ABUSE UNABATED

RESTRAINT AND SECLUSION AT ST. ELIZABETHS HOSPITAL

September 2020

Disability Rights DC at University Legal Services, Inc.
The Protection and Advocacy Agency
for the District of Columbia
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DISABILITY RIGHTS DC

Since 1996, Disability Rights DC at University Legal Services, Inc. ("DRDC"), a private, non-profit legal service agency, has been the federally mandated protection and advocacy (P&A) program for individuals with disabilities in the District of Columbia. In addition, DRDC provides legal advocacy to protect the civil rights of District residents with disabilities.

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

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I. EXECUTIVE SUMMARY

In May of this year, the nation watched in horror as police officers brutally restrained George Floyd and, in doing so, suffocated and killed him. Throughout the restraint, the police officers held him face down on the pavement as Mr. Floyd pleaded with the officers to stop, begging for his life. The video aptly and tragically illustrates just how dangerous, terrifying, and dehumanizing the act of restraining an individual can be.

In July 2019, DRDC released a report, which detailed the alarmingly high use of restraint and seclusion at St. Elizabeths Hospital and highlighted multiple abusive restraints and seclusions.[1] One incident of restraint, captured on video footage, revealed very disturbing conduct, which in many ways parallels the restraint of George Floyd. Hospital video footage reveals staff implementing an unnecessary and abusive restraint of a man who was not aggressive, did not have a weapon, and was heavily outnumbered.[2] The video footage reveals that for *at least* fourteen minutes prior to the restraint, patient Keith Carter[3] was either walking around the unit, speaking with or attempting to speak with staff or standing or sitting quietly.[4] He did not appear on camera to be aggressive or violent. Throughout most of the video, staff did not make meaningful attempts to engage with him. Methodical, and at times casual, staff preparation culminated in an overwhelming scene where thirteen staff and security personnel surrounded Mr. Carter.[5] Despite pleas from Mr. Carter for staff to stop, multiple security guards grabbed him by the arms, dragged him down the hall and pushed him into a room.[6] Records indicate staff then strapped his arms and legs to a bed and forcibly administered an injection of powerful psychotropic medications.[7] The Department of Behavioral Health's ("DBH") own investigation substantiated that the hospital violated District law. The doctor involved described Mr. Carter as an "inconvenience" because staff members were dealing with another patient.[8] DBH's report found that "[n]o one involved in this incident stated or described any dangerous behavior that warranted physical hold, Four-point Restraints, or Drug Restraints."[9]

D.C. law generally prohibits restraint and seclusion and allows its use only in an emergency when it is "necessary to prevent serious injury" and "less restrictive interventions have been considered and determined to be ineffective."[10] St. Elizabeths' own restraint and seclusion policy requires that staff only use restraints and seclusion as a last resort and only if a patient poses an "imminent threat," stating "[i]t is the policy of Saint Elizabeths Hospital to

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[1] *Dangerous Restraints: Mistreatment and Harm at St. Elizabeths Hospital* (July 31, 2019) http://uls-dc.org/media/1183/srreportfinal73119.pdf; *see also Solitary Confinement at St. Elizabeths Hospital* (January 28, 2019), http://www.uls-dc.org/media/1173/reportfinal12819.pdf.
[2] Videotape (St. Elizabeths Hospital January 19, 2019) ("1/19/19 Videotape").
[3] Name changed to protect the patient's privacy.
[4] 1/19/19 Videotape at 11:21:32 a.m. to 11:36:09 a.m.
[5] *Id.* at 11:35:47 a.m.
[6] *Id.*; DRDC interview with Mr. Carter on 2/1/19.
[7] Unusual Incident Report, UI DB #25944, dated 1/17/19.
[8] Keith Carter DBH Investigative Report, dated 7/2/19 at 16, 18.
[9] *Id.* at 16. St. Elizabeths staff plainly stated that Mr. Carter "did not pose an imminent risk of serious injury to himself or others" substantiating that the hospital used drugs as a restraint in violation of District law. *Id.* at 20.
[10] D.C. Code § 7-1231.09(c).

limit the use of restraint or seclusion for behavioral reasons to those emergencies when less intrusive alternative interventions are not viable or have been ineffective. *Seclusion or restraint is not a therapeutic intervention*, but is an emergency safety measure for the protection of individuals and staff, to be used only when less restrictive interventions are not appropriate."[11] The policy also recognizes how harmful and distressing restraint and seclusion can be for their patients, stating, "[b]ecause of the trauma inducing aspects of seclusion and restraint, as well as the potential for physical and psychological harm and loss of dignity, seclusion or restraint shall only be used in emergency situations that pose an immediate risk of an individual physically harming him/herself, staff or others, when less restrictive interventions are not viable or have been ineffective **and** when the individual's behavior at the time poses a greater risk to himself or others than the risk of using seclusion or restraint."[12]

Despite these prohibitions, St. Elizabeths Hospital steadily increased its use of restraint and seclusion. In 2018, staff employed 782 restraints and 291 seclusions -- a shocking increase from only six years earlier, when staff used restraints only five (5) times and seclusions only 30 times for the entire year.[13] From January 2019 through April 2019, *the last time period the hospital published restraint and seclusion numbers*, the hospital employed restraints 252 times and seclusion 66 times.[14] Based on DRDC's review of the hospital's major unusual incident reports, in only the first three months of 2020, staff restrained patients 149 times and secluded patients 55 times.[15]

Moreover, in the first six months of 2020, hospital staff used drugs as a restraint during what the Hospital refers to as "STAT events," a disturbing 207 times.[16] In a one year period -- from July 2019 to June 2020 -- staff used drugs to restrain patients 606 times.[17] Each incident typically involves administering or injecting a patient with multiple psychotropic medications, each requiring a separate doctors' order, thus, during this time period, there were an astounding 1,338 separate medication orders for drugs that were used as a restraint.[18]

On multiple occasions, St. Elizabeths staff disregarded the legal and policy requirements of using restraint and seclusion that were promulgated to prevent widespread use and abuse. In

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[11] SEH Policy 103.00(I) (emphasis added).
[12] SEH Policy 103.00(III)(A) (emphasis added).
[13] PRISM Report December 2018, PRISM Data Tables at #4; PRISM Report December 2012, PRISM Data Tables at #4. These numbers do not include the use of drugs as a restraint. *See infra* Section VI for a detailed discussion of the Hospital's use of drugs as a restraint.
[14] PRISM Report April 2019, PRISM Data Tables at #4.
[15] Data compiled from SEH Unusual Incident Reports from January to March 2020; *see infra* Section IV for a detailed discussion. Since that time, the census of the Hospital has declined significantly -- both because of the efforts of the hospital and courts to protect patients from the COVID-19 outbreak at the hospital and because of the loss of 14 patients who died from the virus. *See* June 2020 PRISM Report at 2, https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/June%20PRISM.pdf. Admissions went from 46 in January 2020 to 3 in April, 2020. The average daily census was 274 in February, 2020, and 194 in May 2020. *Id.* at 3. Nevertheless, the percentage of those restrained in May was almost as high or higher than the average of those restrained in the four months before. *Id.* at 11.
[16] St. Elizabeths PRISM Report June 2020 at 14. The PRISM report tracks "STAT" events, defined as "emergency medication prescribed and administered to a person involuntarily." *See infra* Section VI for a detailed discussion.
[17] St. Elizabeths PRISM Report June 2020 at 14.
[18] *Id.*

September 2019, staff implemented an illegal restraint that was also captured on video footage.[19] Over the course of six minutes, patient Samuel Bates[20] was wandering or pacing around the unit and/or had his hands clasped in front of himself in a non-threatening demeanor.[21] He did not appear aggressive and staff appeared casual and unthreatened by Mr. Bates. They either ignored him or pointed down a hallway. Suddenly, two staff members grabbed his arms and placed him in a physical hold.[22] Nine staff members then surrounded Mr. Bates, took him to the restraint room, and forced him into four-point restraints.[23] Mr. Bates did not resist.

In March 2019, during another unjustified restraint, patient John Holmes[24] suffered a broken hip and arm when staff used unapproved techniques to restrain him.[25] After staff forced open the door,[26] according to Mr. Holmes, staff knocked him to the floor and fell on him, which caused a fracture to his arm and hip.[27] Instead of immediately conducting an assessment and providing medical care, which would have led to discovery of his injuries, staff carried him to the restraint room, strapped his four limbs to a bed and forcibly administered an injection of powerful antipsychotic medications against his will.[28] Shockingly, staff failed to adequately assess his injuries for 16 hours when they then discovered his fractured hip and did not transfer him to another hospital for almost 24 hours, where his arm was placed in a cast and he underwent surgery for his hip.[29]

In June and July 2019, hospital staff restrained and secluded Larry Greene[30] three times when he exhibited suicidal behaviors, in spite of hospital policy that states seclusion is contraindicated for individuals who are suicidal.[31] Records contain no evidence that staff offered or attempted meaningful, less restrictive alternatives during this crisis, nor did the Hospital provide records that demonstrate that staff used therapeutic interventions for a patient who had thoughts of killing himself.[32]

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[19] Videotape (St. Elizabeths Hospital September 8, 2019) ("9/8/19 Videotape").
[20] Name changed to protect the patient's privacy.
[21] 9/8/19 Videotape at 9:50:00 p.m. to 9:55:17 p.m.
[22] *Id.* at 9:55:22 p.m.
[23] *Id.* at 9:55:22 p.m. to 9:55:33 p.m.
[24] Name changed to protect patient's privacy.
[25] GMO Progress Note, dated 4/19/19, timed at 10:39 p.m.; Nurse Practitioner Progress Note dated 4/25/19, timed at 5:50 p.m.
[26] RN Progress Note, dated 4/19/19, timed at 6:48 a.m.
[27] John Holmes interview with DRDC, dated 5/22/19. Medical records confirm that Mr. Holmes sustained these injuries during the restraint. *See* Nurse Practitioner Progress Note dated 4/25/19, timed at 5:50 p.m.
[28] RN Progress Note, dated 4/19/19, timed at 6:48 a.m.
[29] D.C. Mun. Regs. tit. 22A § 501.2(b). It was staff at the second hospital that discovered Mr. Holmes's fractured arm, not staff at St. Elizabeths.
[30] Name changed to protect patient's privacy.
[31] *See* detailed description *infra* at section V.B. RN Progress Note, dated 6/30/19, timed at 12:59 p.m.; RN Progress Note, dated 7/2/19, timed at 6:12 p.m. Hospital policy states that seclusion "is contraindicated for individuals who exhibit suicidal ideation or self-injurious behaviors or have medical conditions that preclude seclusion, as determined by a physician." SEH policy 103.00 III(A)(3).
[32] Clinical Progress Notes from 6/29/19 to 7/4/19.

