



***Murder  
and  
Missed Opportunities  
To Save a Life  
at  
St. Elizabeths Hospital:  
A DRDC Investigation***

*December 2022*

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## Introduction

On March 9, 2022, Donald Howard,<sup>1</sup> a patient at St. Elizabeths Hospital was brutally murdered in his room by another patient (Patient #1). Inexplicably, Patient #1 was able to enter Mr. Howard's room unnoticed by any of the six clinical staff persons or the one security officer assigned to the unit that night.<sup>2</sup> Patient #1 was able to aggressively assault Mr. Howard *for more than thirty-five minutes* before staff finally discovered the gruesome scene.<sup>3</sup> By then it was too late. Mr. Howard lay bleeding on the floor with Patient #1's foot on his neck.<sup>4</sup> He was nonresponsive and was pronounced dead shortly afterwards.<sup>5</sup>

DRDC's investigation into the horrific incident, which included analysis of the videotape footage<sup>6</sup> of Mr. Howard's unit from prior to the killing to after the killing, reveals that all staff persons who were working that night on the unit grossly neglected their duties and failed to follow many Hospital policies. If the staff persons had been adhering to Hospital policies and fulfilling their required duties that night, they should have been able to intervene to prevent this horrible tragedy. The staff persons should have observed Patient #1's agitation and odd activity at three in the morning -- leaving and returning to his room *five times* during the thirty minutes prior to entering Mr. Howard's room.<sup>7</sup> If located where they were supposed to be stationed and monitoring the unit as required, the staff should have observed Patient #1 when he did enter Mr. Howard's room and/or they likely would have heard sounds of the violent assault.<sup>8</sup>

Unfortunately for Mr. Howard and his family, the staff persons failed to follow multiple Hospital policies that were designed to prevent just such incidents and protect the safety of the patients. *None* of the staff persons were monitoring the areas of the unit prior to and during the assault, as required by Hospital policy.<sup>9</sup> Nor did they appear to be observing the unit. Instead, they spent time behind the nursing station, which has tall Plexiglass panels completely covering the front of the station, looking at their cell phones, reading or talking to each other, on a computer, or, in some cases, not even on the unit where assigned.<sup>10</sup> Staff also failed to conduct security checks adequately, and failed to observe that Patient #1 was no longer in his room and that Mr. Howard was being assaulted in his room.<sup>11</sup>

## Hospital Policies

To ensure patient safety, St. Elizabeths policies require that all assigned staff be physically present in the milieu to actively observe, assess, and interact with the patients, including during the overnight hours.<sup>12</sup> Staff persons assigned to the front desk are required to observe the physical movement of the patients in the milieu, including when they come into

and out of bedrooms, showers and bathrooms.<sup>13</sup> Staff assigned to special safety observation status, such as providing one-to-one staff observation of a patient, must have the assigned patient within eyesight at all times so they can rapidly intervene if needed, even if the patient is in his room sleeping.<sup>14</sup> Hospital policy also expects that no more than two staff persons, in addition to the assigned front desk staff person, should be inside of the nursing station at any given time.<sup>15</sup> Additionally, the use of cellular telephones, electronic devices and the reading of magazines or newspapers are not permitted in patient care areas.<sup>16</sup>

Staff must conduct thorough security checks of the unit every thirty minutes.<sup>17</sup> When conducting security checks during hours of sleep, staff persons should directly observe that all of the patients are present and safe in their rooms.<sup>18</sup> In addition to the clinical staff, security officers assigned to the unit must be present on the unit to support the staff persons in monitoring areas that require added security.<sup>19</sup>

