

**REPORT OF
AN INVESTIGATION INTO THE CIRCUMSTANCES OF THE USE OF
POLICE INTERVENTION AND SUBSEQUENT TASER SHOOTING OF A
JUVENILE PATIENT AT THE BRATTLEBORO RETREAT,
TYLER 3 UNIT
ON OCTOBER 10, 2003**

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February 2005

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I. INTRODUCTION

This report presents the results of an investigation conducted by Vermont Protection & Advocacy, Inc. into the circumstances surrounding the request by Brattleboro Retreat staff for police assistance on the juvenile psychiatric inpatient unit, Tyler 3, on October 10, 2003. The incident under investigation culminated in the Brattleboro Police Officers' use of a Taser (electroshock weapon) to subdue a juvenile patient, followed by physical restraint and involuntary medication by Brattleboro Retreat staff. The juvenile patient was discharged from the Brattleboro Retreat, against medical advice but upon his and his parent's request, two days following this incident. In order to protect the involved patient's confidentiality throughout this report, he will be identified by the pseudonym "A.N."

A.N. and his parents remain extremely dissatisfied with the sequence of events that led to police intervention and the ensuing trauma suffered. A.N.'s father wrote the following statements in a letter dated October 30, 2003 to Richard Palmisano, CEO of the Brattleboro Retreat:

"Our son (A.N.) and the rest of the family was reaching out to a professional facility, so we assumed this was the help that we were looking for. (A.N.) had many heavy things weighing on his mind, as he told the intake workers, he was looking for answers to why he was feeling certain ways.

(A.N.) entered your facility on Tuesday October 7th, looking for the help that the Brattleboro Retreat was supposedly there for. The facility boasts a fully trained staff and the ways and means to deal with children in crisis. Unfortunately, on October 10th, the following Friday, that was to be proven to the contrary."

This report will provide the findings of Vermont Protection & Advocacy's independent investigation of the October 10, 2003 incident and recommendations to ensure safe, appropriate, and adequate treatment for juvenile patients at the Brattleboro Retreat. This report was written by Advocate Merry Postemski, with the assistance of Linda Cramer, Ginny McGrath, A.J. Ruben, and at the direction of VP&A's Executive Director, Ed Paquin.

II. BACKGROUND

A. Juvenile A.N.

A.N. was admitted to the adolescent inpatient unit, Tyler 3, at the Brattleboro Retreat on October 7, 2003 after he was suspended from school earlier in the day. This was A.N.'s first psychiatric hospitalization.

A.N. is an 18 year old (16 at the time of the incident under investigation) Caucasian male who lives with his biological parents in rural Vermont. During October 2003, A.N. was in the 10th grade at a public high school. He has been on an Individual Educational Plan (IEP) since the 2nd grade due to emotional, behavioral, and learning disabilities. From the 2nd grade through the 9th grade, A.N. had a one-on-one assistant present with him during the school days whose primary

function was to assist with educational, social, and behavioral difficulties. According to his parents, A.N. had been prescribed psychotropic medication by his primary care physician for Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder since the 3rd grade and for Depression since approximately the 6th grade. He had been receiving outpatient counseling with a private therapist contracted by the school district since the 4th grade and had just begun meeting with an outpatient psychiatrist for medication management three weeks prior to his Brattleboro Retreat admission. He has a long history of oppositional and defiant behaviors, with occasional aggression towards others and/or property destruction, at times requiring physical restraint, particularly within his educational settings. In addition, A.N. reports that since the age of 15 or 16, he has experienced some degree of suicidal ideation and self-injurious behaviors, such as cutting. A.N.'s parents describe their home environment as "very nurturing, loving, and supportive" and describe their son as "a great kid, caring and sensitive, but confused."

B. The Brattleboro Retreat

The Brattleboro Retreat (the Retreat) is a part of Retreat Healthcare, a private, not-for-profit health services organization located in Brattleboro, Vermont. The Retreat provides inpatient psychiatric and addictions treatment for children, adolescents and adults as well as residential and educational programs. The present investigation focuses on the Retreat's Tyler 3 Unit, the inpatient psychiatric unit for individuals aged six through eighteen. According to the Retreat's promotional materials, the Tyler 3 Unit is intended to be a short-term, specialized treatment setting for children and adolescents with severe emotional, behavioral, and/or substance abuse disorders. Tyler 3 is a locked ward with a maximum capacity of 25 patients. It is staffed by board-certified psychiatrists, registered nurses, mental health counselors and social workers. The Brattleboro Retreat, including the Tyler 3 Unit, is licensed as a hospital by the State of Vermont's Department of Health and the Licensing and Protection division of the Department of Aging and Disabilities. The Retreat is certified by the Center for Medicare and Medicaid Services (CMS) and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Currently, and at the time of the incident under investigation, the Retreat's policy in response to behavioral emergencies allows for the use of seclusion and restraint, "...when there is imminent risk of an individual physically harming himself/herself or others (including staff)... We are committed to using non-physical interventions as our first choice of interventions, unless safety issues demand an immediate physical response." (Brattleboro Retreat Policy entitled BEHAVIORAL EMERGENCIES: CRISIS INTERVENTION, SHOW OF SUPPORT, THERAPEUTIC RESTRAINT/SECLUSION AND THE USE OF PROTECTIVE/ASSISTIVE DEVICES, Last Revised on 04/2002).

When deemed necessary by unit staff, the Retreat utilizes a "SHOW OF SUPPORT", the purpose of which is to "...provide adequate numbers of trained hospital staff to support interventions necessary in, or before, a behavioral emergency exists and to ensure the care, welfare, safety, and security of the patients and staff." *Id.* At the time of this incident, the Retreat staff were trained in the use of a crisis de-escalation and physical intervention model entitled the Management of Aggressive Behavior (MOAB®). According to the MOAB website, the program

“presents principles, techniques, and skills for recognizing, reducing, and managing violent and aggressive behavior. The program also provides humane and compassionate methods with aggressive people... MOAB’s goal is to teach participants how to protect themselves from injury, and at the same time, control individuals without causing them harm...”
(www.rebtraining.com).

Additionally, the Retreat’s Behavioral Emergency Policy allows for unit staff to request police assistance and intervention on the unit when deemed necessary. The section entitled “ADDITIONAL SUPPORT REQUIRED DUE TO PRESENCE OF WEAPON, ETC.” states “(a)t times it may be determined that the situation is too dangerous for Retreat staff to manage without additional support. In this case the charge person may determine it is necessary to call the police... The police are to be met at the front door by admissions staff, guided to the area and given report on the situation. They then take charge of the situation. The police are used only in extreme, emergent situations.” (Brattleboro Retreat Policy entitled BEHAVIORAL EMERGENCIES: CRISIS INTERVENTION, SHOW OF SUPPORT, THERAPEUTIC RESTRAINT/SECLUSION AND THE USE OF PROTECTIVE/ASSISTIVE DEVICES, Last Revised on 04/2002).

