

# **DISABILITY LAW CENTER INVESTIGATION REPORT**

## **Patient Deaths at Arbour Health Systems**

### **Westwood Lodge Hospital and Pembroke Hospital**

#### **EXECUTIVE SUMMARY**

The Disability Law Center (“DLC”), the Protection and Advocacy (“P & A”) system for Massachusetts, investigated the deaths of two patients at two Arbour Health Systems facilities: Westwood Lodge (now closed) and Pembroke Hospital. Dan Smith (a pseudonym) died on April 25, 2015, after being at Westwood Lodge for a period of 16 days. Mary Jones (a pseudonym) died on August 30, 2015, after being at Pembroke Hospital for a period of 2 days. DLC analyzed whether these individuals were subject to abuse or neglect in connection with their hospital stays or their deaths. Based upon an extensive review and analysis of relevant documents and primary investigations, DLC finds that both of these individuals had been subject to neglect while each of them had been a patient at their respective facilities. In addition, Westwood Lodge abused Mr. Smith when it administered a medication restraint in violation of state regulations.

In October of 2014, the Department of Mental Health conducted an annual site inspection of Pembroke Hospital. In response to those findings, Pembroke Hospital initiated a “Relearn” program in December of 2014. The curriculum specifically included retraining in the completion of “Patient Observation Rounds.”

In April of 2015, Mr. Smith arrived by ambulance at Westwood Lodge, where he signed in as a “conditional voluntary” patient, complaining that his medications for treating his mental illness were not working and that he had stopped taking the medications. While there, he exhibited self-injurious behaviors, such as punching himself in the face, head banging and trying to choke himself. To treat these symptoms and reduce the behaviors, he was prescribed a variety of strong medications, causing him to sleep for long periods of time. After he awoke, however, the symptoms and behaviors would return again, but with increased severity. Throughout his hospitalization, Mr. Smith went through a recurring cycle of behavior and treatment. During his hospitalization, the level of observation and monitoring varied, from five-minute checks to one-to-one observation, to suicide prevention. On the day before he died, he was taken off of one-to-one observation with suicide protocols and returned to five minute checks. On the day he was found dead, the 5 minute observational rounds had not been conducted properly. The life-saving equipment that was used in an attempt to revive him had not been properly maintained and failed to work.

During his time at Westwood Lodge, Mr. Smith was neglected in a variety of ways. The facility failed to provide a safe environment when it did not properly conduct the observational rounds, which resulted in a substantial delay before he was discovered by staff. The failure of Westwood Lodge to properly maintain its life-saving equipment resulted in the equipment not functioning when staff attempted to revive Mr. Smith. The

facility neglected Mr. Smith when it failed to establish or implement an effective treatment plan. Examples of these failures include: failing to notify a physician of his history of being over-medicated; not effectively addressing his hallucinations, serious self-injurious and suicidal behaviors; not notifying a physician of those well-documented cycles of behavior; not treating Mr. Smith with trauma informed care despite knowing that he had been a victim of sexual assaults; not maintaining Mr. Smith on 1:1 constant observation suicide prevention; despite his need for same. Finally, Westwood Lodge abused Mr. Smith when it administered a medication restraint in violation of DMH regulations. The death of Mr. Smith, a 32 year old man, was caused or may have been caused by the neglect and abuse he experienced during his 16 day hospitalization at Westwood Lodge.

After the death of Mr. Smith, Westwood Lodge provided DMH with its Corrective Action Plan which required that all staff be trained in completing "Observation Rounds" in accordance with hospital policy on September 25, 2015.

In the early morning of August 28, 2015, Mary Jones arrives at Pembroke. Her diagnosis was major depression disorder and bipolar disorder. The comprehensive assessment indicated that she had a plan to "overdose on pills," that past emotional and sexual abuse resulted in her currently experiencing nightmares and flashbacks. Her intelligence, awareness, ability mood and affect, thought process and perceptions were all described as "impaired." Despite her impaired mental status, she was prescribed Abilify, Suboxone, Thorazine, Valium, Lexapro and Tenex. Notably, these medications were in addition to the following "home" medications that were ordered to be continued: Aripiprazole, Lithium, Topiramate, Escitalopram, Prazosin and Chlorpromazine. Despite her condition upon admission, the facility had her sign authorization for treatment, including purportedly giving informed consent for a complicated medication regimen, including some that were "off label." Her age was inaccurately noted as 31, when in fact she was only 20 years old. Upon awakening during the afternoon of August 28, Ms. Jones refused her medications. She was given 10 mg of Valium and 2 mg of Suboxone. At approximately 8:00 PM, Ms. Jones was given 100 mg of Thorazine.

On August 29, 2015, Ms. Jones was feeling nauseous and dry heaving. The duty nurse had concerns that Ms. Jones was pale and vomiting that morning. Since Ms. Jones had recently been started on new medications, the duty nurse questioned whether the symptoms were a side effect of the medications. The duty nurse did not want Ms. Jones to become sedated and was particularly concerned about the combined use of Suboxone and benzodiazepine. That same day, her mother came to visit and expressed her concern about the effect of the medication, stating, "this is not my daughter, she seems like a zombie." When interviewed later, her mother stated that when she visited her daughter, "she did not look right, she looked drugged." Later that afternoon, Ms. Jones requested nicotine gum, but after request was denied, she escalated and demanded a nicotine patch. Ms. Jones began to scream, hit a wall with her fist and ran into her room while continuing to scream. Her request to go to dinner later was denied.

Ten minutes later she was quoted as saying, “I want to die.” Contemporaneous notes stated that “benign neglect utilized with good effect.”

On August 30<sup>th</sup>, according to nursing notes, Ms. Jones was sedated and went to bed after dinner. She went to sleep around 7:30 and did not wake up that evening. Ms. Jones was supposed to be on 15 minute safety checks but Pembroke failed to conduct those safety checks in accordance with hospital policy. Claims of staff that rounds had been properly performed were contradicted by the video evidence. When she was discovered by staff at 5 am, she appeared to be pale and in rigor mortis. Based upon the state of her rigor mortis when discovered, the EMT’s estimated it to have been occurring for two hours – contradicting the claim that safety checks had been timely conducted earlier that morning.

During Ms. Jones’ hospitalization, Pembroke hospital neglected her in numerous ways. Pembroke hospital failed to provide Ms. Jones with a safe environment when it failed to conduct patient observations in accordance with hospital policy. The facility also failed to comply with hospital policy when, after finding her unresponsive, staff left her in her room unattended. Pembroke also neglected Ms. Jones when it failed to maintain an appropriate treatment plan. Specific examples of that failure include the following: Pembroke failed to accurately record her age, which resulted in their failure to consider whether her abnormally elevated heart rate was a medical condition or a medication-related side effect; Pembroke failed to provide her with a “wash out period” before beginning her medication regimen; Pembroke failed to notify a physician that she had vomited and developed a migraine, despite the concern of nursing staff that Ms. Jones was experiencing the side effects of Suboxone and benzodiazepine; staff also failed to notify a physician of the concern of Ms. Jones’ mother that her daughter was being prescribed Lithium nor informing a physician of her mother’s serious concern about her daughter’s condition; Pembroke failed to treat her with trauma informed care despite knowing her history of being a victim of sexual abuse. Pembroke Hospital also neglected Ms. Jones when it failed to obtain informed consent and specific informed consent in violation of state regulations. The death of Ms. Jones, a 20 year old woman, was caused or may have been caused by the neglect she experienced during her 2 day hospitalization of Pembroke Hospital.

After the death of Ms. Jones, Pembroke Hospital provided DMH with its corrective action plan that MHAs and Nurses be retrained on completing patient observation rounds. On August 24, 2017, the State closed the Westwood Lodge Hospital psychiatric hospital due to issues of patient safety, quality of care, and the facility’s failure to comply with DMH requirements.

DLC is demanding a detailed remedial plan to address the concerns identified in its investigation report, including instituting a training program that is effectively presented and received, as well as a robust monitoring plan to ensure that the critical lessons learned from these tragic deaths are never repeated in the future.

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#### **I. Introduction**

The Disability Law Center (DLC) is a private, non-profit organization mandated by Congress and designated by the Governor of Massachusetts to provide protection and advocacy (“P & A”) services to individuals with mental illness, pursuant to the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. §§ 10801 et seq. Pursuant to this federal mandate, DLC is authorized to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to the system or if there is probable cause to believe that the incidents occurred.” 42 U.S.C. § 10805(a)(1)(A).

The PAIMI regulations define the terms “abuse” and “neglect” as follows:

Abuse means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restraints; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment or any other practice which is likely to cause immediate physical or psychological harm or result in long term harm if such practices continue.

42 C.F.R. § 51.2.

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 number of appropriately trained staff.

42 C.F.R. § 51.2.

## II. The Death of “Dan Smith”<sup>1</sup>

### Background

On March 29, 2017 the Disability Law Center received a complaint to the system regarding Dan Smith who died on April 25, 2015 while a patient at Westwood Lodge Hospital.

On March 30, 2016, DLC contacted the Disabled Persons Protection Commission (DPPC) and requested a copy of their investigation report into the death of Mr. Smith, pursuant 42 U.S.C. §10805 (a)(1)(A). Upon review of DPPC’s report DLC determined that there was probable cause to conduct a full investigation.

On April 13, 2017 DLC invoked its statutory authority as the P&A to conduct an investigation, and informed DMH that it was initiating an investigation into the death of Mr. Smith.

### DMH Decision, June 19, 2015

DMH licensing investigated and made, inter alia, the following key findings in its decision dated, June 19, 2015:

- “WWL has no policy specifying the staff requirements relative to completion of the Unit Based Equipment Checks log...and that WWL has no procedure or protocol through which the BVM/oxygen mask tank connection is tested.”<sup>2</sup>
- “The actions of caregivers (e.g. the failure of [staff] to complete safety checks for the patient at the frequency ordered) created or contributed to an incident and/or condition that was dangerous, as defined in DMH Regulations 104 CMR 32.00.”<sup>3</sup>
- “The lack of policy and procedure addressing the viability of unit emergency medical equipment ... by Westwood Lodge further created or contributed to an incident and/or condition that was dangerous.”<sup>4</sup>

DMH found that “Westwood Lodge staff acted in a manner that could be considered as dangerous (as the term is defined in DMH regulation) in regard to the care and treatment of the Client.”<sup>5</sup>

### Cause of Death:

The Office of the Medical Examiner listed the cause of Mr. Smith’s Death as “probable cardiac dysrhythmia in a person with schizophrenia.”<sup>6</sup>

## **Statement of Facts**

On April 8, 2015 Dan Smith self-presented to Lowell General Hospital-Saints Campus (LGH-STC) and informed staff that he was experiencing command hallucinations to kill homeless people. He told staff that it took him over an hour to walk to the campus even though he lived down the street because he thought that people were trying to hurt him and he kept looking over his shoulder. He further reported that he tried to overdose on cocaine the day before.<sup>7</sup>

Mr. Smith informed staff that there are two people who talk to him: Ken & Rye. Of the two, Ken is the bad one who gets him into trouble with the police, and tells him that he has magic powers that allow him to walk in front of cars, and that bullets will bounce off his chest.<sup>8</sup>

The record reflects that Mr. Smith was a trauma survivor as he was raped by an older relative when he was 12 years old. It was recommended that Mr. Smith be admitted as an inpatient for medication stabilization and safety containment.<sup>9</sup>

Mr. Smith was 32 years old when he died. The Office of the Chief Medical Examiner relayed that the cause of death was determined to be “probable cardiac dysrhythmia in a person with schizophrenia.”<sup>10</sup>

## **Course of Hospitalization**

Mr. Smith arrived at Westwood Lodge by ambulance at 6:35 PM on April 9, 2015. He signed in as a “conditional voluntary” patient pursuant to MGL c. 123 §§ 10, 11.<sup>11</sup> His diagnosis was paranoid schizophrenia.<sup>12</sup> Upon admission he was prescribed medication, including: Lisinopril, Haldol, Zyprexa, Benadryl, Tenex, Trileptal, Neurontin and Lexapro.<sup>13</sup> During the course of his hospitalization, various other medications were administered, including Thorazine, Ativan, Klonopin, and Clozaril.<sup>14</sup>

The admission note states that Mr. Smith reported that his “medications are not working” and that he “hears voices telling him that he has powers and can’t get hurt.” He reported that he stopped taking his medication three days ago. He said that he was experiencing increased depression, crying at times and not feeling like a man.”<sup>15</sup>

The nursing assessment reflected that Mr. Smith was a victim of physical and sexual abuse and that he experience flashbacks and nightmares.<sup>16</sup> Mr. Smith informed staff that his medications stopped working and he stopped taking them. He reported that he hears voices and he can’t get rid of them.<sup>17</sup> The initial clinical summary notes that Mr. Smith had a history of substance abuse.<sup>18</sup> Mr. Smith was considered to be at risk of suicide and homicide.<sup>19</sup> He has admitted to Adult Unit 2 and was placed on “5 minute checks for safety.”<sup>20</sup>

On April 10, 2015, Mr. Smith was sent out to the Norwood Hospital Emergency Department for assessment and treatment of a cough. An X-Ray taken of Mr. Smith’s

chest showed that Mr. Smith's heart was of normal size and configuration. And that "no acute cardiopulmonary disease was seen."<sup>21</sup>

While hospitalized Mr. Smith actively engaged in self-injurious behaviors on numerous occasions. He punched himself in the face several times between April 11 and 17, 2015; engaged in head banging on April 22, 2015; and, attempted to choke himself on April 16, 2015. These behaviors were triggered by auditory and visual command hallucinations directing him to hurt himself and others.

To treat his symptoms and to reduce these behaviors, Mr. Smith was prescribed various medications supplemented with PRNs. The medical record indicates that these medications were effective in reducing these behaviors by sedating Mr. Smith to the point that he would sleep for extended periods. Upon awaking, Mr. Smith's symptoms and behaviors would return with increased severity.

The use of medications in this manner drastically impacted Mr. Smith's ability to function. There are numerous examples where he was observed as being highly sedated. Staff regularly observed Mr. Smith being groggy; mumbling and difficult to understand; sluggishly slurring his speech; drooling; unsteady on his feet and stumbling on the unit. In one instance Mr. Smith was so significantly impaired that he was observed futilely attempting to throw a water cooler and a trash container across the unit. The record also reflects that he was observed as being unable to read, wash an apple, or open a package of animal crackers. On more than one instance he was unable to use the bathroom without urinating on himself.

When not sedated, Mr. Smith would pace the unit and demand medication to help him sleep, or to quiet the voices in his head. At one point, Mr. Smith requested to be chemically restrained and staff consented.

