VOPA INVESTIGATION REPORT

DEATH OF EO

VOPA CASE NO. 882009

Virginia Office for Protection and Advocacy

INTRODUCTION

EO was a 70-year-old female psychiatric patient who died by asphyxiation due to aspiration of a cloth undergarment during her hospitalization at Eastern State Hospital (ESH) on September 2, 2007. The death of EO ensued from the failures of ESH to provide a safe environment due to its improper supervision and incompetent monitoring of patients.

Prior to her death, EO exhibited psychotic symptoms by intermittently expressing delusional thoughts and hyper-religiosity, stating that God was trying to communicate to her. Concurrent to these manifestations, she informed staff personnel that God told her to swallow her underwear and that she had tried to do so. She complained of a sore throat, experienced bladder problems, incontinence, and refused her meals. The night of her death, EO was found on the bathroom floor, not breathing and unresponsive, with underwear blocking her airway. This investigation raises questions regarding the exacerbation of EO's mental health symptoms and how her treatment team's failure to address these symptoms in a timely manner contributed to her death.

ESH was negligent in failing to abide by the requisite federal, state, and hospital regulations that aim to preserve the fundamental rights of admitted patients. The omission of statutorily prescribed safeguards demonstrates an inadequate exercise of professional judgment by ESH and an inept implementation of its duty to provide necessary care. As the following investigation report reveals, the death of EO was most likely subject to ESH's negligence in its failure to provide proper protection to its patients from the threat of imminent bodily harm or death.

I. Summary of Facts

EO was a 70-year-old woman with a long history of psychiatric illness and multiple psychiatric hospitalizations. EO was admitted to the Hancock Geriatric Center at ESH on an involuntary basis on September 22, 2005; this was her fourteenth state hospital admission. During this hospitalization she was determined to be ready for discharge on multiple occasions. Her record indicates that she was resistant to discharge, would begin to decompensate psychiatrically whenever discharge was imminent, and would then be taken off of the ready-for-discharge list. During December 2006, EO maintained a stable mood and was subsequently recommended for discharge. By March 2007, while waiting for community placement, she began to decompensate and to refuse medications. A review of EO's chart indicated that her psychotic symptoms persisted and that she intermittently started expressing delusional thoughts and hyper-religiosity, stating that God was trying to communicate with her. On August 26, 2007, EO reported to a Direct Service Attendant (DSA) that God had told her to swallow her underwear and that she had attempted to swallow them, and as a result complained of a sore throat. On September 2, 2007, EO was found on the bathroom floor unresponsive. EO had apparently attempted to swallow her underwear which reportedly blocked her airway and she subsequently died. The medical examiner reported that the cause of death was "asphyxia due to aspiration of a cloth undergarment." [1]

II. Summary of Findings

ESH failed to adequately implement EO's plan of care which provided that the facility would "provide a safe and structured environment," and that staff "would assist with self care tasks as needed" and "would provide assistance with toileting as needed."

[1] Medical Examiner's Report, February 18, 2008

The plan of care also indicated that EO was under falls risk precautions. ESH failed to comply with the hospital's standard procedures for accounting for patients by failing to adequately supervise and monitor EO.[2] This failure is evidenced by the statements of a DSA, who was assigned the duty of conducting fifteen minute checks of EO between the hours of 11:30 p.m. on September 1, 2007 and 2:00 a.m. on September 2, 2007. The statements made by the DSA include that she was "in the day area location and was not able to see the bathroom" and that she "can't recall how she knew she [EO] was in the bathroom." These failures constitute neglect within the meaning of the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act and Virginia state law.

III. Methodology

The Virginia Office for Protection and Advocacy (VOPA) conducted this investigation pursuant to the authority granted to it by the Protection and Advocacy for Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. §10801, *et seq.,* and Virginia Code §51.5-1, *et seq.*

In the course of this investigation, VOPA:

A. Obtained and reviewed records from

1. ESH/Hancock Geriatric Center
2. James City County Fire Department
3. James City County Police Department
4. ESH Police Department
5. Office of the Chief Medical Examiner, Virginia Department of Health

B. Conducted interviews with:

1. ESH/Hancock Geriatric Center staff and treatment team members
2. ESH Chief of Police and police officer

[2] Eastern State Hospital Standard Operating Procedure Number 280-Z "Accountability for Patients in Units."

