



REPORT ON THE DEATH OF MR. RILEY¹

FINAL: September 25, 2015

UNIVERSITY LEGAL SERVICES, INC.

Since 1996, University Legal Services, Inc. (ULS), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. Congress vested the P&As with authority and responsibility to investigate allegations of abuse and neglect of individuals with disabilities. In addition, ULS provides legal advocacy to protect the civil rights of District residents with disabilities.

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

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I. METHODOLOGY

¹ The name has been changed to protect his identity.

Under the Protection and Advocacy for Individuals with Mental Illness (PAIMI) statute, ULS has the authority to “investigate incidents of abuse and neglect of individuals with mental illness if the incidents are reported to [ULS] or if there is probable cause to believe that the incidents occurred . . .”²

ULS obtained and reviewed Mr. Riley’s records from District’s Department of Behavioral Health (DBH), St. Elizabeths Hospital, and United Medical Center. ULS’ review included Mr. Riley’s Unusual Incident reports (UIs) at St. Elizabeths, his Discharge Plan of Care following his death, DBH’s Mortality Review Report, St. Elizabeths’ Nursing Death Summary Report, Sentinel Event Review Committee Report (SERC), and the SERC’s Recommendations and Implementation Status, among other records. ULS also reviewed St. Elizabeths’ internal policies including the following: Mortality Review, Sentinel Events, Levels of Special Observation. DBH did not provide ULS with a formal investigation of the death, either performed by DBH’s Office of Accountability or by St. Elizabeths’ office of risk management.

II. SUMMARY

In May, 2014, Mr. Riley was pronounced dead at the United Medical Center,³ having been transferred from St. Elizabeths Hospital two weeks earlier after he refused to eat and drink and was not responding to verbal questions.⁴ Mr. Riley was in his fifties⁵ and had spent more than 30 years of his life at St. Elizabeths Hospital; he was admitted in the 1980s following his mother’s death.⁶ Mr. Riley had difficulties as an adolescent,⁷ and he stopped attending school after eighth grade.⁸

Neuropsychological tests completed in 2012 and 2014 confirmed that Mr. Riley had an intellectual disability and/or dementia.⁹ However, St. Elizabeths failed to fully implement the recommendations from his neuropsychological evaluation or accommodate his disability, and Mr. Riley continued to struggle with his limitations until his death. See *infra* § III.A. Mr. Riley experienced dangerous episodes of swallowing foreign objects and repeated self-injurious episodes of scratching and swallowing his scabs. However, in the months prior to Mr. Riley’s death, it is unclear what level of observation the hospital did or should have provided, as many of the records conflict with each other on this point. Nor did St. Elizabeths develop, revise, or execute a behavior plan to address his behavioral needs. See discussion *infra* § III.B.2.

² 42 U.S.C. 10805(a)(1)(A).

³ UMC Death Summary Addendum dated 8/23/14; Change in Physical Status dated 4/23/2014 at 3:00 p.m.

⁴ St. Elizabeths Discharge Summary dated 5/9/14 at 3.

⁵ UMC Death Summary Addendum dated 8/23/14.

⁶ SEH Neuropsychological Evaluation dated 2/5/14 at 1 (performed in November and December, 2013).

⁷ *Id.* at 2.

⁸ Clinical Formulation dated 3/10/14 at 1; Discharge Summary dated 5/9/14 at 2.

⁹ SEH Neuropsychological Evaluation dated 2/5/2014 at 2-6. He had not been evaluated in the twenty years before the 2012 assessment. *Id.* at 1.

Finally, (*redacted because it contains discussion of peer review documents*) [] Equally troubling, though there were serious problems surrounding Mr. Riley’s treatment prior to his death, including neglect, inexplicably, neither DBH Office of Accountability nor St. Elizabeths risk management performed an investigation, in violation of D.C. Code § 7–1131.04(13) and its own policies.¹⁰ See discussion *infra* at § III.B.3.

Whether or not St. Elizabeths’ treatment, or lack thereof, directly or indirectly contributed to Mr. Riley’s death, St. Elizabeths’ staff neglected to provide appropriate care during the last months of his life.

III. ST. ELIZABETHS NEGLECTED MR. RILEY’S CARE.

A. St. Elizabeths Failed to Properly Accommodate or Modify Its Services to Address Mr. Riley’s Intellectual Disability and/or Dementia.