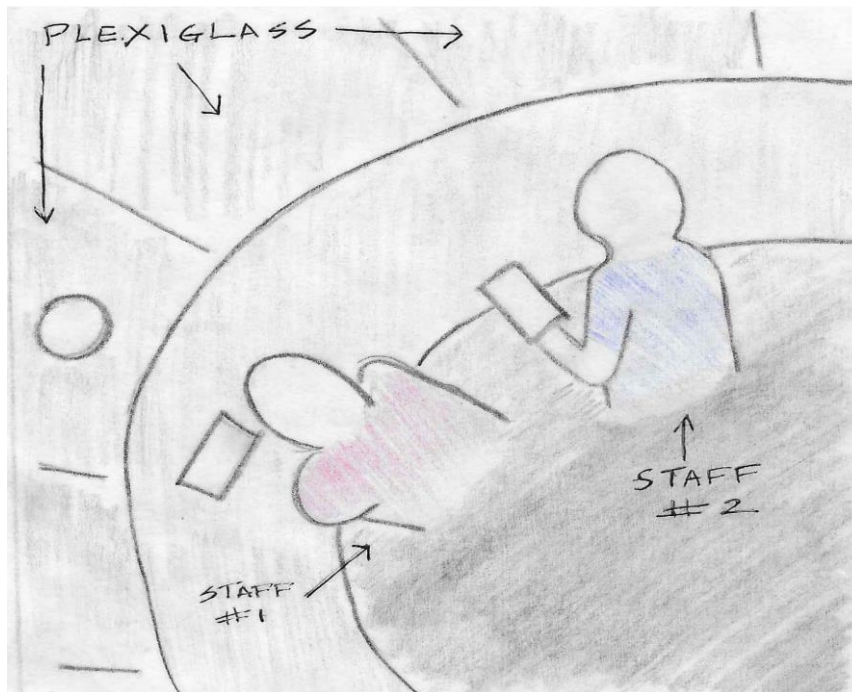
## Missed Opportunities

### **Missed Opportunity #1 – The Staff Persons Failed to Observe the Unit**

Videotape footage reveals that during the approximately thirty minutes prior to Patient #1 entering Mr. Howard's room, Patient #1 exited and returned to his bedroom *five times*.<sup>20</sup> Three times he walked up the hallway from his room to the bathroom, then returned to his room.<sup>21</sup> On one occasion he walked up the hall and out of the videotape camera area, then returned to his room.<sup>22</sup> The fifth time, he walked into the bathroom, then exited and entered Mr. Howard's room.<sup>23</sup> During these times, Patient #1 appears to be looking in the direction of the nurses' station; however, remarkably, no staff persons were actively observing the unit, and there is no evidence that any of the staff observed this unusual behavior or intervened at all.<sup>24</sup>

DRDC's videotape analysis shows that from approximately 2:30 a.m. until the time Patient #1 entered Mr. Howard's room at 2:52 a.m., none of the six staff persons were adequately observing the unit or adhering to Hospital policy.<sup>25</sup> Two staff persons can be seen sitting behind the nurses' station the entire time, mostly looking down at their cell phone or talking to other staff.<sup>26</sup> A third staff person can be seen behind the nurses' station periodically as well, and he also does not appear to be observing the unit.<sup>27</sup> The fourth staff person was not visible on the videotape footage that DRDC received and reviewed but reportedly entered the unit at approximately 2:30 a.m., briefly interacted with other staff and then entered an empty examination room, where he stayed until after staff discovered Mr. Howard's body.<sup>28</sup> A fifth staff person can either be seen intermittently speaking with the nurse in the room behind the nurses' station or is not visible on the videotape footage.<sup>29</sup> The charge nurse was in the room

behind the nurses' station looking at a computer or talking with other staff persons, except when he briefly conducted security checks as described below.<sup>30</sup>