3. ESH/Hancock Geriatric Center former staff
4. James City County Fire Department – Emergency Response Team members
5. James City County Police – telephone interview
6. Chief Medical Examiner – clarification of autopsy report *(email)*

IV. Facts

A. Background

EO was born in Charleston, West Virginia and was an only child. EO completed the twelfth grade and worked as a secretary for public health in Norfolk, Virginia. She was married in 1963 and had a son in 1974. EO had her first psychiatric hospital admission in 1964. EO had multiple psychiatric hospitalizations, including 14 state hospital admissions. Her most recent admission was to Riverside Behavioral Center in Hampton, Virginia and she was subsequently transferred to ESH on September 22, 2005. During her hospitalization at ESH she had multiple periods of stabilization and was referred for discharge on at least two occasions. Her record indicated that she was "resistant" to discharge, would decompensate when discharge was imminent, and would then require further psychiatric stabilization.

During EO's course of treatment at ESH, she showed mood symptoms, psychotic symptoms with paranoid delusions, and agitation. According to EO's ESH record, with medication she showed improvement in self care, attended activities, and showed improvement in social interactions. However, psychotic symptoms persisted and she intermittently expressed delusional thoughts and hyper-religiosity, stating that God was trying to communicate with her.

B. Chronology of events of August 21, 2007 – September 2, 2007

The following chronology is taken from records obtained from ESH/Hancock Geriatric Center, James City Fire Department, James City County Police, Eastern State Police, and from individual interviews.

August 21, 2007

- Patient [EO] received reading her bible loud in her alcove and she was crying during change of shift. Patient [EO] continued to use walker for ambulation. *(Interdisciplinary Note)*

August 22, 2007

- Received report from LPN around 2:30 A.M. that patient [EO] approached her in the nurse's station requesting to wash her underwear with some blood on it. The blood was noted around the garter of the white panty. When asked where the blood came from, she [EO] stated that she spit saliva on the panty and that her throat was sore when she swallows. (Order to give salt water to gargle with by MOD, which patient [EO] accepted). *(Interdisciplinary Note)*

August 23, 2007

- Patient wandering the ward with her walker making bizarre statements about needing to hear what God is saying and asking staff what he is saying to them as she can't hear him. Restless at times but not intrusive. Can be seen talking to unseen others and responding to internal stimuli. Accepting meds and treatments at this time. *(Interdisciplinary Note)*

August 26, 2007

- Patient up throughout the night, patient in bathroom for most of the night washing, patient stated that she keeps having accidents on herself. Patient also stated that earlier throughout night that God was telling her to swallow her underwear and that she did try to. Patient then c/o on night shift that as a result her throat was sore, LPN notified but no documentation is found in ID note. Patient is currently in bed resting with her eyes closed....*(Interdisciplinary Note)*

August 28, 2007

- Patient was in the dayroom during change of shift. During the evening shift patient was crying and talking about the bible, she kneel down on the floor in the dayroom and start praying and crying. She also stated that "she was dirty and something was wrong with her bladder". Patient ate 50% of her meal and was crying while eating. At present patient was in her bed asleep. *(Interdisciplinary Note)*

- Patient pacing all around the ward, crying to herself and then falling to the floor. Patient been incontinent of bowel today, twice so far. Patient been

very delusional saying she don't know what God wants or is saying to her. *(Interdisciplinary Note)*

- Patient is alert and oriented to place, person, responded when spoken to, showed improvement in self care. She continues to express delusional thoughts. She reported difficulty sleeping. She reported hearing voices that disturbed her. She later explained that the voices were from God, telling her different things, sometime telling her how bad she was. She displayed labile affect, she was quickly tearful, while expressing her thoughts. She denied any command hallucinations, no visual hallucinations. No thoughts of feeling hopeless, helpless. No suicidal or homicidal thoughts. Her insight is poor. Dx: Schizoaffective disorder. Continues to have psychotic symptoms, labile mood. Patient is offered supportive therapy with reminiscence, reality testing. Plan to titrate Risperadal dose to 2mg PO HS, no adverse effect noted. *(Physician Progress Notes) (During the interview of the physician he indicated that he conducted this evaluation as a direct result of his finding the August 26, 2007 Interdisciplinary Note indicating the command hallucinations).*

<u>August 29, 2007</u>

- Wander about the ward at times making disjointed comments or conversing with unseen others. Talks frequently about GOD talking to her. She refused her meal this shift even though staff encouraged her to eat due to her diabetes. She kept needing staff to sit her down in front of her tray as she would get up and walk away. Uses her walker ambulating around the ward. Incontinent of urine but will not wear briefs insisting on wearing regular underwear and washing them out by hand in the bathroom and laying them out to in her room to dry. *(Interdisciplinary Note)*

