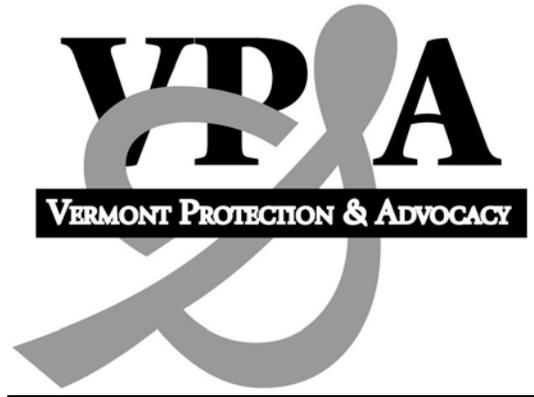


Investigation into the Death of Mr. James Biggar at the Brattleboro Retreat on December 10, 2007



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I. INTRODUCTION

This report presents the results of the investigation conducted by Vermont Protection & Advocacy (VP&A) into the circumstances surrounding the death of Mr. James Biggar on December 10, 2007. Mr. Biggar died of suicide by hanging while a patient on the Co-Occurring Disorders Unit, hereafter referred to as Tyler 1, at the Brattleboro Retreat (the Retreat).

Our investigation identified that Mr. Biggar was very ill and suicidal when he entered the Retreat's care on November 26, 2007. Neither his physical nor mental health improved significantly over the course of his two week stay. While at the Retreat Mr. Biggar voiced several concerns about his treatment and health to his care providers, including asserting he was placed on the wrong unit, having headaches and nausea, and feeling suicidal. In significant aspects the response to these concerns appears to have been inadequate or ineffective. Mr. Biggar's psychiatric condition deteriorated significantly over the weekend before his suicide mid-morning on Monday, December 10, 2007. VP&A identified concerns relating to a lack of communication between unit staff and Mr. Biggar's treating psychiatrist during this critical time and concerns about the assessments and responses by unit staff to his suicidal ideations that weekend and the morning of his death. While the direct enabling factor in Mr. Biggar's death was the existence of a place from which to hang a sheet, the failure to have adequately addressed these areas of concern may have been contributing factors to this tragic event and are relevant to a careful examination of what occurred prior to Mr. Biggar's death. VP&A provides this investigative report in furtherance of our federal mandate and in an effort to illuminate areas of concern and promote improvement in future services, policies and responses to patients at the Retreat and in facilities around Vermont.

At the outset of this report VP&A wishes to acknowledge our gratitude for the high level of cooperation with VP&A's investigation that the staff and administration of the Retreat provided. The Retreat's response to our investigation and the improvements that have been made in the wake of this tragic incident bode well for the continued improvement in services and safety at the Retreat.

II. BACKGROUND

A. James Biggar

Mr. James Biggar was a 42 year old white male who had been admitted for inpatient psychiatric treatment at the Brattleboro Retreat on November 26, 2007. He had lived independently for the past fifteen years in an apartment in Keene, New Hampshire. He had two brothers, one of whom had died of a longstanding health disorder approximately one year prior to James Biggar's death. Mr. Biggar had a very close and supportive relationship with his mother who lived nearby. He was a high school graduate who worked for the prior eighteen years in food services at Keene State College. He enjoyed listening to music, shopping, reading, spending time with his mother, and the company of his pet cats.

According to historical information gathered by the staff at the Brattleboro Retreat, Mr. Biggar had exhibited "oddities of behavior" since early childhood that were diagnosed approximately

seven years ago, during a previous psychiatric hospitalization, as Obsessive Compulsive Disorder (OCD). It was just prior to that hospitalization that symptoms such as hoarding and repeating numbers and routine behaviors became more obvious. He also had been diagnosed previously with the onset of Major Depressive Disorder in the 1980's. He occasionally had been engaged in outpatient mental health treatment services over the past fifteen to twenty years and had numerous trials of psychopharmacological interventions for his OCD disorder, with varying degrees of success.

Records indicate that two years ago Mr. Biggar experienced a "marked decline" in functioning when his ceiling fell in as a result of flooding in the apartment above him. He was fearful that it would happen again, and became even more so when he noticed in the months leading up to his more recent psychiatric hospitalizations that there was a moldy spot on his ceiling in conjunction with a concern that the pipes in his apartment were not working properly.

Additionally, Mr. Biggar experienced physical health conditions including hypertension, asthma, allergies, Celiac Sprue (a chronic disease of the digestive tract), sleep apnea, and restless leg syndrome. He used a Continuous Positive Airway Pressure (CPAP) machine to assist with breathing during sleep and was prescribed medications to alleviate high blood pressure, allergies and psychiatric symptoms.

B. The Brattleboro Retreat

The Brattleboro Retreat is a part of Retreat Healthcare, a private, not-for-profit health services organization located in Brattleboro, Vermont. The Brattleboro Retreat provides inpatient mental health and addictions treatment for children, adolescents and adults. The present investigation focuses on treatment received by Mr. Biggar while a patient on one of the two adult inpatient units at the Brattleboro Retreat.

The Co-Occurring Disorders Unit is also known as the "CORE" Unit, or Co-Occurring Recovery Program. This unit is often referred to as "Tyler 1" due to its location on the first floor of the Brattleboro Retreat's Tyler building. It is a locked ward licensed for a capacity of 21 patients. According to promotional materials on the Brattleboro Retreat's website, the Co-Occurring Disorders Unit is designed to provide:

"...intervention, detoxification and short-term stabilization for individuals who are dealing with alcohol and substance-related disorders as well as psychiatric disorders. Our team meets the difficult challenge of managing co-occurring issues including accurate diagnosis, medication evaluation, education and aggressive treatment. Our program offers 24-hour care in a nurturing and community-based environment that promotes healing and ongoing recovery. Treatment is focused on developing and maintaining sobriety by working with both the client and the family to understand the cycle of addiction and to aggressively develop an aftercare plan to support recovery." (<http://www.retreathealthcare.org/adult/inpatient.html>)

The Adult Psychiatric Unit is also known as the Acute Inpatient Unit and is often referred to as “Tyler 2” due to its location on the second floor of the Brattleboro Retreat’s Tyler building. It is a locked ward licensed for a capacity of 25 patients. According to promotional materials on the Brattleboro Retreat’s website, the Adult Psychiatric Unit is designed to provide:

“...a highly structured and secure setting to meet the needs of adults struggling with psychiatric illness. It provides a comfortable yet safe environment where clients are treated with dignity and respect. Treatment is focused on helping clients manage the symptoms that have disrupted their lives and to assist them in regaining a sense of confidence and stability while teaching and encouraging skills that help them sustain the goals which they achieve throughout treatment.”