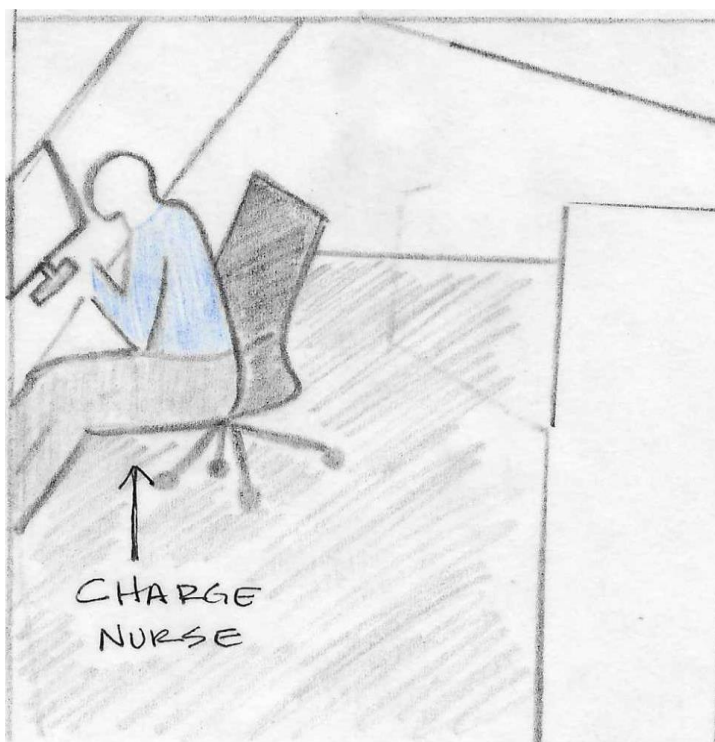
*Two staff at the nurses' station looking down at their cell phones.  
Tracing of videotape footage frame.<sup>31</sup>*

### **Missed Opportunity #2 – The Staff Persons Were Not at Their Assigned One-to-One Observation Posts**

In addition to the requirement that staff actively observe the unit, several staff persons were also assigned to provide close, one-to-one staff observation for two individual patients on the unit throughout the shift.<sup>32</sup> These patients' rooms were located in two separate hallways of the unit.<sup>33</sup> Per Hospital procedures and policies, the two staff persons should have been sitting in the hallway outside of the respective patient rooms at all times so the staff persons could directly observe the patients to whom they were assigned.<sup>34</sup> However, DRDC's videotape footage analysis does not show that any staff sat in any of the hallways outside of any patient rooms during the time analyzed, but were instead in locations behind the nurses' station or not present on the unit as described above.<sup>35</sup> Had the staff persons been at their assigned posts, they would have surely seen Patient #1's unusual behavior of exiting his room five times and then entering Mr. Howard's room. Moreover, they likely would have heard Mr. Howard struggle with Patient #1 fighting off his attacker.<sup>36</sup> They could have intervened appropriately and quickly -- likely preventing the tragic death.

### **Missed Opportunity #3 – The Staff Persons Failed to Observe Patient #1 Enter Mr. Howard’s Room**

Videotape footage shows that Patient #1 entered Mr. Howard’s room unseen and unnoticed at approximately 2:52 a.m.<sup>37</sup> At that time, two staff persons were seated behind the nurses’ station. They appear to be looking down at their cell phones.<sup>38</sup> A third staff person is difficult to see but appeared to be behind the nurses’ station as well.<sup>39</sup> Two other staff persons were not visible on the videotape – one was reportedly in the staff break room and the other was reportedly in an empty examination room.<sup>40</sup> The sixth staff person, the charge nurse, was in a room behind the nurses’ station looking at a computer.<sup>41</sup>



*Charge Nurse in a room behind the nurses' station looking at a computer. Tracing of Videotape footage frame.<sup>42</sup>*

A St. Elizabeths security guard was also assigned to Mr. Howard’s unit on the night of murder.<sup>43</sup> DRDC’s analysis of the videotape footage does not show that a security guard was present on the unit as required by Hospital policy.<sup>44</sup> If he had been present on the unit, he should have observed Patient #1 exiting his room multiple times and/or would likely have observed Patient #1 entering Mr. Howard’s room. The videotape footage shows that just before Patient # 1 entered Mr. Howard’s room, a security guard walked down the hallway approaching the outside locked door of the unit, then approximately 10 seconds later appeared again walking back up the same hallway.<sup>45</sup> Had he come on the unit and executed his duty of ensuring the safety of the unit – for even a few minutes, he likely would have observed Patient #1 enter Mr. Howard’s room or noted his agitated movements and intervened. Again, had any of the six clinical staff persons or the security officer been adhering to Hospital policy and doing

their required duties, it is highly likely one of them would have observed Patient #1 leaving his room and entering Mr. Howard's room and intervened to stop him.

