footage. See *SEH Investigation Report* at 12-14.

<sup>35</sup> See *SEH Investigation Report* at 14.

care.<sup>36</sup> St. Elizabeths' Report briefly outlined Mr. Mann's clinical records, stating that prior to this incident, he had been involved in several instances of aggression involving staff members and his mother.<sup>37</sup> St. Elizabeths' Report specifically noted, however, that there was no indication in progress notes before the May 7<sup>th</sup> visit that Mr. Mann was exhibiting aggressive or other inappropriate behaviors that would warrant cancellation of his mother's visit on that day, though a prior visit had been cancelled for that reason.<sup>38</sup>

In addition, St. Elizabeths' Report excerpted definitions of "abuse" and "psychological or verbal abuse" from St. Elizabeths' Policy regarding *Reporting Suspected Abuse, Neglect and Exploitation of Individuals in Care* as well as some provisions from St. Elizabeths' *Safety-Care Behavioral Safety Training Trainee Manual*.<sup>39</sup> St. Elizabeths' Report reviewed Staff One's training records and stated that Staff One received both *Safety-Care Behavioral Safety* training, and *Reporting Abuse and Neglect* training during April and May of that same year.<sup>40</sup> The report also noted that Staff One was placed on administrative leave after the incident pending the outcome of the investigation.<sup>41</sup>

St. Elizabeths' Investigation Report provided an extensive overview of the facts and circumstances of the incident from different perspectives. After the factual description, St. Elizabeths' Report substantiated staff abuse and found the following:<sup>42</sup>

- When they were in the hallway, Staff One's interaction was "tense, uncomfortable, and possibly abusive but regardless is not an appropriate way to interact with an individual in care, as it can be perceived by the individual in care as threatening or intimidating."<sup>43</sup> It "may well have contributed to [Mr. Mann's] agitation..."<sup>44</sup>
- "As seen on the surveillance video footage, [Staff One] approached [Mr. Mann] from behind, moved the chair away from the area, and pushed him, which caused [Mr. Mann] to become angry, defensive, and aggressive. The surveillance video footage clearly showed [Staff One] making physical contact with [Mr. Mann] via pushing that is not sanctioned nor condoned by the Safety Care Behavioral strategies. It was [Staff One's] shoving of [Mr. Mann] that triggered this incident, if not the possible verbal abuse that may have occurred in the hallway prior to arriving in the Visitation Room."<sup>45</sup> Staff One's "tactics" of attempting to gain control by "shoving," "squaring off," and "lunging" at Mr. Mann are "not sanctioned nor condoned by the Safety Care Behavioral Safety strategies."<sup>46</sup>
- "The allegation of physical abuse against [Staff One] is substantiated, because the surveillance video footage clearly showed [Staff One] using more force than is reasonably necessary," and the physical altercation "most likely could

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<sup>36</sup> *See id.*

<sup>37</sup> *See id.*

<sup>38</sup> *Id.*

<sup>39</sup> *See SEH Investigation Report* at 15.

<sup>40</sup> *See id.* at 15

<sup>41</sup> *See id.* at 16.

<sup>42</sup> *See id.* at 16-17

<sup>43</sup> *See id.* at 16.

<sup>44</sup> *See SEH Investigation Report* at 17.

<sup>45</sup> *See id.* at 16.

<sup>46</sup> *See id.* at 17.

have been avoided if [Staff One] had at least attempted to get away from” Mr. Mann.<sup>47</sup>

Although St. Elizabeths’ Report recognized these significant issues and substantiated staff abuse, its only recommendations in response was:

*We recommend that Safety check the working of that call button at least once per day and ensure that staff are available to respond immediately in the event the call button is used.*<sup>48</sup>

#### **IV. ST. ELIZABETHS IMPROPERLY HANDLED THE INCIDENT.**

##### **a. St. Elizabeths Failed to Properly Handle the Situation in the Visitor’s Room.**

##### **i. Staff One’s Behavior Escalated the Situation before Entering the Visitor’s Room.**

Staff One’s behavior violated the District’s law. Under D.C. law, mental health service providers “shall, at all times, treat consumers with consideration and respect for the consumer’s dignity, autonomy, and privacy. Respectful treatment shall also be extended to the consumer’s family members.”<sup>49</sup> In addition, “Consumers shall be free from physical [or] emotional ... abuse, neglect, harassment, coercion, and exploitation when seeking or receiving mental health services and mental health supports.”<sup>50</sup>

In addition, the Department of Behavioral Health (“DBH”) Policy 482.1 requires “all DBH employees” to “[m]aintain a courteous, respectful, and professional relationship with consumers.”<sup>51</sup> As discussed below, St. Elizabeths failed to comply with both D.C. law and Policy 482.1’s plain language.

