Another Senseless Death at Bridgewater

Death Investigation at Bridgewater State Hospital: Findings and Recommendations

A Public Report
June 27, 2016

The Protection and Advocacy System for Massachusetts
I. Introduction

The Disability Law Center (DLC) is a private, non-profit organization which is designated to provide “protection and advocacy” services to individuals with mental illness, pursuant to a congressional mandate under the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. §§ 10801 et seq., (PAIMI). As part of this mandate, DLC is authorized to fully investigate incidents of alleged abuse and neglect of people with disabilities within the Commonwealth of Massachusetts.  

On April 9, 2016, DLC received a report and complaint to the system of a death of a patient at Bridgewater State Hospital (BSH) the previous day. DLC was able to confirm the report during that weekend and on Monday April 11, 2016, the Boston Globe reported that a 43 year old man named Leo Marino died in his cell at Bridgewater State Hospital. Leo Marino’s death by suicide was further confirmed by Bridgewater staff at a daily risk meeting at BSH and in a subsequent Boston Globe article.

In response to this complaint to the system, DLC invoked its statutory authority as the Protection and Advocacy (P&A) system of Massachusetts to conduct an investigation into the death of Mr. Leo Marino. DLC began its investigation on April 11, 2016 by notifying the Secretary of the Commonwealth’s Executive Office of Public Safety and Security (EOPSS) and the Commissioner of the Massachusetts Department of Corrections (DOC), in writing, and requesting all relevant records from BSH.

DOC and BSH personnel have fully cooperated with DLC’s investigation by providing DLC with requested records in a timely fashion, as well as arranging for DLC to interview relevant BSH officials (medical and correctional). Five attorneys at DLC reviewed all available documents, including extensive medical and correctional records and over 238 hours of video footage. During April, May and June, 2016, DLC conducted on-site interviews with staff of DOC and Massachusetts Partnership for Correctional Healthcare (MPCH) which, pursuant to a contract with the
Commonwealth, provides medical and mental health services in Massachusetts prisons including at BSH.

This Public Report is issued consistent with 42 CFR § 51.45(b)(1) and with the assent of Mr. Marino’s next of kin.4

During DLC’s investigation into Mr. Marino’s death, BSH officials described some corrective measures that have recently been put into place to address the mistakes that caused Mr. Marino’s death. These measures and DLC’s recommendations for the future of BSH are discussed at the end of this report.

II. Executive Summary

Mr. Leo Marino comes from a large, close knit family. He was an accomplished woodworker who, despite a long history of mental health challenges, worked closely with family members in a well-established family business. They were his support system when things were difficult and helped him seek therapy when necessary. Mr. Marino’s siblings remained in constant contact with him whenever he was hospitalized including during his time at Bridgewater State Hospital.

Mr. Marino arrived at Bridgewater in October of 2015 with a long history of suicide attempts. A person with comparable suicidality being treated at a Department of Mental Health hospital would be engaged with the world through meaningful human contact, therapy and programming and closely observed. This did not happen for Mr. Marino at BSH. As noted by the Department of Mental Health in its 2014 environmental scan report issued to DOC, BSH is not classified as a hospital and lacks 24/7 clinical staffing seven days a week (ES Report 6/20/14, p. 29).5
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Rather than receiving intensive clinical care, in the month preceding his suicide, Mr. Marino was frequently placed in isolation in the Intensive Treatment Unit (ITU)\(^6\), a small, bare, segregated cell where patients are secluded from the general population. Under DOC regulations, patients should only be sent to the ITU in emergency situations if they pose an immediate threat to themselves or others. This forced isolation was in direct contradiction with his clinical needs.

Mr. Marino spent the last week of his life in the ITU. Due to Mr. Marino's history of suicide attempts, his clinician ordered that he be observed 24/7 by a specially trained observer (STO), a mental health worker who has been trained to watch and record all of his actions. This was in addition to the 24/7 observation that is supposed to occur for all patients in the ITU. There is a camera in every ITU cell and one or two correctional officers are directed to observe all patient actions within the cell on a monitor in a remote location. Thus, two or more people were charged with closely monitoring Mr. Marino’s actions at all times to prevent him from harming himself or committing suicide.

Despite that level of oversight, Mr. Marino was able to obtain significant amounts of toilet paper from the STOs. Prior to his death on April 8, 2016 he had previously attempted to take his life two earlier times by ingesting toilet paper. All staff, clinicians, STOs and COs were fully aware of his previous attempts. Despite clinician orders to restrict his access to toilet paper, they continued to give him large amounts of toilet paper and failed to monitor his use of it. The system utterly failed in the single task of preventing Mr. Marino from committing suicide which was the sole justification for keeping him in such a harsh, isolated and restrictive setting.