#### **Missed Opportunity #4 – Staff Failed to Complete Security Checks Properly**

DRDC's analysis of the videotape footage reveals that the nurse conducted unit rounds twice prior to the time that Patient #1 entered Mr. Howard's room -- at approximately at 2:03 a.m. and 2:42 a.m.<sup>46</sup> During the 2:42 a.m. check, the nurse failed to complete the checks thoroughly, and failed to shine the flashlight through the room window of Patient #1 or Mr. Howard.<sup>47</sup> At 3:09 a.m., *seventeen minutes after Patient #1 entered Mr. Howard's room*, the nurse completed unit rounds again.<sup>48</sup> Although videotape footage shows that the nurse briefly shined a flashlight through the window of Patient #1's room, he appears to have overlooked the room and did not notice that Patient #1 was not in his room.<sup>49</sup> Even more tragically, the nurse again failed to look in Mr. Howard's room during the 3:09 a.m. security check as required by Hospital policy. Inexplicably, he walked right past Mr. Howard's room with his head down shining his flashlight on the floor.<sup>50</sup> If he had shined his light through the window of Mr. Howard's room, he could have observed the assault taking place inside of the room and intervened.



*Charge Nurse walking by Mr. Howard's room looking down and shining a flashlight on the floor seventeen minutes after Patient #1 entered the room. Tracing of videotape frame.<sup>51</sup>*

The nurse's rounds lasted less than two minutes, and he then returned to the nurses' station.<sup>52</sup> DBH's investigation also revealed that the nurse falsely documented that he observed Patient #1 and Mr. Howard in their beds at this time, an obvious impossibility.<sup>53</sup>

## **Missed Opportunity #5 - Staff Failed to Provide Immediate Emergency Intervention**

The St. Elizabeth's Unusual Incident Report and nursing progress notes describing the incident state that when the nurse observed Patient # 1 in Mr. Howard's room, he saw Mr. Howard in a supine position on the floor, and that Patient #1 had his foot on Mr. Howard's neck.<sup>54</sup> The nurse documented that he called a "Code Blue," then entered the room and shook Mr. Howard, but that Mr. Howard was unresponsive.<sup>55</sup> However, videotape footage reveals *he did not enter the room for approximately three and a half minutes*; therefore, the nurse falsified the documentation.<sup>56</sup> He failed to immediately assess Mr. Howard or provide resuscitative measures, which Hospital policy required,<sup>57</sup> but instead ran down the hallway to the nurses' station.<sup>58</sup> In fact, no staff physically entered the room to assess Mr. Howard directly, begin CPR or other resuscitative measures for approximately three and a half minutes when the nurse brought the crash cart into the room.<sup>59</sup> Videotape footage shows that inexplicably, Patient #1 *was able to remain in Mr. Howard's room for over three minutes after Mr. Howard's body was discovered*, at which time he can be seen exiting the room.<sup>60</sup>

## **Conclusion**

Mr. Howard was loved and is very much missed by his family. His daughter reported that he was "always happy, upbeat and witty" and that "he would do anything in the world for me or any of his other children and grandchildren."<sup>61</sup> According to an interview with the Washington Post shortly after his death, his sister reported that he struggled with mental illness but that he did not deserve a brutal murder.<sup>62</sup> "It's just hard to think that he died the way he did ... He died a violent death in a place where you'd think he would be safe."<sup>63</sup>

In the early morning hours of March 9, 2022, many critical opportunities were missed and so were possible responses that likely could have prevented this horrible murder. All six clinical staff persons assigned to the unit that night neglected their duties, which not only contributed to an unsafe environment leading to Mr. Howard's death, but also placed all the patients on the unit at risk. Prior to and during the attack, staff remained mostly behind the nurses' station -- distracted by talking to each other, on their cell phones or reading, or were not even present on the unit. They failed to notice Patient #1 entering and exiting his room multiple times. They failed to observe Patient #1 enter Mr. Howard's room. They failed to follow policy when completing security checks. They inexplicably did not hear the sounds of a violent assault occurring in Mr. Howard's room. They failed to prevent this tragedy, and Mr. Howard may have paid for their neglect with his life.