St. Elizabeths failed to adequately address Mr. Riley’s intellectual disability and/or dementia. A 2014 neuropsychology evaluation measured Mr. Riley’s full scale IQ at 53,¹¹ in line with a previous evaluation given in March 2012, which measured his full scale IQ at 49.¹² The 2014 neuropsychology evaluation also suggests that Mr. Riley struggled with dementia near his death. A Dementia Rating Scale¹³ placed Mr. Riley below the 1st percentile -- considered Severely Impaired Functioning.¹⁴

Under DC law, care for DBH adult consumers¹⁵ is based on an recovery plan which must address essential human needs and include appropriate crisis intervention, stabilization strategies, residential treatment, support services, and “services to meet special needs,” among other requirements.¹⁶ Thus, providers such as St. Elizabeths Hospital must provide treatment to meet the consumer’s individualized needs, including special needs.

In addition to this D.C. law requirement that St. Elizabeth provide “services to meet special needs” of consumers in care,¹⁷ such treatment is simply good therapeutic practice. Moreover, this requirement is a matter of civil rights. Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131 *et seq.* (“the “ADA”) requires:

¹⁰ D.C. Code § 7–1131.04(13) requires DBH “[u]pon request or on its own initiative, [to] investigate, or ask another agency to investigate, any complaint alleging abuse or neglect of any consumer or mental health services, and, if the investigation by the Department or an investigation by any other agency or entity substantiates the charge of abuse or neglect, take appropriate action to correct the situation, including notification of other appropriate authorities . . .” See also DBH Policy 115.1A Mortality Review, DBH Policy 662.1 Major Investigations.

¹¹ Neuropsychological Evaluation at 5.

¹² Neuropsychological Evaluation at 2.

¹³ The DRS-2nd Ed was used.

¹⁴ Neuropsychological Evaluation at 6.

¹⁵ D.C. Code § 7–1131.04(1).

¹⁶ D.C. Code § 7-1131.02(30).

¹⁷ D.C. Code § 7-1131.02(30).

(b) (1) A public entity, in providing any aid, benefit, or service, may not, directly or through contractual, licensing, or other arrangements, on the basis of disability --

(i) Deny a qualified individual with a disability the opportunity to participate in or benefit from the aid, benefit, or service;

(ii) Afford a qualified individual with a disability an opportunity to participate in or benefit from the aid, benefit, or service that is not equal to that afforded others;

(iii) Provide a qualified individual with a disability with an aid, benefit, or service that is not as effective in affording equal opportunity to obtain the same result, to gain the same benefit, or to reach the same level of achievement as that provided to others.¹⁸

Thus, St. Elizabeths Hospital must reasonably modify its programs, policies, and services when providing services to individuals with intellectual disabilities, including its treatment provided to those with psychiatric disabilities. *See* 28 C.F.R. § 35.130(b)(7) (“A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”)

In Mr. Riley’s case, the Neuropsychological Evaluation included several recommendations to help St. Elizabeths make accommodations and modifications when providing services to Mr. Riley, including recommending a full re-evaluation of all of his psychotropic medications.¹⁹ The Neuropsychological Evaluation also urged “caregivers [to] be patient with Mr. Riley. Due to difficulties with speed of processing, short term memory and learning, he may require individuals to inform him on more than one occasion regarding activities or appointments.”²⁰

However, St. Elizabeths’ records do not indicate that these recommendations were considered in developing follow-up treatment plans. His subsequent Psychiatric Update following the evaluation simply noted that the neuropsychological exam did not give a definitive diagnosis and that staff should “continue his current regimen for now” because “[Mr. Riley’s] behavior is well adapted to the environment.”²¹

Similarly, his Recovery Plan did not incorporate specific accommodations or modifications needed to ensure St. Elizabeths would provide services in accordance with D.C. law and the ADA. Though it did require the psychiatrist to “educate in simplest terms about

¹⁸ 28 C.F.R. § 35.130.

¹⁹ Neuropsychological Evaluation at 7.

²⁰ Neuropsychological Evaluation at 7.

²¹ Psychiatric Update dated 3/18/2014 at 7.

importance of taking prescribed medications and how to report symptoms,²² it did not provide for specific practices which would ensure Mr. Riley did, in fact, understand or was able to report symptoms.