C. Taser Technology

The Taser, an electroshock device manufactured by Taser International, Inc. is the weapon used by the Brattleboro Police Department against A.N., while a patient on the locked Tyler 3 Unit on October 10, 2003. During a Taser demonstration for Retreat staff and VP&A Advocates present during a September 30, 2004 meeting, Chief John Martin of the Brattleboro Police advised that the Taser delivers 50,000 volts and 1/10th of an AMP of electricity for a maximum of five seconds when the skin penetrating probes are fired at a human subject. Taser International’s website reports the result of the firing of a Taser is “...an instant loss of the attacker’s neuromuscular control and any ability to perform coordinated action.” (www.taser.com). According to an Amnesty International media briefing dated November 30, 2004, there are more than 5,000 law enforcement agencies currently reporting the use and/or testing of Tasers in the United States. The growing use of the Taser as an option in the use of force continuum by police around the country is a highly controversial issue, especially given limited empirical data regarding its safety. On November 26, 2004, Alex Berenson reported in the *New York Times* that 70 deaths have occurred since 2001 following the use of the Taser weapon. On January 7, 2005, Robert Anglen and Dawn Gilbertson reported in *The Arizona Republic* that 88 deaths have occurred in the United States and Canada following the use of the Taser by police. Of those, medical examiners cited the Taser as a “cause or contributing factor” in 8 deaths and could not rule it out as a cause in 3 of the deaths. Additionally, in a case involving the use of the Taser weapon against prison inmates with psychiatric disabilities, a California court found that “(t)here is no dispute over the serious harm that can be, and has been, caused to inmates with serious mental disorders when the weapons in question are used against them... there is no dispute that these weapons are used on inmates with serious mental disorders without regard to the impact of those weapons on their psychiatric condition, and without penological justification...” See *Coleman v. Wilson* 912 F.Supp. 1282 (E.D. Cal., 1995).

D. Vermont Protection & Advocacy, Inc.

Vermont Protection & Advocacy, Inc. (VP&A) is a private, independent, not-for profit agency mandated by federal law to provide advocacy services on behalf of people with disabilities to ensure their rights are protected. See Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. § 15001 et seq, 45 C.F.R. Part 1385 et seq; Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq; 42 C.F.R. Part 51 et seq; Protection and Advocacy of Individual Rights, 29 U.S.C. § 794(e) et seq, 34 C.F.R. Part 381 et seq. Under this federal mandate, VP&A has the duty and authority to investigate allegations of abuse and/or neglect involving people 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 Association of Protection and Advocacy systems.

Since November of 2002, Vermont Protection & Advocacy, Inc. has been providing regularly scheduled outreach to patients on the Tyler 3 Unit at the Brattleboro Retreat. VP&A Advocates' visits to the unit typically include providing general information and education about patients' rights, discussing specific concerns and complaints with individual patients, providing referrals to other appropriate agencies and resources, and monitoring treatment setting conditions with a particular focus on patients' safety, welfare, and the protection of rights. Additionally, for the last several months, a VP&A Advocate has been providing extensive technical assistance to Tyler 3 clinical staff in the development of a facility-wide restraint and seclusion free initiative.

III. CHRONOLOGY OF EVENTS AT THE BRATTLEBORO RETREAT

A. A.N.'s Admission to the Retreat, Tyler 3 Unit

A.N. was admitted to the adolescent inpatient unit, Tyler 3, at the Brattleboro Retreat on October 7, 2003. This was A.N.'s first psychiatric hospitalization. Earlier in the day, A.N. had been suspended from school following a verbal altercation with school personnel that escalated into his destruction of school property. While discussing with his parents the events that had occurred at school that day, A.N. disclosed his self-harming behavior and suicidal thoughts. After consultation with his community based treatment providers, A.N.'s mother accompanied him to a mental health crisis evaluation and he was referred to the Brattleboro Retreat by the crisis screener.

Upon admission to the Retreat, A.N.'s mother completed a "Social History Questionnaire" which asked "(w)hat are your expectations from this hospitalization?" A.N.'s mother wrote "(t)o help him figure out how he might be feeling. Any adjustments he may need in medications."

Also upon admission, A.N. and his parents were interviewed as part of a "Multidisciplinary Assessment" completed by Barbra Southworth, RNC. Of significance to the current investigation are the following entries:

“Chief Complaint: (Why is patient in hospital, and why now?) Very bad anger.

Patient’s Stated Treatment Goals: Some answers to why I do what I do.

Precipitating Factors/History of Present Illness: (reason for admission) This 16 yr old male presents for treatment of unstable mood with anger management issues... Pt was suspended from school earlier today after an incident involving verbal outbursts with teachers. Pt has h/o aggression in the school and has required multiple interventions to restrain him. He has had a 1:1 aide with him in school until this year. He is not doing well in school and has had numerous detentions and suspensions. Pt says he has been increasingly more depressed with periods of irritability and anger. Pt says he cannot get along with anyone. He has h/o self-harming acting out and today he ‘punctured’ his arm with a large pin. He has also cut and burned himself but has not required medical intervention. Today he was not able to contract for safety... He has been aggressive to property but not to other people ‘unless they put hands on me first.’ Father reports that pt’s anger and irritability have increased since Zoloft was introduced 3 weeks ago.

Reported Hx of Trauma: physical, emotional, witness of harm to others.

Hx of suicide attempts: yes; Age of first ideation: 14. Last time was this afternoon today he punctured arm with a large pin, has tried to ‘shove a pole into chest’ Has had multiple suicidal thoughts but is vague about any actions.

Violence/legal Assessment: History of violence or aggression toward others or property: long h/o anger management with destruction to property, aggressive acts toward school officials, and threats (sic) towards others.

Criteria for Admission: Imminent/potential danger to self, Intensive psych. observation/intervention required, Failure of outpatient or partial hospitalization, Impaired reality testing with disordered behavior.”

The medications listed at the time of admission, as prescribed by A.N.’s outpatient providers, were Adderoll XR (70 mg), Zoloft (50mg), and Depakote (1250 mg). The Provisional Diagnoses given at time of admission were Attention Deficit Hyperactivity Disorder, Mood Disorder Not Otherwise Specified, Oppositional Defiant Disorder, and Rule Out Bipolar Disorder. Axis II diagnosis was deferred, and the estimated discharge date was noted as October 17, 2003.

An initial treatment plan for A.N. was completed by Barbra Southworth, RNC, on October 7, 2003, and also signed by Dr. William Knorr, Tyler 3 Medical Director, on October 8, 2003. The treatment plan recorded three main goals along with staff interventions to assist in meeting said goals:

Behavioral Goal: To Maintain Safety of Self and Others
Staff Intervention: Staff and patient will develop plan for safety
Staff Intervention: Set limits on aggressive or impulsive behavior

Medical/Medication Goal: Medication intervention will be effective
Staff Intervention: Monitor and evaluate medication compliance
Staff Intervention: Evaluate effect of meds on level of function

Support Goal: Patient to Report Improved Mood
Staff Intervention: Assist in developing coping strategies
Staff Intervention: Offer alternatives to manage aggressive behavior

Upon arrival to the Tyler 3 Unit, A.N. completed an admission checklist indicating that he had been made aware of the policies and procedures on the unit as well as a questionnaire that contained the following entries:

“Why did you come to the hospital? Please tell us what is going on at school, at home with your parents or siblings, and in your personal life.” A.N. wrote a question mark in response to this question.

“What are your interests? How do you spend your free time? What are your hobbies, after school activities or personal lessons you take?” A.N. wrote: “wrestling, hockey, girls.”

“How do you handle situations and people when you get angry?” A.N. wrote a question mark in response to this question.

“Describe what it means to be ‘unsafe.’ How do you handle these feelings. Have you ever tried to hurt yourself? What have you done?” A.N. wrote: “yes, took a sword and stabbed (sic) myself.”

Additionally, A.N. completed a “Behaviors of Concern Checklist” on which he checked off 27 of the 63 listed items that “...are of concern to you, your family, school counselors, etc.” including the following: carrying weapons; fighting, intimidating others; throwing things; sudden outbursts/verbal abuse; obscene language, gestures, defiance of rules; and suicidal statements.

On October 7, 2003 at 7 p.m., a Tyler 3 Unit mental health worker wrote that A.N. was “very cooperative” upon admission and that, per his father’s report, he had displayed an unstable mood with anger issues since the recent breakup of a romantic relationship. The progress note also indicated that A.N.’s father was concerned that the recent addition of Zoloft was responsible for A.N.’s increased irritability and anger.