Staff One’s initial interaction with Mr. Mann before entering the Visitor’s Room escalated Mr. Mann and appears to be abusive. It certainly was not respectful. St. Elizabeths’ own investigation found that Mr. Mann’s “body language indicates that he is shielding himself from Staff One’s actions which can be perceived as threatening or intimidating.”<sup>52</sup> Mr. Mann reported to St. Elizabeths, the investigator, and DRDC that Staff One was aggressive toward him because Mr. Mann walked slowly and Staff One “want[ed] to eat his dinner instead of having to accompany Mr. [Mann] to the Visitation Room.”<sup>53</sup> Certainly, this conduct violated Mr. Mann’s rights, and St. Elizabeths investigation found it “possibly abusive but regardless is not an appropriate way to interact with an individual in care, as it can be perceived by the individual in care as threatening or intimidating.”<sup>54</sup>

##### **ii. Staff Violated St. Elizabeths’ Policy on Restraint.**

Staff One’s behavior was a serious violation of the District’s restraint laws. Restraint is a serious infringement on an individual’s rights and must only be used in extreme circumstances and according to clear guidelines. Not only is restraint traumatic, it is

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<sup>47</sup> *See id.*

<sup>48</sup> *Id.* at 18.

<sup>49</sup> D.C. Code § 7-1231.04(a).

<sup>50</sup> *Id.* § 7-1231.04(c).

<sup>51</sup> Department of Behavioral Health, *Protecting Consumers from Abuse, Neglect or Exploitation*, DBH Policy 482.1 (Jun. 10, 2014) at 6d(1).

<sup>52</sup> *SEH Investigation Report* at 6.

<sup>53</sup> *Id.* at 12.

<sup>54</sup> *Id.* at 16.

inherently dangerous.<sup>55</sup> D.C. Code requires that seclusion or restraint be used only in an emergency when the use of seclusion or restraint is, in the written opinion of the attending physician, necessary to prevent serious injury to the consumers or others; and that less restrictive interventions have been considered and determined to be ineffective to prevent serious injury to the consumer or others.<sup>56</sup> Also, the D.C. Code requires any use of restraint be implemented in the least restrictive manner possible and in accordance with safe and appropriate restraint techniques.<sup>57</sup> The D.C. Municipal Regulations further detail that restraints or seclusion shall never be used in any manner that obstructs the airways or impairs breathing.<sup>58</sup> Staff One’s conduct clearly violated D.C. law and was extremely dangerous.

St Elizabeths has a detailed and substantial policy describing acceptable staff conduct and appropriate methods of restraint. It prohibits specific dangerous acts:

*III. Standards and Procedures*

*D. Prohibited Actions and Measure*

2. *To prevent physical or emotional injury to the individual, the following measures are expressly prohibited when employing restraints or seclusion;*

...

*f. Any technique that obstructs the airways, impairs breathing, or applies a staff member's body weight above an individual's upper thighs. Staff may not lie on, straddle or apply pressure to an individual's chest/trunk;*

...

*i. The use of restraints while the individual is in an open public area. If a psychiatric emergency occurs in a public area necessitating staff physical intervention, every effort should be made to provide a level of privacy and dignity for the individual by use of a blanket, etc., to block view of others;*<sup>59</sup>

After Mr. Mann reached to touch his mother’s face, Staff One’s conduct significantly escalated the situation creating an extremely dangerous environment for other staff, visitors, and individuals in care. His “tactics” for attempting to gain control were “shoving,” “squaring off,” and “lunging” at the consumer.

St. Elizabeths’ Safety-Care Behavioral Safety Training Trainee Manual ( “Safety-Care Manual”)<sup>60</sup> requires that “when a staff member deems it necessary to use physical contact, before initiating contact the staff person should alert the [individual in care] of

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<sup>55</sup> Improper use of restraints can lead to serious injuries and even death. In 1998, a Connecticut newspaper published a series of five reports detailing numerous deaths that occurred while individuals were restrained. The causes of deaths include aspiration, asphyxiation, strangulation, cardiac arrest, reaction to medication while in restraint, and undue physical force.

<http://www.charlydmiller.com/LIB05/1998hartfordcourant11.html>

<sup>56</sup> D.C. Code § 7-1231.09(c). St. Elizabeths’ investigation report did not provide information evaluating Staff One’s conduct as a violation of the restraint law.

<sup>57</sup> *Id.* § 7-1231.09(d).

<sup>58</sup> D.C. Mun. Regs. tit. 22A, § 501.7(b).

<sup>59</sup> St. Elizabeths Policy, *Restraint and Seclusion for Behavioral Reasons*, Policy Number 103 (Revised May 28, 2015) (emphasis in the original). Though made effective after the date of the incident, the prior policy had the same requirements. See St. Elizabeths Policy, *Restraint and Seclusion for Behavioral Reasons*, Policy Number 101.1-04 (Revised June 6, 2011).

<sup>60</sup> Relevant sections were cited by the SEH Investigation Report. See *SEH Investigation Report* at 15.

his/her intention.”<sup>61</sup> Contrary to the Safety-Care Manual’s instruction, Staff One approached Mr. Mann from behind and pushed him from the left side with no prior warning.<sup>62</sup>

Moreover, Staff One used obviously inappropriate and dangerous methods while restraining Mr. Mann. During the May 7<sup>th</sup> incident, Staff One threw his arm around Mr. Mann’s neck and tried to force him down then grabbed Mr. Mann’s waist and pushed him backwards.<sup>63</sup> After they fell, Staff One continued to hold Mr. Mann down on the floor.<sup>64</sup> Staff One applied his body weight and appears to sit on or straddle Mr. Mann’s stomach, who was struggling on the floor.<sup>65</sup> Staff One’s conduct was not simply abusive, it was extremely dangerous for Mr. Mann and all involved. It could have easily resulted in very serious injury.