(<http://www.retreathealthcare.org/adult/inpatient.html>)

Both the Co-Occurring Disorders Unit and the Adult Psychiatric Unit are staffed by board-certified psychiatrists, registered nurses, social workers, mental health workers, and therapeutic activities specialists. The Brattleboro Retreat is licensed as a psychiatric hospital by the Licensing and Protection Division of the State of Vermont’s Department of Disabilities, Aging and Independent Living. They are also certified by the Center for Medicare and Medicaid Services (CMS) and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

C. Vermont Protection & Advocacy, Inc.

Vermont Protection & Advocacy, Inc. (VP&A) is a private, independent, not-for-profit agency mandated by federal law to protect and advance the rights of individuals with disabilities. See Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq.; 42 C.F.R. Part 51 et seq. VP&A has the authority to investigate allegations of abuse and/or neglect involving individuals with disabilities if the incident is reported to VP&A or if VP&A determines there is probable cause that an incident of abuse and/or neglect occurred. Id. VP&A is Vermont’s designated protection and advocacy system and is a member of the National Disability Rights Network (NDRN).

III. VERMONT PROTECTION & ADVOCACY INVESTIGATION

Pursuant to our federal mandates VP&A initiated an investigation into the death of Mr. Biggar which included the following:

- A review of Mr. Biggar’s Brattleboro Retreat medical records;
- A review of the Brattleboro Retreat Policies and Procedures Manual;
- An interview with Brattleboro Retreat Tyler 1 Attending Psychiatrist;
- An interview with Brattleboro Retreat Tyler 1 Charge Nurse 1;
- An interview with Brattleboro Retreat Tyler 1 Charge Nurse 2;
- An interview with Brattleboro Retreat Tyler 1 Social Worker;
- An interview with Brattleboro Retreat Tyler 1 Mental Health Worker 1;
- An interview with Brattleboro Retreat Tyler 1 Mental Health Worker 2;
- An interview with Ms. Nadia Buchanan, Mr. Biggar’s mother.

IV. CHRONOLOGY OF EVENTS

A. Admission to the Brattleboro Retreat

Mr. Biggar was admitted to the Brattleboro Retreat on November 26, 2007 upon referral from his outpatient treatment providers at Monadnock Family Services. He was accompanied by his mother who provided most of the historical information gathered as part of his intake at the Retreat. Admissions records indicated that Mr. Biggar presented as extremely anxious, unable to answer any questions, rocking back and forth, and “whining and moaning saying ‘I’m so stressed, I’m so stressed.’” His primary complaint was documented as “I can’t take it anymore.”

Brattleboro Retreat admission records also indicated that within the prior month Mr. Biggar had been hospitalized on an inpatient psychiatric unit at Cheshire Medical Center in Keene, New Hampshire, for approximately three weeks; had presented at Cheshire Medical Center’s Emergency Department three times since his discharge from that facility; and had been unable to work due to his psychiatric condition. Additional precipitating factors for Mr. Biggar’s admission to the Brattleboro Retreat included suicidal threats and gestures, specifically that he had threatened overdosing, cutting his wrists with a kitchen knife, or choking himself with the cords to his CPAP machine. He had also recently resumed self-harming behaviors such as banging his head, and had declined in his ability to manage activities of daily living. His recent obsession with the idea of his apartment ceiling caving in as it had a few years previously due to flooding above him was noted. Also documented in Mr. Biggar’s admissions records was that he had no history of substance abuse, no history of violence, and no prior history of suicidality.

In addition to the previously noted physical health conditions, Mr. Biggar was provisionally diagnosed with Mood Disorder Not Otherwise Specified, Obsessive Compulsive Disorder, Generalized Anxiety Disorder, R/O [Rule Out] Personality Disorder, and was given a Global Assessment of Functioning (GAF) score of 22 on a scale of 0 to 100. His estimated date of discharge was recorded in his medical records as seven to ten days.

Documentation of Mr. Biggar’s Mental Status Exam upon intake included that his appearance was dirty and disheveled; his behavior was agitated and inappropriate; he was oriented to his name, but not the date and place; his memory was confused; he denied delusions and hallucinations; he had unusual thoughts/behaviors consisting of obsessions and compulsions; he denied homicidal potential; his suicidal potential was marked as “Feel like giving up” and affirmatively checked was “Recent action” pertaining to self-mutilation potential, further elaborated as “Patient has begun banging his head when anxious.” The Brattleboro Retreat admitting nurse recommended that Mr. Biggar be assessed for extra pyramidal symptoms (EPS) due to rigidity of his left arm and again noted his back and forth rocking motions and moaning as part of her nursing assessment.

A list of Mr. Biggar’s current medications was recorded by the admitting nurse as follows: Klonopin 1mg PO at 8a.m. and noon and 2mg PO at bedtime for anxiety; Luvox 100mg PO at 8a.m. and 8p.m. as a mood stabilizer; Seroquel 75mg PO at 8a.m., noon and 100mg at bedtime as a mood stabilizer; Lisinopril/HCTZ 20 12.5mg PO at 8a.m. for hypertension; Colace 10mg PO at

8a.m. for regularity; Nasonex Nasal Spray 2 sprays in each nostril daily for dry nasal passages; Claritin 10mg PO PRN at 8a.m. once daily as needed for allergies; Multivitamin PO at 8a.m. as a supplement; and Vitamin B-12 1000mcg as a supplement. Each of these medications was continued by telephone order of the admitting physician. Additionally, the admitting physician ordered Klonopin 1mg PO NOW which was given to Mr. Biggar at 6:15p.m. that evening; she ordered 15 minute checks for safety with the abbreviation "SI" [suicidal ideation] written on the Admissions Order sheet; and she allowed Mr. Biggar use of his CPAP machine with a note stating "caution - h/o [history of] wrapping cord around neck – not to use if unsafe."

Mr. Biggar completed a Therapeutic Interventions Survey shortly after admission listing his behavioral concerns, describing "what types of behaviors are a problem for you?" as: losing control, feeling unsafe, running away, feeling suicidal, injuring yourself, and suicide attempts. Mr. Biggar affirmatively checked the following warning signs, described as "what other people may notice when you are becoming overwhelmed": sweating, breathing hard, racing heart, clenching teeth, red faced, wringing hands, loud voice, sleeping a lot [three stars written in by Mr. Biggar next to this], pacing, can't sit still, crying "recently", isolating/avoiding people, hyper, eating less "recently", and constipated. Interventions, described as "things that can help you feel better when you're having a hard time" were listed by Mr. Biggar as: voluntary quiet time in your room, going for a walk with staff, taking a hot/cold shower, lying down with a cold facecloth, and lying down. Triggers, described as "what are some of the things that make it more difficult for you when you're already upset" were identified by Mr. Biggar as: being isolated, locked out of room, people in uniform, loud noises, yelling, not being listened to, feeling pressured, lack of privacy, restraints/seclusions, arguments, not having control, darkness, being teased, and feeling lonely.

