Investigating Abuse and Neglect:

The Need for Accountability at Saint Elizabeths Hospital

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Since 1996, Disability Rights DC at University Legal Services, Inc. ("Disability Rights DC"), 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. Additionally, Disability Rights DC provides legal advocacy to protect the civil rights of District residents with disabilities.

Disability Rights DC 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. Disability Rights DC 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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Prior to a recent change in practice, the Department of Behavioral Health’s Office of Accountability (“DBH’s Office of Accountability”) completed detailed, thorough investigations of allegations of serious abuse and neglect at St. Elizabeths Hospital. DBH’s Office of Accountability investigation findings have been critical in not only substantiating allegations of abuse and neglect, but they also provide meaningful recommendations to improve care and treatment practices and to keep patients safe.¹

However, in 2023, DBH’s Office of Accountability informed Disability Rights DC that in order to be efficient with resources, they would no longer be conducting separate, independent investigations. Instead, St. Elizabeths Hospital itself would be conducting all investigations of alleged abuse and neglect.² As described below in Section III, this change in practice has been implemented in a confusing and contradictory manner, causing serious delays in investigations. More importantly, if continued, this new practice will certainly result in placing all patients at St. Elizabeths Hospital at risk, which contravenes the Department of Behavioral Health’s (“DBH”) responsibility to protect consumers from abuse and neglect.³

The importance of independent agency investigations into deaths, injuries and allegations of serious abuse and neglect cannot be overstated. Although St. Elizabeths’ incident management personnel can and have completed adequate investigations for many incidents, because of its expertise and independence in conducting detailed investigations related to behavioral health abuse and neglect, and its ability to independently identify staff deficiencies, it is critical that DBH’s Office of Accountability continues to investigate certain, more serious incidents.

In fact, DBH’s Office of Accountability currently investigates certain serious incidents at psychiatric facilities in the District, including the Psychiatric Institute of

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¹ For example, see DBH Accountability Administration Investigative Report dated 7/10/20; DBH Accountability Administration Investigative Report dated 6/28/22.
² Email from DBH to DRDC (October 30, 2023).
³ See DC Code § 7–1131.04 (13); see also DC Code § 7–1231.04(c) (“Consumers shall be free from... abuse [or] neglect”).
Washington. As is the case with St. Elizabeths Hospital, the Psychiatric Institute of Washington is a stand-alone psychiatric facility and internally governs its own departments, medical and nursing staff, and incident management personnel. Per DBH policy and practice, DBH’s Office of Accountability conducts separate investigations of select, more serious incidents at the Psychiatric Institute of Washington, as well as other District Hospital psychiatric units.\(^4\)

The Department of Behavioral Health should not exclude St. Elizabeths from this important oversight. Efficiency of resources cannot take priority over the safety and wellbeing of the hundreds of patients at St. Elizabeths Hospital. DBH’s Office of Accountability, as the independent oversight agency, must continue to conduct investigations of allegations of serious abuse and neglect at St. Elizabeths as well.

**II. DEPARTMENT OF BEHAVIORAL HEALTH POLICY**

In order to protect mental health consumers in the District from abuse and neglect, DBH developed a policy that obligates DBH’s Office of Accountability to conduct its own investigations of certain incidents, noting that DBH shall, among other incidents, investigate any consumer death and any incidents that raise immediate concerns regarding the health and safety of a consumer.\(^5\)

However, DBH’s Office of Accountability failed to follow this policy and failed to conduct separate investigations for the allegations of abuse and serious neglect at St. Elizabeths Hospital discussed in detail below. The incident involving Craig Thomas\(^6\) was an unexpected death. The other incidents involved allegations of St. Elizabeths staff abuse and neglect, all which raised serious immediate concerns for the safety of the patients and should have been investigated by DBH’s Office of Accountability.

\(^4\) DC Department of Behavioral Health Policy 480.1A (5c) (May 3, 2019).
\(^5\) DC Department of Behavioral Health Policy 480.1A (5c)(1), (5c)(7) (May 3, 2019).
\(^6\) Pseudonym used to protect patient confidentiality.
1. Craig Thomas

Craig Thomas, a patient at St. Elizabeths Hospital, died suddenly and unexpectedly on October 22, 2022. On January 30, 2023, Disability Rights DC sent DBH’s Office of Accountability a detailed analysis of the staff deficiencies uncovered during the Disability Rights DC investigation. After multiple follow-up inquiries, in July 2023, DBH’s Office of Accountability indicated that it was “still working on the investigation” into Mr. Thomas’ death. It was not until over a year after his death, on October 30, 2023, that DBH’s Office of Accountability informed Disability Rights DC that it was not investigating the death, but that St. Elizabeths Hospital was conducting the investigation. However, this information contradicted an email from St. Elizabeths Hospital incident management sent a month earlier on September 28, 2023, which informed Disability Rights DC that St. Elizabeths Hospital did NOT conduct its own investigation because, per policy, DBH’s Office of Accountability investigates unexpected deaths.