In 2019 and 2020, hospital records show that staff repeatedly secluded and restrained Lisa Morgan,[33] a patient with a history of trauma and sexual abuse,[34] in violation of hospital policy which states that restraint and seclusion are contraindicated for individuals with a trauma history.[35] DBH's own investigative report of eight incidents of restraint and seclusion of Ms. Morgan revealed serious staff violations of D.C. law, D.C. regulations and/or hospital policy during each incident, including an incident in which staff restrained her even though she offered "no resistance,"[36] injected her with "double the amount [of medication] that had been previously administered" in past restraints,[37] and left her restrained for 1 hour and 20 minutes.[38] The report notes that "[St. Elizabeths] staff placed Ms. [Morgan] in restraints without an attempt to utilize any alternative techniques," without an emergency or imminent threat, and in direct violation of D.C. regulations mandating that restraint can never be used out of convenience.[39]

Even after DBH completed this report and recommended significant steps to ensure this would not happen again,[40] staff continued using restraints and secluded Ms. Morgan. During one event in February 2020, staff secluded her even though she calmed down immediately after an incident with her psychiatrist, "had slowly walked away . . . and sat on a chair in one of the hallways . . ." and, after being told she would be put in seclusion, "walked quietly in, put down the mattress and lay down."[41] Despite Ms. Morgan's request that a female nurse give her an injection, video footage captures a disturbing scene where seven staff, five of whom were men, converged on her while she was quietly sitting on a mat in the seclusion room.[42] A male RN injected her arm, then staff forcibly rolled her over even though she did not appear to be resisting.[43] Three of the male staff members, including the RN, hovered directly over her and two more male staff and two female staff looked on.[44] A DBH investigation into the incident notes that a male Special Police Officer,[45] who was present during the seclusion, described watching the male RN "slide [Ms. Morgan's] "pants and underwear down to expose the top

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[33] Name changed to protect patient's privacy.
[34] A Social Work Initial Assessment, dated 10/9/15, states "that Ms. Morgan "previously reported a history of sexual, physical and emotional abuse beginning at a young age."
[35] SEH policy 103.00 III(A)(3).
[36] Lisa Morgan DBH Investigative Report, dated 9/24/19 at 9.
[37] *Id.* at 14.
[38] *Id.* at 13.
[39] *Id.*at 10, 13, 14; D.C. Mun. Regs. tit. 22A § 501.7(d). The report continues, "several SEH staff persons interviewed admitted that Ms. Morgan would have been taken to the Seclusion Room had it not been occupied. SEH arbitrarily elevated this incident to a 4pt. restraint because the Seclusion Room was not available." Lisa Morgan DBH Investigative Report, dated 9/24/19 at 9.
[40] *Id*. at 16.
[41] Clinical Records Progress Note, dated 2/28/20, timed at 12:58 p.m.; RN Assessment, dated 2/28/20, timed at 11:10 a.m. Though her prior conduct may have been dangerous, the notes do not indicate that she was dangerous at the time of the restraint and seclusion. The behavior should be addressed by therapeutic interventions, not seclusion and restraint. Using seclusion and restraint, as here, appears punitive -- used to punish her for the prior dangerous behavior.
[42] Videotape, 1F Seclusion room, dated 2/28/20 ("2/28/20 Videotape") at 11:20:57 a.m.
[43] *Id.* at 11:21:25 a.m. Because staff surrounded Ms. Morgan, her buttocks was not visible to the camera. The male nurse crouched at her backside, prepared a shot, administered the shot and a female nurse put a bandage on Ms. Morgan's backside. *Id.* at 11:21:54 a.m. to 11:21:57 a.m.
[44] *Id.* at 11:21:25 a.m.
[45] The hospital has its own "special police officers" who routinely respond in numbers to "Code 13s" and assist in the restraint and seclusion of patients. As was the case during this incident of seclusion, this "show of force" is often unnecessary and frightens and intimidates patients.

portion of her hip and buttocks"[46] and injected her in the buttocks.[47] In addition to multiple violations of the hospital's own policies, which were again substantiated in the DBH investigation report,[48] staff member actions throughout the seclusion and use of drugs as a restraint appear routine, punitive and dehumanizing. Ms. Morgan reports that the entire incident was extremely traumatizing and that no staff offered her support or tried to comfort her prior to, during, or after the incident.[49]

Finally, in 2019 and 2020, staff put Anne Williams[50] -- a patient diagnosed with a mental health disability, an intellectual disability, and an extensive history of trauma[51] -- in a physical hold, mechanical restraint and/or seclusion *over sixty-five (65) times in a six-month period*.[52] Staff implemented restraint or seclusion multiple times on the same day and kept Ms. Williams in restraints for up to over four hours in a single restraint.[53] Staff often justified restraint or seclusion as a planned behavioral intervention, which is strictly prohibited by hospital policy,[54] or inexplicably, restrained or secluded her when she "requested" that staff do so. Staff frequently did not attempt meaningful, less restrictive alternatives, nor did they employ her behavior plan with required strategies developed by her treatment team and her psychologist designed to reduce frequent incidents of restraint and seclusion.[55]

Restraint and seclusion are not only traumatic and degrading, they are also dangerous. Research shows seclusion and restraint are not effective and "can actually fuel violence," creating a vicious cycle where restraint and seclusion "may cause, reinforce, and maintain aggression and violence on the ward."[56] A psychiatric hospital's ability to avoid continuing, systemic staff abuses, as well as the significant reduction or elimination of seclusion and restraint, depends on a strong, effective, caring hospital leadership and administration. Although DBH acted to implement DRDC's July 2019 report recommendation and hired a consultant with significant expertise on reducing restraint and seclusion in institutional settings,[57] as detailed below, DRDC has not seen evidence of significant, sustained reduction in the use of restraints and seclusion, and DRDC continues to discover appalling and abusive staff practices and serious violations of D.C. law and regulations when patients are restrained and secluded. These long-

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[46] 2/28/20 Lisa Morgan DBH Investigative Report, dated 7/10/20 at 5.
[47] Videotape at 11:21:54 a.m.
[48] *See* Lisa Morgan DBH Investigative Report, dated 7/10/20 at 12-14.
[48] Videotape at 11:21:54 a.m.
[49] DRDC Interview with Lisa Morgan on 3/6/20.
[50] Name changed to protect patient's privacy.
[51] Anne Williams Initial Behavioral Intervention, dated 8/28/19 at 3.
[52] Anne Williams Major Unusual Incident Forms from 11/1/19 to 5/6/20; D.C. Code § 7-1231.09(a).
[53] Anne Williams Major Unusual Incident Forms from 11/1/19 to 5/6/20.
[54] SEH Policy103.00(III)(D)(1).
[55] *See Infra* Section V(D).
[56] *See* Amanda Wik, M.A., *Elevating Patient/Staff Safety in State Psychiatric Hospitals,* NAT'L ASS. OF STATE MENTAL HEALTH PROGRAM DIRS. RES. INST. (Jan. 2018), https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf.
[57] DRDC applauds DBH for selecting a consultant, Joan Gillece, with extensive experience and successes in addressing reduction of restraint and seclusion in institutional settings and endorses the trauma informed approach the consultant uses. *See* PPT presentation *Understanding and Addressing Trauma among People Receiving Services in Criminal Justice and Behavioral Health Setting,* https://www.nasmhpd.org/sites/default/files/Trauma_Webinar%20Final%204-13-11.pdf for the consultant's biographical information and trauma informed approaches to treatment.

standing, pervasive, and abusive practices must end. For the dignity and safety of both the patients and the staff, it is past time for the District to implement the needed changes.

II. D.C. LAW, D.C. REGULATIONS, AND HOSPITAL POLICY IMPOSE STRICT LIMITS ON THE USE OF RESTRAINT AND SECLUSION

D.C. law and D.C. regulations generally prohibit the use of restraint and seclusion, carving out narrowly tailored exceptions.[58] D.C. law allows their use only in an emergency when necessary to prevent serious injury to the consumer or others and only when less restrictive alternatives have been considered and determined ineffective.[59] D.C. law specifies that patients "have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff."[60] D.C. law also requires that "any use of seclusion or restraint shall be: (1) implemented in the least restrictive manner possible; (2) implemented in accordance with safe and appropriate seclusion or restraint techniques; (3) continually assessed, monitored, and reevaluated; and (4) ended at the earliest possible time."[61]

St. Elizabeths Hospital policy requires staff to exhaust all less restrictive techniques prior to restraint and seclusion.[62] The policy provides examples of multiple interventions staff should employ before resorting to restraint or seclusion, including that staff should: (1) use non-physical crisis intervention techniques; (2) offer one-to-one verbal counseling; (3) remove stressors that contribute to negative mood and/or behavior; (4) offer sensory-based interventions; (5) allow or suggest that the individual spend time in their room or the comfort room; and (6) provide the opportunity for contact with family or significant others to de-escalate the situation.[63]

D.C. regulations and St. Elizabeths policy dictate specific documentation requirements staff must follow, including that within one hour of the restraint the registered nurse in charge must document: "(1) the justification for the use of restraints or seclusion; (2) alternative strategies which failed to manage the consumer's behavior or why other strategies were

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[58] D.C. Code § 7-1231.09(c); D.C. Mun. Regs. tit. 22A § 505.1. D.C. law defines seclusion as "any involuntary confinement of a consumer alone in a room or an area from which the consumer is either physically prevented from leaving or from which the consumer is led to believe he or she cannot leave at will." D.C. Code § 7-1231.02(24). D.C. law defines restraint as "either a physical restraint or a drug that is being used as a restraint." D.C. Code § 7-1231.02(23).

[59] D.C. Code § 7-1231.09(c).

[60] D.C. Code § 7-1231.09(a); *see also* SEH Policy 103.00(III)(B)(1)(a). St. Elizabeths Restraint and Seclusion Policy states, "Each individual has the right to be free from restraint or seclusion of any form, except as consistent with this policy, and at no time should restraint or seclusion be used as a means of coercion, discipline, convenience, or retaliation." *Id.*

[61] D.C. Code § 7-1231.09(d).

[62] SEH Policy 103.00(III)(E).

[63] *Id.* Specific techniques in this section of the policy include maintaining a calm demeanor and voice, offering help and choices, distracting the individual, allowing the individual to vent and pace, encouraging the individual to use stress management or relaxation techniques such as breathing exercises and removal of the trigger. Other ideas to consider include providing companionship and supportive supervision, offering diversionary and physical activities, and self-timeout. *Id.*

considered but deemed impractical or unsafe; (3) the consumer's current behaviors and mental and emotional status; and (4) the consumer's physical status."[64]

These restrictions and requirements are essential to protect the safety and dignity of St. Elizabeths' patients. D.C. regulations specifically explain the reasons for the multiple legal requirements that staff must follow prior to, during and after a restraint, noting that their purpose includes: (1) to provide a safe and therapeutic environment to significantly reduce the incidence of emergencies that necessitate the use of restraints and seclusion; (2) to establish positive, trusting relationships among consumers and mental health provider staff; and (3) to reduce and minimize the use of restraints and seclusion in an emergency in favor of less restrictive behavior management techniques.[65]

III. ST. ELIZABETHS IS WELL AWARE OF ITS ILLEGAL AND ABUSIVE RESTRAINT AND SECLUSION PRACTICES

In 2019, DRDC released two in-depth reports detailing abusive and illegal staff practices when using restraint and seclusion, which are summarized below.