B. A.N.’s First Few Days of Treatment at the Retreat, Tyler 3 Unit

On October 8, 2003, Dr. Knorr reviewed A.N.’s chart and physician’s orders, and met individually with A.N. for an initial psychiatric assessment. The progress note entered by Dr. Knorr at 10:00 a.m. indicated that A.N. reported an increase in suicidal ideation and self-injurious behaviors over the course of the previous few months, precipitated by the end of a romantic relationship. Dr. Knorr wrote: “...following the break-up in the summer, he became exceedingly distraught and ‘trashed my room.’ He stated this included putting his head through the window, hitting a glass picture and pounding his head with his fist.” A.N. further reported

that he had again had relationship problems in the recent past and had since engaged in self-harming behaviors on a daily basis, "...cutting himself with knives, pins, tacks, and a sword. The patient stated that he cuts himself 'sometimes for fun and just to gross people out.'" Dr. Knorr wrote: "(d)uring the interview, he made a point to emphasize and over-emphasize the amount of cutting that he had done despite the fact that the scarring and marks on his arms were fairly minimal. He also tended to exaggerate his problems, tending to exhibit much bravado as he was talking about his problems." Dr. Knorr assessed A.N.'s mood as depressed with constricted affect, his judgment to be extremely poor and insight absent. He noted that A.N. met the diagnostic criteria for Mood Disorder Not Otherwise Specified, Rule Out Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Oppositional Defiant Disorder and Borderline Personality Traits. Dr. Knorr's treatment plan for A.N. included cognitive behavior therapy, depression, and group therapy, 15 minute checks for safety, contact with A.N.'s outpatient psychiatrist regarding medication plan, a continuation of his current medications with adjustment of doses and the consideration of alternative antidepressants.

On October 8, 2003 at 2:10 p.m. a Tyler 3 mental health worker wrote: "Pt. had rough day – very wise, sinking into peer negativity – later said that he was 'not feeling safe.' Scratched arms... Very honest about feelings – hard time with assignments, doesn't understand them. Pt seems a bit overwhelmed, hard time w/ assignments – maybe just doesn't want to do them – compliant w/ care plan at this time."

On October 8, 2003, Dr. Knorr spoke with A.N.'s outpatient psychiatrist, Dr. Judy Tietz. Dr. Knorr's notes state that Dr. Tietz reported that A.N. "...has a longstanding history of disruptive behavior, but more recently he's become aggressive at home towards himself and family...Dr. Tietze (sic) discussed the patient's behavior at school, stated he is a friend of 'Wrestle Mania' and 'fans' and they tend to 'body-slam' each other on the playground. She also stated the patient appeared depressed to her, that he was probably exaggerating some of his suicidal and self-injurious behaviors, but that she had recently started him on Zoloft about eight days prior to admission. In addition, he's been on Depakote for about a month, and these meds were added in an effort to stabilize his mood." Dr. Knorr wrote: "We agreed to maximize the Depakote, obtain a blood level in the 90-125 range, and also to increase the Zoloft..."

Also on October 8, 2003, Dr. Knorr received a telephone call from A.N.'s father. According to Dr. Knorr's progress notes, Dr. Knorr informed Mr. N. of the contact he had by phone with Dr. Tietz and discussed the medication plans that he and Dr. Tietz had agreed upon. Dr. Knorr wrote that A.N.'s father "...stated that initially after speaking with the school and talking it over with his family, that they saw patient's behavior deterioration accelerate when Zoloft was started. I had stated that he seemed to be depressed and that I thought he was exhibiting more depressive symptoms and perhaps it was not the Zoloft at all that was causing the difficulties, but an inadequate dose, and that I would initially support Dr. Tietz's plan." Dr. Knorr further indicated that he would consider alternative antidepressants if this plan was unsuccessful considering the significant depressive symptoms experienced by A.N. at the time. He wrote that A.N.'s father "...did state he would support Dr. Tietz and trusted her judgment, and agreed to an increase in Zoloft." They also discussed aftercare plans, including a step-down placement to the Harbor House for a week or so to provide for more stabilization and further observation of A.N.'s behaviors on the increased medications.

On October 9, 2003 at 9:00a.m., Dr. Knorr entered two progress notes into A.N.'s chart, most of which are illegible. It appears as if he wrote that A.N. had engaged in SIB's (self-injurious behaviors) on October 8th, refused medications, and "...later committed to safety but at bedtime asked staff to take glasses so he wouldn't cut self, slept in quiet room...he has hard time c peers..." Dr. Knorr, in his second entry, wrote that A.N. said: "I'll try to be a smart allec and hurt people" and that he "knows that his behavior alienates others and he likes shock effects..." Dr. Knorr's plan, as indicated in his notes, included increasing A.N.'s Depakote to 1375 mg and Zoloft to 100 mg.

A Treatment Plan, dated October 9, 2003, was signed by A.N., Dr. Knorr, Mark Anagnostopulos, PhD., David Grist-Weiner, RN, and Sarah (last name illegible), CTRS. The following entries were noted on the plan: "Planned Discharge Date: 10-15-03; Patient Strengths: Family Involvement; Patient Disabilities/Weaknesses: Impulsive self-harm; Assessments completed: MSE (Mental Status Exam) by Dr. Knorr; Justification for Level of Care: self-harm; Primary Problem: unstable mood & self-harm; Aftercare plan: possible move to Harbor House; Outpatient Treatment Needs: continue med mgmt c Dr. Tietz; Projected date for resolution of all problems: Inpt phase by 10/15/03; Discharge Criteria: stable behavior (not cutting/scratching), aftercare in place; Patient Response to Plan: (left blank)."

At 6:40 a.m. on October 9, 2003, a mental health worker reported in the progress notes that A.N. was maintained on 15-minute safety checks and that he slept throughout the night.

According to the 7:00 a.m. to 3:30 p.m. shift nurse's progress note entered on October 9, 2003, A.N. attended groups and was visible on the unit talking with peers. The note indicated that A.N. reported that he no longer wanted to cut himself as he realizes the effect it has on others. He was asked at one point in the day to move away from a female peer who reported that he was "being perverted" and at another time, was confronted by peers in group about them not liking him sticking his tongue out. The day shift nurse wrote that A.N. tolerated being confronted by his peers. No self-harming behaviors were reported and the plan was to discontinue 15-minute checks.

Dr. Mark Anagnostopulos entered a note on October 9, 2003 indicating that he had spoken to A.N.'s father at length, discussing the possibility of A.N. going to Harbour House following discharge from the Retreat. He made contact with Harbour House and was informed that he should call again a few days later regarding space availability.

During the October 9, 2003 3:00 to 11:30 p.m. shift, a mental health worker entered a progress note indicating that A.N. had displayed some attention seeking behavior among his peers, such as playing loudly with a spoon during a movie and asking an inappropriate question during dinner. A.N. was asked to leave the room several times during the movie, according to the progress note, and was redirected during dinner. The mental health worker reported that A.N. asked to sleep in the quiet room because he felt unsafe, but couldn't provide a reason for his unsafe feelings when asked by staff. A.N. asked about the safety of another patient and when he was reassured of her safety, returned to his room. The note indicated that A.N. was "...quiet, but gamey, having little interactions except with those who displayed stress, anxiety, or sadness."

At 6:00 a.m. on October 10, 2003 a mental health worker recorded in the progress notes that A.N. was maintained on routine half-hour checks and that he slept through the night without waking.