## Recommendations

After Mr. Howard’s tragic death, the Department of Behavioral Health conducted a thorough investigation, which confirms DRDC’s report findings and which provided recommendations.<sup>64</sup> The DBH investigation discovered critical information needed for the hospital to use to address its failures. Now the Hospital must take all steps needed to ensure that the patients entrusted to its care are safe and free from abuse and neglect and that this type of tragedy does not occur again. DRDC makes the following recommendations:

1. The Hospital should routinely review videotape footage from all units, with an emphasis on evening and night shifts, to ensure that staff are carrying out their duties and following all hospital policies. The results of these audits should be included in the Hospital’s monthly public PRISM reports.
2. The Hospital administration and/or the Hospital supervising RN (who are assigned and present 24 hours a day) should adopt the practice of conducting frequent, random, unannounced visits to all units on the evening and night shifts to ensure that all staff are fulfilling their assigned duties adequately and are following all Hospital policies. The results of this monitoring should be included in the Hospital’s monthly public PRISM reports.
3. The Hospital administration must ensure that the RNs and nursing leadership on all units are actively monitoring staff and the units to confirm that all staff persons are fulfilling their assigned duties adequately and are following all Hospital policies. The administration **MUST** hold the RNs and the nursing leadership accountable if they fail to ensure that all staff are adhering to their assignments and Hospital policies.

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<sup>1</sup> Pseudonym used to protect patient privacy.

<sup>2</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 2:52 a.m. (March 9, 2022).

<sup>3</sup> According to the Department of Behavioral Health Investigation (DBH) Report, a DC Metropolitan Police affidavit noted that: “The decedent was observed lying supine next to the bed with apparent blood on the floor in the area of the decedent. A pillow with apparent blood was observed between the decedent’s feet. Bed sheets with apparent blood were located against the wall next to the bed. Apparent blood was also observed on the mattress of the bed as well as on the wall. ... [Patient #1] was observed with scratch marks on his face and chest.” Dep’t of Behav. Health Investigation Report at 26, 27 (April 27, 2022).

<sup>4</sup> Dep’t of Behav. Health Major and Unusual Incident Form, St. Elizabeths Hospital (March 9, 2022).

<sup>5</sup> *Id.*

<sup>6</sup> Videotape cameras are not placed in patient rooms for privacy reasons.

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<sup>7</sup> Videotape footage shows that Patient #1 exited his room at approximately 2:24 a.m., 2:26 a.m., 2:36 a.m., 2:41 a.m., and 2:50 a.m. Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 2:52 a.m. (March 9, 2022).

<sup>8</sup> *Id.* at 2:52 a.m. to 3:28 a.m. The DBH investigation report confirms that if staff persons had been at their assigned positions, it is plausible the death may have been deterred. See Dep't of Behav. Health Investigation Report at 4 (April 27, 2022).

<sup>9</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 3:28 a.m.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> SEH Nursing Procedure Manual: *Assignment of Care*, Procedure #12 (Revised March 6, 2018).

<sup>13</sup> SEH Nursing Procedure Manual: *Assignment of Care*, Procedure #14 (Revised March 6, 2018).

<sup>14</sup> SEH Nursing Procedure Manual: *Level of Observation* (III) (A) (2). (Revised October 14, 2011); See also SEH Policy 102.11.

<sup>15</sup> SEH Nursing Procedure Manual: *Assignment of Care*, Procedure #12 (Revised March 6, 2018).

<sup>16</sup> *Id.* at "Policy" section.

<sup>17</sup> SEH Nursing Procedure Manual: *Security Checks and Unit Safety*, Section III (Revised October 18, 2020).

<sup>18</sup> *Id.*

<sup>19</sup> See SEH Policy 406.00 (Effective Date March 18, 2020).