Mr. Smith's course of hospitalization reveals an increasingly serious and repeating cycle of behaviors that would begin with increased agitation, pacing and medication seeking, followed by command hallucinations, threats of homicidal and suicidal behaviors, and resulting in self-injurious behavior. (A detailed recitation of that breakdown is set forth at page 6.) Westwood Lodge would respond by medicating Mr. Smith to the point of insensibility where he would stumble about the unit trying to remain awake until he would eventually pass out and sleep for extensive periods of time.

As Mr. Smith's behaviors worsened, staff varied the level of observation from five-minute checks, to one-to-one observation, to suicide prevention. During Mr. Smith's brief periods of calm, staff would prematurely return Mr. Smith to five-minute checks which ultimately placed him at risk.

On April 24, 2015, Mr. Smith awoke from the third and most extreme manifestation of this cycle after having slept for nearly twenty-four hours. In a matter of a few hours he was taken off of one-to-one observation with suicide prevention protocols and placed back on five-minute checks.

As determined by DMH in its investigation into the death of Mr. Smith, Westwood Lodge staff did not conduct the five-minute checks properly and Mr. Smith was found unresponsive at 3:20 AM on April 25, 2015.

The specific details and a day-to-day breakdown of Mr. Smith's cycle of behavior is described below.

### Cycle of Behavior and Treatment

- April 9 through 14, 2015: Five Minute Checks

On April 10, 2015, Mr. Smith was placed on five-minute checks for safety. The record notes that he was "visible on the unit," "socialized with other patients" and was in no "immediate distress."<sup>22</sup> On April 11, 2015, Mr. Smith punched himself in the face, leaving a large bruise on his right cheek. He reported to staff that that the voices were telling him to hurt himself.<sup>23</sup>

On April 12, 2015, Mr. Smith again began punching himself in the face. Staff gave Mr. Smith Ativan and Thorazine.<sup>24</sup> On April 13, 2015, after reporting to staff that the voices are telling to hurt himself, he was given an Ativan and slept.<sup>25</sup> On April 14, 2015, Mr. Smith reported hearing voices and seeing things that weren't there. Mr. Smith was given Ativan.<sup>26</sup>

- April 15 through 19, 2015: One-to-One Observation

On April 15, 2015, Mr. Smith was placed on 1:1 observation after reporting that the voices were telling him to "kill the patients and kill himself."<sup>27</sup> He was given medication but "continued to hear voices." He was observed to be very groggy and mumbling when he talked. At 1:00 PM he was seen sitting on the floor "punching himself in the face."<sup>28</sup> He was given additional medication and fell asleep. He awoke and reported that the "voices woke him up"<sup>29</sup> and they were telling him to "stab staff and the patients."<sup>30</sup> He was given a PRN so he could "go to sleep."<sup>31</sup> After awaking he reported that he was "seeing people rape him"<sup>32</sup> and identified his assailant as the "guy who raped him."<sup>33</sup> Mr. Smith was later observed as being "highly sedated"<sup>34</sup> or "pacing in the hall."<sup>35</sup>

On April 16, 2015, Mr. Smith was "pacing on the unit," being "very demanding," and "constantly asking for medication." Staff withheld his medication as he was experiencing "very increased sedation."<sup>36</sup> After reporting that the "voices were back he was given Ativan."<sup>37</sup> He told staff that the medication wasn't working and he wanted to "choke himself out."<sup>38</sup> He was given additional medication and was observed sitting in the hall "dozing off."<sup>39</sup> He was observed making attempts to choke himself. Mr. Smith told staff that he wanted to be "chemically restrained, and that he agreed to IM (intramuscular) injections."<sup>40</sup> Mr. Smith was "sedated for his own safety."<sup>41</sup>

On April 17, 2015, Mr. Smith woke up from 'the voices' and reported that they were telling him to stab himself with a pen. He was given additional medication and was observed as being "pretty sedated."<sup>42</sup>

On April 18, 2015, Mr. Smith was “unsteady on his feet,”<sup>43</sup> and “hard to understand.”<sup>44</sup> He told staff that he was “no longer hearing voices.”<sup>45</sup> He attempted to attend the “goals” group, but left because he was unable to read the sheet. He was observed “pacing while waiting for dinner.”<sup>46</sup> After dinner, he reported hearing voices telling him to kill people and that he was homicidal. It was noted that Mr. Smith had a “swollen right eye with a reddened area.”<sup>47</sup> He told staff that he “punched himself in the face.”<sup>48</sup>

On April 19, 2015 Mr. Smith reported pain in his abdomen. He was sent to Norwood Hospital for treatment. He returned to Westwood Lodge that day at 1:30 PM. Mr. Smith briefly went outside, sat at a picnic table and nearly fell off. Mr. Smith spent most of the day sleeping; he fell asleep at approximately 9:15 PM and did not awaken until 7:15 AM where staff noted he was “visibly sleepy.” Mr. Smith went back to bed and slept until 1:30 PM on April 20, 2015.

- April 20 through 21, 2015: Five Minute Checks

On April 20, 2015, Mr. Smith was observed as “pleasant and cooperative” on the unit and the “1:1 observation was discontinued.” A medication order was given to increase his “Clozaril”<sup>49</sup> Mr. Smith slept most of the day.

On April 21, 2015, Mr. Smith was “agitated.”<sup>50</sup> He reported that he was hearing voices and seeing things. When asked what he was seeing he responded “Ken, he’s the guy I always see.”<sup>51</sup> Mr. Smith reported that the voices were telling him to “drown himself in the toilet, to burn the place down and kill the staff.” Mr. Smith was put on “5 minute checks for safety.”<sup>52</sup> He was given Ativan and Zyprexa. He was observed as being “extremely drowsy and falling asleep in the hall.” He refused staff’s suggestion that he lay down because when he did so he experienced increased “drooling caused by his medication.”<sup>53</sup>

- April 22 through 24, 2015: 1:1 Observation with Suicide Precaution II Protocols

On April 22, 2015, Mr. Smith reported that he “hurts himself because it’s the only thing that makes him happy.” At 2:00 PM Mr. Smith was “head banging” and reported that he “heard voices telling him to kill himself in the toilet.”<sup>54</sup> At 12:45 PM he was placed on “1:1 observation with suicide precautions II protocols.”<sup>55</sup> It was noted that Mr. Smith had a “lump on left eyebrow from head banging.”<sup>56</sup> By mid-afternoon Mr. Smith was asking for medication and lined up at the window and “asked for a PRN.”<sup>57</sup> “At 7:52 PM the medication nurse brought him his night medications.”<sup>58</sup> A short time later staff observed that he was in his room sleeping and “drooling from meds.”<sup>59</sup>

On April 23, 2015, Mr. Smith was very sedated and “complained of drooling due to medication.”<sup>60</sup> At 11:00 AM, he met with his doctor and reported that he “still hears voices that tell me I’m worthless.”<sup>61</sup> At 12:30 PM Mr. Smith “took medication and sat in the hallway.”<sup>62</sup> He was “agitated about his drooling problem.”<sup>63</sup> Staff noted that although he was “extremely sedated, he would not lay down because he keeps drooling.”<sup>64</sup> Mr.

Smith was observed stumbling around the hall attempting to throw the trash can and the water cooler before he “laid down at 2:00 PM.”<sup>65</sup>

Mr. Smith got up at mid-afternoon and was “extremely hard to understand, sedated, having difficulty walking, and was drooling a lot.”<sup>66</sup> At one point he got “two packages of animal crackers and an apple, he needed assistance to wash the apple, and was struggling to open the snack packages.”<sup>67</sup> Mr. Smith rested briefly but he was out of bed at 3:45 PM to get medication. “He was told he’s not due anything until 6pm.”<sup>68</sup> Mr. Smith became “agitated by this news and went back to bed.”<sup>69</sup>

On April 24, 2015, Mr. Smith got up and went to the kitchen. At 10:00 AM the record notes that he “was restless, got out of bed and sat in hall waiting for medication.”<sup>70</sup> He told staff that was “feeling much better and denied any auditory hallucinations.”<sup>71</sup> He told staff that “he has a meeting with his social worker and was hoping to go home soon.”<sup>72</sup>

At 11:10 AM, Mr. Smith told staff that on the prior day a patient “offered him some heroin.”<sup>73</sup> By 11:45 AM, he was sitting in the hall “dozing off and got up and asked for and was given Ativan for anxiety.”<sup>74</sup> By noon, Mr. Smith was “pacing in the hallways.”<sup>75</sup> Mr. Smith told staff that “he wants off of this one to one.”<sup>76</sup>

Mr. Smith’s case manager’s daily progress note for April 24, 2015 noted that she “met with Mr. Smith on the unit.” She stated that he was in a “shitty mood, but happy he is not drooling’ anymore.” Mr. Smith wanted to talk to his doctor about a medication change. She noted that Mr. Smith denied feeling suicidal or homicidal but that he “still hears voices.” The case manager noted that Mr. Smith exhibited an “unstable affect.” and that he is hearing voices telling him that “he’s not worth anything.”<sup>77</sup>

At 1:00 PM Mr. Smith met with Dr. Levin and his case manager. According to the record, Dr. Levin thought that Mr. Smith was improving. Dr. Levin told Mr. Smith to “tell the regular Dr. to keep increasing Clozaril and to [discontinue the] Haldol.”<sup>78</sup> Mr. Smith asked Dr. Levin to be taken off 1:1. Dr. Levin “discontinued the 1:1 at 1:20 pm.”

- April 24, 2015: Five Minute Checks

Mr. Smith was placed on five minute checks at 1:20 PM. There are no subsequent entries in the medical record until 3:45 AM when Mr. Smith was found unresponsive.

- April 25, 2015

On the morning of April 25, 2015, Mr. Smith was on five minute checks. It was the responsibility of the assigned staff to conduct the checks in accordance with policy # RI.062. At 3:20 AM Mr. Smith was found not breathing, lying on his stomach with vomit around his mouth. He had no pulse. Staff initiated chest compression, called a code blue and 911.<sup>79</sup>

## Police Report of Officer Christopher Aylward

Officer Aylward of the Westwood Police Department was dispatched to Westwood Lodge at about 03:27 hours on April 25, 2015. He was directed towards Mr. Smith's room where there were "several nurses in the room performing CPR and then the Westwood Fire Paramedics took over."<sup>80</sup> Officer Aylward stated that when he observed Mr. Smith he was "cyanotic," and was told by staff that the "AED was advising no shock."<sup>81</sup>

The on-duty nurse informed Officer Aylward that she had just gotten back from her break, when she started her rounds. She reported that she "checked on Mr. Smith at about 03:20 hours and found him face down on the bed. She did not see any signs of respiration and when she checked, she discovered that he was not breathing and had a small amount of vomit coming from his mouth."<sup>82</sup>

Officer Aylward asked several nurses who was the last to check on Mr. Smith. According to his report, no one could tell him, saying they "would have to look at the check board." (Patient Observation Rounds log) Officer Aylward eventually found a nurse with the board and she told him that the last check was at 03:15. When Officer Aylward asked who did it, the nurse said "it says [the nursing supervisor] but we were performing CPR."<sup>83</sup>

Officer Aylward spoke to the nursing supervisor, who told him that she "checked on Mr. Smith at about 03:11 hours and he was face down on the bed." She stated that she was "absolutely sure that she saw his upper shoulder area move and explained that they are required to witness at least three respirations."<sup>84</sup>

Officer Aylward spoke with Westwood Fire Department Captain Colin McCarthy and asked him how long he thought Mr. Smith had been down. Officer Aylward explained to Captain McCarthy that he was told [by a nurse that] Mr. Smith was "supposedly last seen at 03:11 hours." Captain McCarthy told Officer Aylward that "Mr. Smith's presentation, being "cyanotic and asystolic, would have to be longer than the time frame allowed."<sup>85</sup>

## DPPC/DMH Investigation

A Joint DPPC/DMH Investigation was conducted by Kerry Moore pursuant to MGL c 19C/118 CMR and completed on May 27, 2015. In the course of the investigation Mr. Moore reviewed the record and interviewed witnesses.

- Interview with Trooper Brian Tully

Massachusetts State Trooper Brian Tully stated when interviewed on April 29, 2015 by Mr. Moore that he interviewed all Westwood Lodge staff who were on duty at the time of Mr. Smith's death. Trooper Tully secured two videos of the hall outside Mr. Smith room of the time immediately prior to his being discovered unresponsive.<sup>86</sup>

Although Trooper Tully initially stated that “from these evidence streams, it seemed that the staff had performed patient safety checks at the frequency ordered and that staff reacted as soon as Mr. Smith was discovered to be unresponsive.”<sup>87</sup> He later stated on May 5, 2015 that “when he re-reviewed that videos in the course of his investigation, it was unclear whether staff had performed checks in accordance with orders.”<sup>88</sup>

- Video Review and Interviews with WWL Staff

The mental health technician (MHT) reported to Mr. Moore that she heard Mr. Smith “snoring in a noticeable manner throughout the majority of the shift until she went on break.”<sup>89</sup> A review of the video by Mr. Moore from 2:20 AM to 3:45 AM “reflected that the MHT and the on-duty nurse worked from a desk set up in the hallway of the unit, with the MHT facing toward and the on-duty nurse facing away from Mr. Smith’s room, which was approximately ten feet away.”<sup>90</sup>

Both the MHT and the on-duty nurse reported to Mr. Moore that “although Mr. Smith’s head could be seen from the desk in the hallway, patient safety checks could not be performed as required in policy #RI.062 without observing Mr. Smith from the doorway of his room.”<sup>91</sup>

Although the on-duty nurse reported to Mr. Moor that she had “no reason to believe the checks were not performed as ordered during that shift,”<sup>92</sup> a review of the ‘observation lo rounds and video recording from the third shift of April 24, 2015 reflects evidence incompatible with her statement.”<sup>93</sup>

A review of the Patient Observation Rounds log and video recording by Mr. Moore reflects that the “MHT documented that she had performed checks at the ordered frequency from hand off of the duty at the beginning of that shift (11:20 PM) until 2:40 AM when she and the on-duty nurse were relieved by the nursing supervisor for their shift break.”<sup>94</sup>

The nursing supervisor reported to Mr. Moore that she was “accompanied on the unit that night by an MHT trainee who was being oriented by the nursing supervisor.”<sup>95</sup> The nursing supervisor and the MHT trainee, however, both said that “the trainee did not accompany the nursing supervisor on patient rounds.”<sup>96</sup> This was confirmed through a “review of the video recording.”<sup>97</sup>