### **iii. St. Elizabeths Staff Did Not Act to De-escalate the Situation.**

Rather than acting to deescalate the situation, Staff One reacted explosively, endangering everyone involved. However, District law and St. Elizabeths’ policy require staff to employ less restrictive alternatives prior to initiating the use of restraint or seclusion.<sup>66</sup> Non-physical crisis intervention techniques include: 1) maintaining a calm demeanor and voice, 2) offering help and choices, 3) allowing the individual to vent and pace, and 4) encouraging the individual to use stress management or relaxation techniques.<sup>67</sup> The policy also recommends one to one verbal counseling that includes: 1) respectful listening and talking with the individual, 2) offering alternative activities, or 3) offering alternatives if unable to resolve the individuals’ concerns.<sup>68</sup> Other examples of less restrictive alternatives include, 1) removing stressors that contribute to negative mood and/or behavior, 2) offering sensory-based interventions, 3) offering the comfort room to reduce environmental stimuli, 4) and allowing the individual to speak to significant others.<sup>69</sup>

Accordingly, the policy requires staff training on both less restrictive alternatives and de-escalation:

*5. [Staff] shall have education, training, and demonstrated knowledge . . . in . . . the following areas:*

*a. . . . [A]ppropriately responding to underlying behaviors of individuals that may precipitate a behavioral emergency and possible use of restraints or seclusion;*

*b. Techniques to identify staff interactions . . . that may trigger individual behavior resulting in escalation, a behavioral emergency and possible need for restraint or seclusion;*

*c. . . . [D]istinguishing behavior posing physical harm from behavior that irritates [or] annoys . . . without any potential for physical harm.*

*d. Use of nonphysical, less restrictive intervention skills;*

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<sup>61</sup> See SEH Investigation Report at 15.

<sup>62</sup> See *supra* note 16.

<sup>63</sup> See *supra* Summary of Facts at pages 4-7.

<sup>64</sup> See *supra id.* at 6-7.

<sup>65</sup> See *supra id.*

<sup>66</sup> St. Elizabeths Policy 103 (Revised May 28, 2015), III(E); St Elizabeths Policy 101.1-04 (Revised June 6, 2011), III.

<sup>67</sup> *Id.* at Section III.E.1.

<sup>68</sup> *Id.* at Section III.E.1.a.

<sup>69</sup> *Id.* at Section III.E.1.b–e; 2.a.

e. Choice of least restrictive intervention based on individualized assessment of the individual's condition, medical/behavioral status, the individual's strengths and his/her identified preferences;

f. The expectation to first use de-escalation and other non-physical behavior management techniques, such as mediation, conflict resolution, active listening, and verbal and observational methods, to reduce or eliminate the use of restraints or seclusion;<sup>70</sup>

In addition to this policy, the Safety-Care Manual allows use of physical force only when it is absolutely necessary:

*[P]hysical management of an [individual in care] should only be used when there is no other safe alternative, there is imminent risk of serious harm to the agitated person or someone else, there is no other practical way to prevent harm without physical management, or when the risk of not intervening is greater than the risk of intervening.*<sup>71</sup>

Again, this requires the use of de-escalation techniques prior to the use of physical force. It is critical to note that Staff One received training on these very policies and legal requirements within two months of the incident.

Far from deescalating the situation, Staff One escalated the situation in the Visitor's Room with his abusive conduct as confirmed in St. Elizabeths' investigation.<sup>72</sup> Moreover, despite St. Elizabeth's comprehensive policy and the staff training, the staff did not properly implement such practices during the incident in the Visitor's Room. Staff One failed to try any "safe alternative," or "other practical ways to prevent harm."<sup>73</sup> Staff One pushed Mr. Mann while he was standing opposite his mother and attempted to gain control by 'shoving,' 'squaring off,' and 'lunging',<sup>74</sup> which acted to encourage Mr. Mann to respond aggressively. Not only did Staff One's failure to attempt de-escalating techniques place Mr. Mann in jeopardy, Staff One's escalating conduct posed serious danger to Mr. Mann's mother and others around them and could have caused substantial injury to others.

#### **b. St. Elizabeths' Report Failed to Provide Any Significant Recommendations to Address Very Serious Findings.**

DBH Policy 482.1 requires that "allegations of abuse, neglect or exploitation of consumers shall be reported and investigated as a major unusual incident (MUI) in accordance with DBH policies and regulations."<sup>75</sup> In relevant DBH policy effective at the time of the incident, *Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs)*,<sup>76</sup> DBH requires "timely reporting and investigation of all major unusual incidents, identifying the underlying causes toward immediate and/or systemic quality improvements,

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<sup>70</sup> St. Elizabeths Policy 103 (Revised May 28, 2015), III(C); St Elizabeths Policy 101.1-04 (Revised June 6, 2011), II(B).

<sup>71</sup> *SEH Investigation Report* at 15.

<sup>72</sup> *See id.* at 16.