According to the evening nursing admission note completed by Charge Nurse 1, Mr. Biggar arrived on the Co-Occurring Disorders Unit (Tyler 1) at 5:45p.m. He was brought to room 107B, but was moved to a community area for the night after presenting as very anxious and stating that he could not be with a roommate. She noted that Mr. Biggar stated that his recent inpatient admission in Keene, New Hampshire was not helpful for him and "therefore he believes he cannot be helped." She also wrote "Pt stated at one point that he does not want to live anymore. Pt verbalized on his own, without prompting, that he would not harm himself with his CPAP machine." Mr. Biggar took a shower, spoke briefly about his medications, came out of the community area for his nighttime medications and then went to sleep. Charge Nurse 1 documented her assessment of Mr. Biggar as "VERY ANXIOUS. Redirectable. Passive SI. Depressed. Hopelessness. Polite." She recorded that Mr. Biggar was to be monitored for safety and impaired mental status every 15 minutes. She also recommended "low stimulus" for him.

B. November 27, 2007

Documentation in Mr. Biggar's medical records indicates that Mr. Biggar complained of a headache and received over the counter analgesic medication at 3:30a.m. and again at 6:10a.m. on November 27, 2007. A positive response to the medication was documented in his records.

According to a Psychiatric Admission/Initial Progress Note Mr. Biggar met with his attending psychiatrist on November 27, 2007 for 35 minutes. The attending psychiatrist noted that Mr.

Biggar had no history of suicidal ideation or attempts until recently, had experienced an increase in hoarding and checking/re-checking behaviors, and had been prescribed an increase in Luvox approximately two weeks prior to his admission to the Brattleboro Retreat. The doctor wrote that Mr. Biggar's appearance was disheveled, his mood was depressed and his affect was restricted. His thought process was logical yet lacked details with some tangents and guilt focus evident. The doctor noted that Mr. Biggar denied suicidal ideation, denied homicidal ideation and denied experiencing any pain at the time of his assessment. His initial diagnoses included Obsessive Compulsive Disorder and Major Depressive Disorder, recurrent and severe. In his assessment, the doctor questioned whether Cognitive Behavioral Therapy (CBT) had been attempted with Mr. Biggar and wrote that his "meds appear to have lost effect." The documented plan was to increase Mr. Biggar's Luvox and possibly Seroquel, to discuss Mr. Biggar's treatment history with his outpatient providers and to check whether clomipramine [a tricyclic antidepressant] had been previously prescribed. Additional information recorded on the back of his initial progress note indicated that per information obtained from a crisis worker, Mr. Biggar experienced a decrease in sleep and an increase in obsessions soon after he began a medication for restless leg syndrome.

A Treatment Plan was developed for Mr. Biggar on this day by a multidisciplinary team consisting of his attending psychiatrist, his assigned social worker, a registered nurse, an alcohol and drug counselor, and a therapeutic activities specialist. Documented treatment goals included: compliance with medications; a decrease in symptoms; an improved ability to maintain a stable mood and to be able to manage symptoms in an outpatient setting; attendance at community meetings to help establish meaningful treatment goals; attendance at therapeutic services groups and the verbalization of satisfaction of participation as well as a decreased stress level; the development of coping skills; participation in meetings with treatment team members to discuss his illness, associated symptoms and ways to manage those symptoms more effectively; to approach staff and verbalize unsafe feelings or thoughts; and to work with his social worker to identify an appropriate aftercare plan. Individual staff were identified with specific responsibilities and tasks within the Treatment Plan.

The projected date for resolution noted on Mr. Biggar's Treatment Plan was December 7, 2007. The discharge criteria recommended for Mr. Biggar were that he would be medically stable and safe; that he would report an improved stable mood; that he would verbalize his commitment to outpatient treatment; and that he would have an appropriate aftercare plan that would support these elements.

Although Mr. Biggar signed the Treatment Plan document, the section entitled "Patient Response to Plan" was left blank.

Mr. Biggar attended a goals group this day in which he indicated that he wanted to "get help." He was noted to be anxious and fearful throughout the day and was able to calm himself with "constant prompting and reassurance" by staff, according to progress notes written by a mental health worker. Treatment team notes on this day indicated social worker staff's contact with Mr. Biggar's mother who stated "this is the worst he's been."

At 9:55 p.m., another mental health worker documented that “Pt. has been very anxious (with many somatic complaints. He feels he has been put on the wrong floor and wants to be on t-2 [Tyler 2] to work on his depression.” The mental health worker also wrote that Mr. Biggar appeared to have difficulty understanding the treatment programming, possibly due to his high anxiety and that “he doesn’t always respond to staff support and reassurance.” The documented plan was to offer support and continue 15 minute safety checks.

C. November 28, 2007

On this date Mr. Biggar completed additional assessments and attended several group meetings and sessions but continued to display troubling symptoms, both physical and psychological. For example, at 4:40 a.m. on November 28, 2007 a progress note indicated that Mr. Biggar complained of constipation in the early morning hours and experienced some anxiety “over bodily functions.”

A progress note written by Mr. Biggar’s assigned Social Worker indicated that at 9:00 a.m. Mr. Biggar had been “observed in the community [area of the unit] somewhat disorganized, anxious. Reports feelings of hopelessness – ‘I don’t think I’ll be a success story.’”