As noted in the recent Pioneer Institute Policy Brief, “The Abandoned Legacy of Dorothea Dix,” BSH has been a frequent source of shame for the Commonwealth of Massachusetts. It is an institution being asked to do the impossible: to provide hospital level care in an understaffed, underfunded, antiquated facility that is not a hospital\(^7\), but a prison charged with providing
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a therapeutic, healing milieu in an institution run by the Department of Corrections instead of the Department of Mental Health.

Not surprisingly, 48 other states have come to the conclusion that this is impossible. Yet BSH persists, run with inadequate clinical staffing, minimal therapeutic treatment, leaking roofs, and “temporary” trailer buildings that have long since become permanent. The resources the Commonwealth allocates for BSH is shamefully inadequate and predictably results in precisely the type of tragedy that is the subject of this report. In July of 2014, DLC issued a public letter to then Governor Deval Patrick with its findings from the result of its first Bridgewater State Hospital investigation. They are tragically similar to the recommendations at the conclusion of this report.

III. Factual Findings and Conclusions

A. Treatment Failed

MPCH clinicians acknowledged that upon his admission to BSH, Mr. Marino had been diagnosed with major depressive disorder with suicidal ideations. Yet throughout his time at BSH, MPCH failed to develop or provide an effective treatment program to meet Mr. Marino’s needs.
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According to MPCH, Mr. Marino’s social worker developed a Master Treatment Plan (MTP) for him within the required 15 days of his admission to BSH. The MTP, which is signed by the patient and doctor, is supposed to inform the ongoing treatment of the patient and document whether the patient is making progress. The MTP is intended to be a living document of the patient’s progress and should evolve as the patient’s needs change. However, Mr. Marino’s MTP never changed at all. MPCH officials acknowledged that despite an initial review of the MTP, the patient’s doctor never refers to the MTP or the progress notes that document every visit with the social worker, who is the patient’s primary care clinician. Unfortunately, the lack of leadership by physicians in preparing the MTP has been a long-standing issue at BSH and was specifically addressed by the Department of Mental Health’s environmental scan report conducted by request and issued to DOC in 2014. (ES Report 12/16/14, p. 14)

Mr. Marino’s mental health declined throughout his stay and his self-harm and suicide attempts consistently increased. He also bounced from unit to unit at BSH and was repeatedly placed in seclusion. Nonetheless, his MTP remained the same. Each day MPCH’s treatment of Mr. Marino, as outlined in his MTP, became increasingly futile, and eventually harmful, to him. MPCH completely failed Mr. Marino.

According to MPCH, there are certain conditions and events that should trigger a clinical review of a patient’s treatment. These conditions and events are frequent transfers between different housing units, the infirmary and the ITU, as well as frequent incidents of self-harm. Mr. Marino met all these conditions but MPCH did not conduct a clinical review until the end of March 2016, just two weeks before his death.

Once the clinical review finally happened, it was never followed by a Individual Crisis Plan (ICP). MPCH explained that an Individual Crisis Plan (ICP) could be drafted within days of the clinical review. In addition, if a patient is secluded for so many hours in a given month, or repeatedly secluded in a given month, MPCH is mandated to draft an ICP. The ICP is critically important to address the acute needs of the patient and set forth the strategies necessary to prevent the excessive use of seclusion by
implementing appropriate de-escalation techniques. Once again, MPCH failed Mr. Marino. Despite Mr. Marino meeting the triggering amount of time in seclusion, MPCH never created an ICP for him.\textsuperscript{8}

In addition to the MTP, MPCH must create a Personal De-Escalation Plan for patients upon their admission to BSH. Patients are asked to choose among five different categories of methods of de-escalation, choosing what works best for them. The five de-escalation categories are represented in colored geometrical symbols painted on walls throughout the facility, but few staff or patients understand what the symbols mean, much less use them as intended, to develop a personalized approach to de-escalation.\textsuperscript{9}

Mr. Marino’s personal de-escalation plan was developed with his input upon his admission. However, throughout his stay at BSH, MPCH disregarded that plan. Staff revised Mr. Marino’s Personal De-Escalation Plan with his input during the mandatory review in January 2016. Nonetheless, when Mr. Marino went into crisis, he was placed in an environment of near-total isolation, devoid of almost all human contact, exactly the opposite of the needs he identified in the de-escalation plan signed by Mr. Marino and a BSH clinician. Additionally, MPCH/DOC officials acknowledge that Mr. Marino spent considerable amount of time in the infirmary as well as the ITU cell pacing to such a degree that he wore holes in the soles of multiple pairs of shoes. Despite this and other clear signals that Mr. Marino said were indicators of increased anxiety and he was struggling, MPCH failed to revise his treatment.