<sup>73</sup> *SEH Investigation Report* at 15.

<sup>74</sup> *Id.* at 17.

<sup>75</sup> *See* DBH Policy 482.1, 7a.

<sup>76</sup> Department of Mental Health ("DMH") (prior name of Department of Behavioral Health), *Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs)*, DMH Policy 480.1C (May 3, 2012), *superseded by* Department of Behavioral Health, *Reporting Major Unusual Incidents (MUIs) and Unusual Incidents (UIs)*, DBH Policy 480.1 (Jan. 4, 2016). The new policy did not make substantial changes on sections cited by this report.

as applicable.”<sup>77</sup> Specifically, physical assault is listed in Major Unusual Incident Categories.<sup>78</sup> The policy also requires that the Internal Quality Committee of the provider “shall review the summary analysis” and “provide written recommendations to the DMH Director and [DMH Quality Council] to address any issues and concerns, if needed.”<sup>79</sup>

St. Elizabeths’ Report only made one recommendation: safety check the call button in the visitor’s room at least once per day for malfunctions and “ensure that staff are available to respond immediately in the event the call button is used.”<sup>80</sup> Immediate egress from the Visitor’s Room is a needed safety feature for this and any number of emergency situations. Nevertheless, the report failed to develop essential recommendations related to the very serious finding of abuse.

The recommendation should have addressed systematic flaws. For example, given the fact that Staff One had just been trained in appropriate procedures, was the Safety-Care Behavioral Safety training insufficient and inadequate or provided in an ineffective manner? The recommendation should have required a review of the adequacy of the St. Elizabeths training.

When such incidents occur, immediate response and a well-designed plan could minimize the risk of harm to others involved. The report did not recommend alternative responses to a dangerous situation where a staff member acted in violation of law. One recommendation might have been to consider a well-trained specialized team, sometimes called a Crisis Intervention Team, which responds to behavioral emergencies and could significantly help to de-escalate situations where a staff member has become personally engaged and his conduct is unprofessional or dangerous.<sup>81</sup> Another technique used -- after substantial training -- is sometimes referred to as “Tapping Out,” in which the staff member engaged with the agitated consumer is tapped on the shoulder as a signal to disengage and another staff member attempts to deescalate the situation.

Recommendations should have included a thorough review of the situation and required an in-depth corrective action plan, necessitating exploration of questions such as: What are the best practices to calm potentially aggressive individuals in care? Who are the best persons to respond to such individuals in care? How can the hospital protect other individuals in care and their visitors when others are involved in an incident? Who should focus on evacuating the Visitor’s Room? What are the most efficient exit routes? Safety Officers and staff did not act in a concerted effort to de-escalate the situation and ensure the safety of all involved.

Finally, the design of the Visitor’s Room and the appropriateness of the tables should be reviewed to determine if they are safe. Are glass tables safe? Are the edges likely to result in injury if someone falls against them? The tables in St. Elizabeths’ Visitor’s Room caused a laceration on Staff One’s forehead.<sup>82</sup> Moreover, these tables were not easily moved

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<sup>77</sup> See DMH Policy 480.1C, 4.

<sup>78</sup> See *id.* Exhibit 1, MUI Code 5. (Physical Assault. A physical attack using force or violence upon a consumer, consumer to staff, or DMH staff while on duty.)

<sup>79</sup> DMH Policy 480.1C, 11.

<sup>80</sup> *SEH Investigation Report* at 18.

<sup>81</sup> See Janet S. Richmond, *et al.*, *Verbal De-escalation of the Agitated Patient: Consensus Statement of the American Association for Emergency Psychiatry Project BETA De-escalation Workshop*, 13 *W.J. Emerg. Med.* 17, 19 (2012); see also, The University of Memphis. CIT Center Website: <http://cit.memphis.edu>.

<sup>82</sup> See *SEH Investigation Report* at 17.

away when Staff One and Mr. Mann fell.<sup>83</sup> Recommendations should have addressed all of these issues. Moreover, a corrective action plan with deadlines for implementation and oversight to ensure its completion must be included to reduce the risk that such incidents occur again.

#### V. **ST. ELIZABETHS CONTINUES TO EXPERIENCE EXCESSIVE INCIDENTS OF AGGRESSION.**

St. Elizabeths continues to be a dangerous place to live. DBH's report of Performance Related Information for Staff and Managers ("PRISM Report")<sup>84</sup> provides startling statistics for the year since the physical assault of Mr. Mann.<sup>85</sup> In a hospital with an average patient census of 277, St. Elizabeths reported 1530 Major Unusual Incidents in a single year.<sup>86</sup> In this one year span, there have been 632 physical assaults and 384 injuries.<sup>87</sup> Of the 384 injuries, almost seventy percent were patient injuries.<sup>88</sup> Furthermore, despite St. Elizabeths' policies that require their use only in emergency situations or as a last resort, there were 524 restraints (physical and mechanical) and 252 incidents of seclusion.<sup>89</sup> Even St. Elizabeths acknowledges that incidents of assault and injury are high, stating: "In April 2016, the number of incidents involving aggressive behaviors with non-physical contact increased only marginally but physical assaults, psychiatric emergencies, patient falls and incidents that triggered injuries noticeably increased."<sup>90</sup>

##### a. **Review of St. Elizabeths' Unusual Incident Reports Point to Problems with Addressing Behavioral Challenges.**

Like the incident involving Mr. Mann, other staff involved with consumers in the Hospital who are agitated and become aggressive may be acting so as to escalate situations and fail to deescalate the situations. Risk management should regularly review staff reports of the incidents to discover patterns of inappropriate behavior that can then be addressed to prevent future incidents and improve the safety of the hospital. Given the serious problem with safety at the Hospital, such steps are essential.