Mr. Biggar attended the morning goals group in which his documented goal was to “meet (with MD re move to T2 [Tyler 2].” Mental Health Worker 2 again documented Mr. Biggar’s desire to transfer to Tyler 2 in his day shift progress note and wrote that Mr. Biggar stated he “did not know what treatment would do for him on this unit.” Later that morning Mr. Biggar met with his attending psychiatrist who also documented that Mr. Biggar was anxious and had an increase in somatic complaints i.e. constipation, which may have been a side effect of the Luvox he had been prescribed a few weeks earlier. The doctor noted that he had spoken by phone with Mr. Biggar’s outpatient psychiatrist and that the precipitant to Mr. Biggar’s recent difficulties “appears to be an episode of hypomania induced by Carbidopa/L-dopa” which had been previously prescribed for restless leg syndrome. The attending psychiatrist assessed Mr. Biggar’s mood as depressed, affect blunt, cognition distorted, thought process tangential, and wrote that his thought content included obsessions. He noted that Mr. Biggar was not currently suicidal. He indicated that his plan was to increase Mr. Biggar’s dose of Seroquel, to have Mr. Biggar practice breathing, mindfulness and distraction exercises, and to provide a CBT (Cognitive Behavioral Therapy) approach to treatment while at the Brattleboro Retreat, in addition to his recommendation that the same be sought for him on an outpatient basis. There was no documentation in the physician’s progress note of any discussion nor resolution regarding Mr. Biggar’s desire to transfer from the Co-Occurring Disorders Unit (Tyler 1) to the Adult Psychiatric Unit (Tyler 2).

According to group facilitator notes, Mr. Biggar attended treatment groups throughout the afternoon on the unit, specifically a psycho-educational 12 step recovery group in which he demonstrated passive involvement; a mindfulness skills for stress management group in which he appeared anxious and did not verbally participate; and a men’s recovery group in which he shared in a discussion about acceptance of mental illness.

A 10:00 p.m. nursing note written by a mental health worker indicated that Mr. Biggar had attended evening groups, including “focus, AA mtg, and wrap-up” and was “more visible and less anxious than yesterday.” The documented plan on this progress note was for staff to continue to monitor Mr. Biggar, to encourage him to talk with his doctor about medication concerns he had brought up earlier in the evening and to work on relaxation.

D. November 29, 2007

The attending psychiatrist documented on November 29, 2007 that staff reported a decrease in Mr. Biggar’s level of anxiety. During their meeting that morning Mr. Biggar reported feeling unrested as a result of poor sleep and having difficulty attending to their conversation. Mr. Biggar’s appearance was noted to be disheveled, he displayed decreased psychomotor activity, had difficulty with “word finding” and had “mild latency” of his speech. His mood was assessed as depressed, his affect restricted, and he demonstrated an increase in cognitive distortions. The doctor also noted that Mr. Biggar’s thought content was “hopeless” and that he had made vague statements relative to hurting himself. The documented plan was to continue Mr. Biggar on 15 minute checks, to order Dulcolax for Mr. Biggar’s complaints of constipation, and the use of CBT in response to Mr. Biggar’s distortions and anxiety.

Mr. Biggar complained several times on November 29, 2007 that he was experiencing headaches, for which he received over the counter analgesics four times throughout the day. He also reported feeling unsteady on his feet, continued to experience constipation, and generally was not feeling well. A day shift progress note by a mental health worker documented that Mr. Biggar “stated at one point that he felt (like) hurting himself” but that he did not have a plan to do so. He was provided with grounding techniques to help decrease his anxiety and was continued on 15 minute checks for safety and impaired mental status.

Evening shift nursing notes indicate that Mr. Biggar spent most of the afternoon sleeping and had awoken hot, sweaty and with increased headache pain. He did not attend any of the morning or afternoon treatment groups offered but did attend the evening Focus Group and watched an educational video. The evening shift progress note (author illegible) documented that Mr. Biggar’s anxiety appeared to have increased and that he was “scattered and confused” at times.

E. November 30, 2007

On his November 30, 2007 psychiatric progress note, the attending psychiatrist reported a significant decrease in Mr. Biggar’s level of anxiety. Mr. Biggar demonstrated an increase in fluidity of his speech and there was no word find difficulty noted as had been previously. His mood continued to be assessed as depressed and affect restricted, but it was noted that he had less cognitive distortions. The doctor recommended that Mr. Biggar’s privilege level be increased with a corresponding decrease in safety check intervals. He was raised to “Level 1” and routine 30 minute observational checks were initiated, in accordance with Retreat policy for all patients who do not require special observation. The attending psychiatrist again documented that his recommended treatment plan for Mr. Biggar was to include a CBT focus.

Mr. Biggar's medical records indicate that he attended the morning goals group with a stated goal of working on his depression and anxiety. The day shift progress note by Mental Health Worker 2 indicated that Mr. Biggar was "still obsessing on his anxiety (and) inability to be with people." His anxiety level was recorded as 8, while his level of depression was recorded as 6.

Shortly after the morning group Mr. Biggar began experiencing nausea and subsequently vomited at least three times throughout the day. He received an anti-nausea medication, Compazine, twice on this day. Additionally, he continued to complain of headaches and constipation and received over the counter analgesics three times. Mr. Biggar spent most of the day resting in his room. A healthcare clinic consult was requested by a unit nurse.

F. December 1, 2007

On December 1, 2007, Mr. Biggar continued to complain of headaches, constipation, nausea and vomiting throughout the day and evening. He was given over the counter analgesics four times for his headaches, and received Compazine for his reoccurring nausea and vomiting. Mr. Biggar slept most of the morning, ate a small amount of lunch and showered in the afternoon. Mental Health Worker 2 assessed Mr. Biggar's anxiety on this day as a 9 and depression as a 7.

Mr. Biggar was evaluated in the health care clinic by an Advance Practice Registered Nurse. She assessed that he was experiencing constipation, nausea, vomiting and possible gastritis. She recommended that Mr. Biggar be given magnesium citrate and Miralax to ease his stomach and bowel conditions, and that he put on a clear liquid diet with an advanced diet as tolerated. The nurse also wrote that Mr. Biggar's physical health complaints may be a side effect of the Luvox he was taking and deferred to the attending psychiatrist for a determination of the need to discontinue this medication.

Mr. Biggar took his evening medication, but vomited shortly thereafter. The doctor on call was notified. Compazine and his nighttime medications were re-administered per physician order.

G. December 2, 2007

On the morning of December 2, 2007 Mr. Biggar again reported having a headache, for which he received an over the counter analgesic at 9:55 a.m. He also was experiencing leg discomfort and dizziness. He attended the goals group with a stated goal of "work through my illness." He went back to bed and spent the majority of the day sleeping. He was assessed by Mental Health Worker 2 during the day shift to be "fatigued" and "unable to focus on anything."

Mr. Biggar's scheduled 12 p.m. dose of Klonopin was not given on this day due to "sedation and being unsteady" according to documentation by a unit nurse.

During the evening shift another unit nurse noted Mr. Biggar's continued somatic complaints, including leg pain and headaches. She wrote "two staff members noted that he looked more in pain when he noticed he was being observed than he did when nobody seemed to be watching him." She also wrote that he continued to apologize constantly and assessed that he was still not

well “but may be capitalizing on sympathy to avoid engaging.” The documented plan was to encourage Mr. Biggar’s participation in groups and treatment as tolerated.