C. October 10, 2003 Incident – Show of Support, Special Procedures, and Police Response

On October 10, 2003 (no time recorded), a nurse reported in A.N.'s progress notes that "Pt. was extremely disruptive during another patient's 'show of force.' Verbally abusive towards RN 'you fat bitch' asked to simply go to his room and not interfere during another patient's violence. Once in room, pt began to 'trash' it throwing furniture, flipping over tables, running down corridor tossing over tables in community area. Requiring quiet room. While in quiet room pt making explicit violent threats 'I'll bash you in every orifice...and shove that needle into your eye socket!' Police were called – pt persisted & threatening them as well. Pt. was informed of medication (Haldol) ↑ more combative. Brat. Police, upon being threatened, used 'tazer' device into chest, pt. was restrained by nursing staff + pt given Haldol 5mg IM in RT Glutar maximus. 'Tazers' were removed by clinic (Bonnie) RN practitioner & use of subcut. Lidocane 1%. Pt ostensibly calmer + in locked door Quiet Room. Dr. Knorr ordered + met & pt. about episode. Pt's window was also destroyed during process. A: Grosely (sic) out of control pt. ↑ aggressive, extremely poor boundaries. P: Monitor responses to Haldol. Eventually 'wean' out of Quiet Room. Pt to be placed on care-plan for outrageous aggressivity."

A.N.'s October 10, 2003 Physician's Orders indicate that a telephone order was made by Dr. Knorr at 12:40 p.m. for Seroquel 100mg po every hour prn for agitation, up to 6x/24 hrs. Dr. Knorr made a second telephone order at 1:05 p.m. for Haldol 5mg IM now, Safety Bag up to 2 hours. At 1:15 p.m., Dr. Knorr made a third telephone order for locked seclusion up to 2 hours. The order rationale listed was "assaultive, violent, threatening, out of control, aggressive."

The "SPECIAL PROCEDURES" form completed by Susan Grant, RNC, on October 10, 2003 indicated that a "SHOW OF SUPPORT" was called at 12:45 p.m. due to A.N.'s physical threats to peers and staff, and his throwing of furniture. Staff interventions checked off on the form included "calming techniques, redirection, limit setting, and choice given to patient: prn offered." Seclusion was marked as having been ordered by Dr. Knorr, with the behavioral criteria for release listed as "(n)o longer out of control." According to the form, seclusion was initiated at 1:10 p.m. and ended at 2:30 p.m., while Haldol 5mg IM was given involuntarily at 1:20 p.m., as ordered by Dr. Knorr. No other types of behavioral management techniques, including therapeutic hold or restraint, were marked on the form as having been utilized.

The Brattleboro Police Department's records indicated that a 911 call was received from the Brattleboro Retreat on October 10, 2003 at 13:03 (1:03 p.m.), with the nature of the incident reported as "disorderly." Lieutenant C. Aleck arrived at the Retreat at 13:09 (1:09 p.m.) and Officer M. Carrier arrived at the Retreat at 13:11 (1:11 p.m.).

Lt. Aleck reported the following in his narrative of the incident: "On 10-10-03 at 1303 Officer Carrier and I were sent to Tyler 3 for a JV out of control. Upon arrival at Tyler 3 we were let in. I

observed a desk broken in the hallway. I was advised that (A.N.) had broken the desk. He had broken other items on the way to the 'quiet room'. Once in the quiet room he then broke the lock on the door. Upon walking up to the quiet room I observed (A.N.) in the room. He was very agitated and threatening to kill anyone who got in near him. He was threaten (sic) the staff and myself with hurting/killing us. He was going to hit me in the Adams apple to kill me. He was going to do whatever it takes to kill/hurt me. He was going to take my gun and shove it up my ass. I had Officer Carrier retrieved his Tazer, (Unit #3). While he was gone I told (A.N.) about the Tazer and he would not like it. He told me that he would take the Tazer from us and shove it up our ass. He was pumped up, pounding the wall with his fist and hands and doing 'air' kicks in a threatening manner towards myself and the staff. When Officer Carrier came back with the Tazer (A.N.) was still threaten (sic) us with injuries if we came into the room. Officer Carrier pulled the tazer and ordered (A.N.) to lay down. He refused to and at this time (A.N.) was tazed. (A.N.) then complied with our orders."

Similarly, Officer Carrier reported the following in his supplemental narrative: "...Upon arrival to the 'quiet room', (A.N.) was observed in the room. (A.N.) was yelling at Retreat Staff that he was going to 'kill them' and anyone who came into the room. (A.N.) observed myself and Lt. Aleck and then positioned himself and (sic) a bladed position towards us and clinched his fist in a fighting posture. (A.N.) told us (Carrier/Aleck) if we came into the room he was going to kill Lt. Aleck and myself and do whatever it took to kill us. He told Lt. Aleck he would hit him in the Adams Apple to kill him. At this point, the decision was made to retrieve the Tazer from my cruiser. I left the area and returned with Tazer number 3. (A.N.) was told if he did not comply with the order to allow us in the room he would be tazed. (A.N.) responded by saying, 'go ahead, I'll stick that Tazer up your ass'. I asked (A.N.) to lie down on the ground and he refused. I again asked (A.N.) to comply with the order and he refused. At this time I tazed (A.N.). The two prongs struck (A.N.) in the upper right portion of his chest. (A.N.) fell to the ground and stated he would now comply. (A.N.) was subdued/controlled by hospital staff. The prongs were subsequently removed by hospital staff and placed into evidence..." Officer Carrier listed 11 Retreat staff members as being present during the incident, including 1 doctor, 2 nurses, 1 nurse practitioner, 1 TAS (therapeutic activities services staff), and 6 mental health workers.

The Brattleboro Police Department's "Main Radio Log Table" indicated that Officer Carrier reported the situation as "under control" at 13:37 (1:37pm).

A Nurse Practitioner from the Retreat's Medical Clinic wrote that at 2:00 p.m. on October 10, 2003 she had received a call from the Tyler 3 Unit to remove the Taser points from A.N. "Tazars used by Police when trying to restrain pt. Pt in Restraint on quiet room floor. 2 small Tazars one at right upper chest and at 10th rib." The nursing note further indicated that the Taser barbs were intact and removed without difficulty.

Dr. Knorr's October 10, 2003 2:39 p.m. Progress Note regarding A.N.'s seclusion and restraint indicated the following: "I was called to see (A.N.), who had become extremely disruptive on the inpatient unit. He destroyed his desk, flipped over a table, threw a chair, and required a physical intervention. He eventually went to the Quiet Room, where he continued to be disruptive, threatened to kill staff, and would not cooperate with the 'contraband'. He continued to escalate to the point that the Brattleboro police were called. They also would not intervene physically

with patient, and elected to use a Taser. The patient did receive a Taser, followed by an IM of Haldol 5mg. When I saw the patient the nurse practitioner was removing the Taser points, and the patient was complaining that he felt badly, but there was no other evidence of a physical abnormality. On further review of the situation, the events that occurred began to escalate when another patient was being restrained and the patient intervened in an interfering manner. In addition, he failed to respond to prompts to go to his room, and then became belligerent when he was redirected for interfering with another peer's treatment, i.e., an eating disorder patient. Patient with escalating violent behavior and property destruction, requiring physical restraint and intervention by Brattleboro police. Patient will be on a care plan. Prns have been ordered, if necessary, by mouth. He will continue on his current medications, which are Depakote, Zoloft, and Adderall XR."

D. Brattleboro Retreat Patient, Family, and Staff Debriefing

Following the incident leading to police intervention, seclusion, restraint, and involuntary medication on October 10, 2003, Mark Anagnostopoulos, PhD., wrote a progress note (no time recorded) indicating that he met with A.N.'s parents for therapy and was later joined by Susan Stanclift, RN, "...to process the events leading to police use of tazer on pt." Dr. Anagnostopoulos indicated that A.N.'s parents were concerned that their son had a reaction to the Zoloft, and were worried that he may additionally be experiencing Bipolar Disorder.