The District's Department of Behavioral Health requires its providers and St. Elizabeths Hospital to report all Major Unusual Incidents<sup>91</sup> both timely and accurately.<sup>92</sup>

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<sup>83</sup> Videotape at 7:03:16 PM.

<sup>84</sup> Office of Statistics and Reporting, St. Elizabeths Hospital, *Performance Related Information for Staff and Managers* (dated May 12, 2016).

<sup>85</sup> PRISM Report data spans the year since Mr. Mann's assault from May 2015 to April 2016. *See id.* at Appendix Tables.

<sup>86</sup> *Id.* at Tables 1 & 3.

<sup>87</sup> *Id.* at Table 3.

<sup>88</sup> Total patients injured total 266 over twelve months. *Id.* at Table 3

<sup>89</sup> *PRISM Report* at Table 4. These restraint numbers do not include chemical restraints referred to by St. Elizabeths as emergency medications.

<sup>90</sup> *Id.* at 3.

<sup>91</sup> A Major Unusual Incident is defined as "Adverse events that can compromise the health, safety, and welfare of persons, such as employee misconduct, fraud, and actions that are in violations of law or policy . . ." DBH Policy 480.1 (Jan. 4, 2016) at 11(4). Categories included under Major Unusual Incidents are physical injury, physical assault, restraint (mechanical, physical, or chemical), and seclusion. DBH Policy 480.1 (Jan. 4, 2016) at Exhibit 1, MUI Code 2a, 5, 12a, 12b.

<sup>92</sup> DBH Policy 480.1 (Jan. 4, 2016), 4.

Reporting procedures also require the maintenance of a log of all Major Unusual Incidents in electronic form.<sup>93</sup>

Major Unusual Incidents are to be both reported and analyzed:

- (1) *The [Division of Incident Management and Investigation] shall maintain a computerized database on [Major Unusual Incidents] and submit the summary analysis on [Major Unusual Incident] tracking and trending to the DBH Internal Quality Committee . . . and DBH Quality Council . . .*
- (2) *The Internal Quality Committee . . . shall review the summary analysis submitted by the [Division of Incident Management and Investigation] and provide written recommendations to the DBH Director and [Quality Committee] to address any issues and concerns, if needed.*<sup>94</sup>

Such review should include serious analysis of Unusual Incident Reports, especially those involving incidents of seclusion, restraint (mechanical, physical, and chemical), injuries, and physical assault. These documents should track both individuals involved and techniques used to address problems.

According to St. Elizabeths' *Unusual Incident Reporting and Documentation Policy*:

*It is the policy of [St. Elizabeths] to immediately report and document all unusual hospital-based incidents to the [St. Elizabeths] Risk Manager. Additionally, the Risk Manager must independently conduct a thorough and comprehensive investigation of all Major Unusual Incidents to determine staff adherence to programmatic requirements.*<sup>95</sup>

St. Elizabeths regularly provides DRDC with redacted Unusual Incident Reports involving physical assault and physical injury, restraints (mechanical and physical hold), seclusion, and emergency medication. DRDC's review of three months of Unusual Incident Reports -- those most recently provided to DRDC -- provides significant insight into systemic problems and staff members' failure to follow procedures.

For example, in one Unusual Incident, an individual in care jumped over the nursing station to look for his exercise book. According to the Unusual Incident Report, the individual in care refused to go back to the dayroom, yet the report makes no mention of the use of de-escalation techniques. Instead, a code 13 was called and staff used a physical hold restraint to put him into the seclusion room and then chemically restrained him. The consumer sustained an injury to his big toe (pain rated at 7 on a scale of 1-10), suggesting

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<sup>93</sup> These logs are to include:

- *consumer/client identifying number,*
- *date of incident,*
- *date [Unusual Incident] was reported at the provider level/date [Major Unusual Incident] was reported to DBH [Office of Accountability]*
- *type of incident*
- *immediate administrative actions taken, as applicable, and*
- *outcome/final result.*

DBH Policy 480.1 (Jan. 4, 2016), 7(1).

<sup>94</sup> *Id.* at 8.