H. December 3, 2007

The attending psychiatrist met with Mr. Biggar again on December 3, 2007 and noted that Mr. Biggar experienced “tension headaches” with each of their visits. He documented that Mr. Biggar had appeared relaxed throughout the morning, but more anxious during their meeting. He assessed Mr. Biggar’s mood as depressed with restricted affect, and planned to slowly discontinue Mr. Biggar’s prescribed Luvox due to the physical health side effects he had been experiencing. The doctor documented his consideration of a trial of Cymbalta and left a message for Mr. Biggar’s outpatient psychiatrist, noting a caution of prescribing Cymbalta in combination with Luvox due to SSRI side effects.

Although Mr. Biggar continued to complain of headache and fatigue and expressed hopelessness on this morning, he was able to attend two groups. His anxiousness was noted in documentation for the morning goals group, while it was reported that he actively participated in the recovery group which focused on cognitive distortions. He ate a liquid lunch and spent his free time in his room, stating that his nausea was increasing. Mental Health Worker 2 documented in his day shift progress note that Mr. Biggar’s anxiety level was an 8 and his depression a 6.

Mr. Biggar met with his Social Worker to discuss treatment progress and aftercare plans. The Social Worker wrote that he had difficulty participating in the session with her, frequently complaining of a headache and difficulty staying awake. She observed that Mr. Biggar’s mood remained “dysphoric with depressed affect.” She further documented that he verbalized “no hope for current or future treatment – thought content is helpless and hopeless. Patient reports that he will ‘die of failure.’”

Mr. Biggar spent the afternoon and evening in his room. According to the 3 – 11 p.m. shift progress note, Mr. Biggar stated “I feel miserable, my head is throbbing. I just want to die.” He did not eat dinner and continued to report being in pain throughout the evening.

I. December 4, 2007

On this date Mr. Biggar ate a soft diet on the unit at breakfast, but then vomited. He attended the afternoon recovery group, and was noted as upset when leaving, stating his “head is mush” and “I feel stupid.” He reported being unable to concentrate when asked to review cognitive distortions. The day shift progress note (author illegible) noted that Mr. Biggar was anxious and engaging in negative self-talk. The plan was to offer support, including positively reinforcing positive self-talk, and monitor his mood and behavior.

Mr. Biggar met with his attending psychiatrist who documented their discussion about applying CBT techniques to his contamination fears and hoarding behaviors. The doctor noted that Mr. Biggar expressed difficulty applying CBT to Obsessive Compulsive Disorder when substance

abuse was used as an illustration in groups. He further documented Mr. Biggar's mood as depressed, affect restricted, and noted an increase in cognitive distortions.

Mr. Biggar met again with his Social Worker who noted that he "continues to show improvement slowly – requires ongoing education regarding illness, related symptoms, and ways to manage...quickly overwhelmed and negativistic in thinking. 'I can't do this.'" She arranged for Mr. Biggar to be seen by a doctor at Elliot Behavioral Health for continued CBT upon discharge. She assessed Mr. Biggar's affect as slightly improved and noted that he had shown an increased presence in the community area of the unit, attended groups, and was more clear in his thinking.

Mr. Biggar attended afternoon and evening groups, with depressed affect and anxiety over paperwork documented. He continued to have headaches and received over the counter medication for them twice on this day.

J. December 5, 2007

Mr. Biggar attended several groups this day and was reported to have shown improvement in some of them by demonstrating more active and motivated participation. The attending psychiatrist noted that Mr. Biggar had increased socializing and group attendance, and was "grasping basics of CBT" although he displayed continued ruminations and cognitive distortions during their meeting. Mr. Biggar reported feeling un-rested, his mood was assessed as depressed with restricted affect, yet it was noted that he had attended to activities of daily living as evidenced by his improved hygiene and grooming. The attending psychiatrist changed Mr. Biggar's privilege status to "Level 2", allowing for off unit privileges i.e. eating in cafeteria with staff accompaniment. He was also moved to a new room, 112, which is the room where he hung himself five days later.

The Social Worker met with Mr. Biggar and changed his projected discharge date in her notes from December 7th to December 10th. She documented that Mr. Biggar was showing slow progress in his treatment with some improvement noted. He continued to verbalize anxiety about treatment and self-doubt regarding his ability to be successful. She wrote "Patient reports doubting his ability to convey his feelings effectively to treatment staff and future treatment providers. 'It [treatment] isn't working. I don't do well with therapists.'" Although the Social Worker indicated in her notes that Mr. Biggar's concentration was improved, he was not as easily overwhelmed and his thought content was more coherent, he also reported sleep difficulties, fatigue, and an inability to concentrate in groups. The Social Worker noted she encouraged Mr. Biggar not to nap during the day.

Mr. Biggar received over the counter medication for a headache during the late afternoon. He attended evening groups, asking a lot of questions about medications, therapy and the future according to documentation by a night shift mental health worker. He went off unit for dinner in the cafeteria. He reported awakening at night with racing thoughts and chest pains and although it was noted that he was demonstrating a lower level of anxiety with progress being made, he continued to be "isolative with peers – needy with staff."

K. December 6, 2007

Mr. Biggar attended groups this day but continued to complain that the groups were geared to substance abuse and not relevant to him. Staff notes documented that he “looked lost (always) drowsy...” and that a group facilitator talked to him about the similarities between depression and substance abuse in terms of warning signs and relapse prevention. Mr. Biggar apparently responded by stating he was having an anxiety attack. He later attempted to have lunch off unit but had a panic attack and asked to be returned to his unit.

The attending psychiatrist noted that Mr. Biggar reported increased anxiety and many somatic complaints but was generally feeling better physically. He did express a concern regarding overmedication. The doctor noted that Mr. Biggar continued to demonstrate a depressed mood and restricted affect and the plan was to continue tapering Luvox and continue utilizing a CBT approach.

A 4:30 p.m. progress note by an intern and co-signed by unit staff noted that Mr. Biggar “expressed feeling ‘hopeless’, that he is ‘anxious all of the time’ and that ‘he just wants to end this.’ He described feeling very anxious about his ability to understand the cognitive behavioral material on his desk and suggested perhaps he could have a ‘tutor’ to help him.” According to the intern’s documentation, she relayed this information to the charge nurse however there was no further documentation on follow up to Mr. Biggar’s concerns about his capacity to understand the materials provided.

He continued to complain of headaches and received over the counter medication twice this date for that problem.