\textbf{THIS TRAGICALLY UNNECESSARY DEATH FURTHER ILLUSTRATES WHY INDIVIDUALS SUCH AS MR. MARINO SHOULD RECEIVE MENTAL HEALTH SERVICES IN A PSYCHIATRIC HOSPITAL AND NOT A PRISON.}

Despite a variety of techniques and strategies to help patients like Mr. Marino and to reduce the use of restraint and seclusion, BSH has failed to implement the very strategies developed and documented in the plans described above.
B. MPCH STOs Are Not Properly Trained or Supervised

Mr. Marino’s last admission to the ITU began on 3/30/2016 and lasted until 4/8/2016, the night he died. Mr. Marino was admitted to the ITU after attempting to choke himself with toilet paper on 3/30/2016 while under close observation status in the infirmary. Close observation status means a CO was checking on Mr. Marino every 15 minutes and documenting this on a log sheet. Mr. Marino was secluded as a danger to himself in an ITU cell with a MPCH STO and a DOC correction officer watching him 24/7.

MPCH clinicians determined that a mental health worker must be stationed outside of Mr. Marino’s ITU cell 24 hours a day to prevent him from harming himself or committing suicide. This mental health worker is known as a Specially Trained Observer (STO) who was responsible for watching Mr. Marino, documenting his behavior, alerting others to any suspicious behavior, and observing the contents of Mr. Marino’s cell. However, mental health workers at BSH are not properly trained, are inadequately supervised, and have a conflicting role because it is a correctional facility. Even senior MPCH officials had difficulty describing lines of authority for STOs in the ITU.

Moreover, STOs failed in their duty to watch Mr. Marino. The STO is responsible for ensuring that special instructions and property restrictions are followed. Mr. Marino had property restrictions and doctor orders limiting certain items such as toilet paper, Styrofoam cups and a mattress. This was due to his well-known history of ingesting toilet paper, Styrofoam and mattress stuffing as a means of harming himself and attempting to commit suicide. In interviews with DLC, DOC officials discussed watching videos of Mr. Marino in the ITU during his last admission and seeing him taking material out of his mattress and ingesting Styrofoam from cups left in his cell. DOC officials also described watching Mr. Marino getting toilet paper from various STOs. DOC officials reported observing Mr. Marino taking toilet paper and wetting it in the sink, taking it out of the sink, rolling it up, placing it back in the sink, and ultimately ingesting toilet paper on April 7th and again on April 8th in an effort to choke himself. DOC and MPCH officials noted that the STOs repeatedly gave Mr. Marino toilet paper

...
whenever he requested it despite the fact that there were restrictions limiting his access to toilet paper and that he was clearly not using it for toileting purposes. DOC officials characterized the STOs assigned to observe Mr. Marino as “inattentive.” Whenever STOs gave Mr. Marino toilet paper, although an STO may have noted that Mr. Marino asked for it, they never noted the quantity and/or frequency of what they provided to him.

DOC also reported problems with how STOs recorded data on the observation log sheets. As explained to DLC, data was rigidly limited to what was precisely occurring at ten minute intervals, e.g., if the patient were hitting his head for 8 ½ minutes but had stopped at the 10 minute mark to sit on his bed, the practice was to write that the patient was fine and sitting on his bed. STO training requires standard mental health practice of documenting any significant behaviors despite the time interval. Since important patient behavior between intervals is not noted and data recorded is missing information, vital information about a patient is not communicated to later shifts, to doctors/nurses completing seclusion renewal orders, or relayed at Morning Risk Meeting between DOC and MPCH.

DOC officials also acknowledged that they did not see STOs review Mr. Marino’s records or property restriction forms at change of shift, even though these forms were readily available in a plastic holder mounted outside of Mr. Marino’s cell. Finally, DOC was unfamiliar with the training of STOs by MPCH.

C. DOC Correctional Officers Failed to Watch the ITU Monitors.

Pursuant to DOC regulation, “visual monitoring equipment will be used in all ITU rooms for seclusion and restraint to supplement monitoring by [MPCH] STOs.” (Emphasis added.) 103 DOC 651.02(9). That visual monitoring equipment is to be “monitored twenty-four (24) hours a day, seven (7) days a week by a correction officer specially trained for that purpose.” Id. COs were stationed in a trap, or separate office, located within the ITU that has monitor screens showing in real time what is
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happening in each of the cells in the ITU. DOC officials reviewed and described the protocol for staffing the monitors in the ITU in interviews with DLC. If there are 1-10 patients, only one CO is required. Once the number of patients reaches 11, there must be two CO’s viewing the monitors. During the course of the last day of Mr. Marino’s life, initially there was one CO watching the monitors, it was increased to two, but then reduced to one, as the number of patients in the ITU fluctuated.\(^\text{12}\)

DLC staff reviewed 238 hours of video footage of Mr. Marino’s last admission to the ITU beginning on 3/30/2016 until 4/8/2016, the night he died. Based upon that review, DLC reached the following conclusions:

- STOs continuously provided Mr. Marino toilet paper despite clear direction not to do so;
- In the final hour of his life, Mr. Marino was given arm’s length or more of toilet paper 7 times although he did not use the toilet once;
- Mr. Marino repeatedly and methodically, over a period of time, rolled, wet and pushed the toilet paper wad down his throat;
- This continuous behavior should have been evident to BOTH the STOs stationed immediately outside his cell and the COs watching the monitors of the image from the overhead cameras in the ITU cell;
- Despite these established protections, no one stopped the STO from continuously giving Mr. Marino toilet paper, or prevented Mr. Marino from choking himself with that toilet paper.