<sup>95</sup> St. Elizabeths Policy, *Unusual Incident Reporting and Documentation*, Policy Number 302.1-03.

that excessive force may have been used. A review of the incident may have revealed that the incident could have been avoided all together by helping the individual in care retrieve his book.<sup>96</sup>

In another Unusual Incident, staff attempted to “redirect and counsel” an individual in care who was making threats to another individual in care. Beyond this, the Unusual Incident Report fails to describe any further attempts at de-escalation. Instead, staff called a code 13 and used a physical hold restraint. Even if the physical restraint had been necessary, the restraint injured the individual in care, causing an abrasion to his chest. Sustaining this type of injury during a physical hold could indicate an improperly administered restraint. Review of such records would allow St. Elizabeths to assess whether further training is needed to ensure that staff safely restrain individuals in care when other less restrictive measure have been exhausted, addressing any unsafe practices. Listing the specific steps used to redirect him could have provided insight for future incidents and could have ensured effective alternatives were actually attempted.<sup>97</sup>

In one Unusual Incident, staff used a physical hold restraint on two consumers involved in a physical altercation with each other. Like previous Unusual Incident Reports, the description of de-escalation attempts is minimal and vague, describing only an attempt to “redirect them multiple times from playing around” before staff called a code 13 and used a restraint. Giving the individuals in care opportunities to “play around” outside or in the gym or engage in a sport may have avoided the entire incident. During the staff members’ restraint of the individuals, one of the consumers ended up on the floor and sustained bruises over his chest and arms. The second individual in care complained of a swollen wrist. While it is possible that these injuries were sustained during the physical altercation between the consumers, the nature of the injuries—located on the chest, arms, and wrist—is suggestive of restraint injuries. Further, a staff member experienced pain in his arm after using the physical hold. These injuries could therefore be the result of an improper restraint. Staff must provide more descriptive Unusual Incident reports, especially pertaining to patient injuries when restraints are used to ensure they have been properly administered.<sup>98</sup>

Another Unusual Incident Report describes an individual in care involved in an assault incident.<sup>99</sup> The only attempted de-escalation noted was asking the individual in care to “sit down and watch TV,” failing to provide any individualized assessment or utilize further non-physical management techniques. During the incident with a staff member, other staff members described seeing blood on the consumer’s eyebrow. After using a physical hold to transport the individual to the seclusion room, staff noted a two inch laceration on the

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<sup>96</sup> See *Unusual Incident Report #19261*, St. Elizabeths Hospital (dated Jan. 30, 2016 at 10:04 AM). In addition, the patient’s seclusion is not listed under incident type and the duration of seclusion is not listed. Multiple other Unusual Incident Reports failed to list seclusion or restraint under incident type and/or failed to list the seclusion duration. See, e.g., *Unusual Incident Report #18955*, St. Elizabeths Hospital (dated Dec. 9, 2015 at 4:11 PM); *Unusual Incident Report #19071*, St. Elizabeths Hospital (dated Jan. 2, 2016 at 7:30 AM); *Unusual Incident Report #19210*, St. Elizabeths Hospital (dated Jan. 21, 2016 at 4:05 PM); *Unusual Incident Report #19279*, St. Elizabeths Hospital (dated Feb. 1, 2016 at 8:48 PM); *Unusual Incident Report #19244*, St. Elizabeths Hospital (dated Jan. 27, 2016 at 10:55 AM). Moreover, despite descriptions of patient injuries in the Unusual Incident Reports, they are not consistently categorized or listed as patient injuries even though staff injuries involved in the same incident are regularly recorded. See, e.g., *Unusual Incident Report #19309, 19444*, St. Elizabeths Hospital (dated Feb. 7, 2016 at 6:35 AM; Feb. 26, 2016 at 6:30 PM).

<sup>97</sup> See *Unusual Incident Report #19271*, St. Elizabeths Hospital (dated Jan. 31, 2016 at 6:50 PM).

<sup>98</sup> See *Unusual Incident Report #19326*, St. Elizabeths Hospital (dated Feb. 8, 2016 at 8:20 PM).

<sup>99</sup> See *Unusual Incident Report #19309*, St. Elizabeths Hospital (dated Feb. 7, 2016 at 6:35 AM).

individual in care's left eyebrow, as well as a bruised cheek. The summary provides no insights into the origin of such an injury. Moreover, the Unusual Incident Report fails to include the consumer on the list of those injured, despite noting the staff member's injury.<sup>100</sup>

**b. Review of St. Elizabeths' Unusual Incident Reports Demonstrates Patterns of Staff Involvement in Multiple Incidents of Aggression.**

Staff One was involved in multiple incidents involving agitated individuals at the hospital before the incident with Mr. Mann. Careful review of unusual incident reports can help to identify staff members who need additional training or support. Review of staff involvement in multiple incidents is critical to addressing St. Elizabeths' significant problem with aggression and assaults. Importantly, where the same staff members are frequently involved in incidents of aggression or agitation - which often result in seclusion or restraint, the hospital should conduct detailed reviews of the incidents to determine if there are patterns of staff conduct which may result in escalated behaviors.

In addition to demonstrating that staff members failed to appropriately address the behavior of individuals in care, DRDC's review of the three months of unusual incidents involving physical assault, physical injury, and restraints showed that a small number of staff were involved in a large number of incidents. As many as twenty-three (23) staff members were involved in six or more incidents, like Staff One who, according to the Hospital's investigation, had been involved in six.

Significantly, six (6) staff members were each involved in ten (10) or more of these unusual incidents.<sup>101</sup> Even more significantly, the six staff members were involved in forty serious major unusual incidents.<sup>102</sup> Thirty-three (33) incidents involved restraint using emergency involuntary medications.<sup>103</sup> Twenty-one (21) involved a physical hold

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<sup>100</sup> See *Unusual Incident Report #19309*, St. Elizabeths Hospital (dated Feb. 7, 2016 at 6:35 AM).