L. December 7, 2007 (Friday)

On this day it was noted that Mr. Biggar continued to demonstrate anxiety and sought out staff assistance when distressed. He experienced an increase in thoughts of self-harm, stating a desire to hit his head with his fist and did occasionally engage in this behavior as documented by his attending psychiatrist. He attended two morning groups, goals group in which he stated his desire to control his anxiety and recovery group in which his motivation and active participation was documented. However he was noted in the day shift progress notes by Mental Health Worker 2 as being unable to focus on coping skills for his anxiety and needing a lot of staff time to keep him on track. Mental Health Worker 2 assessed Mr. Biggar’s anxiety level as a 10 and depression as 8. Both the attending psychiatrist and Social Worker noted that Mr. Biggar was voicing hopelessness but did not have a plan for suicide. He was able to talk about life outside of the hospital and some of the hobbies he enjoyed. The Social Worker provided Mr. Biggar with an “anxiety workbook” and encouraged him to read a chapter over the weekend. The attending psychiatrist ordered that Zoloft should be started. The Social Worker spoke to Mr. Biggar’s mother on this date and received her concerns about Mr. Biggar’s current behavior and demeanor being different and worse than what his mother was used to seeing in him. A family meeting was scheduled for December 10, 2007 at 11:00 a.m.

The evening shift progress note indicated that Mr. Biggar had a difficult evening due to increased anxiety and was noted to be sad with depressed affect, had difficulty staying on task, and demonstrated limited progress.

M. December 8, 2007 (Saturday)

On this day Mr. Biggar continued to complain of headaches and received over the counter medication, his Luvox was being tapered down and he received his first dose of Zoloft in the morning. The day shift progress note indicated that he ate breakfast on the unit, complained of stress headaches and his arm shaking, and was reported to have episodes when he hit his head with his fist. Mental Health Worker 2 further recorded that Mr. Biggar “[s]tates he is falling apart (and) just would like to die.” He reportedly required frequent interventions documented as breathing and relaxation exercises. Mental Health Worker 2 assessed Mr. Biggar’s anxiety as an 8, depression as a 6. There was no documentation of a specific suicide assessment in response to his statement of wanting to die. Mr. Biggar continued to express concern about the amount of medications he was on. The evening shift progress note stated that he “seems to be improving some” and that he had expressed an interest in getting back into running.

N. December 9, 2007 (Sunday)

On this day Mr. Biggar continued to complain of panic and headaches and received over the counter pain medication twice in the morning. The day shift progress note by a mental health worker noted that he ate breakfast on unit, did not attend community meeting and repeatedly stated “I want to die, I feel like dying.” At 8:15 a.m. the mental health worker noted that Mr. Biggar signed a “safety contract” in response to his suicidal ideations, stating that if he felt unsafe he would go talk to staff. The duration of the safety contract was documented as 24 hours. There is no record of any specific suicidal assessment occurring in response to Mr. Biggar’s verbalizations, and no documentation as to why the “safety contract” was chosen as a tool to address Mr. Biggar’s presentation, or of whom if anyone was consulted about using the contract in these circumstances. The mental health worker recorded that Mr. Biggar indicated the following: “I’m on too many pills; I need sedatives; I’ll never get better, I’m frustrated.” She worked with him on anxiety reducing techniques such as diaphragmatic breathing, grounding and reframing negative thoughts. Although he took a nap in morning, she found no decrease in his anxiety upon awakening. He reportedly spent most of the afternoon sitting on a chair in his room. The mental health worker assessed him as frustrated with increased anxiety and ambivalent about wanting help, and noted that his “OCD seems to get in the way of managing anxiety.” Her documented plan was to monitor Mr. Biggar’s mood and to help with anxiety reducing techniques.

The evening shift progress note at 10:35 p.m. by another mental health worker documented that Mr. Biggar attended evening groups and watched the educational video. It was noted that Mr. Biggar said “he hopes he’s not paralyzed (with) anxiety on Mon. as he was this AM.” He reported that the walking and breathing exercises were of some help but continued to feel frustrated with his condition.

O. December 10, 2007 (Monday)

On this day, the day of Mr. Biggar's suicide, a 7:25 a.m. progress note "Addendum" written by Mental Health Worker 1 noted: "Pt expressed 'I'm freaking out here' this a.m. 'I can't stand the anxiety any longer, I'm thinking of killing myself.' Pt was reminded that he'd signed a safety contract, when asked if he could hold to it 'aah, yeah.' When writer assist pt per his request, presented reluctant/unable? to do any of the distraction techniques offered/suggested. After an hour pt did finally attempt to shower as relaxation technique. Pt earlier had declined such techniques (distraction) as coloring, walking, breathing techniques. When slower breathing was suggested he actually would breath in more quick shallow breathes. 'It doesn't work (and) it won't work (and) I'm gonna lose it like I lost it before.'" The note went on to state that Mr. Biggar was encouraged to stop using negative self-talk and instead to use positive self-talk. It was noted that he presented with increased anxiety when staff gave him increased attention and time and presented as visibly less anxious when staff was not directly present with him.

Mental Health Worker 1 reported her concerns about Mr. Biggar's continued suicidal ideation to both the current charge nurse and again to the incoming charge nurse at the shift change.

Charge Nurse 2 noted in her 7:30 a.m. to 11 a.m. progress note that morning that Mr. Biggar "was awake in room at 7:30 a.m. change in shift, getting ready for the day, getting dressed and attending to activities of daily living. Came out of room at 8:00 a.m. for routine vital sign checks and morning medications...Pleasant and cooperative. No specific complaints of anxiety at this time. Went off unit for breakfast in café. Attended meditation group at 9:00 a.m. Complained of headache at approximately 9:30 a.m. and was given Tylenol. Went to his room to lie down due to headache. Was observed laying down in his room at 10:00 a.m. during routine 30 minute checks. At approximately 10:26 a.m. [attending psychiatrist] went to meet with Mr. Biggar in his room and found him hanging from his closet by a sheet. Code Blue was called, [attending psychiatrist] brought him to the floor and began administering CPR at 10:28 a.m. 911 Rescue called. CPR was continued by [a different physician], [attending psychiatrist], [other Retreat staff]. Rescue arrived at approximately 10:45 a.m. and took over resuscitation efforts. Transferred to Brattleboro Memorial Hospital at approximately 11:00 a.m." Mr. Biggar was pronounced dead at 11:34 a.m.