<u>August 31, 2007</u>

- Patient refused her breakfast and lunch stating "I just don't want it". Patient [has] been crying off and on today to herself, peers and staff, at this time patient is on the phone crying and talking to the social worker, I believe. *(Interdisciplinary Note)*

- Patient received sitting on the dayroom during change of shift. Patient asked for her ADL box and wants to start washing herself in the beginning of the shift. Patient was told ADL care will be done after dinner. Patient keep knocking on nursing station ask for a lot of things and sometimes she forgot what to say and stated "never mind". At present patient was quietly resting. *(Interdisciplinary Note)*

<u>September 1, 2007</u>

- Patient resting in bed eye[s] closed during change of shift, patient slept through the night, got up in morning performed ADL care, pleasant to staff, noted no behavioral problems. *(Interdisciplinary Note)*

September 2, 2007

- **(00:30)** Building 32 Ward D – Incontinent changes started on the ward. *(Interview with DSA)*

- **(00:45)** EO in bed awake; she had been asleep; some indication that she was awake, not sure what it was. *(Interview with DSA)*

- **(01:00)** EO was in the bathroom; can't recall how she knew she was in the bathroom; bedside commode was recently used. *(Interview with DSA)*

- **(01:10)** DSA II called on 222 for patient EO who was found on the floor, no pulse, not breathing, unresponsive. James City County Police, ESH Police, MOD and Nursing Officer all notified.*(ESH Information Center Report)*

- **(01:12)** I saw EO laying against the floor, so I went up to her and shook her and called her name and she didn't respond, so I yelled out to the nurse, the nurse was only a couple of doors away and she ran in … *(Interview with DSA)*

- **(01:18)** Rescue Squad on scene per ESH Police Officer. *(ESH Information Center Report)*

- **(Exact time unknown – During the time that the rescue squad was on the scene)** James City County Police directed one of their officers to go and check the patient's room to ensure that nothing appeared suspicious or unusual. At this point, ESH Police advised James City County Police Officer that he would have to remove his sidearm and secure it before he could be permitted to enter the building. I [Supervisory Officer] then advised that, because of the nature of the incident, I would not permit the James City County Police Officer to enter the building without his sidearm because of safety concerns and lawful authority. ESH Officer then proceeded to contact his Chief to inform him of the situation. His Chief stated that no firearms would be permitted inside the building and then advised that the Eastern State Hospital Police would handle the incident, adding that our assistance was not needed. At this point, JCC officers cleared the scene. *(James City County Police Report)*

- **(Exact time unknown – During the time that the rescue squad was on the scene)** After about 5 minutes I [ESH Officer] re-entered the building to see if they [rescue] needed any help unlocking the doors to exit. The person in charge of the rescue squad (white male, medium height) came out of the bathroom with a pair of women's panties in his gloved hand and held them out for me to take. He announced to everyone something along the lines of, "we've got to keep these. We think there may have been a

sexual assault and these were shoved down her [EO's] throat to shut her up". I said, "I'm not going to touch these, I need an envelope", and ESH staff got an 8x10 manila envelope that we use for internal mail and gave it to me. I held the envelope out and the fire dept. man dropped the panties in. *(Statement provided by, ESH Police Officer)*

- **(01:37)** Patient was observed on the bathroom floor by ESH DSA laying on her face turned towards the wall with her left arm noted underneath her between her legs. She was noted unresponsive when DSA called her name. DSA called the nurse for help as she was also assisting another patient to the bathroom. LPN immediately responded. She was found to be unresponsive and pulse less. She immediately directed staff to call 222. This writer [RN] and RNM1 were notified and immediately responded to the ward. CPR was administered. MOD was notified. The rescue squad arrived. *(Interdisciplinary Note)*

- **(01:55)** Rescue Squad departing at this time to SWRMC with patient. Nurse [Administrator on Duty] notified Facility Director. MOD notified patient's cousin [Authorized Representative & Next-of –Kin]. *(ESH Information Center Report)*

- **(02:07)** Arrived at Emergency Department – Sentara Williamsburg Community Hospital. *(Emergency room documentation)*