Until the end of his life, Mr. Marino continued to be observed by a STO and presumably, a CO. There should have been two sets of eyes on him at all times. **This was not only a strict security failure, but also a failure in treatment and protocol for a patient with known behaviors.** Given that Mr. Marino had done this exact behavior just the day before, it is particularly egregious that additional precautions were not in place and/or enforced.\(^\text{13}\) The current system is riddled with a lack of interventions, and there were no alternatives or intensive therapy for Mr. Marino when he was
at his most vulnerable. The culmination of all these failures at BSH cost Mr. Marino his life.

**BSH, AS CONTROLLED BY DOC, IS INCAPABLE OF PROVIDING THE APPROPRIATE MEDICAL AND MENTAL HEALTH CARE THESE PATIENTS WERE SENT THERE TO GET.**

D. **Lack of Treatment In The Intensive Treatment Unit**

One of the most glaring violations of law at BSH is the failure of the system to provide therapy to individuals in restraint and seclusion. A patient with comparable suicidality to Mr. Marino at a Department of Mental Health hospital would not only be closely observed, but would remain engaged with the world through meaningful human contact, therapy and programming. BSH operates under a similar requirement, but one routinely disregarded.

G.L. c. 123 sec. 21 provides in relevant part: “No person shall be kept in restraint without a person in attendance specially trained to understand, assist and afford therapy to the person in restraint.” (emphasis supplied).¹⁴ G.L. c. 123 sec.1 defines “restraint” to include both “physical bodily force” and “confinement in a place of seclusion other than the placement of an inpatient or resident in his room for the night, or any other means which unreasonably limit freedom of movement.” This means that staff able to afford therapy must be immediately available outside the room of a secluded person. *O’Sullivan v. Secretary of Human Services*, 402 Mass. 190, 195-196 (1988). Mr. Marino, however, was deprived of meaningful human contact and therapy. STOs wholly failed to appropriately engage, or even watch, Mr. Marino, as set forth below.
The term “therapy” used in this context should mean mental health services provided to the patient by an individual with training, skills and experience in the field. Certainly this is the common usage of the word “therapy.”\(^\text{15}\) The intent of the legislature in passing G.L. c. 123 sec. 21 is even more clear because the person in attendance must be “specially trained to understand, assist and afford therapy…” Yet the staff ostensibly charged by DOC and MPCH with this task are not “specially trained to understand, assist and afford therapy” but merely “specially trained” as observers.\(^\text{16}\) Hence, their job title is “Specially Trained Observer” or “STO.” And they are not “in attendance immediately outside the room in full view of the patient when an individual is being secluded without mechanical restraint….” G.L. c. 123 sec 21. Further, as identified by the Department of Mental Health in the environmental scan report issued to DOC in December of 2014, “In practice, the STO is not conversing or creating a therapeutic dialog with the patient.” (ES Report 12/16/14, p. 13)

MPCH officials acknowledged that there are many errors and omissions on the restraint and seclusion forms. They explained that a seclusion or restraint assessment should not be a regurgitation of data but rather a summary of why that patient is secluded. MPCH stated that shoddy paperwork has been an ongoing problem. MPCH’s latest audit cited widespread legibility failures (BSH does not have an electronic records system), which DLC also found when reviewing Mr. Marino’s records. Mr. Marino’s records are riddled with mistakes. Examples of mistakes are the inclusion of another patient’s name and information in Mr. Marino’s records as well as clinical entries with the wrong date and time.

Another systemic failure of MPCH recordkeeping is that seclusion and restraint orders are supposed to be co-signed in a timely manner to show that the order was completed. However, Mr. Marino’s orders were not consistently cosigned in a timely fashion, and sometimes were not cosigned until hours later, or sometimes even the next day. These delays were systemic and were also found in seclusion and restraint discharge orders. For example, when Mr. Marino was restrained, he remained in 4 point restraints well after a discharge order was signed. These failures are
not just failures to keep accurate records. MPCH is not meeting the legal standard to seclude and/or restrain patients and patients are remaining in seclusion and/or restraint without legal authority or clinical indications to do so.