There was no documentation in the records demonstrating that a specific suicide assessment was done in response to Mr. Biggar's suicidal ideation that morning. There was also no record of specific action taken in relation to the 24 hour "safety contract" expiring at 8:15 that morning. Apparently the attending psychiatrist became aware of Mr. Biggar's difficulties over the weekend upon arrival at the hospital and prioritized seeing Mr. Biggar that morning. The information the doctor received that morning included that over the weekend Mr. Biggar demonstrated that he was anxious, had somatic complaints, and gave expressions of hopelessness around success of treatment. The report also indicated that he had less anxiety and receding tremor in response to staff interventions, that he appeared relaxed when unknowingly observed, and had futuristic thinking, including caring for his mother and his cats and wanting to return to his apartment. The report indicated that Mr. Biggar was struggling with anxiety but had no "concrete SI or plan."

V. FINDINGS AND CONCLUSIONS

A. Special Assessments and Observation

VP&A identified that the failure of Brattleboro Retreat staff to properly assess and provide increased levels of observation in response to Mr. Biggar's suicidal ideations and self-harming behaviors may have been critical factors contributing to Mr. Biggar's death.

The Brattleboro Retreat policy entitled "Specialized Awareness and Observation" (revised 04/2005) identifies that special assessments and levels of observation, such as fifteen minute checks or even more intensive observations, should be considered if staff believe that a patient is at risk of suicide or self harming. The policy identifies that all staff, from the M.D.'s to R.N.'s to other assigned staff such as Mental Health Workers, have a responsibility to maintain ongoing awareness of the potential need for specialized assessment or observation at all times.

Mr. Biggar was taken off 15 minute checks on November 30, 2007 despite the fact that he was not clearly stabilized. The night before this change in status he was described as being "scattered and confused" at times and continuing to have high anxiety. On the 30th he was described as still obsessing about his anxiety, he began vomiting and spent most of the day in his room. VP&A questions whether there was sufficient evidence of improvement during the three full days he had spent on the unit since admission to justify changing his observation level.

Given the conflicting information identified regarding the decision to take Mr. Biggar off of 15 minute checks on the 30th, the failure to document adequate assessments and increase the level of checks following numerous statements referencing suicidal ideation, self-harm, increased hopelessness, anxiety and panic appears to have been inappropriate.

Of particular concern is that a safety contract was made on December 9, 2007 at 8:15 a.m. but checks were not increased. While the policy noted above states that there may be occasions when specialized observation status is not necessary even though a specialized assessment is, in Mr. Biggar's case there is no documentation identifying that any of the relevant staff considered or initiated the process to specifically assess Mr. Biggar for suicidality or danger from self-harming behaviors. There is no documentation demonstrating that staff considered increasing the observation levels or other means to respond to Mr. Biggar's verbalization of distress on this date.

Our investigation identified that staff had concerns about increasing staff contact with Mr. Biggar out of concern it could cause exacerbation of his symptoms. This concern was put forward in the interviews as a reason not to increase the frequency of checks in response to several of Mr. Biggar's troubling statements. Unfortunately we found no record of any detailed

discussion or direction on this issue in the records made available for our review. There was also information obtained by our interviews that suggested increasing the brief check-ins with Mr. Biggar, as opposed to having staff have more intense and long-term contact with him as would be the case in a constant level of observation, would not have been detrimental. The failure to properly document discussion and reasoning on this important issue raises the distinct possibility that these issues were not fully discussed and appropriate direction was not given to the unit staff.

B. Lack of Documented Suicide Assessment

In addition to the failure to institute an increased level of observation, VP&A found that there were no specific suicide assessments documented in response to any of Mr. Biggar's last several statements that he wanted to die. Retreat staff documented that Mr. Biggar voiced thoughts of suicide upon admission and on December 3rd (he was hopeless and will die of failure), December 6th (he just wants to end this), December 8th (he just wants to die), December 9th (he wants to die), and December 10th (he was thinking of killing himself). It appears from the records that no effort to provide specialized assessments in response to these statements occurred nor was there specific consultation with the attending psychiatrist about appropriate responses to most of these statements. Particularly alarming is the lack of documentation of a suicide assessment occurring following implementation of a safety contract on December 9th and a repeated statement specific to his suicidality in the early morning of December 10th "I'm freaking out here this a.m. I can't stand the anxiety and longer, I'm thinking of killing myself."

C. Safety Contracting

VP&A identified that the use of the "safety contract" in Mr. Biggar's case was potentially problematic. A review of policies and interviews identified that the use of a "safety contract" is not considered to be an adequate response, by itself, to a patient's expression of suicidal thinking. VP&A did not identify any specific training unit staff had received on the use of "safety contracts" or any written policies about how and when they should be employed. Without a formal, documented assessment of risk and consultation with the treating psychiatrist, the decision by staff to rely primarily on the "contract" to support Mr. Biggar in staying safe appears to have been inappropriate. The failure of unit staff to notify the treating psychiatrist, or given weekend coverage, the doctor on call, promptly about the initiation of the "safety contract" further demonstrates a breakdown in communication between care providers that may have been a critical factor in Mr. Biggar's suicide.

D. Environment of Care

VP&A's investigation identified the physical environment, specifically the part of the room that Mr. Biggar used to tie his bed sheet on, was a critical factor in his suicide. The Brattleboro Retreat had a duty to check and ensure no ligature points existed in rooms occupied by patients with suicidal ideations. See JCAHO's Behavioral Health Standards EC 8.10 Establishes and maintains appropriate environment – Elements of Performance (2). Furnishing and equipment should be maintained to be safe and in good repair.

E. Tyler 1 Placement vs. Tyler 2

VP&A identified the failure of Brattleboro Retreat Staff to adequately respond to Mr. Biggar's repeated requests to move from Tyler 1 to Tyler 2 as possibly having an important impact on his eventual suicide. Mr. Biggar was noted to have expressed his concerns and dissatisfaction with being placed and kept on Tyler 1 to staff several times during his stay including on November 27th, 28th and December 4th and 6th. With the exception of one staff's attempt to explain similarities between depression and substance abuse, there is no documentation of any response to Mr. Biggar's concerns. One staff person interviewed indicated that attendance at groups on Tyler 2 was an option available to Mr. Biggar, but there is no evidence that this information was conveyed to Mr. Biggar.

Tyler 1 is identified by the Brattleboro Retreat as being primarily for patients needing treatment for detoxification, substance abuse and dependency issues with groups primarily geared towards substance abuse recovery. No substance abuse issues existed with Mr. Biggar. Staff interviews identified that staff did not feel Mr. Biggar would have received substantially different treatment or oversight on Tyler 2. Some staff, including the attending psychiatrist, opined that Tyler 1 was a better placement for Mr. Biggar as it was populated by patients with less acute illnesses and provided more staff contact with Mr. Biggar than may have been the case on Tyler 2.