Both the on-duty nurse and the nursing supervisor reported to Mr. Moore that they had “performed checks as required by WWL policy and at the frequency ordered.”<sup>98</sup> However, when Mr. Moore reviewed the video it “reflected that the MHT was only away from her seat from 2:32 to 2:34 AM and then again when she readied to leave the unit on break at approximately 2:45 AM.”<sup>99</sup> That review also reflected that once the nursing supervisor assumed the checks duty, the “only times she is seen pausing in the doorway of Mr. Smith’s room are at 2:52 and 3:12 AM.”<sup>100</sup>

The nursing supervisor reported to Mr. Moore that she “recalled hearing Mr. Smith breathing or seeing his body move on each check.” The video recording, however, reflects that the next observable check of Mr. Smith was performed at 3:22 AM.”<sup>101</sup>

The on-duty nurse reported to Mr. Moore that “during that 3:22 AM check she first thought she saw Mr. Smith’s chest rise and fall, but had a ‘gut feeling’ and went back to check. She stated that when she did so she found Mr. Smith not breathing so she checked for a pulse and found none. It was at that time, she said, that she noticed vomit on Mr. Smith’s pillow.” She reported that she “reacted immediately by flipping Mr. Smith over onto his back and called out to nursing to call a code blue as she began chest compressions.”<sup>102</sup>

- Interviews with WWL Staff Regarding Equipment Failure

Mr. Moore asked all staff on duty staff at the time of the incident on the date of the incident if “the subsequent emergency medical intervention went according to policy.”<sup>103</sup> The on duty nurse said that she and the other WWL staff who responded to the Code Blue “did the best we could considering the status of the equipment.”<sup>104</sup>

When Mr. Moore asked the nursing supervisor to elaborate she said that the “oxygen tank hose coupling failed to maintain a seal when pressure was applied by the valve being opened so she ran to an adjacent unit to secure another tank/hose assembly. Once the mask was attached and the valve opened to allow pressure flow, the mask was applied to [Mr. Smith’s] face and a seal was established. However, there was no rise and fall of his chest, Instead the [Mr. Smith’s] cheeks puffed out.’ She said she opened [Mr. Smith’s] mouth to check his airway and saw that ‘it was completely occluded by his tongue’ and told the on-duty nurse that she needed the oral pharyngeal airway (OPA) to position the tongue out of the way. The on-duty nurse could not find the OPA and that Westwood Fire and Police personnel arrived on the scene while she searched for it.”<sup>105</sup>

#### MGL c 19C and/or 118 CMR Conclusion

Mr. Moore concluded that “based on information gathered by the Investigator there is sufficient evidence to conclude that [Mr. Smith] is a victim of omission, as defined by MGL c 19C and/or 118 CMR.”<sup>106</sup>

#### **Findings**

**Westwood Lodge, in a series of acts or omissions in the provision of care treatment and services, as described below, neglected Dan Smith, which caused or may have caused his death.**

**A. Westwood Lodge neglected Dan Smith when it failed to provide a safe environment.**

Westwood Lodge staff neglected Mr. Smith when it failed to conduct patient observation rounds in accordance with hospital policy.

The purpose of Westwood Lodge and Pembroke Hospital Policy and Procedure Policy # RI.062 entitled, Observation Rounds, is to ensure patient safety, as well as to provide a process for observing and documenting patient location and behavior.

The Charge Nurse/Nursing Supervisor has the responsibility of assigning the staff who will be performing the rounds and ensures that the rounds are occurring as ordered. The assigned staff observes the patient and documents their observations on the patient's form.

The policy requires that staff observes the patient on bed rest or when sleeping by:

- Entering the patient's room;
- Listening for abnormal respirations;
- Visualize the rise and fall of the chest;
- Counting at least three respirations;
- Always use a flashlight;
- If a patient was snoring and the snoring stops, be sure to assess the patient's respirations.

On the 11:00 PM – 7:00 AM shift on the night of April 24 and 25, 2015 the observation rounds form reflects that five-minute checks were performed as ordered from 11:00 PM until 3:15 AM.

The last entry in the Progress Record prior to Mr. Smith being found unresponsive at 3:20 AM on April 25, 2015, was from 1:00 PM on April 24, 2015 when he was taken off 1:1 constant observation suicide prevention II protocols. It is important to note that at no other place in the record is there such a significant period of time without a note entered into the record. Notably this raises the question as to why no entry was made during the critical hours leading up to Mr. Smith's death.

Accordingly, the only basis to determine what occurred in the hours leading up to Mr. Smith's death is the report of Officer Christopher Aylward of the Westwood Police and the interviews conducted by State Trooper Brian Tully.

Officer Christopher Aylward of the Westwood Police Department was dispatched to Westwood Lodge at about 03:27 hours. Upon his arrival to Westwood Lodge he was directed towards Mr. Smith's room where several nurses were performing CPR until the Westwood Fire Paramedics took over. Officer Aylward reported that when he entered the room, Mr. Smith was cyanotic.

After Mr. Smith was removed from his room, Officer Aylward spoke with Westwood Fire Captain Colin McCarthy. He asked Captain McCarthy how long he thought that Mr. Smith had been down, because staff had told him that Mr. Smith was last seen at 03:11 hours. Capt. McCarthy said that Mr. Smith's presentation of being cyanotic and asystolic, it would have had to have been longer than the time frame allowed.

Trooper Brian Tully interviewed all Westwood Lodge staff who were on duty at the time of the incident. He also secured two videos of the hall outside Mr. Smith's room.

Westwood Lodge staff had told Trooper Tully that there was no reason to believe the checks were not performed as ordered during the shift. Trooper Tully had initially reported that based upon the log it seemed that the safety checks were done at the frequency ordered. When Trooper Tully reviewed the Observation Rounds log and video recording from the third shift of April 24, 2015 he concluded that the evidence was incompatible with staff's statement.

A joint investigation by the Disabled Persons Protection Commission (DPPC) and the Department of Mental Health (DMH) concluded that staff at Westwood Lodge failed to complete patient safety checks for Mr. Smith at the frequency ordered. The failure to conduct these required checks constitutes neglect.

Westwood Lodge neglected Dan Smith when it failed to maintain lifesaving equipment.

According to the staff who were interviewed by Trooper Brian Tully, when they responded to the Code Blue, the oxygen tank hose coupling failed to maintain a seal when pressure was applied by the valve being opened. Staff had to run to an adjacent unit to secure another tank/hose assembly.

Staff reported that once another tank/hose assembly was located and the mask was attached and the valve opened to allow pressure flow, the mask was applied to Mr. Smith's face and a seal was established. However, there was no rise and fall of his chest, instead Mr. Smith's cheeks puffed out. Mr. Smith's mouth was opened to check his airway and staff saw that 'it was completely occluded by his tongue.

To remedy this obstruction, staff looked for the oral pharyngeal airway (OPA) to position the tongue out of the way but it could not be located. As such, the failure of Westwood Lodge to maintain these lifesaving devices, or to simply know the location of the OPA constituted neglect of Dan Smith.

Westwood Lodge neglected Dan Smith when it failed to have a protocol for the routine testing of lifesaving equipment.

When Katie Adair, Westwood Lodge Director of Risk Management, was asked by DMH Investigator Kerry Moore, for copies of any policies and procedures which are applicable to unit medical equipment she forwarded several: (EC.02.04.01-1: Evaluation Criteria for Medical Equipment Inspection, Testing and Maintenance; EC.02.04.01-2:

Evaluation Criteria for Medical Equipment Program; EC.02.04.01-5: Safe Medical Devices Act; EC.02.04.01-6 Medical Equipment Failure; and EC.02.04.03-1: Incoming Medical Equipment).

A review of these policies showed that Westwood Lodge contracts with a vendor (ABM Health) to monitor and test its medical equipment. A review of the vendor Asset History reports of that equipment revealed that the oxygen and the bag-valve-mask are not among the equipment monitored.

When asked for policies specifically addressing the process related to the completion of the Unit Based Equipment Checks log, Ms. Adair reported, there is no policy.

Westwood Lodge had no policy specifying the staff requirements relative to the completion of the Unit Based Checks log. In addition, Westwood Lodge had no procedure or protocol through which the bag-valve-mask and oxygen tank connection is tested.

**B. Westwood Lodge neglected Dan Smith when it failed to maintain an appropriate treatment plan.**

Westwood Lodge neglected Dan Smith when staff failed to notify a physician regarding Mr. Smith's well-documented history of being over-medicated, and when staff failed to notify a physician regarding Mr. Smith's well-documented cycle of periods of calm followed by agitation, medication seeking, hallucinations, threats, self-injurious, suicidal and homicidal behaviors.

The medical record shows that staff routinely observed Mr. Smith as being over-medicated. He was often seen being groggy, slurring his words, mumbling, hard to understand, and experiencing difficulty walking. He was observed stumbling around the halls, unable to open a bag of snacks, or to wash an apple. He was noted to be dozing off on the floor, in the hall, and in the dayroom. He urinated on himself several times, complained of excessive drooling, was unable to read a simple list, and spent extensive periods of time sleeping in his room.

Despite the evidence that Mr. Smith was significantly over-medicated, there is nothing in the record to indicate that any of the direct care or nursing staff took steps to convey to a physician their observations regarding Mr. Smith's presentation.

Similarly, the record illustrates that Mr. Smith's behaviors followed a well-documented and clear cycle that would begin with brief periods of calm upon awaking, followed by increased agitation, medication seeking, auditory and visual command hallucinations, threats of homicidal and suicidal behaviors, and finally self-injurious behaviors.

To treat this cycle Westwood Lodge staff relied exclusively on medication. Westwood Lodge's treatment plan appears to have had no appreciable effect on interrupting Mr. Smith's cyclical behaviors. He continued to exhibit agitation, medication seeking, hallucination, threats and self-injurious behaviors. He would then be given more

medication which resulted in extended periods of insensibility until Mr. Smith eventually passed out. With each successive cycle Mr. Smith's symptoms worsened and the amount of time he spent asleep due to over-medication increased.

The record shows that no less than three full revolutions of this cycle occurred during the fourteen-day period of Mr. Smith's hospitalization. Nonetheless, there is nothing in the record to indicate that any of the direct care or nursing staff at Westwood Lodge took steps to convey to a physician their observations regarding Mr. Smith's presentation.

Westwood Lodge staff neglected Dan Smith when it failed to maintain Dan Smith on 1:1 constant observation suicide prevention II protocols despite his requiring observations.

Upon his admission on April 9, 2015, Mr. Smith was placed on five-minute checks for his safety. The joint DMH/DPPC investigation into Mr. Smith's death concluded that staff at Westwood Lodge failed to conduct these checks in accordance with Policy # RI.062. The failure of staff to appropriately conduct these checks was a serious omission which denied Mr. Smith the opportunity to receive life-saving medical care instead of being discovered "unresponsive" at 3:20 AM on the morning of April 25, 2015. The EMTs on the scene from the Westwood Fire Department, estimated that Mr. Smith had been dead for considerable amount of time before he was "discovered" by staff charged with conducting the five-minute checks.

Mr. Smith remained on five-minute checks until April 16, 2015 when he engaged in self-injurious behavior and 1:1 observation was added to the five-minute checks for the hours when he was awake. Still, Mr. Smith continued to experience command hallucinations and to engage in self-injurious behavior. On April 19, 2015 Mr. Smith was sent to Norwood Hospital on a medical emergency. When he returned the 1:1 was discontinued.

On April 22, 2015 Mr. Smith threatened to "burn the place down" and "kill the staff." He was placed on 1:1 constant observation suicide prevention II protocols. This level of observation was in addition to his remaining on five-minute checks. While on this level of observation, Westwood Lodge staff dutifully monitored Mr. Smith and carried out observation rounds as defined in Policy # RI. 062. Staff entered Mr. Smith's room, listened to his respiration and observed the rise and fall of his chest.

Beginning April 22, 2015 until the morning of April 24, 2015 Mr. Smith was so over-medicated that his speech and his ability to ambulate were significantly impaired, he had exceptionally poor motor skills, and he could not stop drooling. The entries in the record show that Mr. Smith was so highly medicated that he slept for nearly all of April 23, 2015.

When he awoke on the morning on April 24, 2015, the cycle resumed, he was briefly calm, denied having hallucinations, and told staff that he wanted to come off of 1:1 and

go home. By 11:45 AM Mr. Smith was sitting in the hall dozing off. He asked staff for a PRN and was given Ativan for anxiety. By 12:45 Mr. Smith was seen pacing in the hall.

At 1:00 PM Mr. Smith was taken off 1:1 constant observation suicide prevention II protocols and was placed back on five-minute checks, which was the opposite of what he needed. Staff failed to keep the professional staff apprised despite Mr. Smith's well-documented cycle of behaviors, and that he had recently reported that he continued to hear voices. If this information had been shared, Mr. Smith would never have been taken off of 1:1 constant observation suicide prevention II protocols and placed on five-minute checks.

Mr. Smith was found "unresponsive" at 3:20 AM on April 25, 2015 while on five-minute checks that were not conducted in accordance with policy.

**C. Westwood Lodge neglected Dan Smith when it failed to establish or carry out an appropriate individual program or treatment.**

Westwood Lodge's staff neglected Mr. Smith when it failed to provide effective treatment to address Dan Smith' hallucinations, and serious self-injurious and suicidal behaviors.

As stated above, staff at Westwood Lodge Hospital relied solely upon prescribed medication and PRNs to treat Mr. Smith's command hallucinations and serious self-injurious behaviors. As a result, Mr. Smith became a seriously over-medicated patient who slept or stumbled through his days, when he was not actively experiencing command hallucinations and engaging in serious self-injurious behaviors.

During the fourteen days of his hospitalization Mr. Smith's well-documented cycle of behaviors occurred no less than three times. Other than alternating between five-minute checks to 1:1 observation and then back to five-minute checks, staff at Westwood Lodge failed to provide Mr. Smith with any treatment that proved effective in breaking that cycle.

Westwood Lodge never gave Mr. Smith a "wash out" period free of medication in order to determine his baseline and to assess whether he could benefit from Cognitive Behavioral Therapy (CBT) or similar transactional therapies with a psychologist where Mr. Smith could have addressed his history of drug abuse, sexual abuse, and recent suicide attempts.

Instead, Westwood Lodge relied solely upon the use of powerful medications to suppress the symptoms of his illness without developing an effective treatment plan to address the cause of those symptoms.

Westwood Lodge neglected Dan Smith when it failed to provide him with trauma informed care despite being aware of his history of being sexually assaulted.

Mr. Smith's admission documents show that he was raped when he was twelve years old by an older relative who was convicted, but who Mr. Smith had seen after the relative was released from jail. The admission documents show that Mr. Smith could identify the voice he heard when experiencing command hallucinations. Mr. Smith reported that "Ken" tries to get him into trouble and tells him that he has magic powers; that he can walk in front of cars and that bullets will bounce off of him.