The Neurological Evaluation described Mr. Riley's need for an "extensive amount of support and structure."²³ Except for scheduled groups at the TLC to address noted behavioral issues (and there were no specific accommodations or modifications described for these groups to address his intellectual disability), very little was listed to address his limited cognitive ability. Significantly, the Therapeutic Progress Notes indicated that he either did not attend many groups²⁴ or "had a hard time staying engaged in group this month."²⁵ One note stated that "he expressed that he forgot to come to group,"²⁶ a behavior that could easily have been accommodated by staff providing him with reminders. Repeatedly, the notes state that his "participation [was] minimal and [he] appeared inattentive,"²⁷ both behaviors that may have been related to his cognitive disability and behaviors which indicate needs that appropriate accommodations, modifications, and assistive technology likely would have addressed.

Moreover, the Recovery Plan had steps that did not take into consideration his limitations. For example, his one to one was directed to "meet with him on the ward once a week for 5 minutes in the next 60 days to discuss issues he might have with taking shower, applying lotion and give supportive counseling. Progress will be recorded on the RA progress note."²⁸ "[O]nce a week for 5 minutes" is not "extensive," and "supportive counseling" does not address his need for modifications and accommodations in instruction -- such as using visual check lists, providing incentives for accomplishing the tasks, providing oral prompts while doing the task. Tellingly, there are not weekly progress notes as required by the plan.

Numerous steps could have been taken to enable Mr. Riley to benefit from the psychiatric treatment provided at St. Elizabeths, including those steps recommended in the Neuropsychological Evaluation. Nevertheless, his treatment plan did not address the modifications or accommodations he needed, and where it did, St. Elizabeths does not appear to have consistently followed them.

²² Interdisciplinary Recovery Plan (IRP) dated 3/10/2014 at 5.

²³ Neuropsychological Evaluation at 7.

²⁴ Clinical Record – Therapeutic Progress Note dated 3/11/14; Clinical Record – Therapeutic Progress Note dated 4/1/14; Clinical Record – Therapeutic Progress Note dated 4/15/14.

²⁵ Clinical Record – Therapeutic Progress Note dated 2/5/14; see Clinical Record – Therapeutic Progress Note dated 5/13/14.

²⁶ Clinical Record – Therapeutic Progress Note dated 2/5/14.

²⁷ Clinical Record – Therapeutic Progress Note dated 2/11/14; Clinical Record – Therapeutic Progress Note dated 3/11/14; Clinical Record – Therapeutic Progress Note dated 3/12/14; Clinical Record – Therapeutic Progress Note dated 3/18/14; Clinical Record – Therapeutic Progress Note dated 3/18/14 (Library Appreciation Group); Clinical Record – Therapeutic Progress Note dated 4/11/14; Clinical Record – Therapeutic Progress Note dated 4/14/14.

²⁸ Interdisciplinary Recovery Plan ("IRP") dated 3/10/2014 at 4.

Because the goal of the recovery plan and treatment should always be directed to discharge and return to the community, the importance of appropriate treatment is significant; it impacts a liberty interest -- a civil right. Failure to provide accommodations and modifications to treatment can result in failed treatment and continued institutionalization.

Mr. Riley's intellectual capacity was not unusual. According to St. Elizabeths' FY 14 Trend Analysis, 42 individuals in care (approximately 15% of its census) are diagnosed with either an Intellectual Disability or Borderline Intellectual Functioning.²⁹ Forty-eight individuals in care have a cognitive disorder, including dementia.³⁰ These are significant numbers.

Nor did Mr. Riley's older age make him a unique consumer. Almost 61 percent of St. Elizabeths' consumers are over the age of 50; 38 percent are over the age of 60.³¹ As its population continues to age and consumers become more prone to cognitive disabilities, St. Elizabeths must develop policies to ensure staff is (1) properly and timely evaluating consumers' needs, (2) implementing recommendations, and (3) incorporating specific individualized accommodations and modifications into the individuals' treatment so that consumers with cognitive disabilities can benefit from hospital treatment and remain safe. This is not only good therapeutic practice; it is a civil right. Modifications and accommodations of treatment must be implemented to ensure equal treatment and equal access to hospital services and the community.