It was not until over a year and one month after Mr. Thomas’ death that DBH provided Disability Rights DC with a “St. Elizabeths Hospital Summary Review of Unusual Incident Report regarding Craig Thomas,” which was dated November 9, 2023. Unlike prior DBH’s Office of Accountability investigation reports, this St. Elizabeths Summary Review was not an in-depth investigation and failed to:

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7 Email from DBH OA to DRDC (July 27, 2023).
8 Email from DBH OA to DRDC (July 27, 2023).
9 Email from St. Elizabeths to DRDC (September 28, 2023). The email states “Regarding Craig Thomas, since his death was considered unexpected SEH did not initiate an investigation per DBH policy 662.1 (Major Investigations 6.6a.1.b). Historically, my team does not conduct investigations for unexpected deaths because DBH Accountability did them. I know there was some confusion regarding who was doing the investigation. [The Director of the Office of Accountability] mentioned that DBH was deferring to SEH for it, but unfortunately no one communicated that to me...”.
contain witness interviews; (2) provide a detailed, thorough analysis of the videotape and include screenshots; and (3) substantiate St. Elizabets staff neglect. The report also failed to note that, according to Mr. Thomas’ records, on August 12, 2022 – two months before his death – a Code Blue was called because Mr. Thomas was noted to fall to the floor and became unresponsive, and on September 23, 2022, less than a month before his death, a housekeeper found Mr. Thomas verbally unresponsive in the bathroom. Moreover, the St. Elizabets Summary Review failed to recommend or discuss steps the Hospital should take in response to the cause of Mr. Thomas’s death, which was a drug overdose. Recommendations should have included steps such as supplying crash carts and units with Narcan. Unacceptably, the hospital’s own internal analysis of the death was not completed until more than a year after the death, which delayed the implementation of important life-saving recommendations.

Finally, the St. Elizabets Summary Report fails to address and/or substantiate Disability Rights DC’s investigation findings of neglect that were sent to DBH’s Office of Accountability and summarized below.

- Videotape footage of the unit the evening of his death showed that 27 minutes after Mr. Thomas entered the shower, staff persons appeared to be undergoing a security check of the hallway where the shower room was located. One staff person knocked on the door and the other attempted to open the door, however, the staff persons were only able to push the door open a few inches. It appeared as though the door was jammed by something blocking the door. The staff did NOT make further attempts to open the door. Inexplicably, the staff persons did not return to make other attempts to open the door.

- The video shows that over 20 minutes later, at around 9:25 p.m., another patient attempted to open the door to the shower room but was also only able to open it a few inches as it appeared to still be blocked. He then

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11 Id. The report refers on Page 3 to a DC Health review of the incident which concluded that St. Elizabets staff failed to conduct security checks properly, but fails to conclude that staff were negligent.
12 RN Progress note, dated 8/12/22, timed at 11:33 a.m.
13 RN Progress note, dated 9/23/22, timed at 3:19 p.m.
14 Videotape at 9:04 p.m.
15 Id.
16 Id. at 9:25 p.m.
sought the attention of a staff person sitting in a chair in the hallway, and both the staff person and the patient then tried to push open the door but were unable to. Several other individuals finally got the door pushed open at approximately 9:27 p.m., and multiple staff then converged around the shower room. It is not until approximately 9:32 p.m. that staff pulled Mr. Thomas’ body into the hall and began resuscitation measures – almost 30 minutes AFTER staff were initially not able to open the door during the 9:03 p.m. security check. Although the initial incident report states Mr. Thomas was seen in the living area with other patients at 8:30 p.m., review of the video provided to Disability Rights DC – which begins at 8:37 p.m. – demonstrates that Mr. Thomas went into in the shower room at the beginning of the video and did not appear until he was removed by staff at 9:32 p.m., almost an hour after Mr. Thomas entered the shower room.