E. **Illegal Restraint in ITU Cell #14 the Day Before Mr. Marino’s Death**

Both DOC and MPCH officials explained to DLC that Mr. Marino repeatedly received toilet paper from the STO on duty and attempted to commit suicide by rolling and sticking a large amount of that toilet paper in his throat on April 7, 2016. After choking and coughing up the toilet paper, Mr. Marino was calm but MPCH Medical Director explained that he thought it was necessary to place Mr. Marino in 4 point restraint because he had just attempted to commit suicide and thought Mr. Marino was still a danger to himself, despite the fact that over 20 minutes had passed, Mr. Marino was medically cleared, and he was still in seclusion. MPCH staff controlled his access to the very materials he used to attempt to commit suicide. MPCH restrained Mr. Marino for over four hours. Mr. Marino did not meet the legal standard for a restraint, and such a restraint was not clinically appropriate.

The use of 4 point restraints at BSH is specifically controlled by DOC regulations. 103 DOC 651.05(6). The only permissible method for the placement of patients in mechanical restraint is the Humane Restraint System. This system of restraining a patient utilizes a softer bed with an inclined head and straps designed to hold the patient’s hands and legs without injuring them. The Humane Restraint System with Dura Max bed is located in Dorm-01 in the ITU. The room is very large with plenty of space for a STO to sit next to the patient. Although DOC’s own regulations do not permit any system of restraint other than the Humane Restraint System, DOC and MPCH also restrain patients in ITU cell 14 and Room 1 in the Infirmary. Both of these other restraint sites contain an outdated metal bed frame and painful leather posy straps.17
As acknowledged by MPCH officials, after coughing up the toilet paper, MPCH medically cleared Mr. Marino for restraint in cell 14 and ordered DOC to restrain him in cell 14. While MPCH writes the restraint orders, DOC carries out the orders. DOC regulations also require that ALL placement of patients in mechanical restraints “shall be videotaped.” 103

DOC 651.05(6) DOC violates its own regulation by not videotaping any patients who are placed in 4 point restraint. (Currently, DOC only videotapes the administration of intra-muscular medication on a patient in 4 point restraints.) In fact, DOC did not video the placement of Mr. Marino in 4 point restraint in cell 14, or later in Dorm-01. These restraints were only recorded by requesting preservation of the ITU overhead camera footage.

DLC questioned both MPCH and DOC officials about the use of the old restraint system since DLC had been unaware that DOC was violating its own regulations by using anything besides the Humane Restraint System. MPCH and DOC officials acknowledged that they not only use cell 14 for restraints but they also use another old restraint system in the infirmary and referenced a day during the week following Mr. Marino’s death when all three restraint systems were in use. When asked how the use of these alternative restraint sites are documented, DOC reported that Mr. Marino’s cell 14 restraint would have been noted in the inmate housing computer log; it was not. Not only was it illegal to use this form of 4 point restraint in cell 14, it was never documented anywhere that Mr. Marino was restrained in cell 14. Further, MPCH and DOC reported to DLC that patients are only restrained in cell 14 when another patient is already being restrained in the Humane Restraint System in Dorm-01. However, as noted by MPCH in an interview, Mr. Marino’s restraint order was signed at 12:04 pm on April 7, 2016. At that time, Dorm-01 was not in use. Another patient was ordered to be restrained and given intra-muscular medication in Dorm-01 at 12:15 pm on April 7, 2016. This other patient’s restraint in Dorm-01 is well documented. By the time this patient was ordered to be restrained and medicated in Dorm-01, Mr. Marino was already strapped to the metal bed with posies in cell 14. This raises serious concerns about the lack of transparency when a patient is restrained in cell 14 or the infirmary.
F. April 8th, 2016 Cell #11

DOC officials acknowledged that on April 8, 2016, Mr. Marino again obtained copious amounts of toilet paper from the STOs, choked on it and collapsed, and an emergency Code 99 was announced. COs responded to the Code 99 and entered his cell as Mr. Marino was lying motionless on the floor. They placed a shield over his face, hand cuffed him behind his back, and shackled his legs. Once the COs “secured” Mr. Marino on the floor, only then did medical staff enter the cell to determine that he needed immediate CPR. At that point, COs had to un-cuff one of Mr. Marino’s hands to allow for proper CPR administration. MPCH stated that Mr. Marino did not have a shockable pulse so he was not shocked but did receive CPR. Conversely, there was an overabundance of security precautions that contributed to significant delays in medical response times. This juxtaposition of the failure of mental health treatment, with the overabundance of security obstacles, highlights a further weakness in having DOC run BSH.

Approximately 12 minutes after the Code 99 was called, Bridgewater Fire Department (BFD) arrived in the ITU. BFD transported Mr. Marino to Morton Hospital and Mr. Marino was declared dead at 8:33 pm. Mr. Marino’s ITU cell was then sealed as a crime scene. The official death certificate issued by the Medical Examiner declared the cause of death as asphyxia due to an upper airway obstruction. The obstruction was wet tissue paper in Mr. Marino’s oropharynx. The Medical Examiner’s death certificate also noted that Mr. Marino died in a jail cell at BSH.