On April 15, 2015 Mr. Smith's vitals were taken and his pulse was abnormal. Subsequently he reported to staff that the voices were worse and he was given a PRN. He later urinated on himself. After sleeping for a while, Mr. Smith sat in the hallway outside of his room and told staff that he is seeing people rape him.

On April 21, 2015 Mr. Smith was agitated and was hearing voices and seeing things. When staff asked what he was seeing Mr. Smith said, "Ken, he's the guy I always see." Mr. Smith reported that Ken was telling him to "drown himself in the toilet, burn this place down and kill the staff." Mr. Smith was given 2 mg of Ativan and 10 mg of Zyprexa as a PRN.

Despite their awareness of Mr. Smith trauma and childhood sexual abuse, the nature of his hallucinations and that "Ken" was the identified antagonist who commanded Mr. Smith to hurt himself and others, staff at Westwood Lodge Hospital failed to create a trauma-informed treatment plan. Instead, Westwood Lodge hospital continued to rely solely on medication to treat Mr. Smith's symptoms.

Westwood Lodge neglected Dan Smith when it failed to conduct a toxicology screen or risk assessment after he reported being offered heroin by another patient.

According to his admission documents, Mr. Smith attempted to commit suicide by overdosing on cocaine the day before he was admitted to Westwood Lodge. Also noted in these documents was the fact that Mr. Smith had a history of cocaine and heroin substance abuse.

On April 11, 2015 a cigarette was discovered in Mr. Smith's room. As a result, a complete search of his room was conducted. On April 24, 2015 Mr. Smith informed staff that on the previous day another patient offered him some heroin. A review of the progress record for April 23, 2015 shows that Mr. Smith was observed as being highly sedated on that day. He was observed drooling, being extremely hard to understand, having difficulty with motor coordination and sleeping for the better part of the day. However, despite his presentation, his history of heroin abuse, the fact that that he had recently tried to overdose with cocaine, and his being actively self-injurious and suicidal during the entire course of his hospitalization, Westwood Lodge failed to employ best

practices by conducting a toxicology screen, a risk assessment, or even a search of his room after he informed staff that another patient had offered him heroin.

Westwood Lodge staff neglected Dan Smith when it failed to conduct testing to determine whether his emergency visit to Norwood Hospital Emergency Department was the result of side effects caused by medication.

On April 15, 2015 Mr. Smith was placed on 1:1 after punching himself in the right side of his face. At 3:30 PM Mr. Smith's vital signs were taken and it was reported that his pulse was abnormal. He then attempted to use the lavatory and urinated on himself. At 9:00 PM it was noted that he was highly sedated.

On April 16, 2015, staff administered an unlawful medication restraint on Mr. Smith. At 3:00 PM Mr. Smith was observed as being highly sedated. According to the notes, Mr. Smith attempted to urinate twice, but could not. On his third attempt, Mr. Smith urinated in his pants.

On April 17, 2015 Mr. Smith was observed to be unsteady on his feet and his speech was hard to understand. At 8:00 PM it was noted that Mr. Smith looked sedated. At 10:00 AM on April 18, 2015 Mr. Smith attended a goals group but had difficulty reading the "goals" sheet.

On April 19, 2015 Mr. Smith reported feeling pain in his abdominal area. He explained that the pain "comes and goes." He rated his pain as an "8 out of 10." He was sent to Norwood Hospital where he was determined to be retaining urine. Mr. Smith was discharged from Norwood ED after he was strait cathetered and 1200 ml of urine was emptied from bladder. A CT scan of his abdomen was negative.

Upon his return to Westwood Lodge, the record shows that Mr. Smith was visible on the unit. He was observed as being pleasant and cooperative. It was noted that he had a steady gait.

Despite this dramatic change in Mr. Smith's presentation upon his return to Westwood Lodge as compared with his presentation on the days leading up to his being sent to Norwood Hospital, staff at Westwood Lodge failed to employ best practices by conducting tests to determine whether Mr. Smith's highly impaired presentation prior to his emergency visit to Norwood Hospital Emergency Department was an indication of side-effects caused by medication. Instead, staff at Westwood Lodge increased the amount of Clozaril he was being administered.

**Westwood Lodge abused Dan Smith when it knowingly and intentionally administered a chemical restraint in a manner not in compliance with State regulations. The administering of a chemical restraint to Dan Smith in violation of regulation caused or may have caused his death.**

Westwood Lodge abused Dan Smith when it administered a medication restraint in violation of Department of Mental Health regulations.

According to Department of Mental Health regulations a medication restraint may be used,

“...only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.” 104 CMR § 27.12(5) (6).

The regulation is clear, a medication restraint can only be used in an emergency to prevent the occurrence of serious self-destructive behavior. A medication restraint is not treatment -- it is a “behavioral restraint,” used to “unreasonably limit freedom of movement.” 104 CMR § 27.12(5)3.

On April 16, 2015 staff observed Mr. Smith pacing on the unit, being demanding, and asking for medication.” He told staff that the “voices are back” and he was given 2mg of Ativan. He later told staff that the meds weren’t working and that he wanted to “choke himself out.” Mr. Smith told staff that he wanted a medication restraint and that he agreed to IM injections. According to the record, staff then sedated Mr. Smith with a medication restraint.

The record shows that Mr. Smith was already so highly medicated that staff had initially withheld his medications. Nevertheless, Mr. Smith was given his morning medication and was observed sitting in the hallway “dosing off.”

Administering a medication restraint was improper because there was no emergency. Mr. Smith did not pose a substantial risk of serious self-destructive behavior. Staff at Westwood Lodge Hospital administered a medication restraint solely for the purpose of further sedating Mr. Smith, which violates DMH restraint regulations and constitutes abuse.

### **III. The Death of “Mary Jones”<sup>107</sup>**

#### **Background**

The Disability Law Center (DLC) received a complaint to the system on April 9, 2016 regarding Mary Jones a 20 year-old woman who died on August 30, 2015 while a patient at Pembroke Hospital.

On May 10, 2016, DLC notified the Department of Mental Health (DMH) that we were initiating an investigation into Ms. Jones’s death pursuant to our PAIMI authority.

On June 24, 2016, DLC received redacted copies of DMH Director of Licensing Janet Ross' November 15, 2015 Decision Letter and her December 28, 2015 Amended Decision Letter from DMH. In both decision letters, Ms. Ross found that Pembroke Hospital staff acted in a manner that was dangerous, illegal and/or inhumane as defined in DMH regulations 104 CMR 32.00.

Based upon a review of the materials received, DLC determined that there was probable cause that Ms. Jones' death was the result of abuse and/or neglect.

On June 29, 2016, DLC, in its capacity as the designated Protection and Advocacy system for Massachusetts informed DMH was initiating an investigation onto the death of Ms. Jones pursuant to 42 U.S.C. § 10805(a)(1)(A).

#### DMH Decision, November 16, 2015

In its initial decision dated, November 16, 2015 DMH found that,

“Although the Facility’s documentation reflects that patient safety checks were done on a fifteen (15) minute basis ... the facts show that she was discovered in full rigor mortis by a Mental Health Associate at 5:00 AM ... compels the conclusion that safety checks were not in fact conducted in accordance with policy.”<sup>108</sup>

In addition, the decision noted, that “there were a number of other concerns related to documentation of the plan and provision of care to this patient:

- The nursing progress notes repeatedly refer to ‘VSS’ for vital signs stable, but this patient’s pulse rate was recorded at 106 and 113, which are not considered to be within normal limits for a young woman of 20 years old.
- The patient is described as having had a headache, vomiting, nausea, and the important observation of a mother that ‘This is not my daughter. She seems like a zombie.’ These seem to be a change in condition that was attributed to the patient’s report of a history of migraines. Migraines were not noted on the history and physical, where asthma was the only diagnosis.”<sup>109</sup>

With respect to these concerns, the decision notes,

- “There is no reference in the chart to suggest that these conditions prompted consultation with a physician.”<sup>110</sup>

- “Based on the findings, it can be determined that Pembroke Hospital staff failed to conduct safety checks in accordance with...Policy #RI.062...: *Observations Rounds*, Review Date October 2014.”<sup>111</sup>

#### Amended DMH Decision, December 28 2015

The Department, after objections and concerns from the facility, issued an amended decision on December 28, 2015. In the Amended decision, the Department re-stated the November 16 findings cited above and Janet Ross, MS, RN, the Director of Licensing for the Department added the following:

“Having personally reviewed the facility’s surveillance video, I am making an additional finding of fact and order of correction regarding staff response upon discovery of the patient’s condition. It is apparent from the video that the patient was found by one MHA, who left the patient’s room and got the second MFA. One of the MHA’s then left the room, followed by the remaining MHA, leaving no one with the patient. This action contravenes the relevant Hospital policy that provides that ‘Designated licensed medical or nursing personnel shall direct the code...’ I find that the actions of the staff in this moment also contributed to an incident and/or condition that was dangerous and inhumane as defined in DMH Regulations 104 CMR 32.00.”<sup>112</sup>

#### Cause of Death

The Office of the Medical Examiner listed the cause of Ms. Jones’ death as “probable cardiac dysrhythmia complicating (focal) lymphocytic myocarditis of uncertain etiology.”<sup>113</sup>

#### Forensic Expert

To assist DLC in its evaluation of the circumstances surrounding the death of Ms. Jones, DLC retained Dr. Fabian M. Saleh<sup>114</sup> on September 6, 2016 to review the medical record and all documents pertaining to the death of Mary Jones. Dr. Saleh analyzed whether, in his expert opinion, Ms. Jones was subject to abuse and neglect within the meaning of the Protection and Advocacy law.

#### **Statement of Facts**

##### Pre-admission to Pembroke Hospital

On August 27, 2015, at approximately 3:00 PM, Mary Jones was sent from Elliot Community Human Services (Elliot)<sup>115</sup> by ambulance pursuant to MGL c. 123 § 12(a)<sup>116</sup> to North Shore Medical Center (“NSMC”) for “depression and feeling suicidal.”<sup>117</sup> Ms. Jones had been evaluated on August 26, 2015<sup>118</sup> by Elliot at their office and was found to meet “IPLOC”.<sup>119</sup>

The NSMC nursing notes reflect that Ms. Jones' "home medications" included, Prazosin and Hydroxyzine (last doses on August 26, 2015). On August 27, 2015 she had taken, Lexapro, Naltrexone, Paliperidone, Wellbutrin XL and Ativan. She was also taking the following medications as needed: Paliperidone, Lithium Carbonate and Thorazine.<sup>120</sup> While at NSMC Ms. Jones was administered: Lithium, Ativan, Prazosin, Invega, Topamax, and Thorazine.<sup>121</sup>

At approximately 4:00 PM Ms. Jones was assessed by NSMC Emergency Department physician, John Michael.<sup>122</sup> Ms. Jones reported to Dr. Michael that she had been discharged from Bournemouth Hospital ('Bournemouth') the day before where she had been admitted after an attempt to overdose on aspirin.<sup>123</sup> Dr. Michael noted Ms. Jones' cardiovascular signs to be of "regular rate and rhythm, 4+ radial pulse,<sup>124</sup> no pulse deficits."<sup>125</sup> At 4:30 PM Dr. Michael initiated a consult with the psychiatry team and Ms. Jones was medically cleared for admission to a psychiatric facility.<sup>126</sup>

At 8:04 PM Elliot ESP<sup>127</sup> faxed NSMC a copy of Ms. Jones' Child/Adolescent Comprehensive Assessment (ACA). The ACA included Ms. Jones' history, including family history; trauma history of sexual and emotional abuse; substance abuse history, psychiatric hospitalizations; current medication; mental status; risk assessment; psychiatric, medical and psychosocial diagnosis; and, Ms. Lubin's assessment completed on August 26, 2015.<sup>128</sup> The assessment noted that Ms. Jones believed she was discharged from Bournemouth prematurely and that she intentionally cut herself the previous night. The assessment noted that Ms. Jones "was tired and didn't want to live like this anymore."<sup>129</sup> Ms. Jones was noted to be "lethargic" and "disheveled" and her mood was "overwhelmed and tired." Ms. Jones reported to Ms. Lubin that she was "unable to be safe on unlocked unit or to engage in safety planning."<sup>130</sup>

At 10:00 PM Elliot informed NSMC that Pembroke Hospital had accepted Ms. Jones for admission.<sup>131</sup> Dr. Skarulis authorized Ms. Jones' transferred by ambulance pursuant to MGL. C 123 § 12(a) from NSMC. Dr. Pahlozan accepted Ms. Jones as appropriate for inpatient psychiatric hospitalization at Pembroke Hospital.<sup>132</sup> Pembroke Hospital was provided with Ms. Jones' "medical records of her examination and treatment."<sup>133</sup> Additional records received included, all nursing and progress notes, all lab reports, EKG and X-Rays including Cardiac Cath films, ES record, H&P<sup>134</sup>, consultation and discharge summary, and all operative notes.<sup>135</sup>

### Admission to Pembroke Hospital

Ms. Jones arrived at Pembroke Hospital at approximately 1:00 AM on August 28, 2015.<sup>136</sup> Her diagnosis was major depression disorder and bipolar disorder.<sup>137</sup> Upon admission Ms. Jones underwent a comprehensive interdisciplinary assessment (CIA). The CIA listed NSMC ER records and Ms. Jones as "informants" who provided Pembroke Hospital with the initial medical and historic information about Ms. Jones.<sup>138</sup> For example, Ms. Jones informed staff at Pembroke Hospital that she had a plan to "overdose of pills,"<sup>139</sup> and that her sexual and emotional abuse has resulted in her currently experiencing nightmares and flashbacks.<sup>140</sup> The CIA described Ms. Jones'

“cognition”<sup>141</sup> upon admission as “sleepy and somnolent.”<sup>142</sup> Similarly, her intelligence, awareness, ability, mood and affect, thought process, content and perceptions were all described as impaired.<sup>143</sup>

Despite her impaired mental status, Ms. Jones was prescribed medication including, Abilify, Suboxone, Thorazine, Valium, Lexapro, and Tenex<sup>144</sup> and was determined competent to provide specific and informed “consent” for these medications (including any relevant black box warnings).<sup>145</sup> In addition to the prescribed medications, the following “home” medications were ordered to be continued, Aripiprazole, Lithium, Topiramate, Escitalopram, Prazosin and Chlorpromazine.<sup>146</sup> Ms. Jones was also determined upon admission to be competent to sign into Pembroke as a conditional voluntary patient pursuant to MGL c 123 §§ 10, 11.<sup>147</sup> Ms. Jones was admitted onto Unit West 2 and placed on 15 minute checks for 24 hours.<sup>148</sup>

Ms. Jones was 20 years old when she died. The Office of the Chief Medical Examiner reported the cause of death to be Probable Cardiac Dysrhythmia Complicating (Focal) Lymphocytic Myocarditis of Uncertain Etiology.<sup>149</sup> Notably, the form completed by the admitting physician incorrectly noted Ms. Jones’ age to be 31 years old. It was also noted by that physician that her pulse rate was 106.<sup>150</sup>

#### Course of Hospitalization:

- August 28, 2015

Ms. Jones’ treating physician, Dr. Michael McGee’s noted at 2:04 PM on August 28, 2015 that to discharge her at that time would place her at a “foreseeable risk of harm to self.”<sup>151</sup> The note reflects that Dr. McGee examined Ms. Jones, reviewed the chart and discussed her case with the team.<sup>152</sup> He was aware of Ms. Jones’ family history, substance abuse history, suicide attempts, and her trauma history of sexual and emotional abuse.<sup>153</sup> Dr. McGee’s notes reflect that he knew that Ms. Jones had a history of being prescribed Invega.<sup>154</sup> The 2:30 PM nursing note states that Ms. Jones was a late admission and that she had slept late that morning and had refused her morning medications because she hadn’t been given Ativan. Dr. McGee subsequently prescribed Valium<sup>155</sup> and Suboxone.<sup>156</sup> Notably, there are no subsequent entries into the medical record until the 7:00 AM nursing note entered on August 29, 2015.