- Disability Rights DC’s investigation also notes other discrepancies between staff documentation and the videotape footage. The initial incident report and medical records indicate that during the 9:03 p.m. security check, Mr. Thomas was in the shower and responded by name. However, neither the initial incident report nor the medical records note that staff attempted to open the door, that they were only able to get the door open a few inches and it appeared as though something was blocking the door from being opened. It is also questionable whether Mr. Thomas did actually speak to staff.

Inexplicably, in a clear violation of its own policy, DBH’s Office of Accountability failed to investigate this death.

2. Robert Jones

On November 10, 2022, Robert Jones suffered a dislocation of his right shoulder during an unsafe restraint performed by St. Elizabeths staff members. After reviewing a video of the incident, on February 17, 2023, Disability Rights DC sent a letter to DBH’s Office of Accountability outlining Disability Rights DC’s

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17 Id.
18 Id. at 9:27 p.m. to 9:32 p.m.
19 Id. Psychiatry Resident Progress Note dated 10/22/22, timed at 11:14 p.m.
20 Id. at 8:37 p.m. to 9:32 p.m.
21 DBH SEH MUI # I-DBH-051998 (October 22, 2022); RN progress note dated 10/23/22, timed at 8:46 a.m.
preliminary investigation findings and requesting that DBH’s Office of Accountability investigate the incident.\textsuperscript{22}

Disability Rights DC’s review found that the videotape clearly showed (1) that staff failed to use proper technique when multiple staff converged on Mr. Jones resulting in his falling to the floor; and (2) that staff held Mr. Jones on the floor in a prone position on the floor for almost two minutes\textsuperscript{23} – a technique that is very dangerous and strictly prohibited by Hospital policy.\textsuperscript{24} However, it was not until almost a year later, on October 30, 2023, that DBH’s Office of Accountability informed Disability Rights DC that it was not investigating the incident.\textsuperscript{25}

On September 28, 2023, St. Elizabeths Hospital had supplied Disability Rights DC with a “Summary Review of Unusual Incident.”\textsuperscript{26} Although the Summary Review noted in its report that “for a portion of the time he was on the floor he was likely in a prone position,” as noted above, Disability Rights DC’s analysis of the videotape clearly shows multiple staff holding Mr. Jones in a prone position for almost two minutes. Critically, the Summary Review also failed to note that Hospital policy forbids staff to restrain patients in a prone position and that staff used a dangerous technique when multiple staff converged on Mr. Jones, who was retreating from staff, causing him and staff to fall to the floor. The Summary Review failed to substantiate any wrongdoing by staff and as such, did not make any recommendations to ensure that staff avoid techniques that are not only prohibited by policy, but that can cause serious injuries, as was the case with Mr. Jones.

Moreover, the St. Elizabeths investigation report failed to address additional Disability Rights DC findings including:

- The staff documentation did not reflect the activity on the videotape footage. Progress notes indicated that staff “held” Mr. Jones but did not describe that Mr. Jones and staff fell to the floor after staff converged on him.\textsuperscript{27}

\textsuperscript{22} Letter from DRDC to DBH OA (February 17, 2023).
\textsuperscript{23} Videotape: Security Footage of St. Elizabeths Unit 1G at 10:42 a.m. to 10:45 a.m. (November 10, 2022).
\textsuperscript{24} St. Elizabeths Hospital Policy 103 § III.D.2.e.
\textsuperscript{25} Email from DBH OA to DRDC (October 30, 2023).
\textsuperscript{26} Summary Review of Unusual Incident regarding Robert Jones (July 7, 2022).
\textsuperscript{27} RN progress note dated 11/10/22, timed at 2:53 p.m.
• Records indicate Mr. Jones was placed in four-point restraints for an hour and 45 minutes after the incident. Staff documentation stated the reason for continued restraint was that he was delusional or “pulling on restraints.” This does not constitute adequate justification for continued four-point restraint.

• The records contain no evidence that the RNs conducted an adequate physical assessment after the incident or in response to Mr. Jones’ complaints of pain after the restraint.

DBH’s Office of Accountability should have investigated this incident, which resulted in a serious injury and threatened Mr. Jones’ immediate health and safety.

3. Greg Miller

In the spring of 2023, Disability Rights DC sent notice to DBH’s General Counsel’s Office of serious allegations of abuse at St. Elizabeths Hospital that had occurred about three weeks before, including an allegation that a staff member punched patient Greg Miller in the face. DBH responded that they “inquired with the [SEH] Incident Investigations Manager, who acknowledged that they were aware of the incident. They determined that it did not warrant an investigation because staff did not act as alleged. As a result of this decision, no investigation or related interventions (staff separation) occurred.”