An undated (also with no time recorded) Seclusion/Restraint Debriefing form was completed by Susan Grant, RNC, who noted the following:

Discuss and clarify any possible misperceptions the client may have concerning the incident. (left blank)

Support the client's re-entry into the milieu. "Helped into room – parents"

Identify alternative interventions to reduce the potential for additional episodes. "take prns – follow staff direction"

Was the family notified and debriefed of the seclusion and restraint? "Family in hospital – the incident was explained to them + they visited c pt after"

Hear and record the client's perspective on the episode. "in seclusion for 2 short periods – offer fluids at d/c of seclusion"

Ascertain the client's rights and physical well being were addressed during the episode and advise the client of processes to address perceived rights grievances. "Yes"

Address any trauma that may have occurred as a result of the incident. "Pt still sedated at this time"

Modify the treatment plan as needed. (left blank).

Additionally, Susan Grant, RNC, completed a "Seclusion/Restraint Staff Debriefing" form on October 10, 2003 (with no time recorded). The form listed the names of seven staff members involved in the episode, including 3 nurses, 3 mental health workers, and 1 therapeutic activities services manager (TAS). Also indicated on the staff debriefing form was the following:

What led to the incident: "Pt agitated, threw furniture, + threatened staff + co-pts."

How could it have been managed differently: "n/a Refused prn meds."

Were the clients physical and psychological well being addressed? "Yes"

Were the client's rights to privacy addressed/protected? "Yes"

Was the episode processed with the client? "Yes"

Does the progress note reflect the episode and clients response to processing? (left blank)

The October 10, 2003 3-11 p.m. shift progress note entered by a mental health worker indicated that "(A.N.) did not eat. He did not attend any groups. He had no interactions w/ peers, and almost no int(eractions) w/ staff. Pt. had visit from parents which he slept through much of. Pt. slept through almost the entire shift." The plan noted in the progress note was to continue current treatment and monitor.

E. A.N.'s Discharge from the Retreat, Tyler 3 Unit

On October 11, 2003, a mental health worker entered a note at 5:20 a.m. indicating that A.N. was on 15-minute checks for safety and that he slept through the night.

On October 11, 2003 at 1:35 p.m., a mental health worker reported in A.N.'s progress notes that "Pt had a pretty good shift, compliant w/ staff – parents spent most of AM here. Completed ADL's, seemed remorseful for yesterday's behavior but talking w/ peers blaming it on staff. Slept in afternoon. Pt. seems to be telling staff what he feels they want to hear but maybe not being honest."

Dr. Knorr met with A.N. and his parents on October 11, 2003, and wrote in his progress note: "(t)he majority of the meeting was focused on (A.N.'s) most recent behavior which caused some property destruction on the inpatient unit and resulted in an intervention by the police and with (A.N.) receiving a taser to subdue him. Father believed that the police acted with excessive force and that patient could have been subdued by two people rather than using a taser. I stated that when the police arrive on the unit they are in charge of the situation and they will use the method that they think is most appropriate to subdue a patient with least injury to the patient and to others in attendance." According to the progress note, medication concerns and changes were also discussed. Dr. Knorr reported that Zolofit had been discontinued and noted A.N.'s father's appreciation of that change. Discharge plans were also discussed. Dr. Knorr wrote: "I still plan to have patient discharge some time next week to NFI. Father stated he would prefer that he leave for NFI toward the end of the week rather than at the beginning of the week, based on (A.N.'s)

current behavior and insistence that patient show some clinical improvement. I agreed that he would need to have some clinical improvement before moving to Harbor House.”

On October 11, 2003 (no time recorded), a nurse entered a progress note indicating that A.N. “...presents c blunted affect and quiet mood. Pt. states his mood as tired this evening. Pt was in room all evening per his choice (sleeping in bed)...Pts. mom visited this evening for the third time today. Pts. mom talked c a staff person this evening shift. Mom stated she doesn’t think pt. is getting better here. Pt. was compliant and cooperative. Pt. earned okay points this evening. Pt. had no interactions c peers this evening. Pt presents depressed in his room all evening. Cooperative.”

On October 12, 2003, A.N. was discharged against medical advice, per his and his parent’s request. A nurse’s progress note indicated “Pt mood/affect quiet/sullen. ‘What do I have to do to get out of here.’ Pts parents arrived requesting to leave c their son. MD notified. Parents state ‘We’ve reached an agreement c (A.N.).’ Signed copy of AMA & written statement obtained from parents. Parents feel pt’s tx goals have been met. D/C AMA per MD order to custody of parents @ 11:15am.”

Dr. Knorr entered a progress note on October 12, 2003 stating that he had “...received a telephone call from the nursing staff today stating that (A.N.’s) parents had arrived on the unit and they asked to have him discharged today. Dr. Marrella was contacted and he was not willing to discharge patient at this time without my consent. I did speak to nursing staff at length regarding patient’s behavior. Yesterday he was compliant with all aspects of his care plan and also thus far today. He had no aggressive behavior, no self-injury, and was behaving in an appropriate manner.” Dr. Knorr also wrote that he spoken by phone with A.N.’s father. According to Dr. Knorr’s note, A.N.’s father stated that he was “...quite pleased with (A.N.’s) progress, that last night he had spoke with (A.N.) and that they had worked out a plan for home contract and that in addition this morning (A.N.) was upbeat and seemed like his old self.” Dr. Knorr and A.N.’s father discussed discharge plans regarding medication management and educational programming. Additionally, Dr. Knorr wrote: “I did discuss the risks of taking patient home at this time which included ongoing aggressive behaviors, self-injury, and that they may need to seek crisis services post discharge should patient deteriorate. I also noted patient was leaving without appointments in place at this time and that was also a concern and reason for the Against Medical Advice discharge. Father did understand this but still stated he would prefer to take patient home today.”

Dr. Knorr’s Discharge Summary, dictated on October 15, 2003, indicated that A.N. was discharged Against Medical Advice. Dr. Knorr listed A.N.’s final diagnoses as Axis I: Mood Disorder Not Otherwise Specified, Attention Deficit Hyperactivity Disorder, combined type, Oppositional Defiant Disorder; Axis II: Borderline Personality traits; Axis III: Self-inflicted Injuries; Axis IV: School problems, family conflict; Axis V: 35. Dr. Knorr wrote that his prognosis of A.N. was “...guarded, as cognitive reasoning is significantly impaired and he (A.N.) continues to externalize the responsibility for his problems.”

IV. BRATTLEBORO RETREAT'S PEER REVIEW OF THE OCTOBER 10, 2003 INCIDENT - THIS SECTION REDACTED

Pursuant to the Stipulation executed May 21, 2004 by and between the Brattleboro Retreat and Vermont Protection & Advocacy, Inc., the information contained in this section will only be made available to Retreat Healthcare's Administrative Personnel and VP&A staff members involved in the present investigation.

V. PSYCHIATRIC EVALUATIONS AND CRISIS TREATMENT RECEIVED BY A.N. FOLLOWING DISCHARGE FROM THE BRATTLEBORO RETREAT

On October 13, 2003, the day following his discharge from the Brattleboro Retreat, A.N. presented to Health Care and Rehabilitation Services (HCRS) for a crisis evaluation. A.N. and his parents met with an HCRS Psychiatrist, Dr. Debra McQuade, and an HCRS crisis team screener. A.N. was seeking admission to the Harbour House, a short-term crisis stabilization program for children and adolescents. A.N. reported the precipitating incidents and stressors resulting in his inpatient hospitalization as well as the events that occurred while a patient at the Retreat. Based upon A.N.'s description of the new psychological symptoms he was experiencing as a direct result of having been subdued with a Taser weapon by the police, including anxiety and sensitivity to certain stimuli, the crisis screener recorded that A.N. had experienced a "situational traumatic event" while a patient at the Retreat and Dr. McQuade added "Acute Stress Disorder" to his other previously noted psychiatric diagnoses. A.N. was subsequently admitted to the Harbour House, where he "...related a tale of a chaotic, traumatic event..." experienced at the Brattleboro Retreat, according to the Harbour House progress notes.