- **(02:17)** Pronounced at SWRMC at this time. ME will be called later in the A.M. Physician notified. Funeral arrangements are with Funeral Home, Smithfield, VA. RNC notified. *(ESH Information Center Report)*

<u>October 15, 2007</u>

- Ms. EO was a 70 yr. old white female admitted to ESH on involuntary status as a transfer from Riverside Behavioral center on September 22, 2005. Prior to her death, the patient was displaying bizarre behavior. Due to the circumstances related to her death the morality review committee should review the cause of death. *(ESH Mortality Review – Prescreening Criteria)*

<u>February 18, 2008</u>

- This was a 70 year old schizophrenic patient at Eastern State Hospital who had been complaining to staff that God was telling her to eat her underwear. She was found unresponsive at Eastern State Hospital with underwear blocking her airway. The underwear was removed by EMS and she was transported to Sentara Williamsburg Regional Hospital where she was pronounced dead. The cause of death is asphyxia due to aspiration of a cloth undergarment. *(Report of Investigation by Medical Examiner/Investigator – Autopsy T-449-07)*

V. Findings

A. EO was the victim of "neglect" as defined by the PAIMI Act.

1. The PAIMI Act

a. Definition of "Neglect"

> The term "neglect" means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to a [sic] individual with mental illness or which placed a [sic] individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for a [sic] individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to a [sic] individual with mental illness, or the failure to provide a safe environment for a [sic] individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff. [3]

b. Definition of "Facility"

> The term "facilities" may include, but need not be limited to, hospitals, nursing homes, community facilities for individuals with mental illness, board and care homes, homeless shelters, and jails and prisons. [4]

c. Definition of "Individual with a Mental Illness"

> The term "individual with mental illness" means…an individual – (A) who has a significant mental illness or emotional impairment, as determined by a mental health professional qualified under the laws and regulations of the State; and (B)(i)(I) who is an inpatient or resident in a facility rendering care or treatment…[5]

B. ESH committed "neglect" as defined in the PAIMI Act.

[3] 42 U.S.C. § 10802(5)
[4] 42 U.S.C. § 10802(3)
[5] 42 U.S.C. § 10802(4)(A)-(B)(i)(I)

Based upon the evidence in this case, VOPA finds that EO was the victim of "neglect" as defined by the PAIMI Act. In other words, VOPA finds that individuals "responsible for providing services in a facility rendering care or treatment" committed "negligent act[s] or omission[s]" and that these acts or omissions caused the death of EO, an individual with a mental illness.

1. ESH is a "facility" under federal law and EO was as an "individual with a mental illness."

As a hospital for individuals with mental illnesses, ESH unambiguously qualifies as a "facility" under PAIMI. Likewise, given that EO had a long history of psychiatric illness, that this illness has been verified by mental health professionals, and that she was resident at ESH at the time of her death, there is no doubt that EO qualifies as an "individual with a mental illness" as defined by the PAIMI Act.

2. The actions or failure to act on the part of individuals responsible for providing services at ESH constituted negligent acts or omissions and resulted in a failure to provide EO with a safe environment.

VOPA has identified two principal negligent acts or omissions in this case: (1) the failure of ESH staff to adequately supervise and monitor EO; and (2) the failure of ESH staff to adequately report and respond to allegations that EO was sexually assaulted and to respond to other incidents of neglect. Both are part of a greater failure: the failure to provide a safe environment to an individual with a mental illness. The provision of a safe environment is fundamental; not only is it required under ESH's "Plan of Care" for EO, the failure to provide a safe environment is specifically cited in the PAIMI Act as constituting neglect.

The evidence in this case shows that ESH staff failed to adequately supervise and monitor EO. According to their interdisciplinary notes, staff knew on August 26, 2007 that EO was experiencing auditory hallucinations in which God was telling her to swallow her underwear. In the days leading up to EO's September 2, 2007 death, EO continued to exhibit abnormal behaviors (i.e. crying while reading the Bible and while praying; saying that something was wrong with her and that she couldn't understand what God was trying to tell her; experiencing bladder problems, incontinence, and loss of appetite; having difficulty sleeping; experiencing delusions, a labile affect, and psychotic symptoms; hearing voices; making frequent references to God, etc.).