A. St. Elizabeths' Use of Solitary Confinement

In 2018, DRDC initiated an investigation into allegations of unlawful and abusive seclusion practices at St. Elizabeths and released a public report in January 2019, *Solitary Confinement at St. Elizabeths Hospital*.[66] DRDC discovered that the hospital was locking and confining patients in solitary confinement-like rooms or the "safety suite" for indefinite periods of time, in clear violation of D.C. laws and regulations described above.

At least four patients were locked in these solitary confinement type rooms.[67] Each patient's record contained "plans" for their confinements, which mandated the amount of time that the patients were to be locked in the rooms. One patient's plan specified he be locked in the room for a minimum of 11 days, two patients' plans specified they be locked in for a minimum of 20 days, and another patient for a minimum of 25 days.[68] Disturbingly, the fourth patient was also required to spend two days in "shackles."[69] These four plans contained punitive requirements and restrictions during each phase, and required the patients to demonstrate consistent "safe behaviors" as determined by the treatment team drafting the step-down plans.[70] Under the plans, the patients were punished if they failed to comply with the required behaviors since they were prevented from moving to the next phase, which could significantly prolong the

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[64] D.C. Mun. Regs. tit. 22A § 506.2 (b); *see also* SEH Policy 103.00(III)(G)-(H).
[65] D.C. Mun. Regs. tit. 22A § 500.1.
[66] The report can be found at http://www.uls-dc.org/media/1173/reportfinal12819.pdf.
[67] DRDC Report, *Solitary Confinement at St. Elizabeths Hospital* (Jan. 28, 2019), http://www.uls-dc.org/media/1173/reportfinal12819.pdf.
[68] *Id.* at 8, 9.
[69] *Id.* at 10. D.C. regulations expressly forbid shackling a patient. D.C. Mun. Reg. 22-A § 505.1(b). The regulations prohibit the use of ambulatory restraints, defined as "restraints which allow the consumer to walk around while restrained, such as wristlets or anklets." *Id.*
[70] *Id.* at 8-10.

length of time the patient was locked in the solitary confinement seclusion room. Prolonging seclusion to punish unwanted behavior is strictly prohibited by D.C. law.[71] Subsequent to DRDC's report and an investigation by the D.C. Department of Health, which substantiated that the hospital was illegally secluding patients in the "safety suite" rooms, the hospital asserted that it would no longer place patients in the solitary confinement rooms.[72]

B. St. Elizabeths' Use of Dangerous Restraints

In July 2019, DRDC released a second public report, *Dangerous Restraints: Mistreatment and Harm at St. Elizabeths Hospital*, which detailed abusive staff practices related to restraint and seclusion.[73] The report highlighted the alarming increase in the number of times staff were using restraint and seclusion, noting that in 2018, staff used restraint 782 times -- an astounding increase from 2012, when staff used restraint only five times.[74] Patients were secluded 291 times and spent a total of over 400 hours in seclusion rooms.[75] Equally disturbing, staff used drugs as a restraint 768 times in 2018.[76]

The report detailed three incidents of seclusion and restraint during which the St. Elizabeths staff violated numerous D.C. laws, D.C. regulations and hospital policies.[77] First, in April 2019, staff violently restrained John Holmes, a newly admitted patient. After staff forced open the door,[78] according to Mr. Holmes, staff knocked him to the floor and fell on him, which caused a fracture to his arm and hip.[79] Instead of immediately conducting an assessment and providing medical care, which would have discovered his injuries, staff carried him to the restraint room, strapped his four limbs to a bed and forcibly administered an injection of powerful antipsychotic medications against his will.[80] DBH's investigation of the incident found that staff actions "were direct violations of the [St. Elizabeths Hospital] Safety-Care Manual."[81]

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[71] D.C. Code § 7-1231.09(a).
[72] D.C. HRLA Investigation Report Letter for complaint # 4744, not dated.
[73] The report can be found at http://www.uls-dc.org/media/1183/srreportfinal73119.pdf.
[74] PRISM Report December 2018, PRISM Data Tables at # 4; PRISM Report December 2012, PRISM Data Tables at # 4. In 2018, patients spent a collective 719 hours in restraints. PRISM Report December 2018, PRISM Data Tables at # 4. In December of 2018, the hospital restrained over 20% of all its patients. PRISM Report December 2018, PRISM Data Tables at #4.
[75] *Id.* This was a drastic increase from 2012, when patients were only secluded for 49 hours. PRISM Report December 2012, PRISM Data Tables at # 4. We note that beginning in 2019, the hospital began to make use of a solitary confinement area but did not count patient time in this room as seclusion. Therefore, rates of seclusion could be substantially higher once these hours are included in the statistics. *See* DRDC Report, *Solitary Confinement at St. Elizabeths Hospital* (Jan. 28, 2019), http://www.uls-dc.org/media/1173/reportfinal12819.pdf.
[76] PRISM Report December 2018, PRISM Data Tables at #3; *see infra* Sections IV, VI for updated statistics and a discussion of "STAT" events.
[77] Staff failed to document or implement meaningful, less restrictive alternatives to restraint. D.C. Mun. Regs. tit. 22A § 501.2(b). Staff did not employ safe techniques prior to and during the restraint. D.C. Code § 7-1231.09(d)(2); *see* Safety Care - Behavioral Safety Training Manual. Staff did not provide adequate or timely medical care to a patient after he sustained serious injuries. D.C. Code §7-1231.09(f); SEH Policy 103.00(III)(A)(20).
[78] RN Progress Note, dated 4/19/19, timed at 6:48 a.m.
[79] John Holmes interview with DRDC on 5/22/19. Medical records confirm that Mr. Holmes sustained these injuries during the restraint, however, the records do not indicate at what point during the restraint they occurred.
[80] RN Progress Note, dated 4/19/19, timed at 6:48 a.m.
[81] John Holmes DBH Investigative Report, dated 6/18/19 at 36.

Shockingly, staff failed to adequately assess his injuries for 16 hours when they then discovered his fractured hip and did not transfer him to another hospital for almost 24 hours, where his arm was placed in a cast and he underwent surgery for his hip.[82]

Second, in early 2019, patient Keith Carter was also abused by staff during a restraint. A review of video footage of the restraint reveals very disturbing staff conduct during an unnecessary and abusive physical, chemical, and four-point restraint.[83] The video footage reveals, that for *at least* fourteen minutes immediately prior to the restraint, Mr. Carter was either walking around the unit, speaking with or attempting to speak with staff or standing or sitting quietly.[84] At no point during that time did he appear to be aggressive or violent. Throughout most of the video footage, staff did not make meaningful attempts to engage with him. Methodical staff preparation culminated in an overwhelming scene, in which thirteen staff and security personnel surrounded Mr. Carter.[85] Multiple security guards then grabbed him by the arms, dragged him down the hall and pushed him into a room.[86] Records indicate staff then strapped his arms and legs to a bed and forcibly administered injections of psychotropic medications.[87] DBH's own investigation substantiated that the hospital violated District law. The doctor involved described Mr. Carter as an "inconvenience" because staff members were dealing with another patient.[88] DBH's report found that "[n]o one involved in this incident stated or described any dangerous behavior that warranted physical hold, Four-point Restraints, or Drug Restraints."[89]

Finally, in the spring of 2019, staff repeatedly secluded and restrained Lisa Morgan, a patient with a history of physical and sexual abuse, in violation of St. Elizabeths' policy that specifies that seclusion is clinically contraindicated for individuals with a trauma history.[90] The record provided no evidence that the psychiatrist considered Ms. Morgan's trauma history prior to ordering the restraint and seclusions, as required by D.C. regulations and hospital policy[91] and contained little evidence that staff attempted to employ meaningful, less restrictive measures to avoid the restraints.[92] Moreover, staff failed to (1) release Ms. Morgan from restraints and seclusion at the earliest possible time;[93] (2) conduct post-event debriefings;[94] and (3) adjust

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[82] D.C. Mun. Regs. tit. 22A § 501.2(b). It was staff at the second hospital that discovered Mr. Holmes's fractured arm, not staff at St. Elizabeths.
[83] 1/19/19 Videotape.
[84] *Id.* at 11:21:32 a.m. to 11:36:09 a.m.
[85] *Id.* at 11:35:47 a.m.
[86] *Id.*
[87] Unusual Incident Report, UI DB #25944, dated 1/17/19.
[88] Keith Carter DBH Investigative Report, dated 7/2/19 at 16, 18.
[89] *Id.* at 16. St. Elizabeths staff plainly stated that Mr. Carter "did not pose an imminent risk of serious injury to himself or others" substantiating that the hospital used drugs as a restraint in violation of District law. *Id.* at 20.
[90] SEH Policy 103.00(III)(A)(3) states that seclusion is contraindicated for individuals with suicidal ideation, self-injurious behaviors, medical conditions that preclude seclusion *and* "*for individuals with a trauma history.*" SEH Policy 103.00(III)(A)(3) (emphasis added). In addition, D.C. regulations require restraints or seclusion to be "appropriate for the severity of the consumer's condition or behavior, as well as the consumer's . . . personal history, including any history of trauma, physical, sexual or mental abuse." D.C. Mun. Regs. tit. 22A § 501.3(b)(2).
[91] *Id.*; SEH Policy 103.00(III)(A)(3).
[92] *See* DRDC Report, section V(3), *Dangerous Restraints: Mistreatment and Harm at St. Elizabeths Hospital* (July 31, 2019), http://www.uls-dc.org/media/1183/srreportfinal73119.pdf.
[93] *Id.* at 23-36.
[94] *Id.*

treatment planning and behavioral approaches after the restraint and seclusions, all of which are required by D.C. law and the hospital's own policy.[95]

IV. ST. ELIZABETHS CONTINUES TO EMPLOY RESTRAINTS AND SECLUSIONS AT UNACCEPTABLY HIGH RATES

For years, St. Elizabeths Hospital steadily increased its use of restraint[96] and seclusion. In 2012, St. Elizabeths restrained patients only five (5) times and secluded patients 30 times.[97] In 2013, seclusions more than doubled to 74 and restraints stayed low at four (4).[98] These numbers grew, and by 2014, St. Elizabeths restrained patients 43 times and secluded patients 183 times.[99] Numbers drastically increased in 2015, with 402 restraints, almost ten times more than the previous year, and 239 seclusions.[100] In 2016, the numbers continued to increase and staff used restraints 647 times and seclusion 271 times.[101] Staff restrained patients 640 times in 2017 and secluded patients 328 times.[102] 2018 followed the same trajectory, with 782 restraints and 291 seclusions.[103] In just the first four months of 2019, which was the last time the hospital published restraint and seclusion numbers, St. Elizabeths used restraints 252 times and secluded patients 61 times.[104]