A second HCRS Psychiatrist, Dr. Craig Donnelly, evaluated A.N. on October 15, 2003. Dr. Donnelly, in addition to diagnosing A.N. with an "Acute Stress Reaction", reported in his psychiatric formulation that A.N. continued to have flashbacks, hyper vigilance, intrusive thoughts, and sleep problems related to the traumatic Taser incident. He wrote, "(t)his more recent episode represents a complication of a situation already characterized by acute decompensation..."

Within the six months directly following A.N.'s discharge from the Retreat, he requested emergency crisis screening services from HCRS six times. He was admitted to the Harbour House for crisis stabilization a total of five times and to the Northeastern Family Institute's (NFI) residential hospital diversion program one time, where he discharged per his request two days after admission. According to HCRS records, A.N. continued to experience distressing symptoms related to the Taser incident at the Retreat and declined inpatient treatment when recommended on more than one occasion "...based on a bad experience at the Brattleboro Retreat."

VI. OTHER ACTIONS TAKEN IN RESPONSE TO THE OCTOBER 10, 2003 INCIDENT AT THE BRATTLEBORO RETREAT

A. Complaint Letter sent by A.N.'s Father to the Brattleboro Retreat

A.N.'s father sent a letter, dated October 30, 2003, to Richard Palmisano, President and Chief Executive Officer of the Brattleboro Retreat, expressing a number of concerns about A.N.'s experience at the Retreat. Mr. N. explained the crisis circumstances under which his son was placed at the Retreat and explained that "(A.N.) stated that he was feeling detached, depressed, and suicidal. We were not sure where to turn but knew we needed help." Mr. N. wrote that during the intake at the Retreat, he, A.N.'s mother, and A.N., himself, asked many specific questions about policies, procedures, and about "...what would happen if certain behaviors presented themselves." Mr. N. reported that they were informed about the potential for the use of restraints, about the staff's training in the use of restraints, and that such events rarely occurred. Mr. N. wrote: "(n)othing was ever mentioned of Police procedures or of the Brattleboro Police department being called to your facility."

Mr. N. wrote that A.N. had entered the Retreat on October 7, 2003, "...looking for the help that the Brattleboro Retreat was supposedly there for." On October 10th, A.N.'s parents were at the facility for a family meeting with A.N.'s social worker, Mark Anagnostopulos. After calling the unit to see what was delaying A.N. from attending the meeting, Dr. Anagnostopulos reported that a nurse from Tyler 3 had called the police because A.N. had become combative. Mr. N. wrote: "(u)pon entering the retreat everyone had been informed that (A.N.) was an A.D.H.D. child with oppositional aggressive (sic) disorder. We were then informed that (A.N.) had verbally threatened the staff and that after refusing to calm down and refusing to be medicated (A.N.) had kicked the plexiglass loose from its frame in his room. He also had shoved a desk out into the hallway while cursing and swearing at staff. We were told the police department had been called in at that point. (A.N.) then refused to cooperate with the police which led to the officers using a taser gun on my son within your supposed fully trained facility. After subduing (A.N.) with the Taser, the nurse gave him a injection of Haladol (sic)." He wrote that he and his wife walked over to the Tyler 3 Unit and were informed by a nurse that "(A.N.) had been placed in the 'Quiet Room' and that he had also kicked the lock open on that room, but 'not to worry about the plaster because that had been broken by a previous child and not repaired yet.' When my wife and I arrived on the unit the condition and way that we found our son (A.N.) was very disturbing." Mr. N. reported that there were pieces of plaster all over the floor, A.N.'s pants were down to his knees, his socks were missing, and that he had plaster stuck to his face, hands, arms, and feet. He also wrote that A.N. was "...barely coherent. He could barely walk even with my wife's and my help. (A.N.) also could not speak real well having slurred speech and showing great signs of being heavily drugged." After escorting their son to a different room, A.N. told his mother that the police had shot him with a Taser.

Mr. N. advised that he and A.N.'s mother stayed with A.N. for approximately three more hours the night of the incident, while A.N. slept. The family called repeatedly to check on their son's condition and was told that he had slept throughout the entire night. A.N.'s mother and father arrived at the Retreat again around 9:30 a.m. on October 11, 2003 to find that A.N. was still sleeping. He wrote that A.N.'s mother was able to wake him just long enough to have a drink but

the remainder of the time, he slept deeply. Upon his mother's return later in the day, she found A.N. to still be asleep. Aside from managing to awaken him for a short period of time, during which his mother reported that A.N. was "still acting quite medicated and very 'spacy,' he slept on and off for the remainder of the night... (A.N.) did not actually get up until Sunday morning. It is my belief that the dosage given to A.N. of Haladol (sic) was quite high. That Sunday (A.N.) was removed from your facility, scared and with more to deal with than when he arrived..."

Mr. N. also wrote "(w)e feel the Retreat failed to protect my son. Now my son and the entire family have another trauma to deal with. My son checked into your facility looking for answers to why he feels the way he does. Not only did the Retreat not assist him in his quest for answers, but you have given him new questions to be answered. (A.N.) now has new fears, new anxieties that he must deal with, he now can't even use an electric razor! His experience in your facility has not helped him, but to the contrary has made him worse. (A.N.'s) stay at Tyler 3 has created an emotional upheaval for (A.N.) and the entire family. We are disappointed with your system."

B. Letter from Retreat President/CEO to A.N.'s Father

In response to A.N.'s father's October 30, 2003 complaint letter, Richard Palmisano, President and CEO of the Brattleboro Retreat, sent a letter dated December 3, 2003 to Mr. N., acknowledging that it was clear that the family was upset about the events that occurred resulting in police intervention. Mr. Palmisano wrote that the Retreat staff "...receive extensive training in the management of aggressive behavior, with emphasis placed on utilizing non-physical techniques to assist patients with regaining control." Through a review of A.N.'s medical record and discussion with involved staff, Mr. Palmisano concluded that the use of physical restraint was determined to be necessary to prevent injury to A.N. or the staff after non-physical interventions by staff failed to help him regain control of his behavior.

Mr. Palmisano wrote that his understanding of the October 10th incident is as follows: "Your son became agitated and threatening in response to another patient's aggressive behavior while on the unit, although not directed at your son. As a result he destroyed his desk, flipped over a table, threw a chair and broke the thick Plexiglas protecting the window in his room. Despite all of these behaviors, staff did not intervene physically and rather worked to calm him verbally and encouraged him to go to a safe area known as the 'Quiet Room' where he could regain control of his behavior. In order to maintain your son's safety while in the Quiet Room, it is necessary to remove items that could intentionally or accidentally be utilized to hurt himself or staff. This would include his heavy boots, socks, belt, sharp objects and heavy clothes, which would obstruct the staff's view of his body and could be utilized to conceal potentially dangerous items. Your son was offered medication to assist him in regaining control and asked to participate in removing the items that I have described. Not only did he refuse but his behavior continued to escalate to include specific threats to cause serious physical harm to staff. He pounded on the door, popping the lock, suggesting a very violent and aggressive state. Based on these circumstances and the staff's determination that to intervene with the patient was likely to result in physical harm to either them or to your son, the Brattleboro Police were contacted."