VP&A questions these assertions given that Tyler 2 staff, a unit primarily focused on patients with solely psychiatric disorders, may have been more familiar and adept at such skills as monitoring patients for negative reaction to psychiatric medications, providing timely and adequate suicide/self-harm assessments, and keeping the treating psychiatrist informed of problems the patient was experiencing in terms of hopelessness, self-harming behavior and suicidal ideation. According to the Banking, Insurance, Securities and Health Care Administration (BISHCA) 2008 Hospital Report Card Nurse Staffing Data, the percentage of total nursing hours provided by RN's on Tyler 1 was 33% in Nov. 2007, 30% in Dec. 2007; the percentage of total nursing hours provided by RN's on Tyler 2 was 43% in Nov. 2007, 44% in Dec. 2007 (http://www.bishca.state.vt.us/HcaDiv/HRAP_Act53/HCR_BISHCAcomparison_2008/nurse_staff_date/BrRetreat_08r.pdf). These statistics indicate that there was more nursing staff available on Tyler 2 than Tyler 1 during the time period Mr. Biggar received inpatient treatment at the Brattleboro Retreat. Our interviews and experience monitoring Tyler 1 and Tyler 2 over the last several years both identified a general feeling among Retreat staff that nursing staff on Tyler 2 were often more experienced with solely psychiatric illnesses than their counterparts on Tyler 1 who are more experienced with substance abuse and detoxification issues. We are left to wonder whether the nursing staff on Tyler 2 would have made more adequate assessments and utilized more appropriate tools than the "safety contract" that was used. Also it is unclear as to whether any rooms in Tyler 2 have features that could be used to commit suicide. Tyler 2 also has a low stimulus area that may have been calming to Mr. Biggar as was recommended upon his admission to the Retreat.

In light of these concerns that Mr. Biggar's treatment may have been more optimal and safer on Tyler 2 rather than Tyler 1, the failure of staff to adequately respond to Mr. Biggar's legitimate requests to move to a unit that has as its focus psychiatric illness rather than substance abuse,

from which he did not suffer, appears to have been a significant oversight and may have contributed to Mr. Biggar's sense of hopelessness and stated concerns for treatment failure.

F. Failure to Assure Adequate Monitoring and Reporting of Medication Changes

VP&A's investigation identified the introduction of a new medicine, Zoloft, two days before Mr. Biggar's death as a potentially contributing factor to his death. According to the records, manifestations of Mr. Biggar's illness became significantly more acute after Zoloft was introduced on Saturday December 8th. At the same time Mr. Biggar's dose of Luvox was being tapered. VP&A found no clear order and effort to monitor and respond to the impacts of the reduction of Luvox and the introduction of Zoloft in the days before Mr. Biggar's death. While the Retreat's Medication Order Requirements policy (revised 02/2007) provides guidance on the need to monitor these conditions ("5. Titrating and Taper orders: ...Patient response to medication shall be monitored during the titration period") and the Medical Record Progress Note Guidelines (revised 06/2004) also identify that the medical record should contain "...the patient's response to medications...and adverse reactions and/or any reported side effects to medication", there was no specific direction documented regarding what signs and symptoms should be identified or how and when they would be conveyed to the treating doctor.

G. Potential Traumatic Brain Injury Issues

VP&A identified no assessment of the possibility that Mr. Biggar was experiencing problems associated with a physical impairment, such as a Traumatic Brain Injury, rather than simply somatic and medication complaints. Mr. Biggar complained throughout his stay of headaches, nausea, vomiting, unsteadiness/dizziness, fatigue/lethargy, confusion, and difficulty with thinking skills. He also had a recent history of head banging behavior. These symptoms were generally attributed to his high anxiety and to somatic manifestations of his illness. These symptoms and his recent reported head banging behaviors possibly indicate that Mr. Biggar suffered from a concussion or some other head injury that was not properly assessed.

VI. CHANGES AT THE BRATTLEBORO RETREAT IN RESPONSE TO MR. BIGGAR'S DEATH

A. Safety Checks

A new "Safety Checks" policy was approved at the Brattleboro Retreat in January 2008 with a stated purpose of ensuring that observations at appropriate frequencies based on age, acuity, safety risk and disability are initiated in order to assure the provision of suitable interventions and to minimize incidences of harm.

B. Suicide Assessment

A new “Levels of Observation for Safety” policy has been implemented, requiring additional nurse and/or physician assessment following the expression of suicidal ideation. This policy includes a new “Nursing Assessment of Patient Safety” that requires documentation of the rationale for a particular safety check level based on a specific assessment of a patient’s symptoms and behaviors. Progress note formats have also been revised to incorporate specific documentation regarding the identification of suicidal ideation and completion of the required assessment(s).

C. Environment of Care

According to staff interviewed, the closet hole that through which Mr. Biggar tied a sheet in order to hang himself was repaired and each room was checked for similar hazards. All armoire doors were removed and shelving has been installed. Curtain rods in patient rooms were removed and the beds are now fixed to the floor and are no longer moveable as they were previously. Additionally, staff have been directed to perform and document “environmental safety rounds” during each shift and a charge nurse review of safety round logs is to be completed during each 8 hour shift. This requirement is stated in the aforementioned noted “Safety Checks” policy.

VII. CONCLUSION

Mr. Biggar and his family sought treatment at the Brattleboro Retreat precisely because they feared that Mr. Biggar’s mental illness would prompt him to harm himself severely or commit suicide. Despite reasonable efforts, this tragedy was not avoided, leaving everyone involved and who cared about Mr. Biggar very sad and discouraged. VP&A offers this report as a means to illuminate areas of concern and promote improvement in future services, policies and responses to patients at the Retreat and in facilities around Vermont. Throughout our investigation we were impressed by the efforts made by Retreat staff to analyze the circumstances of Mr. Biggar’s death, their willingness to share information with us about the death, and their efforts to put in place changes to policies and practices that may help to avoid another similar tragedy in the future. Through our investigation and report VP&A hopes that some good can come from Mr. Biggar’s experience and untimely death in terms of improving understanding of what opportunities were missed and what processes and policies can be improved to assure better outcomes in the future.

VP&A welcomes comments on our report. Please direct any communications regarding this report to Ed Paquin, Executive Director, Vermont Protection and Advocacy, Inc., 141 Main Street, Suite 7, Montpelier, Vermont 05602, 1-800-834-7890, www.vtpa.org.