St. Elizabeths' trend of restraints and seclusions has remained alarmingly high. In just the first three months of 2020, staff employed restraints almost 150 times, and secluded patients 55 times.[105] Patients spent about 120 hours in restraints and over 62 hours in seclusion.[106] January 2020 was especially egregious when staff used physical holds 29 times, mechanical restraints 22 times, and seclusion 27 times, for a total of 78 separate incidents of restraint and seclusion in just one month.[107]

V. ST. ELIZABETHS CONTINUED TO EMPLOY ABUSIVE RESTRAINTS AND SECLUSIONS

Even after DRDC's first two reports and the involvement of a national expert, Hospital staff continued to restrain and seclude patients without adhering to hospital policy and in

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[95] *Id.*; *see* D.C. Code §7-1231.09(d)(4), (j)(3); SEH Policy 103.00(III)(N)(2).
[96] Prior to May 2019, the Hospital's PRISM reports' restraint statistics included each incident of mechanical (four-point) restraints and physical holds. PRISM Report April 2019. These numbers do not include the use of drugs as a restraint. *See infra* Section VI for a detailed discussion of the Hospital's use of drugs as a restraint.
[97] PRISM Report December 2012, PRISM Data Tables at # 4.
[98] PRISM Report December 2013, PRISM Data Tables at # 4.
[99] PRISM Report December 2014, PRISM Data Tables at # 4.
[100] PRISM Report December 2015, PRISM Data Tables at # 4.
[101] PRISM Report December 2016, PRISM Data Tables at # 4.
[102] PRISM Report December 2017, PRISM Data Tables at # 4.
[103] PRISM Report December 2018, PRISM Data Tables at # 4.
[104] PRISM Report April 2019, PRISM Data Tables at # 4.
[105] Data compiled from SEH Unusual Incident Reports from January 2020 to March 2020. Again, these numbers do not include the Hospital's use of drugs as a restraint.
[106] *Id.*
[107] *Id.*

violation of D.C. laws and regulations. Restraints and seclusions continued that were unjustified, employed as punishment, and implemented without attempts at less restrictive alternatives to restraint and seclusion. Staff also repeatedly employed restraint and seclusion on certain individual patients without following D.C. regulations and hospital policies designed to reduce and prevent multiple restraints, and without consideration of a patient's history of trauma or suicidal ideation.

A. Lisa Morgan

Staff continued to restrain and seclude Lisa Morgan (the same patient featured in DRDC's 2019 report) in violation of multiple legal and hospital policy requirements, including the policy that restraint and seclusion are clinically contraindicated for individuals such as Ms. Morgan, who has a history of trauma and sexual abuse.[108] Hospital policy recognizes that patients with a trauma history are particularly vulnerable to psychological harm from restraint and seclusion, noting that they can be "trauma-inducing" and lead to the "potential for physical and psychological harm and loss of dignity."[109] Ms. Morgan reports that each episode of seclusion and restraint has left her feeling traumatized, frightened and humiliated.[110]

Specifically, D.C. regulations require hospital staff to consider an individual's trauma history and implement restraint and seclusion "in accordance with safe and appropriate techniques … appropriate for the severity of the consumer's condition or behavior, as well as the consumer's … physical, mental, and emotional condition, and personal history, including any history of trauma, physical, sexual or mental abuse."[111] Records contain no evidence that hospital staff or Ms. Morgan's psychiatrist considered Ms. Morgan's documented trauma history before ordering restraints and seclusions. One DBH investigative report notes that Ms. Morgan's psychiatrist ordered her to be restrained without any mention of her trauma history and even told Ms. Morgan that restraints are to be used "whenever someone demonstrates dangerous behavior, irrespective of the person's history of trauma."[112]

2019 Restraints and Seclusions

DBH's own investigation into eight restraints and seclusions of Ms. Morgan from April to August 2019 -- including those that occurred after the July 2019 DRDC report describing prior violations -- revealed serious staff violations of hospital policy and D.C. regulations during each incident.[113] The report highlighted one of three consecutive restraints and seclusions in August 2019, where staff committed at least eight violations of D.C. laws, regulations and/or hospital policy requirements.[114] The report notes that after an altercation with Ms. Morgan and a Special

[108] SEH Policy103.00(III)(A)(3) states that seclusion is contraindicated for individuals with suicidal ideation, self-injurious behaviors, medical conditions that preclude seclusion, *and for individuals with a trauma history.* SEH Policy103.00(III)(A)(3) (emphasis added). Many, if not most, patients at St. Elizabeths hospital have a history of trauma.
[109] SEH Policy 103.00(III)(A).
[110] DRDC Interview with Lisa Morgan on 3/6/20.
[111] D.C. Mun. Regs. tit. 22A 501.3(b); *see also* SEH Policy103.00(III)(A)(3).
[112] Lisa Morgan DBH Investigative Report, dated 9/24/19 at 12.
[113] *Id.* at 11.
[114] *Id.* at 13,14.

Police Officer, he quickly removed himself from the situation and two other officers took over and put Ms. Morgan in a physical hold.[115] She quickly calmed down, offering "no resistance."[116] Nevertheless, instead of providing therapeutic intervention, staff reflexively put Ms. Morgan in a physical hold, forced her into restraints, injected her with "double the amount [of medication] that had been previously administered" in past restraints, and left her restrained for 1 hour and 20 minutes.[117] The investigation confirmed that staff failed to employ less restrictive alternatives prior to the restraint and seclusion of Ms. Morgan, stating that "[St. Elizabeths] staff placed Ms. [Morgan] in restraints without an attempt to utilize any alternative techniques."[118]

D.C. law clearly states that patients "have the right to be free from seclusion and restraint of any form … that is used as a means of coercion, discipline, convenience, or retaliation by staff,"[119] however, the report concludes that "SEH staff placed [Ms. Morgan] in [restraints] out of convenience,"[120] Indeed, Ms. Morgan reports that she often felt staff were punishing her with restraints, injections and seclusion.[121] In three of the incidents, Ms. Morgan voluntarily walked into the seclusion room, which shows that she was calm and cooperated with staff instructions and was not an imminent threat to herself or others.[122] In another incident, Ms. Morgan voluntarily went to her room, yet staff still injected her with psychotropic medications without her consent.[123]

In addition, the DBH investigation found instances where staff falsified documentation or failed to complete required documentation. For example, in one incident of restraint, the staff member who completed the Unusual Incident Report did not witness the incident herself, even though she filled out the form in the first person.[124] The DBH investigation found that video footage contradicted the staff members' documentation that Ms. Morgan was offered appropriate interventions prior to the restraint, noting that "evidence obtained (witness statements and the surveillance video) … does not support ... [the nurse's] statement" and Ms. Morgan was not

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[115] *Id.* at 9.
[116] *Id.*
[117] *Id.* at 10, 14; D.C. Mun. Regs. tit. 22A § 514.2. Documentation shows that Ms. Morgan's behavior did not change significantly from when she was placed into restraints to when she was released, demonstrating that the use of restraints was an ineffective deterrent. The DBH Report found that "staff failed to document or state what 'emergency' Ms. Morgan presented." Lisa Morgan DBH Investigative Report, dated 9/24/19 at 14; *see id.* at 10.
[118] *Id.* at 10, 13, 14; D.C. Mun. Regs. tit. 22A § 501.7(d). The report continues, "several SEH staff persons interviewed admitted that Ms. Morgan would have been taken to the Seclusion Room had it not been occupied. SEH arbitrarily elevated this incident to a 4pt. restraint because the Seclusion Room was not available." Lisa Morgan DBH Investigative Report, dated 9/24/19 at 9.
[119] D.C. Code § 7-1231.09(a).
[120] *Id.* at 13; D.C. Mun. Regs. tit. 22A § 501.7, §501.7(a). The report continues "several SEH staff persons interviewed admitted that Ms. Morgan would have been taken to the Seclusion Room had it not been occupied. SEH arbitrarily elevated this incident to a 4pt. restraint because the Seclusion Room was not available." Lisa Morgan DBH Investigative Report, dated 9/24/19 at 9.
[121] DRDC Interview with Lisa Morgan on 3/6/20.
[122] Lisa Morgan DBH Investigative Report, dated 9/24/19 at 11.
[123] *Id.*
[124] Lisa Morgan DBH Investigative Report, dated 9/24/19 at 13. The DBH report found that staff routinely mischaracterized Ms. Morgan's UIs. For the 8 incidents recorded in 2019, all UIs listed the "Level of Severity" as Medium. DBH reported "despite the documented Medium severity, SEH staff response to these incidents varied with great degree." *Id.* at 11.

actually offered a moderate intervention before restraint and seclusion.[125] The required "Post-Event Analysis" mostly consisted of "an impromptu meeting held in the hallway."[126] Moreover, staff only debriefed four out of the eight incidents.[127] Ms. Morgan was present at only two of those debriefs, and disturbingly, in one debrief, Ms. Morgan was still in restraints.[128]

2020 Incident of Restraint and Seclusion

Again, even following DRDC's July, 2019 report and the second report -- that of the DBH Office of Accountability completed in September 2019 -- in February 2020, staff implemented another abusive seclusion and injected Ms. Morgan with drugs as a restraint, which was captured again on video footage.[129] Records indicate that after an altercation with her psychiatrist, Ms. Morgan calmed down very quickly, slowly walked away and sat in a chair in the hallway.[130] She told her psychiatrist "you don't need to call a code or give me anything."[131] Ms. Morgan reported that despite her informing staff that she was calm and no longer felt angry or aggressive, staff told her that she had to go to the seclusion room and that she would be getting an injection.[132] She then walked calmly into the seclusion room[133] and requested that a female staff give her the injection.[134] A male RN, however, insisted that he would be giving the injection, even though a female nurse was assigned to give medications that day.[135] Significantly, DRDC's investigation discovered that this male RN's Maryland nursing license was suspended in July 2012 for abusing a psychiatric patient.[136] Equally alarming is that four other male staff witnessed the male RN pull down Ms. Morgan's pants and administer the injection and took no action.[137]