- August 29, 2015

On August 29, 2015, the progress record reflects that Ms. Jones was “feeling nauseous and was dry heaving at times during the morning.” She was “sipping fluids and given medication as tolerated,” and had spent most of the day in bed.<sup>157</sup> At 11:00 AM Ms. Jones requested her morning medication. Nursing withheld her Valium as she still appeared drowsy. Ms. Jones refused Prazosin<sup>158</sup> ordered for anxiety, “I only take that medication at night for nightmares.”<sup>159</sup>

The 1:00 PM nursing note stated that Ms. Jones vomited once that morning which was witnessed by the RN and that Ms. Jones' medications were initially held due to nursing concerns for possible side effects of newly started medication. Ms. Jones was noted to be "drowsy and pale" and that she reported that she had a headache and this was her typical presentation with migraines which she gets occasionally.<sup>160</sup>

On September 1, 2015 David Eaton, Jr., Investigator, DMH Office of Investigations was appointed as Investigator.<sup>161</sup>

On October 7, 2015 the unit nurse reported to Mr. Eaton that on August 29, 2015 she "had concerns that Ms. Jones was pale and had vomited that morning."<sup>162</sup> She said that Ms. Jones had recently been "started on several new medications"<sup>163</sup> and she questioned whether her symptoms were a "side effect of the medication."<sup>164</sup> She was specifically "concerned about the combined use of Suboxone and benzodiazepine."<sup>165</sup> The unit nurse reported that she "didn't want Ms. Jones to become sedated"<sup>166</sup> and she considered the combination a "bad use of Suboxone."<sup>167</sup> She told Mr. Eaton that she had "written a letter"<sup>168</sup> to Pembroke Hospital's "leadership team"<sup>169</sup> about her concerns regarding the practice of combining these medications "two weeks before Ms. Jones died."<sup>170</sup>

According to the medical record Ms. Jones' mother came to visit on August 29, 2015 and requested to speak with the charge nurse. Ms. Jones' mother expressed her concern regarding medication, saying, "[t]his is not my daughter, she seems like a zombie."<sup>171</sup> When interviewed by Mr. Eaton on October 6, 2015, Ms. Jones' mother said that when she visited her daughter she "did not look right, she looked drugged"<sup>172</sup> and that she was concerned about Mary's medication.<sup>173</sup> The unit nurse reported to Mr. Eaton that Ms. Jones' mother was fixated on Ms. Jones being administered Lithium which she did not feel was safe.<sup>174</sup>

The medical record reflects that nursing informed Ms. Jones' mother about the medication changes and that Ms. Jones' AM medications were held due to nursing's "concerns about sedation."<sup>175</sup> Ms. Jones' mother said that she would like to "speak to Dr. McGee on Monday to assist in coordinating care for Mary."<sup>176</sup> The nursing note states, Ms. Jones "denied suicidal or homicidal ideations, or that she was experiencing auditory or visual hallucinations" or urges to self-injure. Ms. Jones stated, "I don't want to hurt myself...yet."<sup>177</sup>

At 3:00 PM Ms. Jones requested nicotine gum. When her request was denied she escalated and demanded a nicotine patch. She began screaming, hit a wall with her fist, and ran into her room while continuing to scream. Twenty minutes later Ms. Jones asked to go to the cafeteria for dinner. She was told by staff that she must first demonstrate self-control. Ten minutes later she was noted as having said "I want to die."<sup>178</sup> The notes state that "benign neglect utilized with good effect."<sup>179</sup>

- August 30, 2015

A nursing note entered on August 30, 2015 stated that Ms. Jones was “sedated and went to bed after dinner. Nursing tried to wake Ms. Jones to give her Lithium, but she was either asleep or ignoring the nurse.”<sup>180</sup>

The overnight charge nurse reported to Mr. Eaton that Ms. Jones had “fallen asleep after dinner and received her PM medication at 6:00 PM.”<sup>181</sup> She stated that Ms. Jones was to be “administered her lithium at 10:00 PM.”<sup>182</sup> She reported that she entered Ms. Jones’ room after 10:00 PM but that Ms. Jones “would not respond to her prompts to wake up.”<sup>183</sup> The charge nurse reported this to her supervisor who said, “[a]dminister the medication if Ms. Jones wakes up,”<sup>184</sup> which she did not. The male MHA on duty that night reported to Mr. Eaton that he didn’t recall what checks he was conducting during the 11:00 PM to 7:00 AM shift. He said that “nothing stood out” except that he was instructed to “keep an eye on Ms. Jones because she had a difficult night.”<sup>185</sup>

When interviewed by Mr. Eaton the female MHA reported that during the 3:00 PM to 11:00 PM shift Ms. Jones had been upset and had spent much of the shift in her bedroom. She said that Ms. Jones ate dinner, sat in the day room until 7:00 PM, then went to bed, was asleep at 7:30 PM and did not wake up at all during the night.<sup>186</sup> She reported that she conducted safety checks throughout the 11:00 PM to 7:00 AM shift and heard Ms. Jones snoring and observed that her bedding had moved. At 3:00 AM she saw Ms. Jones lying on her left side. She entered the room and observed her chest rising and falling approximately three to five times.<sup>187</sup>

The charge nurse reported to Mr. Eaton that she conducted the 4:00 AM and 4:15 AM safety checks on Ms. Jones. She stated that she heard what she figured was snoring and that Ms. Jones “seemed all right.” The charge nurse told Mr. Eaton that when she conducted the safety checks, she entered the bedroom and observed Ms. Jones from “fifteen feet or more away.”<sup>188</sup>

The male MHA reported to Mr. Eaton that at 4:50 AM as he was conducting safety checks on Ms. Jones, “I looked, I couldn’t hear or see anything.” He said that he observed Ms. Jones “facing the wall with her back to me.” He reported that he did not enter the room but “called out to Ms. Jones” in an attempt to wake her up.<sup>189</sup> He stated that he called out to the female MHA and they both entered Ms. Jones’ bedroom. They attempted, but were unable to “get a pulse” from Ms. Jones’ right wrist. He reported that he observed “foam” around Ms. Jones’ mouth and that her arm was “a little bit stiff.” He said that he “ran out of the room to get the nurse,” and asked her to “call 911 and to get the supervisor.” He stated that he took the med-pack and pump back to Ms. Jones’ bedroom. He stated that CPR had been started and he “switched in when staff got tired.”<sup>190</sup>

The female MHA reported to Mr. Eaton that at “approximately 5:00 AM the male MFA was conducting safety checks.”<sup>191</sup> He called her down to Ms. Jones’ bedroom and said Ms. Jones “was not breathing.”<sup>192</sup> The female MHA reported that she “shook the client’s

leg but did not get a response.”<sup>193</sup> She reported that the charge nurse arrived at Ms. Jones’ bedroom and she continued safety checks while the “male MFA and the charge nurse attended to Ms. Jones.”<sup>194</sup>

The charge nurse reported to Mr. Eaton that at approximately 5:00 AM, the female MHA came to her and said that Ms. Jones was “not looking good.”<sup>195</sup> The charge nurse reported that Ms. Jones was observed lying on her “left side facing the wall.” The charge nurse called the nursing supervisor and asked for assistance. She stated that she attempted a “sternal rub”<sup>196</sup> on Ms. Jones without any reaction. She reported that Ms. Jones was “cyanotic on left side and had some bluing on face.”<sup>197</sup>

According to the nursing note in the medical record, “the MHA came to me and said to check the patient. We went to the room and was trying to find a pulse.”<sup>198</sup> The charge nurse “called the nursing supervisor and CPR was started.”<sup>199</sup> The nursing notes state that “Ms. Jones started to foam from mouth.”<sup>200</sup> And that the nursing supervisor checked Ms. Jones pulse and “felt a flutter.”<sup>201</sup> “911 was called at 5:15 AM, CPR was continued. The nursing supervisor called the DOC (doctor-on-call) and the DOC assisted with CPR and AED. The EMTs arrived at 5:30AM and Ms. Jones was taken to SSH (South Shore Hospital).”<sup>202</sup>

When interviewed by Mr. Eaton the nursing supervisor reported that at approximately 5:00 AM she received a call from the charge nurse informing her that there was a “situation” and Ms. Jones “wasn’t responding.”<sup>203</sup> The supervising nurse reported that on her way to Unit West 2, she “banged on the doctor on call’s window” to alert him to the potential situation. When she arrived at Ms. Jones’ bedroom she observed Ms. Jones lying on her bed “with her back to me on her left side.” She stated that Ms. Jones’ “hands were cold” and she observed “lividity”<sup>204</sup> on her face.” Ms. Jones’ jaw “could not be opened and her tongue was clenched between her teeth.” She stated that it appeared as if Ms. Jones “had a seizure” as her hands were in a “clenched position.” She stated that “everyone came in” and staff moved Ms. Jones from her bed to the floor.”<sup>205</sup>

Pembroke Police Officer Kevin Doyle stated that he was dispatched along with the Pembroke Fire Department to Pembroke Hospital at approximately “5:01 AM” for the report of a patient that was unresponsive and having trouble breathing.<sup>206</sup> Officer Doyle reported that Pembroke Fire Department (PFD) Captain McCormick, Firefighters Gassira, Hall and Smith arrived on scene at 5:11 AM.<sup>207</sup> Upon PFD’s arrival hospital staff transferred the case to the PFD. Captain McCormick reported to Officer Doyle obvious signs of rigor mortis, mottling and lividity.”<sup>208</sup>

At 5:05 AM on August 30, 2015, Dr. Konrad Mark, the DOC entered into the record that Ms. Jones was “found by staff at 5:00 AM.”<sup>209</sup> That she appeared pale and “in rigor mortis.”<sup>210</sup> CPR was administered, the defibrillator read “no shock advised.” 911 was called and the EMTs identified Ms. Jones as “two hours of rigor mortis.” The “EKG flat lined” and Ms. Jones was “transported to the South Shore Hospital.”<sup>211</sup>

When interviewed at the scene by Officer Doyle, Dr. Mark stated that he responded after he was alerted to an “ongoing emergency.”<sup>212</sup> He reported that he responded to the room at an approximate time of 5:15 AM and that he observed “rigor mortis in the body of Ms. Jones.”<sup>213</sup> When asked by Officer Doyle again if he clearly saw rigor mortis in the body of Ms. Jones, Dr. Mark stated “Yes.”<sup>214</sup>

When interviewed by Mr. Eaton on October 10, 2015, Dr. Mark provided additional detail by stating that upon his arrival Ms. Jones was on the floor with indications of rigor mortis. Specifically, “Jones’ arms were flexed and up in front of her, her skin was a pale bluish color and her airway was difficult to access due to her teeth being clenched together. The AED arrived and the pads were placed on Ms. Jones but no shock was advised. The Pembroke Fire Department EMTs arrived and took charge. Dr. Mark stated that the EMTs informed him that “it looked like rigor mortis for two hours.”<sup>215</sup>

Pembroke Fire Department Incident Report states that the call was received at 5:05 AM and they were on the scene at 5:11AM. The clinical impression was one of cardiac arrest. Ms. Jones was found lying supine on floor in her room. She was pulse-less and apneic with staff applying AED with no shock advised. Ms. Jones had obvious signs of death with rigor mortis to all extremities and jaw. CPR was continued but was unable to insert airway due to rigor mortis. Her legs and arms were in the bent position. Ms. Jones was transported to South Shore Hospital and care was transferred to ED staff.<sup>216</sup>

### Time of Death

Dr. Mark Toyer of the South Shore Hospital Emergency Department placed the time of Ms. Jones’ death at 5:45 AM.<sup>217</sup>

### Report of Treating Psychiatrist

The treating psychiatrist, Dr. Michael McGee, reported to Mr. Eaton that Ms. Jones was pleasant, but emotionally dysregulated. He used medication to stabilize her mood. He discontinued the Abilify as she had no psychosis. He continued the lithium. Her vital signs were stable and he speculated that she may have had a blood clot. Dr. McGee stated that he had two regrets: that he never ordered that Ms. Jones could use a nicotine patch; and, that he never followed up regarding medication.<sup>218</sup>

### No Treatment Plan at the Time of the Incident

Pembroke Hospital policy, titled: Interdisciplinary Treatment Plan, states, “each patient admitted to the hospital shall have a written individualized treatment plan within 72 hours of admission.” As Ms. Jones was admitted on August 28, 2015, the policy did not require that she have a treatment plan until 72 hours later, which would not have occurred until after her death on August 30, 2015.<sup>219</sup>

### Conclusions of DMH Investigator David Eaton, Jr

- It cannot be determined that Pembroke Hospital staff conducted patient safety checks in accordance with Westwood Lodge and Pembroke Hospital Policy and Procedure, Policy #RI.062; and,
- It is the conclusion of this Investigator that the findings of this investigation and report would support a determination that the actions of the caregivers contributed to an incident and/or condition that was dangerous and inhumane as defined in DMG Regulations 104 CMR § 32.00.<sup>220</sup>

### Cause of Death:

According to the autopsy report, the cause of Ms. Jones' death was: "Probable Cardiac Dysrhythmia; Complicating (Focal) Lymphocytic Myocarditis of uncertain etiology."<sup>221</sup>  
Report of Dr. Fabian M. Saleh, M.D., D.F.A.P.A.