Until the end of his life, Mr. Marino continued to be observed by an STO and presumably a CO watching his cell via the camera and monitor. DOC and MPCH staff had absolute control over Mr. Marino and his environment, yet they provided him with the exact materials they already knew he had previously used one day earlier to try to end his life. This tragically unnecessary death further illustrates why individuals such as Mr. Marino should receive mental health services in a psychiatric hospital and not a prison.
G. Piecemeal Corrective Actions Wholly Fail to Address the Fundamental Problem with Bridgewater State Hospital

DOC officials discussed corrective actions they have taken or implemented as a result of deficiencies they noted from their own internal investigation of Mr. Marino’s suicide. DLC finds that each of these corrective action plans is insufficient and that the sole effective remedy must be to assign responsibility of Bridgewater to the Department of Mental Health.

The first and most obvious item discussed was the implementation of a restrictive protocol on toilet paper. DOC officials stated that it was necessary to have such a protocol because the STOs observing Mr. Marino did not follow the property restriction or doctor’s orders restricting his access to toilet paper. The new protocol will state how much toilet paper may be dispensed. The new protocol also addressed other things like access to Styrofoam cups, toothbrushes and serving trays. The written protocol will also require the STO to watch the person using the toilet paper, and document how the patient disposes of the toilet paper. These new protocols would be implemented for any patients deemed clinically appropriate by MPCH. The protocols would be clear that the STO would have to get someone’s attention, like a nurse or CO, if a patient turned his back to them and they couldn’t see what he was doing. DLC has not yet received a copy of these protocols.

Next, DOC officials reported to DLC that they are implementing a policy for patients who are being observed by a STO and for whom it is clinically appropriate, to have STOs able to see “heads and hands” at all times. This new policy is meant to address not only Mr. Marino’s suicide, but also several recent almost fatal suicide attempts at BSH. DOC officials also discussed as a corrective action the rewriting of Post Orders for COs in the ITU who are charged with viewing the camera monitors. Under such an order, there would be clear direction as to which of the monitors a CO would watch once the total number of patients in the ITU exceeds ten. As
part of an overall project to upgrade and increase monitoring by camera in the facility, 470 new cameras are being installed. These new cameras will provide the COs with the ability to tilt and zoom the cameras. More importantly, there will also be a camera in the room where the COs monitor the ITU cells via live camera footage. This would give DOC the opportunity to verify what the COs are actually doing.

There are several death investigations proceeding. There is a mortality review underway, a Root Cause Analysis (as per Joint Commission requirements), and a morbidity review of the other patient who almost bled to death despite an assigned STO and CO watching the cell remotely. DOC informed DLC that the Marino death investigation is proceeding and the State Police/District Attorney’s office was interviewing MPCH and DOC staff.

While it is important that DOC and MPCH staff address some of the mistakes and failure to follow their own regulations and policies, it is evident that this is at best a piecemeal approach. Until fundamental systemic changes occur, BSH will continue to threaten and risk the lives of these vulnerable patients.

None of these incremental changes in policies and practices or reviews come close to the structural and transformative change that is needed. In fact, the Commonwealth’s own analysis, done through two Department of Mental Health (DMH) on site environmental scans recorded in a written report, (“ES Report”) \(^\text{18}\) illustrates this point. Among other things, DMH found that BSH is challenged to provide a dual-mission, multi-modal service: a medium security prison, a jail, a mental health treatment service in a **structure and environment that is inconsistent with standards for contemporary psychiatric care.** (ES Report at 6; emphasis supplied) DMH noted that the most critical feature observed is the level of fear, and sense of chaos, trauma and confusion about the hospital’s mission that seems to be pervasive in the environment. (ES Report at 7.) While DMH concluded at the time that “[s]ustainable culture and practice change has not occurred….\)” \(^\text{19}\), ES Report at 7, it is even more disturbing to review ways
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in which the physical plant, resources, policies and culture of BSH have not changed in the 18 to 24 months since both reports were issued.

**DLC DEMANDS THAT CONTROL OF BSH BE TRANSFERRED TO DMH AND PLACED INTO RECEIVERSHIP TO PREVENT FURTHER DEATHS AND HARM TO PATIENTS.**

IV. Recommendations

As a result of DLC’s experience monitoring Bridgewater State Hospital for the past 16 months and in light of the findings in this death investigation, it is abundantly clear that Bridgewater State Hospital, as controlled by the Department of Corrections (DOC), is incapable of providing the appropriate medical and mental health staffing necessary for the care and treatment of patients with mental illness. DOC is also incapable of effectively changing the prison culture that exists in a correctional facility where patients receive punishment in lieu of treatment. Therefore, DLC is once again demanding the following:

The Governor, through the Executive Office of Public Safety and Security (EOPSS), and the Executive Office of Health and Human Services (EOHHS), should immediately take the following action:

1) Remove the functions of administration, operations, medical and mental health care, treatment and programming at Bridgewater State Hospital (BSH) from the purview of EOPSS and DOC, placing these responsibilities solely under the Department of Mental Health (DMH) and EOHHS.