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[125] *Id.* at 9.
[126] *Id.* at 12. "The Post-Event Analysis mandates that the meeting be documented on the Post-Event Analysis form, and at a minimum describe the emergency that required the restraint, the alternative techniques that were used to prevent the restraint, procedures to prevent recurrence, and the outcome of the intervention." *Id.*
[127] *Id.* Only 4 Recovery Team Debriefing Forms were filled out, which are required with every Treatment Team debrief. *Id.* The Treatment Team debrief is distinct from the Post-Event Analysis because it "assist[s] staff and the IIC in understanding the behaviors that necessitated the restraint or seclusion, for the IIC to identify coping mechanisms, develop appropriate alternatives, to develop IRP interventions, and to update Comfort Plans." *Id.*
[128] *Id*. Hospital policy also requires staff to update an "Individual Recovery Plan" if the patient has been restrained or secluded more than three times within a four-week period, or two or more episodes within a 12-hour period. SEH Policy 103.00(III)(N)(2). Although Ms. Morgan met these criteria earlier in 2019, her IRPs before and after being restrained more than 5 times in a four-week period were "essentially identical and no modifications appear[ed] to have been made." Lisa Morgan 2019 DBH Investigative Report at 11.
[129] *See* Videotape, 1F Seclusion room, dated 2/28/20 ("2/28/20 Videotape").
[130] Clinical Records Progress Note, dated 2/28/20, timed at 12:58 p.m.
[131] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 6.
[132] *Id.* at 1. Ms. Morgan did not want or give consent for this injection but was told by staff that she had to accept it. DRDC Interview with Lisa Morgan on 3/6/20.
[133] 2/28/20 Videotape at 11:10:26 a.m.
[134] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 1.
[135] *Id.* at 8, 10. The male nurse "decided to administer the IM injections, as [Ms. Morgan] was unpredictable and aggressive" even though he also said that Ms. Morgan "followed staff direction and . . . was not a threat to herself or others" during this incident. *Id.* at 10.
[136] *In re J[] B[]*, Consent Order (July 20, 2012). According to the Maryland Board of Nursing, video footage revealed that he "kicked [the patient] in the chest, causing [the patient] to fall backward onto the floor," "picked up [the patient] and threw him forcibly to the ground," and "lied about [the patient's] actions" during the hospital's investigation.
[137] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 5; 2/28/20 Videotape at 11:21:58 a.m.

Video footage confirms that there was not a legal basis to seclude Ms. Morgan. The footage begins with Ms. Morgan voluntarily walking into the seclusion room.[138] She is calm and lays down on a mattress on the floor.[139] Ten minutes later, seven staff members, five men and two women, enter the room.[140] Ms. Morgan remains calm and extends her arm towards the male RN.[141] He injects her arm, then staff forcibly roll her over, even though she does not appear to be resisting.[142] Three of the male staff members, including the RN, are hovering directly over her and appear to be physically holding her down while two more male staff and two female staff casually look on.[143] The male RN pulls down Ms. Morgan's "pants and underwear to expose the top portion of her hip and buttocks,"[144] and injects her in the buttocks,[145] something Ms. Morgan reported was especially traumatizing and humiliating.[146] All staff then abruptly leave the seclusion room.[147] Ms. Morgan lies down on the mat again and is in seclusion for a total of 1 hour and 40 minutes.[148]

Staff documentation fails to justify the restraint or explain how Ms. Morgan -- who had calmed down immediately after the incident, sat quietly in a chair, walked voluntarily to the seclusion room, laid down quietly on a mat, exposed her arm so the nurse could inject her, allowed staff to roll her over and accepted a humiliating injection in her buttocks while seven staff were watching -- was an imminent threat.[149] In fact, the RN documented that Ms. Morgan "displayed no immediate signs of aggression."[150] The psychiatrist provided evidence that Ms. Morgan was not an imminent threat, recounting that after the assault Ms. Morgan "had slowly walked away . . . and sat on a chair in one of the hallways. . . ." and that after being told she would be in seclusion, Ms. Morgan "walked quietly in, put down the mattress and lay down."[151] According to the DBH report, the psychiatrist justified the seclusion and the chemical restraint orders by stating, "the imminent emergency is what triggered [Ms. Morgan] to become assaultive,"[152] and "by placing [Ms. Morgan] in the Seclusion Room and giving her [injections]. . . he was treating the emergency."[153] D.C. regulation forbids the use of restraint and seclusion

[138] *Id.* at 11:10:26 a.m.
[139] *Id.* at 11:10:43 a.m.
[140] *Id.* at 11:20:24 a.m.
[141] *Id.* at 11:20:43 a.m.
[142] *Id.* at 11:20:57 a.m., 11:21:25 a.m. Because staff surrounded Ms. Morgan, her buttocks is not visible to the camera. The male RN crouches at her backside, prepares a shot, administers a shot and a female nurse puts a bandage on Ms. Morgan's backside. *Id.* at 11:21:54 a.m. to 11:21:57 a.m.
[143] *Id.* at 11:21:25 a.m.
[144] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 5.
[145] 2/28/20 Videotape at 11:21:54 a.m.
[146] DRDC Interview with Lisa Morgan on 3/6/20.
[147] 2/28/20 Videotape at 11:22:13 a.m.
[148] *Id.* at 11:22:32 a.m. to 1:02:43 p.m.
[149] D.C. Code § 7-1231.09(c).
[150] RN Assessment, dated 2/28/20, timed at 11:10 a.m.
[151] Clinical Records Progress Note, dated 2/28/20, timed at 12:58 p.m.
[152] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 7.
[153] *Id.*

as a form of treatment, stating "restraints and seclusion are not treatment modalities"[154] and hospital policy clearly states that "seclusion or restraint is not a therapeutic intervention."[155]

Tellingly, the DBH report notes that the male RN "could not identify any instances in the video in which [Ms. Morgan] was aggressive or 'misbehaving.'"[156] When asked to comment on how Ms. Morgan was an imminent threat while being shown a still video footage image of Ms. Morgan calmly seated on the mattress, the male RN said Ms. Morgan was only "cooperating because of the show of force."[157] An approach meant to frighten and intimidate a patient with "a show of force" is not only traumatic, it can often escalate a situation.[158]

Staff members' actions throughout this incident of seclusion and chemical restraint appear routine, punitive and dehumanizing. There is no evidence showing that staff attempted or implemented meaningful therapeutic measures, offered her support, or tried to comfort her. Moreover, the DBH investigation noted that multiple staff reported that they were familiar with Ms. Morgan's trauma-related concerns,[159] but the record contains no evidence the psychiatrist or staff considered her trauma history prior to secluding her and forcing her to accept an injection. To the contrary, the DBH investigative report notes that the male RN said he was unaware of her trauma history, even though he had been working on Ms. Morgan's unit for five years as a team leader.[160]

Staff further violated D.C. law, D.C. regulations and hospital policy when staff falsified documentation and wrongly asserted that Ms. Morgan met the criteria for continued seclusion, and thus failed to release Ms. Morgan from seclusion at the earliest possible time.[161] Video footage directly contradicts staff documentation that Ms. Morgan could not be released from seclusion because she was "anxious and yelling," "shouting angrily and arguing with staff" "pacing the room," "not willing to discuss with staff" and "unable to cooperate."[162] The video footage clearly shows that after the injections, Ms. Morgan was lying still on the mat or calmly standing up and looking at the door for one hour and forty minutes, until staff let her out of the seclusion room.[163] The DBH investigation substantiated that Ms. Morgan "remained calm and compliant during the entirety of her seclusion" and that staff "left [Ms. Morgan] in seclusion for

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[154] D.C. Mun. Regs. tit. 22A § 501.6. The regulation continues, "[n]either the use of restraints nor the placement of a consumer in seclusion shall be included as a mental health support or mental health service in a consumer's service plan." *Id.*; *see* D.C. Code § 7-1231.09(a).
[155] SEH Policy 103.00(I).
[156] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 11.
[157] *Id.* at 10-11.
[158] This mentality only frightens patients and contributes to a "cycle of violence." *See* Amanda Wik, M.A., *Elevating Patient/Staff Safety in State Psychiatric Hospitals,* NAT'L ASS'N. OF STATE MENTAL HEALTH PROGRAM DIRS. RES. INST. (Jan. 2018), https://www.nri-inc.org/media/1465/2018-elevatingpatient_endnotesfinal.pdf
[159] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 12. The psychiatrist's notes listed nurses that Ms. Morgan preferred to receive injections from, and the male nurse in this incident was not on the list. *Id.* at 7. The investigation identified "several inconsistencies in the staff's knowledge of [Ms. Morgan's] care and concerns with staff." *Id.* at 12. The DBH report reasoned that "staff could have easily mitigated complaints from [Ms. Morgan] receiving injections from male staff by updating her Code 13 plan, and communicating directly with staff on her unit." *Id.* at 9.
[160] *Id.*
[161] D.C. Code § 7-1231.09(d); D.C. Mun. Regs. tit. 22A § 501.3(d).
[162] RN Assessment, dated 2/28/20, timed at 11:10 a.m.
[163] Videotape at 11:22:32 a.m. to 1:01:57 p.m.

longer than necessary." [164] Finally, the DBH investigation confirms that hospital staff falsified documentation, noting that "documented observations contradict the surveillance video" in violation of SEH policy, and the nurse "misrepresented her observation on official medical records," leading to Ms. Morgan's prolonged seclusion.[165] Over the course of nine observation entries, the nurse correctly recorded Ms. Morgan's actions only one time.[166] The nurse filled out two forms, which DBH found to "contradict one another," and documented the start of seclusion as two different times.[167]

DBH also found that St. Elizabeths did not update Ms. Morgan's Individual Recovery Plan ("IRP") according to hospital policy, which is essential to mitigating patient restraint and seclusions.[168] Staff are required to update a patient's IRP if a patient has been restrained more than three times within a four-week period, however, "[Ms. Morgan's] treatment team made no significant modifications to [Ms. Morgan's] IRP in the past year despite the multiple instances of restraint and seclusion."[169] Staff should have been aware that it was especially important to update Ms. Morgan's IRP since, not only had DRDC reported on abusive staff conduct in July 2019, but the September 2019 DBH investigative report also substantiated that St. Elizabeths staff did not update Ms. Morgan's IRP in accordance with hospital policy prior to this incident of seclusion.[170]

B. Larry Greene

In June 2019, staff restrained and/or secluded Larry Greene three times while he was exhibiting suicidal behaviors in violation of the hospital's policy that "seclusion is contraindicated for individuals with suicidal ideation or self-injurious behaviors."[171] The policy recognizes that restraint and seclusion are especially harmful for suicidal patients because they can be "trauma inducing" and lead to "the potential for physical and psychological harm and loss of dignity."[172] Further, the policy notes that restraint and seclusion is to be used as a last resort and "is not a therapeutic intervention."[173] D.C. regulations require that restraints be "appropriate for the severity of the consumer's condition or behavior" and the patient's mental and emotional condition.[174]

Mr. Greene described being in four-point restraints as very frightening.[175] He said that he did not understand why staff put him in restraints when he had thoughts that he wanted to kill

[164] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 13-14.
[165] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 13-14; SEH Policy 103.00, NPM 4.2.
[166] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 14-16.
[167] *Id.* at 15.
[168] *Id.* at 14; SEH Policy 103.00(III)(N)(2).
[169] Lisa Morgan DBH Investigative Report, dated 7/10/20 at 14.
[170] Lisa Morgan DBH Investigative Report, dated 9/24/19 at 11.
[171] SEH Policy 103.00(III)(A)(3); D.C. Mun. Regs. tit. 22A § 504.3(a). Hospital policy mirrors a D.C. regulation that "seclusion is contraindicated for consumers who: (a) exhibit suicidal behaviors . . . ." *Id.*
[172] SEH Policy 103.00(III)(A).
[173] SEH Policy 103.00(I).
[174] D.C. Mun. Regs. tit. 22A § 501.3(b)(2); D.C. Mun. Regs. tit. 22A § 504.3(a).
[175] DRDC Interview with Larry Greene on 9/11/19.

himself. He reported being confused and upset since he thought staff were supposed to help him with his suicidal feelings, and that being forced into restraints only made him feel worse.[176]

Prior to one restraint, Mr. Greene placed a phone cord around his neck and then stuffed paper into his mouth.[177] Staff proceeded to force Mr. Greene into four-point restraints without offering meaningful alternatives to restraints and without documenting why those alternatives were deemed impractical or unsafe, as required by D.C. law.[178] Although the RN documented alternatives such as: "talked with the individual in care," "redirected the individual verbally" and "separate[ed] patient from the area,"[179] the documentation lacks the necessary detail demonstrating that staff *meaningfully* attempted those alternatives or why those interventions were deemed not effective to the degree that restraint was still needed.