<sup>20</sup> Videotape footage shows that Patient #1 exited his room at approximately 2:24 a.m., 2:26 a.m., 2:36 a.m., 2:41 a.m., and 2:50 a.m. Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 2:52 a.m. (March 9, 2022).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* DBH report confirms Patient #1 seemed to be looking for staff whereabouts prior to entering Mr. Howard's room. Dep't of Behav. Health Investigation Report at 8 (April 27, 2022).

<sup>25</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:30 a.m. to 2:52 a.m. (March 9, 2022). The DBH Investigation Report confirms DRDC's videotape analysis findings and notes the following:

- Staff #1 was reportedly assigned to the front desk until 3:00 a.m., then assigned as one-to-one staff from 3:00 a.m. to 4:00 a.m.; however, she remained behind the nurses' station until staff discovered Mr. Howard's body.
- Staff # 2 was assigned as one-to-one staff observation from 1:00 to 3:00; however, she too remained behind the nurses' station until staff discovered Mr. Howard's body.
- Staff # 3 was assigned one-to-one patient observation from 1:00 a.m. to 3:00 a.m.; however, he "was seen on video during this time frame sitting behind the nursing station reading a book, sitting in the vestibule/entry hall on his cell phone, in the milieu on his cell phone, and pacing throughout the milieu. While sitting in the vestibule using his cell phone, his body was not facing the direction of the unit milieu, making it impossible for him to keep line of sight supervision on [the patient] per his assignment."
- Staff # 4 was scheduled to cover the front desk, between 2:00 a.m. and 3:00 a.m. However, he was not on the unit until 2:29 a.m. -- where he remained behind the nursing station for approximately 50 seconds before leaving and entering the examination room, remaining there for approximately 25 minutes, which was during the time that Patient #1 entered Mr. Howard's room.
- Staff # 5 was assigned to one-to-one patient observation from 3:00 a.m. to 5:00 a.m.; however, he was not in a patient care area of the unit when patient #1 entered Mr. Howard's room at approximately 2:53 a.m., nor was he on a scheduled break. He positioned himself at the beginning of the hallway at approximately 3:04 a.m.; however, if he had been outside of the assigned patient's room as required, he should have heard the struggle or Mr. Howard's pleas for help.
- Staff # 6 was the assigned charge nurse.
- Staff # 7 was the security officer assigned to the unit; however, he exited the unit at approximately 12:23 a.m., and he did not return until after the incident.

Dep't of Behav. Health Investigation Report at 4 - 8 (April 27, 2022).

<sup>26</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:30 a.m. to 2:52 a.m. (March 9, 2022).