Mr. Palmisano indicated in his letter that although the police are rarely utilized, they tend to have a calming effect for most patients under such circumstances. This was not the case, however,

with A.N. who "...continued to escalate and made serious threats of bodily harm, not only to staff, but also to the Brattleboro Police." Mr. Palmisano wrote that following his discussion with the involved officers and the Chief of Police, "...it is my understanding that it was determined that the safest way to subdue your son and to prevent injury to him, staff and to the police officers was to utilize the Taser technology." He continued to explain that given the circumstances, "(i)t was the best clinical judgment of the treatment team that day that your son's behavior was so threatening and dangerous as to necessitate, in addition to the ten staff who responded to the call for assistance, contact with the Brattleboro Police was made. This is a very rare occurrence. My point in raising this is to tell you that the decision is not made lightly by our experienced professional staff. Clearly, the police also determined that your son's behavior was so substantially dangerous to staff and to them as to necessitate the Taser intervention."

Regarding the concerns presented by Mr. N. in his October 30th letter about the medication given to A.N. and the effects of same, Mr. Palmisano wrote that A.N. had been given an injection of 5 mg of Haldol which he stated was not a large or excessive dose given A.N.'s weight and height. Mr. Palmisano wrote: "(t)he excessive sleepiness that you describe is unlikely to have been caused by the medication, although it is possible. Consistent with your letter, the staff's report regarding the incident is that in fact your son was on the floor in the Quiet Room where he was recovering from the application of the Taser and had begun to absorb the Haldol. He was somewhat groggy, likely in response to both of these events. The staff recall that your son's pants were not pulled down and in fact that staff assisted your son in returning to his room. The escort included the charge nurse and a male staff member. You may have escorted them to his room as well."

Mr. Palmisano concluded his letter by reporting that the clinical treatment team and senior staff, in consultation with the Brattleboro Police, participated in a "substantial review" of the care provided to A.N. and the clinical judgments made. He specifically wrote: "(b)ased on those reviews, I am convinced that the appropriate judgment was made in order to protect your son and the staff at the Brattleboro Retreat. The alternative would likely to have resulted in injury to your son and/or to staff based on your son's condition and his failure to respond to earlier levels of intervention. Nonetheless, as a parent I fully understand your distress and your desire to assure that your son was safe. I believe that the decisions of the clinical staff on that day were made with his interest in mind...I hope that (A.N.), can over time, understand and accept how his behavior and continued escalation resulted in the events of that day."

C. Brattleboro Police Department Affidavit of Probable Cause

Referencing the October 10, 2003 incident resulting in police involvement on the Tyler 3 unit at the Retreat, Brattleboro Police Department Captain Steven Rowell sent a memo dated November 10, 2003 to Lieutenant Chuck Aleck, stating: "The BRATTLEBORO RETREAT has requested that we charge folks involved in illegal behavior at the RETREAT as they want people to be held responsible for their actions and the legal system can force 'treatment' through probation. I understand that charging offenders with crimes is the Police Department policy. (Police Chief) John (Martin) and I had meeting last week where they again asked us to charge when possible. I have checked with DAN DAVIS (Windham County State's Attorney) and he believes this is a

DISORDERLY CONDUCT that his office will prosecute. Please have someone prepare an affidavit for charges.”

On December 2, 2003, Officer Michael Carrier submitted an Affidavit of Probable Cause petitioning the Windham County Family Court to have A.N. answer to the charge of Disorderly Conduct as a result of his actions on October 10, 2003 at the Brattleboro Retreat. The Affidavit presented information written in the aforementioned officers’ narratives, specifically regarding the call for assistance with an out of control subject made by the Retreat, A.N.’s property destruction as reported by the Retreat staff, his threats to harm the staff and the police, his refusal to comply with a lawful order, the use of the Taser to enforce the order, and the subsequent restraint of A.N., followed by the administration of medication by Retreat staff.

According to a February 18, 2004 letter sent to the Brattleboro Retreat by the Windham County State’s Attorney’s Office, the Disorderly Conduct charge against A.N. was dismissed due to the Retreat’s failure to provide dates of birth for all witnesses who were on the Tyler 3 Unit at the time of the incident, thereby impeding the State’s ability to successfully prosecute the case.

D. Department of Aging and Disabilities, Division of Licensing and Protection Investigation

On December 4, 2003, A.N.’s father made a complaint by telephone to the Division of Licensing and Protection, part of the Department of Aging and Disabilities within the Agency of Human Services for the State of Vermont. The Division of Licensing and Protection (L&P) is Vermont’s state survey agency authorized by the Center for Medicare and Medicaid Services (CMS) to investigate allegations of regulatory violations in facilities receiving Medicare and Medicaid reimbursement.

Mr. N. reported to L&P the October 10, 2003 incident in which his son was shot with a Taser by the Brattleboro Police at the Retreat, along with the concerns he had written about in his October 30th complaint letter to the Retreat.

Susan Perry, RN, Public Health Nurse Surveyor for the Division of Licensing and Protection wrote a letter to Mr. N., dated May 6, 2004, in response to his December 4, 2003 complaint, stating: “(a)n unannounced onsite investigation was conducted as authorized by the Centers for Medicare and Medicaid Services. The investigation consisted of observations, record review, and staff interview. Based upon the results of this investigation, it was confirmed that law enforcement was summoned in response to a significant behavioral incident on 10/10/2003. However, there was evidence that staff tried less restrictive interventions before a decision was made to contact the police. It was confirmed that an injection of Haldol was administered as ordered by the physician. It could not be verified that your son was left on a bare concrete floor in the ‘quiet room’ on 10/10/03 after receiving the injection. In addition, some repairs had been made to the walls in the ‘quiet room’ prior to your son being placed there on 10/10/2003. However, additional work was required to the walls following your son’s stay in this room due to further damage.”

Ms. Perry wrote that no regulatory violations were identified specific to the October 10, 2003 incident involving A.N., however, unrelated regulatory deficiencies were cited during the investigation.

E. Vermont Protection & Advocacy, Inc. Investigation

Vermont Protection & Advocacy received a telephone call from A.N.'s father on December 5, 2003, at which time Mr. N. reported his grave concerns about the October 10, 2003 incident in which the Brattleboro Police shot his son with a Taser. Mr. N. spoke of his dissatisfaction with the response he received from Mr. Palmisano, President/CEO of the Retreat, and stated: "since leaving, (A.N.'s) condition has worsened due to the trauma he experienced – he is having nightmares, is scared of the police, and has been cutting his arms."

Pursuant to VP&A's federal mandates, VP&A began an investigation that included the following:

- Review of A.N.'s entire Brattleboro Retreat psychiatric treatment record dated October 7, 2003 through October 12, 2003.
- Review of A.N.'s Health Care and Rehabilitation Services (HCRS) and Harbour House psychiatric treatment records dated October 7, 2003 through August 30, 2004.
- Review of Brattleboro Retreat's Behavioral Emergency Policy.
- Review of Brattleboro Retreat Peer Review Records regarding the October 10, 2003 incident (note: VP&A's review of these documents are redacted from public viewing pursuant to relevant law and a stipulation executed on May 21, 2003 by and between VP&A and the Retreat).
- Review of Brattleboro Police Department records regarding the October 10, 2003 response to the Retreat's call for assistance.
- Review of the Department of Developmental and Mental Health Services (DDMHS) records regarding A.N.'s placement at the Retreat between October 7, 2003 and October 12, 2003.
- Review of the Management of Aggressive Behavior (MOAB) training curriculum.
- Review of the Retreat's Tyler 3 Unit maintenance work orders dated October 2003 through December 2003.
- Review of correspondence by and between A.N.'s father, the Brattleboro Retreat, and the Division of Licensing and Protection.
- Discussion with the Retreat's Tyler 3 Unit staff.
- Telephone consultation with the Brattleboro Chief of Police, John Martin, regarding the officers' response to the Retreat's October 10, 2003 call for assistance and general information regarding the Taser technology and other use of force options.
- Telephone consultation with a representative from the State of Vermont Division of Mental Health Acute Care Program regarding the October 10, 2003 incident at the Retreat

VII. VERMONT PROTECTION & ADVOCACY, INC. FINDINGS OF FACT AND CONCLUSIONS

It is noted that the authors of this report were not present during the chain of events that occurred on October 10, 2003, and therefore may not fully appreciate the level of fear the staff may have felt for their safety, the safety of other patients, and/or that of A.N., himself. However, an exhaustive review of the available records relating to A.N.'s treatment at the Retreat indicates that a number of potential treatment failures existed related to the incident under review, as well as failures of a more systemic nature as they relate to record keeping, staff debriefing, physical plant circumstances, and the use of the Taser technology on juvenile patients.