Again in July 2019, Mr. Greene exhibited suicidal behaviors when he attempted to tie a paper scrub top he had placed around his neck to the metal wiring in the courtyard.[180] Staff immediately restrained Mr. Greene[181] but again failed to document evidence that they followed legal requirements and attempted meaningful alternatives prior to the restraint.[182] Although staff checked off alternatives to restraint on a preprinted form, staff failed to provide any narrative explanation of meaningful, less restrictive alternatives they attempted, nor did staff documentation indicate staff provided meaningful therapeutic interactions to address his suicidal ideation.[183] Describing in detail these steps and actions are not only required, they could prevent future traumatic restraints.

Moreover, Mr. Greene had been assigned a 1:1 staff at the time of each restraint.[184] The record does not explain why a four-point restraint was necessary when his 1:1 staff was presumably at arm's length distance and could provide immediate intervention. In fact, there were times when Mr. Greene displayed self-harming behavior and staff did employ less restrictive alternatives. For example, in June 2019 staff documented that Mr. Greene wrapped a bed sheet around his neck and then wrapped his sweatpants and top around his neck. Staff were able to take the items from him and give him paper scrubs.[185] Restraint was not used, and the trauma of its use avoided.

C. Samuel Bates

In September 2019, St. Elizabeths staff restrained Samuel Bates, again in violation of D.C. laws and hospital policies designed to protect patients from unnecessary and abusive

[176] *Id.*
[177] RN Progress Note, dated 6/30/19, timed at 12:59 p.m.
[178] D.C. Code § 7-1231.09(c); D.C. Mun. Regs. tit. 22A § 506.2(b); SEH Policy103.00(III)(M)(1)(b).
[179] Initiation of Seclusion or Restraint: RN Assessment, dated 6/30/19, timed at 12:30 p.m.
[180] RN Progress Note, dated 7/2/19, timed at 6:12 p.m.
[181] *Id.*
[182] D.C. Code § 7-1231.09(c); D.C. Mun. Regs. tit. 22A § 506.2(b); SEH Policy103.00(III)(M)(1)(b). RN progress notes state that staff "immediately" called a code 13. RN Progress Note, dated 7/2/19, timed at 6:12 p.m.
[183] *Id.*
[184] *See* Clinical Progress Notes.
[185] RN Progress Note, dated 6/29/19, timed at 3:17 p.m.

restraints.[186] Mr. Bates described the restraint event as traumatic and frightening.[187] He recalls being upset but that "no one would help me."[188] He indicated that he did not understand why staff put him in restraints and gave him a shot and said that it was very frightening to have so many staff surround him and force him into restraints.[189] He denies being aggressive, threatening, or a danger to himself or others prior to the restraint.[190]

Hospital video footage of the incident shows that over the course of six minutes prior to the restraint, staff failed to address Mr. Bates in a therapeutic manner and failed to adhere to the legal and policy requirements prior to initiating a restraint.[191] The video footage begins as Mr. Bates throws a small white object down the hallway, which appears to be a bar of soap, and then he retrieves it.[192] For the remainder of the time, Mr. Bates is pacing in a circle in front of the nurses' station, attempting to speak to staff.[193] He appears agitated at times, but often clasps his hands in front of himself in a non-threatening manner.[194] He does not appear aggressive.[195] Staff members either ignore him or point down a hallway, however, they do not appear to be threatened or interested in Mr. Bates' behavior.[196] In fact, at one point, staff leave Mr. Bates unattended at the nurses' station.[197] Six minutes into the video footage, Mr. Bates has a conversation with an off-camera individual.[198] A security guard and hospital staff person then suddenly grab Mr. Bates and put him in a physical hold.[199] In yet another show of force, nine staff members surround Mr. Bates, take him to the restraint room, and place him into four-point restraints.[200] Mr. Bates does not resist the physical hold or being escorted to the restraint room.

Once again, staff documentation of the incident is inconsistent with the video footage. Progress notes state that prior to the restraint, Mr. Bates "suddenly attempted to attack staff."[201] At no point on the video did Mr. Bates appear to be an imminent threat to anyone's safety. To the contrary, the video footage shows that for six minutes prior to the restraint, staff appear casual and unthreatened by Mr. Bates.[202] They do not appear to even interact with Mr. Bates prior to the restraint, indicating that he was not an imminent threat to himself or others.[203]

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[186] D.C. Code § 7-1231.09(a) ("Consumers have the right to be free from seclusion and restraint of any form that is not medically necessary or that is used as a means of coercion, discipline, convenience, or retaliation by staff.").
[187] DRDC Interview with Samuel Bates on 9/11/19.
[188] *Id.*
[189] *Id.*
[190] *Id.*
[191] *See* 9/8/19 Videotape.
[192] *Id.* at 9:49:26 p.m.
[193] *Id.* at 9:50:00 p.m. to 9:54:59 p.m.
[194] *See* 9/8/19 Videotape.
[195] *Id.*
[196] *Id.*
[197] *Id.* at 9:53:18 p.m.
[198] *Id.* at 9:55:00 p.m. to 9:55:17 p.m.
[199] *Id.* at 9:55:22 p.m.
[200] *Id.* at 9:55:22 p.m. to 9:55:33 p.m.
[201] Psychiatry Resident Progress Note, dated 9/9/19, timed at 2:45 a.m.
[202] 9/8/19 Videotape.
[203] *Id.*

Staff are required to provide therapeutic, positive behavioral approaches and de-escalation techniques prior to restraint.[204] Although the RN documentation indicates, with checked choices on a preprinted list, that staff attempted less restrictive interventions including, "talking with the individual in care," "separating patient from the area," and "offering voluntary quiet time and medication,"[205] this documentation is contradicted by the video footage, which shows that nursing staff made little meaningful attempt to speak with or assist Mr. Bates prior to the restraint. Regardless, D.C. regulations require that the RN document meaningful alternative strategies considered and why they were deemed impractical or unsafe.[206] Generalized, checked choices, without more explanation, are insufficient.

D. Anne Williams

Anne Williams, also a patient at St. Elizabeths, is diagnosed with a mental health disability, an intellectual disability,[207] and has a history of trauma and neglect.[208] Without meaningful consideration of these factors, and often in egregious violations of D.C. laws, D.C. regulations and hospital policies, staff put Ms. Williams in a physical hold, mechanical restraint and/or seclusion *over sixty-five (65) times in a six-month period*.[209] Staff implemented restraint or seclusion multiple times in the same day and kept Ms. Williams in restraints for up to over four hours in a single restraint.[210] Staff often reflexively employed seclusion or restraints: (1) when Ms. Williams "requested" that staff do so; (2) without evidence that staff attempted meaningful, less restrictive alternatives; (3) without employing the required treatment team strategies designed to reduce frequent incidents of restraint and seclusion; (4) without completing the required post-event analysis or debriefing; and (5) without the required doctor's orders.[211]

Ms. Williams has a history of self-harming and aggressive behavior and, at times, presented behavioral challenges to staff. However, this does not allow the treatment team to disregard D.C. regulations and hospital policy requirements. Staffs' frequent reliance on seclusion and restraint exemplifies why strict requirements are in place; here, staff routinely relied on restraint and seclusion in lieu of therapeutic and less restrictive interventions. This created a "vicious cycle," where Ms. Williams was so used to being placed in restraint and seclusion that she even requested it -- she asked to have staff strap her arms and legs to a bed or

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[204] *See* SEH Policy 103.00(III)(E).
[205] Initiation of Seclusion or Restraint: RN Assessment, dated 9/8/19, timed at 9:55 p.m.
[206] D.C. Mun. Regs. tit. 22A § 506.2(b); *see* SEH Policy103.00(III)(M)(1)(b).
[207] It is important to note that Ms. Williams also receives services from the District's Developmental Disabilities Administration. Individualized Recover Plan dated 2/10/20 at 1. (Ms. Williams "remains in the hospital because DDS has been unsuccessful in identifying appropriate placement in the community"). Thus, she has substantial additional protections that prevent the use of seclusion and restraint. See e.g., D.C. Code 7-1305.10. In fact, seclusion is prohibited. D.C. Code 7-1305.10 (d) ("Seclusion, defined as a placement of a person alone in a locked room, shall not be employed.")
[208] Anne Williams' Initial Behavioral Intervention, dated 9/4/19 at 3.
[209] D.C. Code § 7-1231.09(a); SEH Policy103.00(III)(D)(1) ("Neither restraint nor seclusion shall be used as a part of any planned behavioral guideline or positive behavioral support plan."); Anne Williams' Unusual Incident Reports from 11/1/19 to 5/6/20.
[210] For example, in March 2020, staff restrained Ms. Williams four times in a single day and she spent over two and a half hours in a physical hold or four point restraints.[210] Unusual Incident Reports, UI DB #s 29497, 29502, 29503, 29969, dated 3/9/20.
[211] *See infra* text accompanying footnotes 213 to 241.

lock her in a small, windowless room alone, both of which likely caused her more distress and trauma.[212] Sadly, Ms. Williams requested seclusion or voluntarily walked to the restraint room *at least* sixteen times in a six-month period.[213]

Ms. Williams' Individual Behavioral Intervention Plan ("IBI Plan") provides multiple interventions and strategies for staff to address Ms. Williams' need for attention and target behaviors, including (1) calmly asking her what her concerns are; (2) distracting her by talking to her or taking her on a walk; (3) offering to listen to music with her; (4) exercising; (5) practicing deep breathing; (6) offering the comfort room as a place to calm down; and (7) using a towel to protect from self-harm.[214] If she "engages in behaviors that pose an imminent danger to herself or others," the IBI Plan requires staff to follow required procedure.[215] However, in many instances, staff justified the restraints or seclusion as a planned behavioral intervention, in violation of hospital policy which specifically states that *restraints can induce trauma, are not a therapeutic intervention and cannot be used as part of planned behavioral interventions.*[216]