2) In order to achieve this transfer, which must be accomplished no later than end of calendar year 2016, the facility and all of its operations should be placed into receivership under the purview of EOHHS.
For purposes of the PAIMI Act, a “full investigation” is defined as “the access to facilities, clients and records… that is necessary for a P&A system to make a determination about whether an allegation of abuse or neglect is taking place or has taken place.” 42 C.F.R. § 51.2.

Further, “neglect means a negligent act or omission by an individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes, but is not limited to, acts or omissions such as failure to: establish or carry out an appropriate individual program or treatment plan (including a discharge plan); provide adequate nutrition, clothing, or health care; and the failure to provide a safe environment which also includes failure to maintain adequate numbers of appropriately trained staff.” 42 C.F.R. § 51.2.

Finally, “complaint includes, but is not limited to any report or communication, whether formal or informal, written or oral, received by the P&A system . . . (including anonymous calls) from any source alleging abuse or neglect of an individual with mental illness.” 42 C.F.R. § 51.2.

DLC also serves as the monitor under our December 15, 2014 agreement with the Commonwealth as well as under the terms of the Minich settlement, but as was explicitly stated in both of those agreements, nothing in either of those agreements limits DLC’s statutory authority under 42 U.S.C. § 10805(a) or 42 U.S.C. § 15403 as the Protection and Advocacy System for Massachusetts.

Specifically, DLC requested, and received: 1) the name and identification number for the individual who died; 2) any and all videotapes, camera footage or photos of the deceased in the ITU from the time period of his most recent admission to the ITU until 24 hours after the pronouncement of death; 3) all records concerning the deceased, including any and all incident reports, morning and afternoon risk meeting minutes, and any reports or documents concerning his death created subsequent to his death; 4) any and all documents from the ITU which refer to the deceased, including any logs of the mental health workers, observation sheets, medication orders, seclusion and restraint orders, individual crisis plans, and documents reflecting whether the deceased showered or did recreation activities during his most recent admission to the ITU.

This report is being issued simultaneously with a more detailed private report to the Executive Office of Public Safety and Security and the Massachusetts Department of Corrections, containing confidential information that is outside of the public record.

The environmental scan reports are discussed in more detail below.

The name for Bridgewater’s seclusion unit is another sad, ironic twist. Clinical and correctional staff alike agree that the ITU offers no “intensive treatment” and exists only to prevent self-harm of patients, or harm to other patients or staff. The theory is that this can be accomplished through isolation and observation.

Bridgewater State Hospital is not a “hospital” and it is inappropriate for the state to label it as such. As noted in the DMH environmental scan discussed below, it is a medium security prison accredited by the Joint Commission only under lesser standards for a behavioral healthcare facility.

Individual Crisis Plans (ICPs) are mandated under both settlement agreements. ICPs should be age and developmentally appropriate, identify triggers that may signal or lead to agitation or distress in committed patient, and identify specific strategies to help patients and all BSH staff intervene with de-escalation techniques to reduce agitation and distress so as to decrease and/or avoid the use of seclusion or restraint. See Counsel Agreement p. 4, DLC Agreement p. 17. These ICPs are to be drafted with input with input from the patient, or patient’s legal guardian, and may include consultation with DMH and the patient’s family. See Minich Agreement p. 13, 4. Since patients are often able to articulate interventions that would help calm them during periods of agitation and anxiety, patient involvement and these
interventions will be articulated in the ICP. See DLC Agreement p. 17. Each patient’s treatment team at BSH should discuss ICPs that are developed for a patient to ensure proper implementation of the plan. See Minich Agreement p. 14.

BSH clinical staff should develop an ICP for a patient, or review and refine a patient’s existing ICP, as deemed clinically appropriate with the goal of reducing or avoiding the further use of seclusion and restraint with such patient. BSH clinical staff should also review and modify such patient’s master treatment plan during this process. Additionally, ICPs may be developed for any other patients who may benefit from one. See Minich Agreement p. 13.

9 A fundamental hallmark of the federal constitutional right to treatment for involuntarily institutionalized persons is the development and use of a treatment plan that is individualized for each patient. See Wyatt v. Stickney, 334 F. Supp. 1341 (M.D. Ala. 1971), opinion supplemented by 344 F. Supp. 373 (M.D. Ala. 1972) modified sub nom. Wyatt v Aderholt, 502 F2d 1305 (5th Cir. 1974).