B. St. Elizabeths Failed to Properly Address Mr. Riley's Physical Needs.

1. St. Elizabeths Failed to Provide Treatment to Properly Address Mr. Riley's Risk of Swallowing Objects and Self-Injurious Behavior.

St. Elizabeths' failure to address the danger from Mr. Riley's repeated swallowing of objects jeopardized his life on several occasions in the years prior to his death. Mr. Riley had a history of swallowing nonedible items; he swallowed both foreign objects and his own scabs after picking at his skin. There were several very dangerous swallowing incidents in the two years prior to Mr. Riley's death, including the incident directly leading to Mr. Riley's May 2014 hospitalization during which he died.³²

One swallowing incident in the record occurred on March, 2012, when Mr. Riley swallowed a bottle cap and did not tell anyone. Staff only became aware of the incident after realizing Mr. Riley could not breathe or swallow.³³ Mr. Riley was hospitalized³⁴ requiring

²⁹ St. Elizabeths' FY 14 Trend Analysis (dated April 30, 2015) at 31.

³⁰ *Id.* at 30.

³¹ St. Elizabeths, *Performance Related Information for Staff and Managers- July 2015* at 10 (2015).

³² Moreover, numerous objects discovered upon examination during his last stay in the hospital indicate that he may have been swallowing objects regularly without the act being discovered.

³³ Neuropsychological Evaluation at 2.

³⁴ Clinical Formulation dated 3/10/2014 at 3.

surgery.³⁵ A few months later, in June 2012, Mr. Riley again swallowed multiple beads, and again he was hospitalized.³⁶

Then, in April 2014, nursing staff noticed that Mr. Riley's mental status was different. He was "confused and unable to respond to verbal commands . . ." ³⁷ He was lethargic and did not respond when staff called his name. He was incontinent, then "doubled over and grimaced as if in pain . . ." ³⁸ He was evaluated by the doctor and transferred to the emergency room by ambulance.³⁹

At the hospital he was placed on antibiotics because he had a fever, elevated white blood cell count, and "noted to have positive blood cultures."⁴⁰ He spent almost a week "moaning" and in pain.⁴¹ A CT scan of his abdomen was done and revealed a foreign body. A second CT scan was done to evaluate his appendix; "there was a foreign body, which was highly suspicious for intracolonic lesion."⁴² During a subsequent x-ray, the radiologist noted "3 separate foreign bodies which had the appearance of a chain with a medallion hanging on it, a ring, and a button."⁴³ A colonoscopy was completed on April 30, and the gastroenterologist removed one object⁴⁴ – rosary beads⁴⁵ - and decided to "allow these remaining items to pass with normal fecal strain . . ." ⁴⁶

A discharge back to St. Elizabeths was planned for May 1; however, he was not able to function independently, had an altered mental state, and had an elevated white blood cell count. An IV was started.⁴⁷ The next day he was found unconscious, and his cardiac monitors showed "PEA [pulseless electrical activity]. . . [R]esuscitation attempts were unsuccessful and the patient went into asystole, and . . . pronounced dead at 15:59 on May 3, 2014."⁴⁸

Though it is unknown whether the presence of foreign objects or a possible resulting "intracolonic lesion" directly caused Mr. Riley's death, it is likely their presence contributed to his extreme pain, suffering, and the hospitalization that ended in death.⁴⁹

³⁵ Neuropsychological Evaluation at 2.

³⁶ Clinical Formulation at 3-4; St. Elizabeths Discharge Summary dated 5/9/14 at 3.

³⁷ UI dated 4/23/14 at 7:30 p.m.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ UMC Discharge Summary dated 5/01/14 timed at 00:32 at 1.

⁴¹ UMC Patient Progress Notes dated 4/24/14 at 4:00 p.m., 4/24/14 at 10:30 p.m., 4/25/14 at 2:00 p.m., 4/25/14 at 7:30 p.m., 4/27/14 at 12:30, 4/28/14 at 6:15.

⁴² UMC Discharge Summary dated 5/01/14 timed at 00:32 at 1.

⁴³ UMC Discharge Summary dated 5/01/14 timed at 00:32 at 1.

⁴⁴ UMC Discharge Summary dated 5/01/14 timed at 00:32 at 1.

⁴⁵ Unusual Incident Report dated 5/3/14 timed at 3:59.

⁴⁶ UMC Discharge Summary dated 8/22/14 timed at 02:24.