In countless incidents of restraint and seclusion, staff failed to implement the strategies required by Ms. Williams' IBI Plan that were designed to assist her when she was distressed and to avoid restraint or seclusion, nor did they offer any other meaningful, less restrictive alternatives as required by D.C. law and hospital policy.[217] For example, records indicate that prior to one four-point restraint, Ms. Williams "felt distressed and sought out staff for assistance. She had become very tearful, stated that she was feeling frightened, felt unsafe, and said she was hearing voices."[218] Staff did not attempt to comfort her, attempt the therapeutic techniques in her IBI Plan or attempt other meaningful, less restrictive alternatives. Staff noted only that they talked with her "to no avail," and that she "refused to observe quiet time."[219] Staff noted that Ms. Williams, "requested" four point restraints, "walked to the restraint room," and that "restraints [were] initiated … to avoid hearing command hallucinations."[220] Ms. Williams remained in restraint for more than an hour.[221]

Prior to another four-point restraint, records state that Ms. Williams was upset because she was experiencing stomach pain and wished to go to her room to rest. She "ran to the group

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[212] Anne Williams Unusual Incident Reports from 11/1/19 to 5/6/20.
[213] *Id.*
[214] Anne Williams Initial Behavioral Intervention, dated 9/4/19 at 5.
[215] *Id.* at 6.
[216] *See* SEH Policy 103.00(I), (III). (emphasis added); *see* D.C. Mun. Regs. tit. 22A § 501.6. For example, despite 18 incidents of restraint and seclusion during the previous 60 days, very limited strategic approaches were discussed in Ms. Williams' February 2020 Individual Recovery Plan. "[C]oping skills [were] discussed. Options for coping identified are as follows: relaxing in comfort room, using a weighted blanket when the need to do so is identified, listening to music on her when the option is available. [Ms. Williams] [was] encouraged to make needs and concerns known to staff." 2/20/20 Individual Recovery Plan at 2.
[217] D.C. Code § 7-1231.09(c); D.C. Mun. Regs. tit. 22A § 501.2(b). In addition, the psychiatrist frequently failed to adequately document meaningful, less restrictive alternatives. In fact, the psychiatrist often repeated the same single phrase that "verbal redirection was unsuccessful" as the only less restrictive alternative attempted when completing the restraint and seclusion order form.
[218] Doctor's Order for Restraint and Seclusion dated 11/25/19, timed at 3:28 p.m.
[219] Initiation of Seclusion or Restraint: RN Assessment, dated 11/25/19, timed at 3:30 p.m.
[220] *Id.* As previously discussed, restraints are not, and cannot be used as, treatment. Staff fail to explain how placing Ms. Williams in restraints "avoided" her hearing command hallucinations.
[221] Unusual Incident Report, UI DB #28914, dated 11/25/19.

room where she laid on the chair crying loudly while staff asked her to go back to the [other] unit." According to the records, she "refused" to go back into the unit and her psychiatrist "ordered that security should be called to assist in transferring her to restraint room per her code 13 policy."[222] Although the doctor's order states that Ms. Williams was, "combative while being escorted out of the group room back to the unit milieu,"[223] no other documentation of the incident refers to Ms. Williams as being aggressive, nor is there an explanation of the initial danger to self or others that required the "escort." Regardless, staff failed to document use of meaningful, less restrictive interventions or strategies in her IBI Plan. The narrative portion of the RN assessment only noted that Ms. Williams "was redirected by staff which did not yield any positive effect," and "the doctor ordered that patient should be transferred to restraint room."[224] Staff placed Ms. William in a physical hold and placed her in four-point restraints, where she remained for an hour.[225]

During another incident, RN documentation indicates that Ms. Williams scratched herself with a plastic cup, "a tool she fashioned" and was "yelling, threatening to harm self."[226] Staff then first placed Ms. Williams in a physical hold then a four-point restraint, noting only that "verbal redirection was unsuccessful."[227] Again, the records contain no evidence that staff attempted any of the therapeutic strategies outlined in her IBI Plan. Ms. Williams remained in four-point restraint for an hour and a half.[228] On another occasion, Ms. Williams reported to staff that she "wasn't feeling too well due to overstimulation on the unit" and that she "requested to go to the seclusion room and spend time alone."[229] Staff failed to provide therapeutic interventions or implement any of the suggested strategies in Ms. Williams' IBI Plan, noting only that "[s]taff did nothing" and that Ms. Williams was "allowed" to go to seclusion "based on her behavior intervention."[230]

Significantly, staff failed to follow hospital policy designed to protect patients from frequent, repeated use of restraint and seclusions. Hospital policy requires that the treatment team, with participation of the patient, review and update the comfort plan and Individual Recovery Plan ("IRP") *within 24 hours* if a patient (1) experiences two or more episodes of restraint or seclusion in a 24-hour period; or (2) experiences three or more episodes of restraint or seclusion within a 30-day period.[231] Staff did not adequately examine Ms. Williams' IRP to determine how the frequent restraints and seclusions could be reduced or eliminated.[232] The treatment team updated Ms. Williams' IRPs only four times in the six-month period.[233] The

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[222] Unusual Incident Report, UI DB #29344, dated 2/12/20.
[223] Doctor's Order for Restraint and Seclusion, dated 2/12/20, timed at 11:46 a.m.
[224] RN Assessment, dated 2/12/20, not timed.
[225] Unusual Incident Report, UI DB #29344, dated 2/12/20.
[226] Initiation of Seclusion or Restraint: RN Assessment, dated 3/9/20, not timed.
[227] *Id.*
[228] Unusual Incident Report, UI DB #29497, dated 3/9/20.
[229] RN Assessment, dated 12/11/19, timed at 10:10 a.m.
[230] *Id.*
[231] SEH Policy 103.00(III)(N)(2).
[232] In fact, one form stated that the Individual Recovery Plan was not updated because "[t]here were already interventions in place to manage this individual." Recovery Team Debriefing Form dated 1/28/20 at 1.
[233] 11/25/19 Individual Recovery Plan; 12/12/19 Individual Recovery Plan; 2/10/20 Individual Recovery Plan; 4/6/20 Individual Recovery Plan. For example, Ms. Williams was restrained or secluded at least 22 times between

updates contained only minimal changes to staff interventions and, ultimately, failed to recommend treatment that would result in the successful elimination of restraint and seclusion.[234]

Again, in order to avoid the trauma and overuse of restraint or seclusion, D.C. law and hospital policy require that staff review each episode of restraint and seclusion to examine staff interventions and receive input from the patient to assist in developing strategies to reduce or eliminate the need for restraint.[235] Hospital policy requires staff to complete a post-event analysis report "immediately after every episode of restraint or seclusion to discuss the events surrounding the emergency that required the use of restraint or seclusion."[236] Despite over sixty-five (65) incidents of restraint and seclusion from November 1, 2019, through May 6, 2020, records provided to DRDC by the District contained only one post-event analysis form, and even that was not fully completed.[237] Debriefings, also required by D.C. law and hospital policy,[238] were not meaningfully conducted. Debriefing forms were missing or not completed, and no forms indicated that Ms. Williams' IRP was updated.[239]

Finally, records provided indicate that staff failed to obtain the necessary doctor's orders to restrain and seclude Ms. Williams. D.C. law requires a physician to renew an expired order for restraint or seclusion, and if not done, requires staff to release the patient from restraint or seclusion.[240] Each of the doctor's orders to seclude or restrain Ms. Williams that DRDC received stated that the episode could not last more than one hour. However, records provided demonstrate that staff frequently kept Ms. Williams in restraint or seclusion far longer than one hour without a subsequent doctor's order and indicate that staff obtained a new doctor's order to extend a restraint in only one incident.[241] Even then, Ms. Williams was in restraint for over four hours, which would have required at least three subsequent orders instead of just one.[242] In other egregious instances, according to records provided, staff secluded Ms. Williams for one and a

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the 12/12/19 IRP and the 2/10/20 IRP. Based on hospital policy, Ms. Williams' IRP should have been updated at least six times within that period. SEH Policy 103.00(III)(N)(2).

[234] 11/25/19 Individual Recovery Plan; 12/12/19 Individual Recovery Plan; 2/10/20 Individual Recovery Plan; 4/6/20 Individual Recovery Plan.

[235] SEH Policy 103.00(III)(J)-(K).

[236] SEH Policy 103.00(III)(J). The policy requires that the post-event analysis shall, at a minimum, include a discussion of: (1) the emergency that required the use of restraints or seclusion, including a discussion of the precipitating factors that led up to the use of restraint or seclusion; (2) alternative techniques that might have prevented the use of the restraint or seclusion; (3) the interventions, if any, that are to be considered in the future to minimize additional behavioral emergencies for this individual; and (4) review of staff well-being, including any injuries that may have resulted from the use of restraints or seclusion. *Id.*

[237] Post-event Analysis Report, dated 2/14/20, not timed. Interventions (comfort plan and IBI) and safety care de-escalation strategies (help and prompt) were just checked on the form without any narrative describing specific steps.

[238] D.C. Code § 7-1231.09(j)(3); SEH Policy 103.00(III)(K).

[239] DRDC did not receive any debriefing forms for many of the documented restraints and seclusions. Moreover, on 1/28/20, 1/30/20, and 3/12/20, staff filled out a debriefing form but recorded that Ms. Williams could not be debriefed because she was in restraints, seclusion, or court. Debriefing Form, dated 1/28/20, timed at 4:00 p.m.; Debriefing Form, dated 1/30/20, timed at 11:30 a.m.; Debriefing Form, dated 3/12/20, timed at 10:45 a.m.

[240] D.C. Code § 7-1231.09(f); D.C. Mun. Regs. tit. 22A § 506.8, 506.2(c)-(d).

[241] *See* Doctor's orders in Anne Williams' medical record from 11/1/2019 - 5/6/2020. Doctor's Order for Restraint and Seclusion, dated 12/27/19, timed at 6:35 p.m.; Doctor's Order for Restraint and Seclusion, dated 12/27/19, timed at 8:57 p.m.

[242] Unusual Incident Report, UI DB #29058, dated 12/27/19.

half hours,[243] restrained her for two hours,[244] and restrained her for three and a half hours,[245] all without the required additional doctor's orders.