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- <sup>27</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:30 a.m. to 2:52 a.m. (March 9, 2022).
- <sup>28</sup> Dep't of Behav. Health Investigation Report at 7 (April 27, 2022).
- <sup>29</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:30 a.m. to 2:52 a.m. (March 9, 2022).
- <sup>30</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:30 a.m. to 2:52 a.m. (March 9, 2022).
- <sup>31</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:45 a.m. (March 9, 2022).
- <sup>32</sup> See Dep't of Behav. Health Investigation Report at 6, 7 (April 27, 2022).
- <sup>33</sup> *Id.*
- <sup>34</sup> SEH Nursing Procedure Manual: *Level of Observation* (III) (A) (2). (Revised October 14, 2011); See also SEH Policy 102.11.
- <sup>35</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 3:28 a.m. (March 9, 2022).
- <sup>36</sup> *Id.*
- <sup>37</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:52 a.m. (March 9, 2022).
- <sup>38</sup> *Id.* The DBH investigation report confirms that at the time Patient #1 entered Mr. Howard's room, the nurse was in the rear of the nursing station and three staff persons were at the nursing station. One staff person was in the staff break room and the sixth staff person was still in the examination room. Dep't of Behav. Health Investigation Report at 13 (April 27, 2022).
- <sup>39</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:52 a.m. (March 9, 2022).
- <sup>40</sup> Dep't of Behav. Health Investigation Report at 7 (April 27, 2022).
- <sup>41</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:52 a.m. (March 9, 2022).
- <sup>42</sup> *Id.*
- <sup>43</sup> The DBH investigation report notes that a Special Police Officer was assigned that night to support the Unit staff persons and provide extra coverage on the forensic units. According to the evidence reviewed, the security officer exited Unit 1D at approximately 12:23 a.m., and he did not return until after this incident, in violation of Hospital policy. "[The security officer's] sole purpose of being contracted to work on Unit 1D was to provide additional support to the SEH staff persons. [His] presence in the milieu may have been a deterrent to [Patient #1]." Dep't of Behav. Health Investigation Report at 8 (April 27, 2022).
- <sup>44</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 2:22 a.m. to 2:52 a.m. (March 9, 2022). See SEH Policy # 403.00.
- <sup>45</sup> *Id.* at 2:51:31 a.m. to 2:51:44 a.m.
- <sup>46</sup> *Id.* at 2:03 a.m., 2:42 a.m.
- <sup>47</sup> *Id.* at 2:43 a.m.
- <sup>48</sup> *Id.* at 3:09 a.m.
- <sup>49</sup> *Id.* at 3:10 a.m.
- <sup>50</sup> *Id.*
- <sup>51</sup> Videotape: Security Footage of St. Elizabeths Unit 1D at 3:09 a.m. (March 9, 2022).
- <sup>52</sup> *Id.* at 3:12 a.m.
- <sup>53</sup> The DBH Investigation Report notes that the nurse falsely reported to DC Metropolitan Police that at approximately 3:00 a.m., he observed Mr. Howard asleep in his bed and Patient #1 awake moving around in his room. The Report also notes that the nurse documented this false information on the Safety-Security Check form. Dep't of Behav. Health Investigation Report at 5 (April 27, 2022).
- <sup>54</sup> Clinical Records RN Progress Note, dated 3/9/22; Dep't of Behav. Health Major and Unusual Incident Form (March 9, 2022).
- <sup>55</sup> Clinical Records RN Progress Note, dated 3/9/22; Dep't of Behav. Health Major and Unusual Incident Form (March 9, 2022).
- <sup>56</sup> Videotape: Security Footage of St. Elizabeths Unit 1D 3:28 a.m. to 3:31 a.m. (March 9, 2022).
- <sup>57</sup> St. Elizabeths Hospital Policy 107.00 (IV)(A)(2). The DBH report corroborates that the charge nurse failed to provide emergency intervention, noting that the nurse should have immediately intervened, and that SEH Policy stipulates that the first nurse on the scene should provide all emergency interventions as appropriate, such as initiating or continuing cardiopulmonary resuscitation (CPR). Dep't of Behav. Health Investigation Report at 6 (April 27, 2022).
- <sup>58</sup> Videotape: Security Footage of St. Elizabeths Unit 1D 3:28 a.m. to 3:31 a.m. (March 9, 2022).
- <sup>59</sup> *Id.*

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<sup>60</sup> *Id.* A nurse from another unit (Nurse # 2) who responded to the “Code Blue” reported that, when he came on the unit, three staff persons, including the unit charge nurse, were standing in the hallway outside of Mr. Howard’s room. When they entered the room, Nurse # 2 reported that blood was smeared on the floor, and Patient #1 was still in Mr. Howard’s room standing against the wall looking down at Mr. Howard who was lying on the floor. Nurse # 2 reported that he (Nurse # 2) stated to the unit staff persons, “Why the hell is [Patient # 1] still standing in this room? Get him the hell out of here. This man (Mr. Howard) is blue (with) no movement, rising or falling of the chest!” Dep’t of Behav. Health Investigation Report at 38 (April 27, 2022).

<sup>61</sup> Email from Mr. Howard’s daughter to DRDC (December 12, 2022).

<sup>62</sup> Justin Moyer, *He was supposed to be safe in a mental hospital. Police say a fellow patient killed him*, Washington Post (March 19, 2022). <https://www.washingtonpost.com/dc-md-va/2022/03/19/st-elizabeths-psychiatric-homicide-patient/>

<sup>63</sup> *Id.*

<sup>64</sup> Dep’t of Behav. Health Investigation Report at 9 (April 27, 2022).