<sup>101</sup> Staff names are abbreviated as "Staff [Last Initial] (Total Number of Unusual Incidents)".

**Staff A (14):** *Unusual Incident Report #18985, 19032, 19073, 19225, 19266, 19271, 19272, 19279, 19290, 19301, 19360, 19365, 19366, 19408*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:20 PM to Feb. 21, 2016 at 6:30 PM).

**Staff B (14):** *Unusual Incident Report #19044, 19199, 19244, 19261, 19262, 19286, 19288, 19330, 19332, 19333, 19442, 19443, 19446, 19450*, St. Elizabeths Hospital (dated Dec. 26, 2015 at 11:25 AM to Feb. 28, 2016 at 8:15 AM).

**Staff K1 (14):** *Unusual Incident Report #19071, 19131, 19178, 19199, 19208, 19217, 19244, 19261, 19262, 19269, 19286, 19288, 19330, 19446*, St. Elizabeths Hospital (dated Jan. 2, 2016 at 7:30 AM to Feb. 27, 2016 at 8:25 AM).

**Staff K2 (11):** *Unusual Incident Report #19044, 19135, 19199, 19244, 19261, 19262, 19286, 19288, 19316, 19332, 19446*, St. Elizabeths Hospital (dated Dec. 26, 2015 at 11:25 AM to Feb. 27, 2016 at 8:25 AM).

**Staff T (10):** *Unusual Incident Report #18982, 19032, 19261, 19262, 19271, 19286, 19288, 19333, 19360, 19364*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:30 AM to Feb. 14, 2016 at 4:16 PM).

**Staff U (11):** *Unusual Incident Report #19071, 19131, 19261, 19266, 19271, 19323, 19330, 19333, 19363, 19442, 19450*, St. Elizabeths Hospital (dated Jan. 2, 2016 at 7:30 AM to Feb. 28, 2016 at 8:15 AM).

<sup>102</sup> See *id.* 11(4) & Exhibit 1, MUI Code 2a, 5, 12a, 12b.

<sup>103</sup> *Unusual Incident Report #18982, 18985, 19032, 19044, 19071, 19073, 19131, 19135, 19178, 19199, 19208, 19217, 19225, 19244, 19261, 19266, 19269, 19271, 19272, 19279, 19286, 19288, 19301, 19332, 19363, 19364, 19365, 19366, 19408, 19442, 19443, 19446, 19450*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:30 AM to Feb. 28, 2016 at 8:15 AM). These are categorized as "Emergency IM" on the Unusual Incident Reports.

restraint,<sup>104</sup> and three (3) involved mechanical restraint.<sup>105</sup> Eleven (11) involved seclusion.<sup>106</sup> Finally, eight (8) incidents involved both injury and physical assault.<sup>107</sup>

Because these incidents involved restraint, injury, and assault, St. Elizabeths' policy requires that these forty Major Unusual Incident Reports<sup>108</sup> be submitted to and analyzed by both the St. Elizabeth Internal Quality Committee and Quality Council. Such a review should result in a recognition that a limited number of staff are involved in a large number of these serious unusual incidents.

Moreover, detailed review of Unusual Incidents would enable St. Elizabeths to determine how staff are implementing de-escalation procedures and the extent to which staff use the least restrictive measures in assisting individuals in care. For example, some Unusual Incident Reports more accurately describe de-escalation attempts before the implementation of more severe mechanisms. In one Unusual Incident Report, the report writer explained that "the unit social worker and psychologist attempted to talk to [the individual in care]" and "Nursing staff who are known to have good rapport with her continued to try and talk with her" before the psychiatrist ordered emergency medication.<sup>109</sup> Though more steps could have been attempted, better descriptions illustrate what did not work so a better response can be tried in the future.

Thorough and descriptive Unusual Incident Reports best allow St. Elizabeths to identify systematic issues. By requiring detailed records and regularly reviewing them, St. Elizabeths and the DBH are then better able to recognize when staff are repeatedly involved in Unusual Incidents and the type of de-escalation techniques those staff are using. Once identified, St. Elizabeths should then take appropriate action with respect to these staff members, including requiring demonstrated comprehension of training material, providing improved oversight, mentoring, staff support, and disciplining individuals where needed. Perhaps such effort could have addressed Staff One's behavior before it resulted in the abuse of Mr. Mann, creating a safer environment at St. Elizabeths Hospital.

## **VI. DBH FAILED TO PERFORM ITS OWN INVESTIGATION OF THE INCIDENT.**

DBH did not perform an investigation of this incident or a secondary investigation of St. Elizabeths' own investigation to ensure it was adequate, complied with law, and included substantial recommendations and completed corrective actions. DBH Policy effective at the

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<sup>104</sup> *Unusual Incident Report #18982, 18985, 19071, 19131, 19178, 19199, 19225, 19244, 19261, 19262, 19266, 19271, 19286, 19288, 19290, 19323, 19333, 19363, 19442, 19443, 19446*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:30 AM to Feb. 27, 2016 at 8:25 AM). Categorized as "Restraint (physical hold)" on the Unusual Incident Reports.