⁴⁷ UMC Discharge Summary dated 8/22/14 timed at 02:24.

⁴⁸ UMC Discharge Summary dated 8/22/14 timed at 02:24.

⁴⁹ Mr. Riley also had fecal impaction. UMC Discharge Summary dated 5/01/14 timed at 00:32 at 1.

There is little evidence that St. Elizabeths' staff took steps to treat Mr. Riley's deliberate ingestion of foreign objects, or acted to ensure it was not occurring on a regular basis. Ingesting foreign object often results in a "lack of outward evidence that harm has been done and in the latent risk of further injury"⁵⁰ because the individual can swallow an object without being noticed. Thus, Mr. Riley may have been regularly swallowing foreign objects without detection.

The deliberate ingestion of foreign bodies can occur in persons with intellectual disabilities and those with psychiatric disorders for any number of reasons.⁵¹ This behavior can have serious, life threatening consequences. It can result in malnutrition, intestinal blockages, and potential toxicity from the ingested substance. Treatment strategies require a well-coordinated treatment team approach, fostering successful collaboration between teams, and active involvement of a psychiatrist and psychologist. Clinical interventions can include maintaining a safe environment and attempting to prevent future episodes by using a variety of pharmacological and psychosocial management strategies, including behavioral interventions.⁵²

Nevertheless, the record does not show a coordinated effort to address his very serious issues. Mr. Riley's Recovery Plan did describe certain steps for the team to take, such as to counsel him and to "remove dangerous objects from the client environment and destruction [sic] (listening music)."⁵³ These steps alone do not appear to have been effective or were not actually implemented. The plan also required a "one to one for risk of consumption of foreign objects."⁵⁴ If the hospital did, in fact, have one-to-one observation for Mr. Riley, it was not documented. See *infra*, Section III.B.2. This failure to provide such critical safety protection specifically included in Mr. Riley's recovery plan constitutes neglect.

In addition, Mr. Riley had serious issues with multiple acts of self-injurious scratching and then ingesting his own skin.⁵⁵ In the months before his death, Mr. Riley was seen repeatedly

⁵⁰ Foreign-Body Ingestion in Patients with Personality Disorders, *Psychosomatics* 48:2 (March-April 2007) at 165, <http://www.psychiatry.utoronto.ca/wp-content/uploads/2013/05/1322669400-ForeignBodyIngestion.pdf> .

⁵¹ *Id.* at 162-63.

⁵² See Swallowing Foreign Bodies as an Example of Impulse Control Disorder in a Patient With Intellectual Disabilities, *Psychiatry* 7:34-37 (Sept. 2010), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2952645/>; Hard to Swallow: a Systematic Review of Deliberate Foreign Body Ingestion, *General Hospital Psychiatry* 33: 518-524 (2011), <https://www-clinicalkey-com.ezproxy.med.nyu.edu/#!/content/playContent/1-s2.0-S0163834311002350?returnurl=null&referrer=null>; Foreign-Body Ingestion in Patients with Personality Disorders, *Psychosomatics* 48:2 (March-April 2007) at 165, <http://www.psychiatry.utoronto.ca/wp-content/uploads/2013/05/1322669400-ForeignBodyIngestion.pdf>.

⁵³ IRP dated 3/10/2014 at 2-3.

⁵⁴ IRP at 3. The plan directs "Nursing staff to . . . provide documentation for one to one." *Id.*

⁵⁵ Monthly Nursing Plan dated 4/5/14 at 2.

“putting something in his mouth.”⁵⁶ There were multiple episodes of “digging into the skin with his fingernails then eating the skin.”⁵⁷ Even though there was well documented self-injurious conduct, there was little evidence of a coordinated therapeutic response. Notes indicated on March 8, 2014, that the nursing response was simply “counsel about skin picking.”⁵⁸ As explained in the previous section, III.A. *supra*, “counseling” may have had little impact on Mr. Riley, who may not have understand the consequences or been able to control the conduct.