VI. THE HOSPITAL FREQUENTLY ADMINISTERS DRUGS AS A RESTRAINT

A. St. Elizabeths Wrongly Asserts that it Does Not Use Drugs as a Restraint

D.C. law classifies medication administered during an emergency as "drugs used as a restraint" which is defined as "a medication that is used in addition to or in place of the consumer's regular, prescribed drug regimen to control extreme behavior **during an emergency**, but does not include medications that comprise the consumer's regular, prescribed medical regimen and that are part of the consumer's service plan, even if their purpose is to control ongoing behavior."[246] Similarly, D.C. regulations define a drug used as a restraint as "a medication that is used to control extreme behavioral symptoms during an emergency."[247] All restraints, including "drugs used as restraint" must follow comprehensive D.C. law and D.C. regulations controlling and restricting their use.

D.C. regulations have additional specific requirements for drugs as a restraint, including that (1) the physician ordering a drug(s) to be used as a restraint shall conduct a face-to-face assessment of the consumer within one hour of administration of the medication; and (2) a trained competent staff person shall regularly assess the consumer for the first two hours after the drug is administered.[248] The regulations require that for each order, the physician, physician assistant or RN shall also document a note separate from the order, which shall include (a) less restrictive techniques used, attempted, or considered prior to ordering the drug; (b) whether there are any pre-existing medical conditions or any physical disabilities that would place the consumer at potentially greater risk due to the use of the drug; and (c) the basis, including a description of the consumer's behavior and the circumstances leading to the use of the drug.[249]

Previous St. Elizabeths' policy provided that any emergency administration of drugs is a "chemical restraint."[250] That policy correctly stated "[t]he emergency administration of involuntary medications **shall be considered to be an incident of drugs as a restraint** . . . and the requirements of that policy shall apply."[251] Despite no change in the D.C. law definition of

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[243] Doctor's Order for Restraint and Seclusion, dated 12/4/19, timed at 3:30 p.m. ("Not to exceed 1 for restraint"); Unusual Incident Report, UI DB #29109, dated 12/4/19.
[244] Doctor's Order for Restraint and Seclusion, dated 12/31/19, timed at 9:12 p.m. ("Not to exceed 1 for restraint"); Unusual Incident Report, UI DB #29086, dated 12/31/19.
[245] Doctor's Order for Restraint and Seclusion, dated 2/14/20, timed at 4:15 p.m. ("Not to exceed 1 for restraint"); Unusual Incident Report, UI DB #29370, dated 2/14/20. Here, a second order was not signed until 20 minutes before she was released from restraints. Doctor's Order for Restraint and Seclusion, dated 2/14/20, timed at 4:55 p.m.
[246] D.C. Code § 7-1231.02(9) (emphasis added).
[247] D.C. Mun. Regs. tit. 22A § 503.8.
[248] D.C. Mun. Regs. tit. 22A § 514.4, 514.7.
[249] D.C. Mun. Regs. tit. 22A § 514.6.
[250] SEH Policy 201-05(IV)(c) (2007).
[251] SEH Policy 201-05(IV)(C)(1) (Nov. 15, 2007) (emphasis added).

drugs as a restraint, in 2010, the hospital abruptly altered the definition of "drugs used as a restraint" in its "Involuntary Medication Administration" policy.[252] The new definition asserts that *any* drug administered that is a *standard treatment* for the patient's condition will no longer be considered a drug as a restraint even if it is not a part of the "consumer's regular, prescribed drug regimen."[253] Since drugs given in emergency situations are almost always psychotropic medications, which can be considered a standard treatment for many mental health conditions, the hospital now wrongly asserts that one-time, involuntary injections of powerful psychotropic medication -- injected against a patient's will -- are "a standard treatment" and exempts the action from the legal requirements of drugs used as a restraint. Forcibly injecting psychotropic medications -- an action which frequently involves multiple staff physically holding a patient down -- is not treatment. These injections are often combinations of powerful psychotropic medications. They have the potential for extremely serious side effects.[254]

Significantly, DBH's Office of Accountability has found that such staff action constitutes using drugs as a restraint. For example, DBH's investigative report of Keith Carter repeatedly refers to staff's action of injecting Mr. Carter with psychotropic medication after he was placed in mechanical restraints as drugs used as a restraint.[255] Not only does the report cite D.C. regulations governing the use of drugs as a restraint, the report notes "… [T]here was no statements or material rationale provided as to why Mr. [Carter] was required to be placed in Four-point Restraints and administered Drug Restraints," and that staff "failed to complete an array of procedural functions prior to the use of … Four Point Restraints and Drug restraint.[256]

B. St. Elizabeths Routinely Administers Drugs as a Restraint

St. Elizabeths' own reporting indicates that staff are using drugs as a restraint, which the Hospital refers to as "STAT Events," at equally alarmingly high rates. The hospital defines "STAT Events" as "emergency medication prescribed and administered to a person involuntarily,"[257] which, as discussed above, fits squarely in the definition of drugs used as a restraint under D.C. law.[258] In the first six months of 2020, hospital staff administered drugs as a restraint, or "STAT events" a disturbing 210 times.[259] In a one year period -- from July 2019

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[252] SEH Policy 201-05.

[253] The changed policy defines "drugs as a restraint" as a "drug or medication when it is used as a restriction to manage the individual's behavior or restrict the individual's freedom of movement and is **not a standard treatment or dosage for the individual's condition**." SEH Policy 201-05(II) (emphasis added). *Compare* to the District laws definition of "drugs used as a restraint" -- "a medication that is used in addition to or in place of the consumer's regular, prescribed drug regimen to control extreme behavior during an emergency, but does not include medications that comprise **the consumer's regular, prescribed medical regimen and that are part of the consumer's service plan**, even if their purpose is to control ongoing behavior." D.C. Code § 7-1231.02(9) (emphasis added).

[254] Side effects can include uncontrollable movements, such as ticks and tremors, seizures, vomiting, nausea, blurred vision and even death. *Mental Health Medication*, NAT'L INST. OF MENTAL HEALTH (Oct. 2016), https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml#part_149866.

[255] *See* Keith Carter DBH Investigative Report, dated 7/2/19.

[256] *Id.* at 5, 15.

[257] *See* St. Elizabeths PRISM reports.

[258] D.C. Code § 7-1231.02(9).

[259] St. Elizabeths PRISM Report June 2020 at 14. The PRISM report tracks "STAT Events," defined as "emergency medication prescribed and administered to a person involuntarily."

to June 2020 -- staff used drugs as a restraint 606 times.[260] Each incident typically involves administering or injecting a patient with multiple psychotropic medications, each requiring a separate doctor's order, thus, during this time period, there were an astounding 1,338 separate medication orders for drugs that were used as a restraint.[261]

Though St. Elizabeths has changed a policy definition of a legally recognized form of restraint thereby reducing its restraint statistics, it is essential that incidents of drugs as a restraint be classified as such and counted in the hospital's restraint statistics so that the hospital and the public are given an accurate account of how routinely hospital staff are engaged in this highly traumatizing, dehumanizing conduct. The current hospital policy circumvents D.C. law and renders all the protections pertaining to drugs used as a restraint unenforceable, thus depriving St. Elizabeths patients of valuable rights and essential legal protections.[262]

It is also disturbing that the Hospital has stopped providing the public with numerical information on how often seclusion and restraint are being used in the hospital, the number of serious incidents by ward location, and other information that gives the public important, significant information about the status of the Hospital. The public watched a deadly restraint kill George Floyd, and the public responded. The use of seclusion and restraint should never be hidden. Such conduct should be limited using every possible means with a goal to eliminate its use. And, importantly, any use should be scrutinized to ensure nothing could have been done to prevent it and it was done with all required protections. Hospital risk management should review incidents and carefully analyze when, where, and how often they take place so the Hospital can address problems. Limiting public oversight by limiting information provided to the public does not help the Hospital or its individuals in care. Ultimately, becoming less accountable results in the Hospital losing the trust of the public that supports it.

VII. CONCLUSION

St. Elizabeths Hospital's own vision statement professes that, "[o]ur team of clinicians and behavioral health support staff are committed to making sure that each person who comes through our doors is treated with respect, dignity, and sensitivity to spiritual and cultural norms."[263] Widely used, abusive restraints and seclusions are far from respectful or dignified treatment. Locking patients alone in their room, strapping their arms and legs to a bed, and forcibly injecting them with powerful psychotropic medications are all treatment failures. These extreme measures have no therapeutic value, cause suffering, may trigger severe pain from past trauma and frequently result in emotional and physical harm, and even death.

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[260] *Id.*

[261] St. Elizabeths PRISM Report June 2020 at 14.

[262] The legal protections include the standards and justification for initiating a restraint, monitoring during the restraint, and debriefing and monitoring procedures after the restraint. D.C. Code § 7-1231.09; D.C. Mun. Regs. tit. 22A § 514. Other protections include prohibiting drugs "with the intention of immobilizing the consumer's movements or rendering unconscious," a face-to-face assessment with the patient within one hour of the injection, assessments for injury or medical distress every fifteen minutes for two hours after the injection, and elicitation of vital signs. *Id.*

[263] *Saint Elizabeths Hospital*, DEP'T OF BEHAVIORAL HEALTH, https://dbh.dc.gov/page/saint-elizabeths-hospital.

Despite the assistance and input from a consultant who has significant experience in reforming abusive restraint and seclusion practices in institutional settings, St. Elizabeths' administration did not end unacceptably high rates of restraint and seclusion and pervasive abusive practices. Tragically, the trauma, fear, and humiliation that patients routinely suffer when being forced into restraints or seclusion could have been and should be prevented. The Department of Behavioral health must ensure these practices end.

VIII. RECOMMENDATIONS

1. DBH must hold St. Elizabeths Hospital leadership and administration accountable for the continued abusive restraint and seclusion practices at the hospital. The Department of Behavioral Health must ensure that St. Elizabeths' administration make significant, ***sustained*** reductions in the number of restraints and seclusions and ensure that abusive staff practices during restraints and seclusions end.

2. DBH must provide additional resources to the consultant so that her reforms are effectively implemented by all staff at the hospital. DBH and the hospital administration must set and meet clear goals, including the number of restraints and seclusions to be reduced each month, with the goal of eliminating the use of any restraints and seclusions.

3. St. Elizabeths, in conjunction with DBH, must ensure that that staff documentation of every restraint and seclusion is complete and accurate. Falsifying medical records cannot be tolerated or allowed to continue. Staff must understand that falsifying medical documentation is illegal and strictly against hospital policy. Staff who do so must be held accountable. DBH should require an audit by the Hospital's risk management of any instance of restraint, including an observation of any video of the incident, until the Hospital can demonstrate that staff are no longer falsifying documentation.

4. DBH must ensure that St. Elizabeths revise the current hospital policy definition of "drugs as a restraint" so that it complies with D.C. law.

5. DBH should reinstitute its prior practice of including tables in its published monthly data PRISM reports, which included the actual number of mechanical restraints, physical holds and seclusions. The hospital must also include every incident of drugs as a restraint in its restraint statistics as well to enable effective risk management and oversight. Moreover, the hospital should provide ward specific information as in the prior PRISM report in order to facilitate analysis and improvement.