Dr. Fabian M. Saleh found that staff at Pembroke Hospital made a series of critical errors concerning the care and services that were provided to Ms. Jones, which would constitute "neglect" within the meaning of the Protection and Advocacy law.

### Informed and Specific Consent

As noted above, when Ms. Jones presented at Pembroke Hospital, she had been administered substantial medication.

Ms. Jones was sent by ambulance to Pembroke Hospital where she arrived on August 28, 2015 at 1:00 AM. Upon admission, Ms. Jones underwent a Comprehensive Interdisciplinary Assessment (CIA) signed at 2:00 AM which suggests that "informed consent for medication ordered upon admission"<sup>222</sup> was obtained from Ms. Jones. In his report, Dr. Saleh stated, "I highly doubt that Ms. Jones had the capacity to give informed consent to a medication regimen that was not only complex in nature, but also included medications that were used 'off label'<sup>223</sup>."<sup>224</sup>

Dr. Saleh arrived at this conclusion based upon Ms. Jones' presentation as described in the CIA. Specifically, Ms. Jones was reportedly, "sleepy"; her "level of consciousness" was described as "somnolent"; she was psychomotorically "slowed"; her concentration and attention span were reportedly "not intact"; her estimated level of intelligence was assessed as being "below average"; and, her thought process and thought content were noted to be "sleepy."<sup>225</sup> Dr. Saleh concluded, "Although Ms. Jones' signature appears on a document titled, 'Authorization for Treatment,' I doubt that Ms. Jones had the capacity to understand and appreciate her rights when signing this document at 2:30 AM."<sup>226</sup>

Regarding a note added into the record on August 28, 2015, Dr. Saleh notes,

"Although a note from Dr. Michael McGee reads that informed consent was obtained from Ms. Jones in the afternoon of August 28, 2015. There are no data to suggest that Ms. Jones was adequately informed about the potentially life-threatening cardiovascular side effects (e.g., pro-arrhythmic potential) associated with the drugs given to her alone or in combination. There is also no evidence to suggest that she was adequately informed about the potential drug-drug interactions of her prescribed medication regimen. In fact, based upon my review of the records, I cannot establish - let alone to a reasonable degree of medical certainty - that Ms. Jones was adequately informed about the additive and/or synergetic effects of her prescribed medications. Likewise, there is no data to suggest that Ms. Jones was informed about the potential drug-drug interactions pertaining to the medications that she had taken on and before August 27, 2015 and the medication that she was prescribed right upon her admission to Pembroke Hospital."<sup>227</sup>

Dr. Saleh points out in a footnote, "Concurrent use of two or more drugs that can cause QT interval prolonging<sup>228</sup> may result in additive effects and increased risk of ventricular arrhythmias including torsade de points<sup>229</sup> and sudden death."<sup>230</sup> In a separate footnote Dr. Saleh states, "Based on the records, Ms. Jones seems to have received paliperidone (Invega<sup>231</sup>) on August 27, 2015 at both 9 AM and at 10:28 PM."<sup>232</sup>

Dr. Saleh notes, "Although Ms. Jones was not given paliperidone (Invega) at Pembroke Hospital, there are no data to suggest that Ms. Jones was given or offered a wash-out period before being started on her new medication regimen."<sup>233</sup> Notably, Ms. Jones died of probable cardiac dysrhythmia.

DMH Regulation 104 CMR § 2710(1)(a)(b) defines informed and specific consent.<sup>234</sup>

#### Failure to Identify Symptoms as Possible Drug-Drug Interactions

"Although Ms. Jones' heart rate fluctuated from 95 to 110 (abnormally elevated heart rate), there are no data to suggest that a medical condition or a medication-related side effect was considered and satisfactorily ruled out as a possible cause of her clinical presentation at that time."<sup>235</sup>

"Although Ms. Jones reportedly vomited on August 29, 2015 and was noted to be drowsy and pale, there are no data to suggest that a physician was notified to evaluate her medical status prior to her death on or about August 30, 2015. Specifically, there is no evidence to suggest that a careful assessment of her fluid and electrolyte status was considered and/or undertaken to rule out lithium toxicity or a potential electrolyte abnormality that if present and properly identified, could have been corrected."<sup>236</sup>

In a footnote, Dr Saleh states, "Most episodes of drug-induced cardiac dysrhythmias occur in the setting of multiple risk amplifiers including, but not limited to, heart disease, female gender, electrolyte abnormalities, drug interactions, or high drug doses."<sup>237</sup>

#### Failure to Treat,

"Although diagnoses with Tobacco Use Disorder, (See Dr. McGee's note, dated August 28, 2015) there is no evidence to suggest that Ms. Jones was adequately treated for tobacco withdrawal phenomenon."<sup>238</sup>

"Ms. Jones' mother, visited her daughter on August 29, 2015. She reportedly expressed concern regarding her medications and stated, 'This is not my daughter. She seems like a zombie.' Although Ms. Jones' mother was reportedly educated regarding 'med changes and rationale,' there is no evidence that that Ms. Jones' doctor was notified and informed about her mother's concerns and observations."<sup>239</sup>

#### Failure to Evaluate Risk

Although Ms. Jones had overdosed on medications prior to her Pembroke Hospital admission, and had engaged in self-injurious behaviors and stated that she 'wanted to die' on August 29, 2015 (17:00), there is no data to suggest that a proper risk assessment (even informal) was conducted at the time she made that statement. With the exception of 'benign neglect' and 'will continue to monitor' as the only risk management strategies to address Ms. Jones' clinical needs at the time."<sup>240</sup>

#### Findings of Dr. Saleh

Dr. Saleh found that Pembroke Hospital's failure to consult with a physician constituted neglect within the meaning of 42 U.S.C. § 10802(5).<sup>241</sup> Dr. Saleh also found that Pembroke Hospital's failure to obtain informed and specific consent; failure to identify symptoms as possible drug-drug interactions; failure to treat; and, their failure to evaluate risk also constituted neglect within the meaning of the statute.

#### **Findings**

**Pembroke Hospital, in a series of acts or omissions in the provision of care treatment and services, as described below, neglected Mary Jones, which caused or may have caused her death.**

**A Pembroke Hospital staff neglected Ms. Jones when it failed to provide a safe environment.**

Pembroke Hospital staff neglected Ms. Jones when it failed to conduct patient observation rounds in accordance with its hospital policy.

The purpose of Westwood Lodge and Pembroke Hospital Policy # RI.062, entitled "Observation Rounds," is to ensure patient safety, as well as to provide a process for observing and documenting patient location and behavior.

On the 11:00 PM – 7:00 AM shift on the night of August 29 and 30, 2015 the observation rounds form reflects that fifteen-minute checks were performed as ordered from 11:00 PM until 5:30 AM.

At 5:05 AM the DOC, Dr. Konrad Mark entered into the medical record that Ms. Jones was found by staff at 5:00 AM, that she appeared pale and in rigor mortis and that the EMTs identified Ms. Jones as “two hours in rigor mortis.” When interviewed by Officer Kevin Doyle of the Pembroke Police Department, Dr. Mark stated that he observed rigor mortis in the body of Ms. Jones. When asked again if he clearly saw rigor mortis in the body of Ms. Jones, Dr. Konrad responded, “Yes.”

According to Officer Doyle he was dispatched to Pembroke Hospital Wing West 2 at 5:01 AM along with the Pembroke Fire Department. He was escorted to room W2-5 where staff was performing CPR on Ms. Jones. Hospital staff transferred the case to Pembroke Fire Department Captain McCormick who reported that he observed obvious signs of rigor mortis, mottling and lividity.

A joint investigation by the Disabled Persons Protection Commission (DPPC) and the Department of Mental Health (DMH) concluded that although the documentation reflects that patient safety checks were done on a fifteen (15) minute basis from when Ms. Jones went to bed on August 29, 2015 until she was found on August 30, 2015 at approximately 5:00 AM, the fact that she was discovered in full rigor mortis compels the finding that safety checks were not done in accordance with hospital policy.

Pembroke Hospital staff neglected Mary Jones when it violated hospital policy by leaving her alone in her room after finding her unresponsive.

Westwood Lodge and Pembroke Hospital Policy # PC.003, entitled “Code Blue,” requires that the “designated licensed medical or nursing personnel shall direct the code in the following manner:”

- Send one staff member to the lobby to escort the paramedics to the patient’s location.
- Instruct one staff member to direct patients/visitors away from the code area and provide emotional support.
- Assign a nurse to monitor vital signs.
- A designated nursing personnel shall record all Code Blue data.
- The designated Nursing Supervisor or nursing staff prepare(s) appropriate forms for transfer as per policy # PC.029.
- The physician or designated Nursing Supervisor gives a verbal report of the incident to the paramedics.

In determining whether the actions of the staff created or contributed to an incident and/or condition that was dangerous, illegal and/or inhumane, as defined in DMH regulations, Director of Licensing, Janet E. Ross, MS, RN concluded in her December 28, 2015 decision that Ms. Jones was found by one mental health associate (MHA), who left Ms. Jones' room and got the second MHA. One of the MHAs then left the room to get the nurse. After entering Ms. Jones' room, the RN left the room, followed by the remaining MHA, leaving no one with Ms. Jones.

Ms. Ross determined that by leaving Ms. Jones alone in her room, staff violated Police # PC.003 and by doing so contributed to an incident and/or condition that was dangerous and inhumane in violation of DMH regulations.

**B      Pembroke Hospital neglected Mary Jones when it failed to maintain an appropriate treatment plan.**

Pembroke Hospital neglected Mary Jones when it incorrectly reported her age as thirty-one which resulted in their failure to consider whether her abnormally elevated heart rate was her medical condition or a medication-related side effect.

Upon her admission to Pembroke Hospital, Ms. Jones' age was inaccurately recorded as thirty-one years old. In fact, Ms. Jones was twenty years old. At 1:00 AM her pulse rate was recorded as 106, shortly thereafter it was recorded as being 113.

In her decision letter dated December 28, 2015, Ms. Ross stated:

The nursing notes repeatedly refer to "VSS" for vital signs stable, but this patient's pulse rate was recorded at 106 and 113, which are not considered to be stable vital signs for a young woman of 20 years old.

Ms. Ross adds that there is no reference in the chart to suggest that that these conditions prompted consultation with a physician.

Due to the failure of Pembroke Hospital to correctly note Ms. Jones' age, staff failed to recognize or to take any steps to determine why Ms. Jones' were not stable for a twenty year old woman and whether her elevated heart rate was her medical condition or a medication-related side effect.

Pembroke Hospital neglected Mary Jones when it failed to provide medical care.

Pembroke Hospital did not provide Ms. Jones with necessary medical treatment during the hours and days which led up to her death. Pembroke Hospital relied upon hospital policy # PC.067 which allows seventy-two hours to develop a "written, individualized treatment plan" as justification for their failure to provide Ms. Jones with medical treatment. Pembroke Hospital attempted to justify this failure by trying to suggest that because Ms. Jones had died before the third day of her admission they had no responsibility to provide Ms. Jones with necessary medical care.

The failure of Pembroke Hospital's logic lies in the fact that Pembroke Hospital is principally a psychiatric facility and that the intent of the policy # PC.067 is to allow the psychiatric staff seventy-two hours to develop a treatment plan to assess and treat a patient's clinical psychiatric needs.

Policy # PC.067 does not allow Pembroke Hospital to fail to address medical issues that are present upon admission or that become apparent during the course of a patient's hospitalization. In fact, DMH regulation 104 CMR § 27.10 requires that "upon admission to a facility for care and treatment, a person shall...receive treatment and rehabilitation in accordance with accepted therapeutic practice" and, "upon admission be informed of the routine and preventative treatment performed at or arranged by the facility."

Pembroke Hospital failed to provide Ms. Jones with appropriate medical care or to develop a treatment plan to address the multiple physical signs and symptoms that she presented upon admission, and displayed during the course of her hospitalization.

Pembroke Hospital neglected Mary Jones when it failed to inform her of the potential life-threatening cardiovascular side effects associated with the drugs given to her.

The form completed by Dr. Michael McGee at 2:00 PM on August 28, 2015, shows that Dr. McGee authorized multiple and significant changes to the medications that Ms. Jones had been taking prior to her admission to Pembroke Hospital. In doing so, Dr. McGee also checked the box entitled "informed consent" in which he attested to the fact that for any new medications, all benefit and risk information, including "Black Box warnings" were given and informed consent was obtained from patient.

Despite having check the informed consent box, there is no evidence in the medical record to support that Ms. Jones was adequately informed about the potential life-threatening cardiovascular side effects, including pro-arrhythmic potential, associated with the drugs given to her alone or in combination with other medication. Nor was she adequately informed about the respective drug-drug interaction of her prescribed medication regimen.

In fact, there is no evidence to establish that Ms. Jones was informed about the additive and/or synergetic effects of her prescribed medications, or that she was informed about the potential drug-drug interactions pertaining to medication that she had taken on or before August 27, 2015 and the medication that she was prescribed upon her admission to Pembroke Hospital.

This is of particular concern because the concurrent use of two or more drugs of the type that Ms. Jones was prescribed can cause QT interval prolongation<sup>242</sup> and may result in additive effects and increased risk of ventricular arrhythmias including torsade de pointes<sup>243</sup> and sudden death.

Notably the Office of the Chief Medical Examiner lists Ms. Jones' cause of death as probable cardiac dysrhythmia complicating (focal) lymphocytic myocarditis of uncertain

etiology. As noted above, Dr. McGee failed to discuss with Ms. Jones the potential life-threatening cardiovascular side effects, including pro-arrhythmic associated with the drugs given to her alone or in combination with other medication.

Pembroke Hospital neglected Mary Jones when it failed to give her a wash out period before starting her on a new medication regimen.

Prior to her admission to Pembroke Hospital, Ms. Jones presented herself at the Union Hospital Emergency Department (ED) at the North Shore Medical Center (NSMC) at approximately 3:00 PM on August 27, 2015. According to the record, prior to her arrival at the ED, Ms. Jones had been taking various medications including: Lexapro; naltexone, albuterol, paliperidone; Lactaid, desmopressin acetate, Wellbutrin, Topomax, paliperidone (prn); Ativan; Lithium Carbonate; Thorazine; Prazosin and Hydroxyzine.

While at NSMC Ms. Jones was administered the following medications: Lithium; Ativan; Prazosin; Invega; Topamax and Thorazine. And upon her admission to Pembroke Hospital on August 28, 2015 Ms. Jones was prescribed: Aripiprazole; buprenorphine-naloxone; chlorpromazine; diazepam; escitalopram and ibuprofen for pain.