The records reference a behavior plan having been developed to address Mr. Riley’s repeated self-injurious scratching,⁵⁹ but if the plan was being followed, the treatment notes do not describe how. It was not even referenced in the March 2014 Recovery Plan, much less described, discussed, or evaluated for its effectiveness -- an important step when the troubling behaviors continue to exist. Disturbingly, when his Recovery Plan was updated on March 10, 2014, the plan stated that “[h]e has not engaged in self mutilating behavior during this review period.”⁶⁰

The D.C. Developmental Disabilities Administration has specific procedures for addressing serious behavioral challenges of individuals with intellectual disabilities, including the provision of behavioral supports where an individual “displays a pattern or patterns of behavior which . . . threaten the physical safety of the person . . .”⁶¹ Behavioral Support Plans should be developed based on functional assessments. Functional assessments are detailed and “provide a clear, measurable, operational definition of each target behavior, which includes (as applicable) frequency, duration, and intensity of the behavior;” “identif[ies] the antecedents to the target behavior and . . . outcomes that follow the behavior; and [p]ropose[s] the specific function of the target behavior . . .”⁶² The behavioral plan “shall adhere to the principles of Positive Behavior Support (PBS). PBS is an evidence-based, person-centered approach to preventing challenging behavior that is based on a functional assessment of the behavior to determine the purpose of the behavior and the circumstances under which it occurs. PBS strengthens existing skills and teaches new behaviors that accomplish the same functional purpose as the challenging behavior, making the challenging behavior unnecessary. Through positive reinforcement strategies and modifications to the environment, PBS facilitates behavioral changes that promote independence and community integration.”⁶³

⁵⁶ Clinical Record- Progress Notes dated 3/8/2014 at 4:56.

⁵⁷ Clinical Record- Progress Notes dated 3/21/14 at 9:44; see Clinical Record- Progress Notes at 2/18/14 at 11:31; Clinical Record- Progress Notes dated 2/20/14 at 10:19; Clinical Record- Progress Notes dated 2/21/14 at 7:17; Clinical Record- Progress Notes dated 3/31/14 at 7:17 (“he is supposed to have treatment plan today to discussed [sic] his self-injurious behavior of digging his skin and eat scabs.” If this meeting took place, there is no record of it.)

⁵⁸ Clinical Record- Progress Notes dated 3/8/2014 at 4:56.

⁵⁹ Clinical Formulation dated 3/10/2014 at 3.

⁶⁰ IRP dated 3/10/2014 at 2.

⁶¹ DDS Behavior Support Plan Requirements, Procedure No. 2013-DDA-H&W-PR016 (2013) at 1.

⁶² *Id.* at 3.

⁶³ *Id.* at 2.

St. Elizabeths employs a knowledgeable psychologist, Dr. Richard Boesch, with experience addressing the needs of individuals with intellectual disabilities. Nothing in the records provided shows that he was either involved in Mr. Riley’s treatment near the time of his death or took steps to create or revise a behavior plan to address his significant needs. Mr. Riley’s very significant behavioral challenges should have been addressed with a well-coordinated treatment team approach including the active involvement of a psychiatrist and psychologist. A functional behavioral assessment could have been performed to determine if his act of ingesting foreign objects could be addressed through a behavioral support plan. At a minimum, a specific plan should have been created which spelled out in detail how to ensure Mr. Riley’s safety, including whether one-to-one monitoring was needed, whether he could have been hiding materials to ingest later, and what specific steps staff should take to eliminate the dangerous behavior. Certainly, his prior ineffective behavioral plan created to address his self-injurious scratching should have been reevaluated, and Mr. Riley could have been provided with substitutes to address his behavioral needs. Merely counseling, especially for someone with a significant cognitive disability, may do little, if anything, to change these serious behaviors.

2. St. Elizabeths Failed to Follow the Treatment Plan to Provide One-to-One Observation and Violated their Levels of Observation Procedure in the Care of Mr. Riley.

The record is wholly unclear regarding how frequently staff were required to observe Mr. Riley’s conduct during the last months of his life -- in particular whether he should have had constant one-to-one observation or more limited 15 minute observation checks. There were no standing doctors’ orders for any one-to-one observation, yet numerous records show that continuous observation by staff was required. The chart below illustrates some of the conflicting records:

Record	Date of Record	Documented Status of One-to-One Observation
Nursing Update from 2/8/2014 ⁶⁴	2/8/2014	Mr. Riley has a “1:1 RN” who discusses the importance of taking his medications, avoiding self-injury, maintaining personal hygiene. Mr. Riley’s “observation level is now Q 30 minutes which used to be Q 15 minutes.”
Nursing Update from 3/8/2014 ⁶⁵	3/8/2014	Mr. Riley has a 1:1 RN who discusses the importance of taking his medications,

⁶⁴ Nursing Update dated 2/8/2014 at 2.