In the summer of 2023, Disability Rights DC sent a letter to DBH’s Office of Accountability outlining initial investigation findings from the records reviewed of a serious likelihood of staff physical abuse. The letter asked DBH’s Office of Accountability to specifically investigate whether a staff person struck Mr. Miller in the face during a restraint incident, noting that Mr. Miller’s medical records confirmed and documented that Mr. Miller sustained a facial injury during the restraint. A doctor’s progress note from the day after the incident stated: “Patient was involved in a Code 13 yesterday. He was struck in the face and sustained slight swelling under his right eye. There was no bleeding or drainage. He was treated with an ice pack ... ” Mr. Miller reported to the doctor that staff had “punched”

28 RN Assessment of Individual in Seclusion or Restraint (November 10, 2022).
29 See RN progress notes dated 1/10/22, timed at 7:16 p.m. and dated 11/11/22, timed at 7:00 a.m.
30 Letter from DRDC to DBH OA (Spring 2023).
31 Email from DBH to DRDC (Spring 2023).
32 Letter from DRDC to DBH OA (Summer 2023).
33 GMO Progress Note dated Spring 2023, timed at 8:52 a.m.
him, the doctor noted the swelling under Mr. Miller’s right eye. There is no follow up note regarding his facial injuries.\textsuperscript{34}

Approximately one month later, DBH’s Office of Accountability confirmed to Disability Rights DC that the investigation was complete.\textsuperscript{35} To this date, DBH’s Office of Accountability has not provided Disability Rights DC with its own investigation of the complaint of staff abuse. Moreover, in the fall of 2023, an email from the St. Elizabeths Incident Investigations Manager to Disability Rights DC confirmed that the Hospital itself did “not complete a formal report” after viewing the initial videotape which showed that Mr. Miller was the aggressor.\textsuperscript{36}

This incident should have been investigated by DBH’s Office of Accountability as required. A serious allegation that staff punched a patient in the face, along with documented facial injuries of the patient after the allegation, warrants an investigation by DBH’s Office of Accountability. St. Elizabeths’ response that they did not investigate the incident because “staff did not act as alleged” is woefully inadequate. There should have been a more thorough review of the records by DBH’s Office of Accountability, the independent oversight authority.

4. \textit{Charles Smith}

In March 2023, Disability Rights DC investigated an allegation of excessive use of restraint and seclusion at Saint Elizabeths Hospital, yet another allegation that threatened the safety and wellbeing of a St. Elizabeths patient. The investigation found that Mr. Smith was restrained nine times\textsuperscript{37} and placed in seclusion once\textsuperscript{38} over a one-month period at the end of 2022. Disability Rights DC requested that DBH’s Office of Accountability investigate the alleged violations of D.C. Law, D.C. regulations, and SEH policy which occurred during the restraints and seclusions.\textsuperscript{39} In response, DBH’s Office of Accountability did not agree to investigate as requested, but sent only a “Summary Investigation of Unusual

\begin{itemize}
  \item \textsuperscript{34} Id.
  \item \textsuperscript{35} Email from DBH OA to DRDC (Summer 2023).
  \item \textsuperscript{36} Email from St. Elizabeths Investigator to DRDC (Fall 2023).
  \item \textsuperscript{37} SEH Unusual Incident Reports dated 11/30/22 (UI DB #I-DBH-052342), 12/1/22 (two separate incidents on this date: UI DB #I-DBH-052348 and UI DB #I-DBH-052352), 12/10/22 (UI DB #I-DBH-052464), 12/12/22 (two separate incidents on this date: UI DB #I-DBH-052482 and UI DB #I-DBH-052483), 12/14/22 (UI DB #I-DBH-052513), 12/19/22 (UI DB #I-DBH-052571), and 12/25/22 (UI DB #I-DBH-052610). The videotape footage was not available for DRDC’s review.
  \item \textsuperscript{38} SEH Unusual Incident Report (UI DB #I-DBH-052610) dated 12/25/22. Seclusion was ordered during the morning incident on 12/12/22, but four-point restraint was used instead.
  \item \textsuperscript{39} DRDC Letter to DBH OA (May 25, 2023).
\end{itemize}
Incident Report” completed by St. Elizabeths Incident Management and dated June 27, 2023.40