Despite all of these problems, the staff member in charge of checking on EO at 15 minute intervals did not enter EO's room to make her 1:00 a.m. check on September 2, 2007. Instead, the staff member stayed in the dayroom. Although she later claimed EO had been in the bathroom during the 1:00 a.m. check, the staff member was unable to explain how she could have ascertained EO's whereabouts given her location in the dayroom. The staff member's conduct in this case violates ESH's Standard Operating Procedure Number 280-Z (Accountability for Patients in Units). This operating procedure states that "[n]ursing staff are accountable to know the whereabouts of their assigned patients at all times and to communicate that information to the charge nurse…If patients are in their rooms or have their heads covered, staff must enter the room and use a flashlight, if necessary, to verify that patient is in bed and is breathing (note rise and fall of chest) and is identified by his/her face." As this procedure indicates, the staff member is required to verify the exact location of the patient and determine whether the patient is breathing. In other words, staff cannot stay in the dayroom and

make a guess about the whereabouts of a patient. These requirements are not mere formalities – as the ESH operating procedure says, they are necessary to “ensure [that] patients are residing in a safe environment.”[6]

The evidence shows another “omission” by ESH staff: their failure to respond to and report allegations that EO was sexually assaulted. As noted above, responding emergency personnel expressed their concern that EO may have been sexually assaulted. However, instead of following proper procedure under both and the ESH and Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) Department policy, ESH did not launch an investigation.[7]

In addition, through its investigation VOPA identified multiple acts of neglect on the part of hospital staff, yet ESH’s director failed to initiate an abuse and neglect investigation as required by DMHMRSAS Departmental policy.[8] The hospital director also failed to follow his hospital’s own policy which clearly states that upon the receipt of an allegation of abuse or neglect, the hospital director must act to secure the incident scene and preserve any evidence until collected by an assigned investigator.[9] ESH Police collected evidence at the scene of the incident and failed to protect, preserve or even retain the evidence which is clearly not in conformance with acceptable Virginia law

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[6] The staff member’s conduct in this case also likely violated EO’s “Plan of Care”. EO’s “Plan of Care” states that EO requires assistance with self-care and toileting. It also lists EO as being a fall-risk. If staff had suspected that EO was the bathroom, they should have seen if she needed assistance and checked on her to make sure that she hadn’t fallen.

[7] Eastern State Hospital Policy #RI 050-57, “Reporting and Investigating Abuse and Neglect of Individuals Receiving Service” and Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) Departmental Instruction 201 (RTS)03, “Reporting and Investigating Abuse and Neglect of Individuals Receiving Services in Department Facilities.” Eastern State Hospital reported that they conducted a Root Cause Analysis as prescribed by JACHO; however, this is not an investigation as it focuses primarily on organization systems and processes, not on individual performances.

[8] DMHMRSAS Department Instruction 201(RTS)(03).

[9] RI 050-57, “Reporting and Investigating Abuse and Neglect of Residents.”

enforcement standards. The failure to act in all of these regards created an unsafe environment.

3. ESH staff's failure to monitor and supervise caused the death of EO – an individual with mental illness. ESH staff's failure to report and respond to incidents of sexual assault and neglect placed ESH residents – individuals with mental illnesses – at risk of injury or death.

By failing to adequately monitor and supervise EO, ESH failed to protect her from harm. Had staff adequately monitored EO, it is likely that she would not have attempted swallow her underwear and subsequently die. While the failure to report or respond to the allegation of sexual assault and to incidents of neglect was not a cause of EO's death, it was an omission that placed other individuals on the unit at risk of harm. The failure to monitor and supervise and the failure to respond and report were omissions committed by individuals responsible for providing facility services. These omissions either caused the death of an individual with mental illness or placed an individual with mental illness at risk of injury or death. VOPA therefore finds that ESH committed "neglect" within the meaning of the PAIMI Act.

EXHIBIT A

COMMONWEALTH of VIRGINIA

Department of
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

JOHN M. FAVRET
Director

Eastern State Hospital

4601 IRONBOUND ROAD
WILLIAMSBURG, VA 23188-2652
Telephone: (757) 253-5161
Fax: (757) 253-5065
V/TDD: (757) 253-4638
http://www.esh.dbhds.virginia.gov

October 13, 2009

Mark Stevens, Disability Rights Advocate
Virginia Office for Protection and Advocacy
1910 Byrd Avenue, Suite 5
Richmond, VA 23230

Dear Mark:

We are in receipt of the updated version of your report for case number 882009, dated September 30, 2009.

As you mentioned, we responded March 27, 2009. Because it appears this version of the report is substantially the same, we have nothing further to add at this time.

Thank you for being certain we had the latest version and for sharing our dedication to quality patient care.