According to the record, Ms. Jones took paliperidone (Invega) on August 27, 2015 at 9 a.m. and again at 10:28 p.m. while she was at NSMC, and although she was not given additional Invega at Pembroke Hospital she was not given or offered a “wash-out period<sup>244</sup>” before being started on her new medication regimen. Additionally, Pembroke Hospital failed to factor in Ms. Jones’ significant history of polysubstance abuse including a recent heroin use when starting her on new medication.

As stated above, the potential drug-drug interactions and the potential life-threatening cardiovascular side effects, including pro-arrhythmic potential associated with the drugs given to Ms. Jones either alone or in combination with other medication, as well as the additive and/or synergetic effects of these medications warranted a wash-out period before putting Ms. Jones on a new medication regimen. It is well established that a medication wash out “establishes a new baseline of the disorder, helps identify medication efficacy from their adverse effects, and provides clarity of diagnosis and potential reduction of drug treatments, drug interactions, and costs. It may also reduce overall adverse effects, not to mention a potential to reduce liability.”<sup>245</sup>

Pembroke Hospital staff neglected Mary Jones when it failed to notify a physician that she had vomited and developed a migraine headache despite the concern of nursing staff that she was experiencing side effects from a combination of Suboxone and benzodiazepine

The 2:35 PM note for August 28, 2015 states that Ms. Jones was a late admission and slept in that morning. Ms. Jones had refused her morning medication because there was no Ativan. According to the record, Dr. McGee gave Ms. Jones 10 mg of Valium, and 2 mg Suboxone that afternoon. Ms. Jones did not awake until the morning of August 29, 2015.

The 11:00 AM notes for August 29, 2015 state that Ms. Jones requested her AM medication but that the Valium was held, as Ms. Jones still appeared drowsy. Subsequent notes entered during the 7:00 AM to 3:00 PM shift report that Ms. Jones was feeling nauseous and was dry heaving at times that morning. She was reported to be sipping fluids and was given medication “as tolerated” and spent most of the day in bed.

A 1:00 PM nursing note states that Ms. Jones’ medications were held due to nursing concerns for side-effects of newly started medications and that Ms. Jones was observed as drowsy and pale. When interviewed by DMH, the on-duty nurse reported that Ms. Jones had a headache and had vomited that morning. Nursing further reported that Ms. Jones was insistent that the headache was a symptom of the vomiting.

When interviewed by DMH, the on-duty nurse reported that she was concerned that Ms. Jones was pale and had vomited that morning because she had recently been started on new medication and the nurse thought Ms. Jones’ presentation were side-effects from the medication. The nurse was particularly concerned about Ms. Jones being administered a combination of Suboxone and benzodiazepine. She reported to DMH that she didn’t want Ms. Jones to become sedated and that she considered it a bad use of Suboxone. The on-duty nurse stated that she wrote a letter to the leadership of Pembroke Hospital about this practice two weeks before Ms. Jones died. Likewise, when the on-duty nurse was interviewed by Officer Doyle about this incident she reported that Ms. Jones had been started on several new medication and she was concerned about side effects.

However, despite the expressed concerns of the on-duty nurse, about side-effects due to the combination of Suboxone and benzodiazepine, there are nothing in the record to suggest that nursing contacted a physician about their concerns, or requested that Ms. Jones be evaluated.

Pembroke Hospital staff neglected Mary Jones when it failed to assess her fluid and electrolyte status to rule out lithium toxicity or a potential electrolyte abnormality, after she vomited and developed a migraine headache

As stated above, Ms. Jones vomited on the morning of August 29, 2015, that she had a headache and was noted to be drowsy and pale, and that there is nothing in the record to suggest that a physician was notified to evaluate her medical status.

Specifically, there is no evidence to suggest that a careful assessment of her fluid and electrolyte status was considered or undertaken to rule out lithium toxicity or a potential electrolyte abnormality that may have been present, which if identified, could have been corrected.

This is particularly problematic as the on-duty nurse had expressed her specific concerns that Ms. Jones’ symptoms and presentation were a result of her having been

administered a combination of Suboxone and benzodiazepine. Additionally, most episodes of drug-induced cardiac dysrhythmias occur in the setting of multiple risk amplifiers including, but not limited to, heart disease, female gender, electrolyte abnormalities, drug interactions, or high drug doses.

Pembroke Hospital staff neglected Mary Jones when it failed to notify a physician of her mother's concerns regarding Ms. Jones being prescribed lithium and her stating, "This is not my daughter. She looks like a zombie."

On August 29, 2015 Ms. Jones' mother, visited her daughter at Pembroke Hospital from 12:00 to 3:00 PM. Ms. Jones' mother informed staff that her daughter did not look right, and that she looked drugged. Ms. Jones' mother raised specific concerns about Ms. Jones' medication. Ms. Jones' mother requested to speak with the charge nurse and Ms. Mary Jones signed a release authorizing staff to speak with her mother.

Ms. Jones' mother told the charge nurse, "[t]his is not my daughter, she seems like a zombie." The nurse informed Ms. Jones' mother about her daughter's medication changes and that staff had withheld some of Ms. Jones' morning medication due to nursing's concerns of sedation. Ms. Jones' mother told nursing that she would like to speak to Dr. Mark on Monday to assist in coordinating care for her daughter.

When interviewed by DMH, the on-duty nurse reported that Ms. Jones' mother was fixated on Mary Jones being administered Lithium. According to the on-duty nurse, Ms. Jones' mother did not feel as though Lithium was safe.

Despite Ms. Jones' mother's concerns about her daughter's presentation and not feeling as though Lithium was safe, there is no evidence in the record to indicate that Ms. Mary Jones' doctor was notified and informed about her mother's concerns and observations."

Pembroke Hospital staff neglected Mary Jones when it utilized "benign neglect" instead of conducting a risk assessment or placing her on 1:1 suicide protocols after she stated "I want to die" and "I don't want to hurt myself...yet."

During Ms. Jones' visit with her mother Ms. Jones' mother discussed her concerns with the on-duty nurse regarding her daughter's "drugged" presentation and her worry that Ms. Jones had been given Lithium, Ms. Jones denied that she had an urge to self-injure and stated, "I don't want to die...yet."

At 4:00 PM on August 29, 2015 Ms. Jones requested nicotine gum. When her request was denied she escalated and demanded a nicotine patch. Ms. Jones began screaming, she hit a wall with her fist, ran into her room and continued screaming. Twenty minutes later she asked to go to the cafeteria for dinner. She was told that she must first demonstrate self-control. Ten minutes later she said "I want to die." Despite this threat of self-harm, Ms. Jones was not placed on a suicide protocol, nor was she

placed on 1:1 observation. Instead the record notes, “Benign neglect utilized with good effect.”

In addition to Ms. Jones’ statements and her recent attempts at suicide and cutting, there is nothing in the record to suggest that a risk assessment was conducted or that a physician was made aware of these statements. And despite Ms. Jones’ admission documents noting that she is at risk of suicide, no recommendation was made to place Ms. Jones on 1:1 observation. Instead the only strategy considered was employing “benign neglect” as the best way to address Ms. Jones’ clinical needs at the time.

Pembroke Hospital neglected Mary Jones when it failed to provide her with trauma informed care despite knowing her history of being sexually assaulted.

The Emergency Department (ED) notes from North Shore Medical Center documents that Ms. Jones has a history of sexual and emotional abuse and has had multiple hospitalizations since she was 13 years-old. The ED notes list her Axis IV diagnosis as psychosocial trauma history. Ms. Jones reported that she experiences nightmares related to her trauma.

Ms. Jones’ admission document from Pembroke Hospital notes that she was a victim of sexual assault. Ms. Jones reported to Dr. Michael McGee that she was molested by a friend of the family from the age of six until fifteen. Ms. Jones reported that her mother did not believe her when she told her about the sexual abuse. The admission documents further show that Ms. Jones’ trauma history affects her today in that she experiences nightmares and that seeing pictures of the perpetrator is a trigger for her. On August 29, 2015 Ms. Jones refused Prazosin ordered for anxiety. She told Pembroke Hospital, “I only take that medication at night for nightmares.”

Despite Pembroke Hospital’s awareness of Ms. Jones’ history of sexual abuse and trauma, staff at Pembroke Hospital failed to create a trauma-informed treatment plan. Instead, Pembroke Hospital relied solely on medication to treat Ms. Jones’ symptoms.

Pembroke Hospital neglected Mary Jones when it failed to create a medical treatment plan to treat her asthma and her nicotine withdrawal.

The ED notes from North Shore Medical Center state that Ms. Jones has asthma and uses an Albuterol inhaler on an as needed basis. The ED notes also indicate that Ms. Jones smokes one pack of cigarettes per day.

When Ms. Jones was admitted to Pembroke Hospital the fact that she has asthma was noted in the record, as was the fact that Ms. Jones was a smoker.

Upon admission to Pembroke Hospital Ms. Jones Albuterol inhaler was confiscated by staff and it was not replaced, nor was she offered any treatment for her asthma. With respect to her nicotine addiction, the admission documents also reflect that Ms. Jones

was a smoker. Pembroke Hospital provided Ms. Jones with information on coping skills and information on quitting smoking as a means to address her nicotine withdrawal.

When interviewed by DMH Dr. Michael McGee, reported that Ms. Jones was pleasant, but emotionally dysregulated. Dr. McGee volunteered that he had had two regrets: that he didn't provide Ms. Jones with a nicotine patch and that he never followed up regarding her medication.

**C Pembroke Hospital neglected Mary Jones when it failed to obtain informed consent and specific informed consent in violation of State Regulations.**

Pembroke Hospital staff neglected Mary Jones when it failed to consider her cognitively impaired presentation but instead accepted her consent to receive treatment, including her specific consent to be treated with antipsychotic medication whose side effects include death.

DMH regulations provide that:

“Upon admission to a facility for care and treatment, a person shall, upon giving informed consent, receive treatment and rehabilitation in accordance with accepted therapeutic practice... Informed consent means the knowing consent, voluntarily given by the patient... who can understand and weigh the risks and benefits of the particular treatment being proposed.” 104 CMR § 27.10(1)(a).

“Treatment with antipsychotic medication... may not be administered... without the patient's specific informed consent.” 104 CMR § 27.10(1)(b).

According to documents titled, Pembroke Hospital Comprehensive Interdisciplinary Assessment, Ms. Jones was assessed as sleepy and somnolent. Her eye contact was poor; level of consciousness: somnolent; psychomotor: slowed; concentration and attention span: not intact; estimated intelligence: below average; thought process and thought content: sleepy. Yet according to this document, informed consent was obtained for medication ordered upon admission, including relevant black box warnings.<sup>246</sup> Ms. Jones' impaired condition as stated in the record show that she was incapable of providing informed consent to receive treatment.

Moreover, absent documentation in the record that Dr. McGee clearly explained to Ms. Jones the numerous serious risks, including her death by cardiac dysrhythmia, associated with the antipsychotic medication that Dr. McGee prescribed, the checking of a box on a form does not constitute Ms. Jones giving her specific informed consent to be treated with antipsychotic medication.

#### **IV. Ineffective Training at Arbour Health Systems**

The Department of Mental Health conducted an annual site inspection of Pembroke Hospital on October 14, 2014. As a result of DMH's findings and citations, Pembroke Hospital initiated its "MHA Relearn" program in December 2014. The curriculum included retraining in the completion of "Patient Observation Rounds."<sup>247</sup>

This retraining was in addition to Pembroke's Hospital's Orientation curriculum for new hires, which in addition to training on "Observation Rounds" also required new staff to be competent in, Emergency Codes, Vital Signs, EKGs, Medical Emergencies and CPR.<sup>248</sup>

After the death of Mr. Smith, Westwood Lodge provided DMH with its Corrective Action Plan that required all staff to be trained in completing "Observation Rounds" in accordance with hospital policy.<sup>249</sup>

After the death of Ms. Jones, Pembroke Hospital's provided DMH with its Corrective Action Plan that required that MHAs and Nurses be retrained on completing patient observation rounds.<sup>250</sup>

#### **V. Current Status of the Facilities**

On August 24, 2017 the state of Massachusetts closed the Westwood Lodge psychiatric hospital due to issues of patient safety, quality of care, and the facility's failure to comply with Department of Mental Health requirements.<sup>251</sup>

#### **VI. Remedial Plan**

In order to address the concerns identified above, Arbour Health Systems must create a detailed measurable remedial plan, which includes the following elements and submit its plan to DLC within 45 days of the release of this report:

- Arbour Health Systems will develop policies and procedures by which the patient's individualized treatment plan captures all pertinent information and data regarding a patient's recent history, including, but not limited to, age, medical status, vital signs, recently prescribed medications, current diagnosis, suicidal and homicidal behaviors, self-injurious behaviors, risk assessments, medical history, substance abuse and trauma history, is reviewed, discussed and fully incorporated into the patient's individualized treatment plan.
- Arbour Health Systems will develop policies and procedures to ensure that upon admission all patients will receive routine and preventative medical treatment consistent with 104 CMR § 27.10(3), and patients requiring specific medical treatment beyond the scope the facility will be transferred to a facility that can provide the treatment.
- Arbour Health Systems will develop policies and procedures consistent with DMH regulations to ensure that prior to starting a patient on a medication regimen, all

risks and benefits associated with both the proposed medication, including all potential drug-drug interactions, and all medications taken on or before admission are fully discussed with the patient. These policies and procedures will ensure that safeguards are put in place to ensure that the patient is both competent and has the capacity to provide Specific and Informed Consent before being administering psychiatric medication.

- Arbour Health Systems will interpret and implement its policy #PC.067, titled Interdisciplinary Treatment Plan, to allow up to 72 hours for the psychiatric and medical staff to assess, diagnose, and develop a written, individualized treatment plan, including the provision of a “wash out” period to the patient prior to starting that patient on new medication. Arbour Health Systems will develop and introduce policies that ensure that the full extent of a patient’s history of trauma and substance abuse is accurately captured and that history becomes an integrated part of the patient’s individualized treatment plan, and is used and relied upon in the formulation an appropriate individualized treatment plan.
- Arbour Health Systems will develop and implement policies that facilitate timely and effective communication between the direct care, nursing, and psychiatric staff to ensure that any information regarding the patient’s health, presentation, affect, reaction to medication, possible side-effects, threats or instances of self-injury are immediately shared with all staff and incorporated into the patients’ individualized treatment plan.
- Arbour Health Systems will develop and implement policies and in-service training schedules to ensure that observation rounds are conducted in a manner consistent with policy # RI.062.
- Arbour Health Systems will develop and implement policies to ensure that all life-saving equipment is inspected and services on a regular basis to ensure that said equipment is in proper working order and is easily located when needed.
- Arbour Health Systems will develop necessary training elements on implementing each of these policies and procedures. All staff, including administrative staff, will receive training in these policies and procedures both when initially launched and every six months thereafter. In formulating its training programs, Arbour Health Systems must ensure that the training is effectively presented and received, including a robust testing/monitoring plan to ensure that the critical lessons learned from these tragic deaths are not repeated in the future.
- Arbour Health Systems will report to the Disability Law Center and provide documentation of the dates of trainings, names and positions of persons trained, and the training curriculum used in implementing these policies and procedures no more than thirty days after the completion of each training session.
- Arbour Health Systems will provide copies to DLC of all new or modified policies and practices developed as part of its remedial plan.