⁶⁵ Nursing Update dated 3/8/2014 at 2.

		avoiding self-injury, maintaining personal hygiene. The Nursing Update again repeats: Mr. Riley’s “observation level is now Q 30 minutes which used to be Q 15 minutes.”
Clinical Formulation dated 3/10/14 ⁶⁶	3/10/14	Mr. Riley “is currently 15 minute checks for risk of consumption of foreign objects and picking at his healing wounds (self injurious behaviors).”
Interdisciplinary Recovery Plan ⁶⁷	3/10/2014	Mr. Riley “is currently on one to one for consumption of foreign objects and picking at his healing wounds (self-injurious behaviors)”
Nursing Update from 4/5/2014 ⁶⁸	4/5/2014	Mr. Riley has a 1:1 RN who discusses the importance of taking his medications, avoiding self-injury, maintaining personal hygiene. The Nursing Update repeats: Mr. Riley’s “observation level is now Q 30 minutes.”

St. Elizabeths’ Levels of Observation policy clearly states that a doctor’s order is required for any elevated level of observation.⁶⁹ This physician’s order must specify the particular level of elevated observation, the reason for elevated observation and requirements for discontinuing the order.⁷⁰ It is only “valid for 24 hours and must be rewritten daily if assessment indicates the high risk behaviors have not resolved.”⁷¹

Where the one-to-one observation level is constant or fifteen minute checks (Q 15 Checks), the assigned staff is required to complete a Level of Observation Flow Sheet following specific documentation guidelines, including making notations every 15 minutes; completion of multiple 15 minute block notations at the same time is prohibited. The patient’s location and

⁶⁶ Clinical Formulation dated 3/10/14 at 5.

⁶⁷ IRP at 3.

⁶⁸ Nursing Update dated 3/8/2014 at 2.

⁶⁹ Levels of Observation updated 10/14/2011 at 1.

⁷⁰ *Id.*

⁷¹ Levels of Observation updated 10/14/2011 at 1.

observed behaviors are to be noted. “The staff member . . . should not only observe, but engage with the individual to offer support and observe the individual’s mental state.”⁷²

There was no record of a doctor’s order prescribing the status of the one-to-one and no Level of Observation Flow Sheets in records DBH provided. In fact, rather than 15 minute notations, there were days in which not even a progress note was written for Mr. Riley in the months before his death.⁷³ Again, there were no progress notes describing adherence to a behavior plan that might have addressed his dangerous behaviors.

3. ST. ELIZABETHS’ RESPONSE TO MR. RILEY’S DEATH

A. [] Redacted for public report because it addresses peer review records.

B. DBH Failed to Perform Its Own Investigation of Mr. Riley’s Death.

District law requires DBH “[u]pon request or on its own initiative, [to] investigate, or ask another agency to investigate, any complaint alleging abuse or neglect of any consumer of mental health services, and, if the investigation by the Department or an investigation by any other agency or entity substantiates the charge of abuse or neglect, take appropriate action to correct the situation, including notification of other appropriate authorities . . .”⁷⁴ Thus, DBH should have taken steps to review the circumstances of Mr. Riley’s death and, once concerns were noted, DBH should have on its own initiative begun a thorough investigation of Mr. Riley’s death and treatment during his stay at St. Elizabeths.

DBH’s Major Investigation Policy 662.1 also requires an investigation by its Office of Accountability whenever there is an unexpected death at St. Elizabeths.⁷⁵ It is to be completed within sixty days and remedial action/recommendations are to be monitored to ensure implementation.⁷⁶ DBH did not perform such an investigation; thereby missing the opportunity to correct systemic issues at St. Elizabeths and protect other individuals in care.

⁷² Levels of Observation updated 10/14/2011 at 2 - 3.

⁷³ See i.e., Progress Notes dated 2/1/14 to 5/3/14 (no progress notes between 3/11/14 and 3/21/14; no progress notes between 3/21/14 and 3/31/14).

⁷⁴ D.C. Code § 7–1131.04(13).