10 MPCH reported to DLC that there are approximately 30 full time mental health worker employee positions, but about 60 mental health workers employed at BSH because there is a large per diem pool. MHWs also change posts and may be pulled from one unit to another. This turnover, and shifting posts, negatively impact the continuity of care for patients at BSH. MPCH explained that the Director of MHW supposedly oversees MHWs, but on units MHWs are really supervised by nurses. The Director of Nursing oversees both nurses and the Director of MHWs. MPCH has approximately 40 full time employee nursing positions at BSH, but approximately 85 nurses are employed because shifts are not consistently filled.

11 It is important to note that throughout his stay at BSH, Mr. Marino was severely constipated and would go very long stretches of time without using the toilet, except to urinate. This compounds the egregiousness of continuously giving toilet paper to a suicidal patient with major depression in seclusion who had attempted suicide by choking on toilet paper twice previously, within the last 9 days at BSH.

12 Apparently although the protocol calls for there to be two COs once there are 11 or more patients in the ITU, the protocol does not spell out which CO is responsible for watching which cell numbers, so in essence, both COs are responsible for the overall group, rather than sub-dividing them in any systematic way. DOC is revising the CO ITU camera viewing “Post Order” which will spell out more clearly that when the number of patients if 11 and up, that CO no. 1 is responsible for monitors for 1-6, and CO no. 2 is responsible for cells 7-14. In addition, they are also planning to re-locate the monitoring COs. ITU COs will be going back to the trap near the front door (where they were when DLC did its first investigation) to reduce distractions from their specific duties. Ironically, this is the original trap that was being repaired when Mr. Marino was in the ITU during periods of loud construction noise.

13 The BSH Medical Director working for DOC’s medical provider told DLC that they could not have been expected to anticipate Mr. Marino’s actions because suicide using toilet paper has not been reported in the medical literature. The larger point here is that Mr. Marino showed by both his words and his actions his intention and his expected method for attempting suicide. Beyond this, DLC’s own examination of reports in the medical literature and the popular media showed many examples of suicide using similar means, when patients and prisoners are confined in isolation and lack other alternatives. A digest of case reports is available from DLC upon request.

14 This portion of the statute continues: “The person may by [sic] in attendance immediately outside the room in full view of the patient when an individual is being secluded without mechanical restraint; provided, however, that in emergency situations when a person specially trained is not available, an adult, may be kept in restraint unattended for a period not to exceed two hours. In that event, the person kept in restraints must be observed at least every five minutes; provided, further, that the superintendent, director, or designated physician shall attach to the restraint form a written report as to why the specially
trained attendant was not available. The maintenance of any adult in restraint for more than eight hours in any twenty-four hour period must be authorized by the superintendent or facility director or the person specifically designated to act in the absence of the superintendent or facility director; provided, however, that when such restraint is authorized in the absence of the superintendent or facility director, such authorization must be reviewed by the superintendent or facility director upon his return.”

15 “The treatment of mental or psychological disorders by psychological means…” See Oxford Dictionary, available at http://www.oxforddictionaries.com/us/definition/american_english/therapy. Moreover, this would be in keeping with how “therapy” is used in state regulations. See 130 CMR. 429.421B (Division of Medical Assistance Mental Health Center Services) (referring to long-term, short-term, individual, couple, family and group therapy); 130 CMR. 429.402 and 432.402 (defining these terms); 105 CMR. 140.520(D)(1) (requiring individual, group, couple, and family therapies to be provided by mental health clinics being licensed by the Department of Mental Health).

16 In light of the facts leading to the death of Mr. Marino, set forth in detail in Section III of this report, the efficacy of this training appears highly questionable.

17 If a patient is restrained, and administered IM medication, that medication administration is hand-held video recorded. If the patient is not administered medication, then no part of the restraint is hand-held video recorded, despite the regulatory requirement that all restraints must be videotaped. 103 DOC 551.05(6). If both Dorm-01 and cell 14 are in use, DOC uses a bed in the Infirmary for further overflow. Recently, MPCH was looking for a fourth restraint bed because the Humane Restraint System, cell 14 and the Infirmary bed were all in use with patients being restrained.

18 LeBel et. al., “Bridgewater State Hospital Environmental Scan- Follow Up,” Department of Mental Health, December 16, 2014 (p. 1-22) and Appendix A, “Bridgewater State Hospital Environmental Scan,” Department of Mental Health, June 20, 2014 (p. 23-29).

19 To choose but one small example: DOC officials are constrained by the collective bargaining agreement for corrections officers (COs) and are required to accept COs with seniority who choose to transfer from correctional facilities to BSH for geographical or other reasons – even if an individual lacks the temperament or interest in working with patients with serious mental illness.