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- <sup>1</sup> Pseudonym for Westwood Lodge patient
  - <sup>2</sup> Page 2, 15-WWL-033
  - <sup>3</sup> Id, Page 3
  - <sup>4</sup> Id
  - <sup>5</sup> Id.
  - <sup>6</sup> Addendum to DMH Investigation Report 9/22/16
  - <sup>7</sup> Adult Comprehensive Assessment, 4/8/15
  - <sup>8</sup> Id
  - <sup>9</sup> Id
  - <sup>10</sup> Addendum to Investigation Report, September 22, 2016
  - <sup>11</sup> Westwood Lodge Nursing Assessment, 4/9/15
  - <sup>12</sup> Physician's Orders, 4/9/15.
  - <sup>13</sup> Id
  - <sup>14</sup> Physician's Orders, April 10 through 24, 2015
  - <sup>15</sup> Progress Record, 4/9/15
  - <sup>16</sup> Nursing Assessment, 4/9/15
  - <sup>17</sup> Initial Clinical Summary, 4/10/15
  - <sup>18</sup> Id
  - <sup>19</sup> Nursing Assessment, 4/9/15
  - <sup>20</sup> Progress Record, 4/9/15
  - <sup>21</sup> Radiology Report, 4/12/15
  - <sup>22</sup> Progress Record, 4/10/15
  - <sup>23</sup> Progress Record, 4/11/15
  - <sup>24</sup> Progress Record, 4/12/15
  - <sup>25</sup> Progress Record, 4/13/15
  - <sup>26</sup> Progress Record, 4/14/15
  - <sup>27</sup> Progress Record, 4/15/15
  - <sup>28</sup> Progress Record, 4/15/15
  - <sup>29</sup> Progress Record, 4/15/15
  - <sup>30</sup> Progress Record, 4/15/15
  - <sup>31</sup> Progress Record, 4/15/15
  - <sup>32</sup> Progress Record, 4/15/15
  - <sup>33</sup> Progress Record, 4/15/15
  - <sup>34</sup> Progress Record, 4/15/15
  - <sup>35</sup> Progress Record, 4/15/15
  - <sup>36</sup> Progress Record, 4/16/15
  - <sup>37</sup> Progress Record, 4/16/15
  - <sup>38</sup> Progress Record, 4/16/15
  - <sup>39</sup> Progress Record, 4/16/15
  - <sup>40</sup> Progress Record, 4/16/15
  - <sup>41</sup> Progress Record, 4/16/15
  - <sup>42</sup> Progress Record, 4/16/15.
  - <sup>43</sup> Progress Record, 4/17/15
  - <sup>44</sup> Progress Record, 4/17/15
  - <sup>45</sup> Progress Record, 4/18/15
  - <sup>46</sup> Progress Record, 4/18/15
  - <sup>47</sup> Progress Record, 4/18/15
  - <sup>48</sup> Progress Record, 4/18/15
  - <sup>49</sup> Progress Record, 4/19/15
  - <sup>50</sup> Progress Record, 4/21/15

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51 Progress Record, 4/21/15  
52 Progress Record, 4/21/15  
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55 Progress Record, 4/22/15  
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72 Progress Record, 4/24/15  
73 Progress Record, 4/24/15  
74 Progress Record, 4/24/15  
75 Progress Record, 4/24/15  
76 Progress Record, 4/24/15  
77 Case Manager Daily  
78 Progress Record, 4/24/15  
79 Progress Record, 4/25/15  
80 Westwood Police Department Incident Report  
81 Id  
82 Id  
83 Id  
84 Id  
85 Id  
86 DPPC/DMH Investigation Report  
87 Id  
88 Id  
89 Id  
90 Id  
91 Id  
92 Id  
93 Id  
94 Id  
95 Id  
96 Id  
97 Id  
98 Id  
99 Id  
100 Id  
101 Id

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102 Id

103 Id

104 Id

105 Id

106 Id

107 Pseudonym for Pembroke patient

108 Id

109 Id

110 Id

111 Id

112 Page 4, 15-PEMB-012 amended

113 Office of the Chief Medical Examiner, Report of Autopsy, 8/30/15

114 Dr. Fabian M. Saleh, M.D., D.F.A.P.A is a board certified in general and forensic psychiatry and fellowship trained in child and adolescent psychiatry. He has served as a consultant to a number of state agencies and has been retained or qualified as an expert in matters ranging from homicide, sexual assault, manslaughter, competency to risk management, malpractice, psychopharmacology, and guardianship cases. He has served as an expert on over 1000 cases for both the defense and prosecution, and has also been appointed by federal court judges. He has testified in different states including, but not limited to, WA, NC, SC, DC, MA, and NH.

115 Elliot Community Human Services, Inc.

116 "Any licensed physician.... who, after examining a person, has reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness may restrain or authorize the restraint of such person and apply for the hospitalization of such person for a 3 day period at a public facility or at a private facility authorized for such purposes by the department."

117 NSMC ED Nursing, page 1

118 Assessment by Medgyne Lubin, LCSW

119 Inpatient Locked Unit

120 NSMC ED Nursing, page 1

121 NSMC ED Nursing, page 2

122 NSMC ED Physician, page 1

123 NSMC ED Physician, page 1

124 Classification. 0 = absent: 1+ = diminished: 2+ = Normal: 3+ = Moderately Increased: 4+ = Markedly Increased.

125 NSMC ED physician, page 2

126 Id

127 Emergency Services Programs. ESPs provides behavioral health crisis assessment, intervention and stabilization services.

128 ESP Child/Adolescent Comprehensive Assessment

129 Id

130 Id, page 8

131 NSMC ED Nursing, page 3

132 Physician Authorization for Transfer, 8/27/15

133 Id

134 H and P: shorthand for history and physical, the initial clinical evaluation and examination of the patient.

135 Nursing Transfer, 8/27/15

136 Physician Orders – Final 8/28/15

137 Physician's orders, 8/28/15

138 Interdisciplinary Assessment

139 Interdisciplinary Assessment, page 1

140 Id at page 4

141 Id at page 13

142 Id

143 Id

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<sup>144</sup>Physician Orders Final, 8/28/15  
<sup>145</sup> Interdisciplinary Assessment, page 16  
<sup>146</sup> Signed Admission Home Medication Orders, 8/28/15  
<sup>147</sup> 10/11 Form 8/28/15  
<sup>148</sup> Initial Admitting Orders, 8/28/15  
<sup>149</sup> Repot of Autopsy  
<sup>150</sup> Consultation/Physical Evaluation. 8/28/15  
<sup>151</sup> Attending Onservice Note, 8/28/15  
<sup>152</sup> Progress Record, 8/28/15  
<sup>153</sup> Progress Record, 8/28/15  
<sup>154</sup> Progress Record, 8/28/15  
<sup>155</sup> Valium (diazepam) is a benzodiazepine  
<sup>156</sup> Progress Record, 8/28/15  
<sup>157</sup> Progress Record, 8/29/15  
<sup>158</sup> Prazosin is used to treat PTSD.  
<sup>159</sup> Progress Record, 8/29/15  
<sup>160</sup> Progress Record, 8/29/15  
<sup>161</sup> The death of Ms. Jones was reported to DPPC by Susan Higgins of Elliot Community Human Services on August 31, 2105. DPPC assigned the case number 138283. Trooper Coker suggested that a civil investigation proceed to obtain more information. John Hubbard was assigned as the DPPC Investigator and Officer Bukow was assigned as the oversight officer. The DPPC intake report was forwarded to DMH. On August 1, 2015 Stacey Burn, Risk Manager at Pembroke Hospital reported the death of Ms. Jones to DMH. On August 31, 2015 the incident was logged as 15-PEMB-012 as forwarded to DMH Office of Investigations for the assignment of an Investigator. On September 1, 2015 David Eaton, Jr., Investigator, DMH Office of Investigations was appointed as Investigator. In the course of his investigation Mr. Eaton interviewed witnesses and reviewed the record. The investigation was conducted pursuant to DMH regulations 104 CMR § 32.00  
<sup>162</sup> DMH Interview Notes  
<sup>163</sup> Id  
<sup>164</sup> Id  
<sup>165</sup> Id  
<sup>166</sup> Id  
<sup>167</sup> Id  
<sup>168</sup> Id  
<sup>169</sup> Id  
<sup>170</sup> Id  
<sup>171</sup> Progress Record 8/29/15  
<sup>172</sup> DMH Interview Notes  
<sup>173</sup> DMH Interview Notes  
<sup>174</sup> DMH Interview Notes  
<sup>175</sup> Progress Record, 8/29/15.  
<sup>176</sup> Id.  
<sup>177</sup> Id  
<sup>178</sup> Id  
<sup>179</sup> Id  
<sup>180</sup> Progress Record, 8/30/15  
<sup>181</sup> DMH Investigation Report  
<sup>182</sup> Id  
<sup>183</sup> Id  
<sup>184</sup> Id  
<sup>185</sup> Id

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186 Id  
187 Id  
188 Id  
189 Id  
190 Id  
191 Id  
192 Id  
193 Id  
194 Id  
195 Id  
196 The application of painful stimulus with the knuckles of closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli.  
197 DMH Investigation Report  
198 Progress Record 8/30/15  
199 Id  
200 Id  
201 Id  
202 Id  
203 DMH Investigation Report  
204 Livor mortis (Latin: livor—"bluish color," mortis—"of death"), postmortem lividity (Latin: postmortem—"after death", lividity—"black and blue"), hypostasis (Greek: hypo, meaning "under, beneath"; stasis, meaning "a standing") or suggillation, is the fourth stage and one of the signs of death.  
205 DMH Investigation Report.  
206 Pembroke Police Department Incident Report  
207 Id  
208 Id  
209 Progress Record, 8/30/15  
210 Id  
211 Id  
212 Pembroke Police Department Incident Report  
213 Id  
214 Id  
215 DMH Investigation Report  
216 Pembroke Fire Department Report  
217 DMH Investigation Report  
218 DMH Interview Notes  
219 DMH Investigation Report  
220 DMH Investigation Report  
221 Report of Autopsy, 8/30/15  
222 Dr. Saleh, Forensic Report, dated March 8, 2016, page 9.  
223 Not approved by the U.S Food and Drug Administrations for the conditions used.  
224 Dr. Saleh, Forensic Report, dated March 8, 2016, page 9.  
225 Pembroke Hospital Comprehensive Interdisciplinary Assessment, 8/28/15  
226 Id.  
227 Dr. Saleh Forensic Report, March 8, 2016, page 10.  
228 Long QT syndrome (LQTS) is a disorder of the heart's electrical activity. It can cause sudden, uncontrollable, dangerous arrhythmias

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<sup>229</sup> Torsade de pointes is a specific form of polymorphic ventricular tachycardia in patients with a long QT interval. It is characterized by rapid, irregular QRS complexes, which appear to be twisting around the ECG baseline. This arrhythmia may cease spontaneously or degenerate into ventricular fibrillation.

<sup>230</sup> Dr. Saleh, Forensic Report, dated March 8, 2016, page 9, footnote 10.

<sup>231</sup> Paliperidone causes a modest increase in the corrected QT (QTc) interval. Avoid the use of drugs that also increase QT interval and in patients with risk factors for prolonged QT interval. Paliperidone should also be avoided in patients with congenital long QT syndrome and in patients with a history of cardiac arrhythmias. Certain circumstances may increase the risk of the occurrence of torsade de pointes and/or sudden death in association with the use of drugs that prolong the QTc interval. <http://www.janssencns.com/invega>

<sup>232</sup> Dr. Saleh, Forensic Report, dated March 8, 2016, page 9, footnote 11.

<sup>233</sup> Dr. Saleh Forensic Report, March 8, 2016, page 10.

<sup>234</sup> 104 CMR 27.10 (1) Consent to Treatment.

(a) Informed consent means the knowing consent, voluntarily given by the patient, or his or her legally authorized representative, who can understand and weigh the risks and benefits of the particular treatment being proposed.

(b) Treatment with antipsychotic medication, Electroconvulsive Treatment (ECT), psychosurgery, involuntary sterilization or abortion, and other highly intrusive or high risk interventions may not be administered or performed without the patient's specific informed consent.

<sup>235</sup> Dr. Saleh Forensic Report, March 8, 2016, page 10

<sup>236</sup> Id.

<sup>237</sup> Dr. Saleh Forensic Report, March 8, 2016, Footnote #13

<sup>238</sup> Dr. Saleh Forensic Report, March 8, 2016, page 10.

<sup>239</sup> Id, page 11.

<sup>240</sup> Id, page 11

<sup>241</sup> Id, page 9

<sup>242</sup> Long QT syndrome (LQTS) is a heart rhythm condition that can potentially cause fast, chaotic heartbeats. These rapid heartbeats might trigger a sudden fainting spell or seizure. In some cases, the heart can beat erratically for so long that it causes sudden death.

<sup>243</sup> A form of tachycardia in which the electrical pulse in the heart undergoes a cyclical variation in strength, giving a characteristic electrocardiogram resembling a twisted fringe of spikes.

<sup>244</sup> When a subject is asked to stop taking some or all medications prior to beginning a drug treatment study, this is called a drug washout.

<sup>245</sup> Polypharmacy or medication washout: an old tool revisited. Daniel A. Hoffman, Mark Schiller, James Greenblatt, and Dan Vlosifeue, © 2011 Hoffman et al

<sup>246</sup> A black box warning is the strictest warning put in the labeling of prescription drugs or drug products by the Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug.

<sup>247</sup> Pembroke Hospital MHA Relearn December, 2014

<sup>248</sup> Pembroke Hospital Orientation Syllabus, February 2, 2015

<sup>249</sup> Westwood Lodge Corrective Action Plan, September 25, 2015

<sup>250</sup> Pembroke Hospital Corrective Action Plan, January 12, 2016

<sup>251</sup> Boston Globe, June 10, 2017