Sincerely,

John M. Favret
Hospital Director

COMMONWEALTH *of* VIRGINIA

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September 30, 2009

John Favret
Hospital Director
Eastern State Hospital
4501 Ironbound Road
Williamsburg, VA 23187-8791

Re: [redacted]

Dear Mr. Favret,

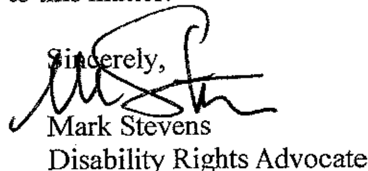
The Virginia Office for Protection and Advocacy has completed its investigation into the death of [redacted] while she was a patient at Hancock Geriatric Center. We have completed a review of our investigation with regard to the comments provided by Marty S. Kline in his March 27, 2009 letter. We disagree with his assertion that alleged sexual assault did not constitute a reportable allegation of sexual assault. On page 8 of our investigation, a statement provided by the Eastern State Hospital Police Officer on the scene, indicated that the EMS responder announced that "we think there may have been a sexual assault and these were shoved down her throat to shut her up". The officer then proceeded to collect evidence.

We are providing you with a copy of the report and findings for your review and comments.

Please provide your comments to this office by October 9, 2009 so they can be incorporated into this investigative document. This document is being considered for publication.

Thank you for your attention to this matter.

Sincerely,



Mark Stevens
Disability Rights Advocate

Enclosure

COMMONWEALTH of VIRGINIA

Department of
MENTAL HEALTH, MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES

JOHN M. FAVRET
Director

Eastern State Hospital

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fsweb.wm.edu.crossroads/firstpage.htm

March 27, 2009

Mark Stevens, Disability Rights Advocate
Virginia Office for Protection and Advocacy
1910 Byrd Avenue, Suite 5
Richmond, VA 23230

Dear Mr. Stevens;

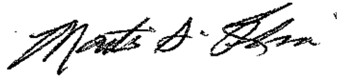
Thank you for allowing us to review and comment on your VOPA Investigation Report – Death of EO – VOPA Case No. 882009.

We all agree this was a tragic event and a cause to look for insight into the incident with regard to possible avoidance of future similar situations. As you are aware, however, the population of residents we serve is not always predictable. We do believe that the statements we obtained following the incident, which were cited by you in your report, evidence that the resident was monitored. Nonetheless, we intend to ensure that all nursing staff are well-educated on the Hospital's Standard Operating Procedure Number 280-Z articulating the requirements for patient accountability.

The sexual assault aspect of your investigation claims that no investigation was conducted based on an allegation of assault. The mention of possible sexual assault made by the responding EMT does not constitute a reportable allegation of sexual assault. Please see the letter to the James City County Fire Chief dated September 5, 2007 expressing the Director's concern for the comments. The Deputy Fire Chief's response of September 28, 2007 explains their reasoning, which is based on criminal investigation. Note that even in that letter, he states that "[O]ur staff verbalized comments more to their bewilderment than with any other intent." Other than the fact that the resident's undergarment was used resulting in her choking death, no other sexual indications were noted. In addition, the time between when the patient was observed entering the bathroom and when she was found was relatively short. Finally, there were other staff and patients present in that general area. Based on all this, there was no probable cause to suspect a sexual assault had occurred. The results of the autopsy did not find any indication of assault. Therefore, we disagree with your allegation that the failure to launch a sexual assault investigation was an omission that placed other individuals on the unit at risk of harm.

We appreciate the role you play in helping to safeguard the rights of individuals with mental illness.

Sincerely,



Martin S. Kline
Acting Hospital Director

Attachments:

1. ESH Letter to Tal Luton, Fire Chief, September 5, 2007
2. Deputy Fire Chief letter to John Favret, September 28, 2007

Cc: Heidi Dix, Deputy Commissioner
Stephen Herrick, Director PGH
Willie Barnes, Advocate

COMMONWEALTH *of* VIRGINIA

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March 4, 2009

John Favret
Hospital Director
Eastern State Hospital
4501 Ironbound Road
Williamsburg, VA 23187-8791

Re: [redacted]

Dear Mr. Favret,

The Virginia Office for Protection and Advocacy has completed its investigation into the death of [redacted] while she was a patient at Hancock Geriatric Center. We are providing you with a copy of the report and findings for your review and comments.