⁷⁵ DBH Major Investigations Policy, No. 662.1(6a)(1)(b).

⁷⁶ DBH Major Investigations Policy, No. 662.1(6e).

IV. RECOMMENDATIONS

ULS makes the following recommendations based on its findings:

- A. St. Elizabeths should develop a policy to address the needs of individuals in its care who have an intellectual disability and/or dementia.** This policy should include steps that ensure the civil rights protections required by the Americans with Disabilities Act are easily incorporated into the individual's treatment plan and actually implemented in the individual's care. There should be a protocol which includes the following: (1) a regular evaluation of patients who are suspected of having cognitive disabilities, (2) an assessment to determine what accommodations and modifications in care are needed to meet the individual's needs, and (3) an oversight mechanism to ensure that the accommodations and modifications, including any needed behavior plans, are actually implemented. St. Elizabeths should consult with the Developmental Disabilities Administration in this process to take advantage of its experience developing policies and practices.
- B. St. Elizabeths should create a policy to protect consumers at risk for swallowing foreign objects, pica, and other self-injurious behaviors.** Mr. Riley had sporadic episodes of swallowing inappropriate and dangerous objects. Based on the objects found in Mr. Riley during his last hospitalization – “a chain with a medallion hanging on it, a ring, and a button,”⁷⁷ these swallowing incidents were likely more often than noted in the records. Though this is a serious and potentially very dangerous activity, St. Elizabeths does not have a policy, procedure, or protocol directing staff on best practices for handling such conduct.⁷⁸ St. Elizabeth should develop a policy which addresses best practices in treating these and other serious behavioral issues. Such procedure should include the development of appropriate behavior plans, where indicated, and require adequate oversight.
- C. St. Elizabeths must address the internal failures that resulted in unclear one-to-one observation without a physicians' orders or oversight.** The lack of consensus regarding Mr. Riley's correct level of observation is very troubling. St. Elizabeths should review all treatment plans that note the existence of one-to-one care and ensure that adequate documentation exists in the individual's records and that the level noted in the treatment plan is accurate and appropriate. The individual's records must, at a minimum, include (1) a physician's order every 24 hours which describes the level of care required, (2) the reason for the elevated observation, and (3) requirements for discontinuation.
- D. St. Elizabeths should create a task force to address the needs of individuals with cognitive disabilities.** This task force should meet regularly and begin by developing policies and practices that 1) specifically guide staff in the creation of accommodations

⁷⁷ UMC Discharge Summary dated 5/01/14 timed at 00:32.

⁷⁸ The DBH response ULS received did not include a policy for ingestion of foreign objects or minimizing or treating self-injurious behavior and stated that no draft policy existed. Response from DBH to ULS dated 5/19/2015 at 2.

and modifications that meet the specific needs of the individual, 2) direct when and how to develop behavior plans, and 3) describe the oversight mechanism to ensure that these policies and practices are actually implemented. The task force should also meet regularly to discuss and address the needs of specific consumers, to revisit ineffective behavior plans, and to review the implementation of the policies. Membership of the committee should include staff psychologists, including Dr. Binks and Dr. Boesch, and representatives of the District's Developmental Disabilities Administration ("DDA"). ULS would like to participate in the task force's efforts to create specific policies, much as it has recently participated in a task force revising numerous policies at DDA. A central focus of the task force should be to eliminate barriers to discharge for individuals with intellectual disabilities and to facilitate coordination of services with DDA, enabling an expedited DDA intake process where appropriate.

E. DBH should perform its own investigation of Mr. Riley's death. DBH should have conducted its own investigation after it performed the initial review of Mr. Riley's death. Now that ULS has formally documented neglect in his care, D.C. law requires DBH perform its own investigation. Moreover, DBH's own policy requires such an investigation because Mr. Riley's death was unexpected. There should be a thorough internal investigation into, at a minimum: (1) how the staff mischaracterized Mr. Riley's observation status, (2) whether -- given his propensity to swallow inappropriate objects -- he needed more aggressive interventions, such as a behavior plan or a higher level of observation, (3) whether his intellectual disability and/or dementia was appropriately addressed in his treatment plan. Individual and systemic flaws in the process should be addressed with recommendations, and DBH should ensure that those recommendations are implemented quickly, including ensuring that staff are trained on any new policies or protocols that are created as a result of the recommendations.