<sup>105</sup> *Unusual Incident Report #19199, 19286, 19363*, St. Elizabeths Hospital (dated Jan. 20, 2016 at 9:00 AM to Feb. 14, 2016 at 1:32 PM). Categorized as "Restraint (mechanical)" on Unusual Incident Reports.

<sup>106</sup> *Unusual Incident Report #18982, 18985, 19032, 19208, 19262, 19266, 19279, 19288, 19442, 19443, 19446*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:30 AM to Feb. 26, 2016 at 1:30 AM). Categorized as "Seclusion" on Unusual Incident Reports.

<sup>107</sup> *Unusual Incident Report #18982, 19032, 19178, 19199, 19316, 19330, 19360, 19365*, St. Elizabeths Hospital (dated Dec. 14, 2015 at 8:30 AM to Feb. 15, 2016 at 8:30 PM). Injury and physical assault are categorized separately. The search used for these Unusual Incidents have both "Injury" and "Physical Assault" under the Incident Type.

<sup>108</sup> *Supra* note 88.

<sup>109</sup> *Id.*

time of the incident, DMH Policy 662.1,<sup>110</sup> provided that the DMH Office of Accountability should conduct a systematic examination of the types of incidents involving consumer care and/or administrative issues<sup>111</sup> and required the Office of Accountability to perform an investigation of issues determined by the Director of DBH and Deputy Director of the Office of Accountability to require a major investigation.<sup>112</sup> The current DBH policy effective August 31, 2015, now explicitly states physical abuse of a consumer is an example of an action that should require a major investigation.<sup>113</sup>

St. Elizabeths' investigations should have "identif[ied] the cause(s) of incidents in order to eliminate conditions that may contribute to the reoccurrence of similar events through the identification and correction of causal factors."<sup>114</sup> Where the provider fails to address such significant problems with appropriate recommendations and where consumer abuse is substantiated, it is critical that DBH perform its own secondary review of the provider's response and determine if the provider has addressed the problem with substantial measures. Moreover, DBH must ensure that there is a corrective action plan and that it is actually implemented. DRDC requested "Any incident investigation reports generated by St. Elizabeths, DBH, any [Community Resident Facility], and/or his [Core Services Agency], relating to the time period from May 1 to present and continuing, relating to the incident in the visiting area on May 7, 2015 or involving [Mr. Mann]."<sup>115</sup> DRDC did not receive a DBH investigation of this incident even though it involved substantial staff abuse. DBH should have performed its own review of St. Elizabeths' investigation, provided more extensive recommendations, required a significant corrective action plan, and followed the hospital's progress to ensure changes were made.

Moreover, given the excessive number of patient injuries in the last year and instances of physical assault described above, DBH should now perform its own investigation of St. Elizabeths Hospital to determine if there are systemic failures, including the failure to identify staff members whose behaviors are escalating aggression and who are failing to implement de-escalation techniques, resulting in the unsafe environment.

## VII. RECOMMENDATIONS

1. St. Elizabeths and DBH must provide more substantial recommendations with specific action steps and follow up to address the serious staff abuse described in this investigation.
2. St. Elizabeths should review the training protocol to determine how competency is assessed and how such an incident could occur after staff had just been trained.

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<sup>110</sup> *Major Investigations*, DMH Policy 662.1 (May 03, 2012), 4a *superseded by* Department of Behavioral Health, *Major Investigations* DBH Policy 662.1 (Aug. 31, 2015), 4a.

<sup>111</sup> DMH Policy 662.1 (May 03, 2012), 4a.

<sup>112</sup> *Id.* 6a(2).

<sup>113</sup> *See* DBH Policy 662.1 (Aug. 31, 2015), 6a(2). Other examples include exploitation, neglect, sexual abuse of a consumer, work place violence, and sexual harassment.

<sup>114</sup> DBH Policy 662.1 (Aug. 31, 2015).

<sup>115</sup> Request for Records from Mary Nell Clark, DRDC (May 15, 2015) (on file with DRDC).

3. St. Elizabeths should determine if there are adequate staff to meet its needs. The fact that Staff One was agitated because he was unable to eat dinner may indicate that staffing is inadequate.
4. St. Elizabeths should assess the training and coordination of security and safety officers.
5. St. Elizabeths should review the safety of features in the visitor's room, including the dangerousness of the tables.
6. St. Elizabeths should take steps to protect all other individuals in care by ensuring staff who abuse patients are appropriately sanctioned and removed from the setting. These steps should include a review of all staff involved in multiple incidents of aggression and provision of individualized training in appropriate methods of seclusion and restraints including de-escalation techniques.
7. St. Elizabeths should ensure it records sufficient details in Unusual Incidents in order to evaluate whether staff implemented St. Elizabeth's de-escalation policy and, where necessary, safely performed seclusion and restraint methods.
8. DBH should perform its own hospital-wide investigation of the excessive instances of patient injury and assaults (1) to determine if there are systemic failures resulting in the unsafe environment at the hospital and (2) to provide systemic measures to address the unsafe conditions.