Please provide your comments to this office by March 27, 2009 so they can be incorporated into this investigative document. This document is being considered for publication and distribution to [redacted]'s next-of-kin.

Thank you for your attention to this matter.

Sincerely,

Mark Stevens
Disability Rights Advocate

Enclosure

COMMONWEALTH of VIRGINIA

Department of
MENTAL HEALTH, MENTAL RETARDATION AND
SUBSTANCE ABUSE SERVICES

Eastern State Hospital

JOHN M. FAVRET
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fsweb.wm.edu/crossroads/firstpage.htm

September 5, 2007

Tal Luton
James City County Fire Chief
300 McLaws Circle
Suite 200
Williamsburg, VA 23185

Dear Chief Luton;

Eastern State Hospital has enjoyed a long-standing, cooperative relationship with the James City County Emergency Response Team. Your service has always been highly responsive, professional, and effective. For this reason I know that the recent response was an aberration but nevertheless felt that you should be informed.

On Sunday, September 2, EMS received a call from Eastern State regarding an unresponsive client. The client subsequently died. During the course of their duties, the emergency response team did not fully appreciate or take into consideration that this client was someone about whom the staff and other patients cared. The staff were upset and claim that they were yelled at repeatedly by the paramedics. For example, staff claim that the EMTs were yelling for proof of a DNR when they were repeatedly told that this individual was a full code. One of your response team reportedly said, "I am not wasting my time if she's a DNR." Our staff were doing the best they could under such stressful circumstances.

After panties were removed from this client's airway, one EMT speculated loudly that the client had been sexually assaulted and her underwear stuffed down her throat to shut her up. The speculation was unnecessary and caused further grief to the staff who were present. Staff's perception was that they were rude and belittling to the patient.

I am certain that you regularly educate your staff on Sensitivity Training and Crisis Debriefing. We understand that during a crisis of this type, the focus is on saving a life and we are aware that in times of stress people often say things they may later regret. However, it would be very much appreciated if you could remind your EMTs that many of our clients have been residents here for many years as was the individual in this case. Because caring relationships develop over the years, our staff often consider their charges family. I appreciate your service to ESH and the attention I know you will give this issue.

Sincerely,

John M. Favret
Hospital Director

RECEIVED

OCT 01 2007
EASTERN STATE HOSPITAL
DIRECTOR'S OFFICE

FIRE

300 McLaws Circle, Suite 200, Williamsburg, Virginia 23185

E-mail: fire@james-city.va.us
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Emergency Communications (757)566-0112 | Emergency Medical Services | Emergency Management (757) 5664315 | Fire Prevention/Investigatio

September 28, 2007

10/1/07

Mr. John Favret
Hospital Director
Eastern State Hospital
P.O. Box 8791

Williamsburg, VA 23187-8791

Mr. Favret.

Upon receipt of your letter dated September 5 and upon speaking to you on the telephone on September 11, 2007, I conducted an investigation looking into the concerns from an incident occurring on September 2, 2007 at your facility. I agree with your sentiment in which we have enjoyed a long-standing cooperative relationship—I will work toward and hope this continues.

Firstly, I appreciate your staff and the closeness they maintain with the patients. I also understand they are very concerned over a patient's welfare, especially in a life-threatening medical or traumatic emergency. We strive to show compassion to patients, caregivers and family. I will acknowledge our actions and words may seem, at times, abrupt or short, as some situations will have us performing life-saving procedures in less than optimal conditions. Time is so often of the essence in our work. I apologize for any impression of being rude or belittling.

Secondly, in this particular instance, our staff, even with the volume of calls we respond to, were taken a bit off guard as to the reason for the patient's obstructed airway. We have rarely encountered similar events and our staff verbalized comments more to their bewilderment than with any other intent.

In the statements and interviews of my staff, we requested the patient's chart for medical history and any DNR orders without an apparent timely response as requests were made several times. One of our medics noted a hematoma to the head on the patient, and in conjunction with the discovery of the object obstructing the airway, reasoned a crime may have occurred. Comments or actions may. have also been taken out of context after the object was removed from the patient and hospital staff went to pick it up; we advised to leave it as its discovery is part of a potential crime scene. These actions and comments were not intended to be rude or demeaning to staff or patient.

I apologize for any confusion as a result of this unusual incident and consider this the exception rather than the rule. We will continue to place the patient and family with the highest consideration while we attempt to manage the emergency

Very sincerely,

Joe Davis

Joe Davis
Deputy Fire Chief