As was the case in the other St. Elizabeths “Summary Investigations” described herein, the Hospital’s summary did not identify important deficiencies discovered in Disability Rights DC’s investigation, including that hospital staff failed to comply with D.C. law and regulations, as well as St. Elizabeths Hospital policy, when staff failed to document that they considered Mr. Smith’s history of trauma as required.41 This is especially important when patients with a history of trauma are subjected to multiple incidents of restraint and seclusion, as was Mr. Smith. Hospital policy safeguards are in place to prevent the trauma associated with repeated restraint and seclusion, which is especially important for patients with a history of trauma.42

Additionally, patient records lack required documentation which demonstrates that staff (1) failed to conduct post-event analyses and debriefing following each incident of restraint and seclusion43; and (2) failed to follow Hospital policy which requires that the St. Elizabeths Director of Medical Affairs review the patient’s chart44 and the Interdisciplinary Recovery Team review the patient’s IRP and comfort plan45 when a patient experiences two or more episodes of restraint and/or seclusion within 24 hours or three or more episodes within a 30-day period.46 This review is necessary so that professionals can assess the causes of the behavior and make changes to the patient’s care in order to avoid the use of

40 Saint Elizabeths Hospital, Summary Investigation of Unusual Incident Report Regarding Charles Smith, Individual in Care (Involved) [SEH Restraint and Seclusion Review].
41 See D.C. Mun. Regs. Tit. 22A § 506.10(c); SEH Policy 103.00 III(A)(3).
42 SEH's own policy recognizes the potential trauma that restraint and seclusion can inflict on a patient, noting the “trauma inducing aspects of seclusion and restraint” and the “potential for physical and psychological harm and loss of dignity.” SEH Policy 103.00 III(A)(1).
43 See D.C. Code § 7-1231.09(jj)(3); D.C. Mun. Regs. Tit. 22A § 510.1-3; SEH Policy 103.00 III(K).
44 St. Elizabeths Hospital Policy 103.00 III(O)(4).
45 St. Elizabeths Hospital Policy 103.00 III(N)(4).
46 In addition, Disability Rights DC found that, for two restraints, SEH staff failed to document in detail what less restrictive strategies were attempted and why they were not effective. See SEH Unusual Incident Report dated 12/14/22 (UI DB #I-DBH-052513); SEH Initiation of Seclusion or Restraint: RN Assessment form, dated 12/14/22 at 5:18 PM; SEH Unusual Incident Report dated 12/19/22 (UI DB #I-DBH-052571); SEH Initiation of Seclusion or Restraint: RN Assessment form, dated 12/19/22 at 7:15 PM. St. Elizabeth's Summary Investigation of Unusual Incident Report did not fully address this allegation. Disability Rights DC also found that, based on a description of events in the records, one incident of restraint was continued beyond the point when the patient no longer posed an imminent risk of serious injury to himself or others. See SEH Unusual Incident Report dated 12/19/22 (UI DB #I-DBH-052571); SEH Progress Note, dated 12/19/22, timed at 9:39 PM. Again, St. Elizabeth's Summary Investigation of Unusual Incident Report did not address this allegation.
seclusion and restraint. These concerns were not addressed in St. Elizabeths’ investigation of its own conduct.

DBH’s Office of Accountability should have investigated this incident, which threatened Mr. Smith’s immediate health and safety and involved multiple violations of policy and District law.

VII. CONCLUSION/RECOMMENDATIONS

Disability Rights DC’s review of St. Elizabeths Hospital’s response to allegations of serious abuse or neglect demonstrates that the facility alone should not be the sole investigator of serious allegations of abuse and neglect against its own staff. It is clear that St. Elizabeths Hospital failed to uncover important staff deficiencies in its investigations of its own facility. It is also clear -- from prior DBH’s Office of Accountability investigation reports of serious allegations of St. Elizabeths staff abuse and neglect -- that DBH’s Office of Accountability not only has the requisite independence, but also has the knowledge and expertise to uncover staff deficiencies. Such deficiencies must be uncovered so they can be addressed. Failure to do so only increases the risk of serious injury and trauma to patients and can result in preventable deaths.

DBH’s Office of Accountability must adhere to DBH’s own policy and independently investigate unexpected deaths and serious allegations of St. Elizabeths staff abuse and neglect that threaten the health and safety of patients, such as the incidents described herein: serious injuries, abuse and neglect during repeated restraints and seclusions of an individual, and serious neglect perhaps leading to death.