Vermont Protection & Advocacy concludes that the Brattleboro Retreat's reliance on the police and the subsequent use of a Taser on A.N. was a treatment failure of serious proportions. Our investigation demonstrates that A.N. and his parents were clear about their concerns leading up to his hospitalization and the difficulties the Retreat could expect to encounter related to A.N.'s behavior. Further, our review of the Retreat's response to the October 10, 2003 incident indicates an overly heavy reliance on psychopharmacological interventions. VP&A concludes that the use of force on A.N. by the police and the subsequent administration of involuntary medication may have been unnecessary had adequate treatment planning and proactive crisis planning occurred prior to the triggering events that led to A.N.'s agitated and aggressive behavior on October 10, 2003. VP&A also concludes that the Retreat apparently failed to adequately exhaust the de-escalation techniques that staff are trained and certified in, including therapeutic hold when appropriate, prior to calling for police intervention. The facility's documentation around the resort to police assistance was inadequate to demonstrate its contention that all other reasonable means of de-escalation were attempted and applied appropriately. Our concerns about the physical environment, that being the location of the seclusion room, and the failure of the seclusion room door to withstand damage, are also areas where VP&A believes more forethought by Retreat staff and administration could have provided for a different outcome in this situation.

The above-referenced treatment and planning failures resulted in at least long-term emotional harm to A.N. and could have been much worse given the concerns associated with the use of the Taser weapon on medicated juvenile psychiatric patients. Perhaps the most disconcerting result of the October 10, 2003 incident is the trauma experienced by A.N., who was diagnosed with Acute Stress Disorder directly following his discharge from the Retreat. To the present date, A.N. continues to report additional symptoms such as increased anxiety, flashbacks, and intrusive thoughts related to having been shot with a Taser by the police. A.N.'s first experience in an inpatient psychiatric hospital has left him with a strong aversion to similar placements, with the attendant impact of decreasing the available resources to help him when his need is greatest. Additionally, VP&A is concerned with the concept of proportionality regarding the use of the Taser weapon on A.N. It is clear that the Taser was not used as an alternative to the need for "lethal force" but rather it was likely utilized against A.N. as a means to quickly subdue him for the specific purpose of administering involuntary medication. The staff and police did not clearly exhaust more traditional means of managing A.N.'s aggressiveness, apparently out of their concern for potential injury to themselves, to A.N., and perhaps to other patients on the unit.

Instead, they exposed a juvenile psychiatric patient in a locked unit to unknown harm and subsequent trauma by using a weapon with the potential for deadly consequences.

A. Brattleboro Retreat's Lack of Detailed Record Keeping

Retreat records indicate, in general terms, that non-violent de-escalation techniques were employed unsuccessfully during the October 10, 2003 incident in response to A.N.'s agitated and threatening behavior. VP&A was unable to deduce from the records exactly what specific techniques, and to what extent such techniques were used. A.N.'s progress notes did indicate that attempts at redirection were used, i.e., "...asked to simply go to his room and not interfere in another patient's violence..." and that a choice, specifically PRN medication, was offered to him. However, nowhere in the record was the type of "calming techniques" as recorded on the "SPECIAL PROCEDURES" form, described nor who attempted these techniques. With such a lack of detail, it is impossible for an independent oversight agency, or even for the Retreat itself, to objectively determine that staff's response to A.N.'s escalated behavior was optimal or compliant with their training before resorting to the police and use of a Taser weapon on this locked, juvenile inpatient psychiatric ward.

It is apparent from the notes on the day of the Taser incident that A.N. was extremely agitated, verbally insulting to staff, and destroying property. The notes indicate that his behavior became increasingly more threatening once in the Quiet Room. The notes do not reflect, however, how he managed to get to the Quiet Room. The nurse's October 10, 2003 progress note simply states "(r)equiring quiet room" after A.N. had begun damaging furniture in his room and the unit hallway, while Dr. Knorr's progress note states "...and required a physical intervention. He eventually went to the Quiet Room..." Again, without detailed records, it is difficult to ascertain what occurred prior to the explicit threats of harm to staff that A.N. began making once in the Quiet Room. In addition, there is no indication on the "SPECIAL PROCEDURES" form that any type of therapeutic hold or restraint was used at all on October 10, 2003, even though the progress notes and the Brattleboro Police Department records clearly state A.N. was restrained by staff after having been subdued with the Taser, in order to administer involuntary medication. The failure of the "SPECIAL PROCEDURES" form to indicate the use of any physical intervention prior to A.N.'s containment in the Quiet Room, as cited in Dr. Knorr's notes, as well as the utilization of a physical restraint directly following the Taser shooting, as cited in both the nursing notes and police records, demonstrates the need for improvement in the Retreat's record-keeping. Similarly, no records were found indicating what, if any, staff consultation occurred resulting in the decision to call the police and who actually placed the call. The Retreat's "BEHAVIORAL EMERGENCIES" policy states that if a situation is determined to be too dangerous for staff to manage without additional support, "...the charge person may determine it is necessary to call the police." There is no indication that the Tyler 3 Unit charge nurse was the person who in fact made the determination that police intervention was needed or appropriate given the circumstances at the time.

Additionally, A.N. and his parents report that not only are there discrepancies in their recollection of what was provided for information as well as what they observed on the unit, there was a lack of significant detail in some instances. The family noted that there were inaccuracies specific to some information reported in the records, such as how long A.N. had

been receiving Depakote in the community, how long he had been experiencing suicidal and self-harming behaviors and what types of behaviors he had engaged in, when and with whom they had discussed possible discharge planning to the Harbour House, when they had requested the Zoloft be discontinued, and who was present during A.N.'s discharge against medical advice. Information not actually reported in the records included A.N.'s recollection of the police making direct contact with the Taser weapon on his body while threatening to reactivate the shock mechanism upon his attempt to stand up after having been initially shocked from a distance, and the difficulty he states was involved in removing the Taser barbs from his chest. A.N. stated to VP&A that because he was rolled over on the floor in a prone position during the restraint and involuntary medication procedure that followed the Taser shooting, the barbs penetrated deeper into his skin resulting in difficulty removing them as well as considerable bleeding. Also missing from the records is any report of the plaster covering A.N.'s body when his parents were brought to see him in the Quiet Room, the blood they observed to be on his body and on the floor of the Quiet Room, and their observation that his pants were still down around his ankles following the need to remove them for the administration of involuntary medication.

B. Brattleboro Retreat's Failure to Evaluate and/or Utilize Alternative Interventions

“The management of aggressive behavior begins with diagnosing and treating the underlying psychiatric illness...” according to the “Practice Parameter For The Prevention And Management of Aggressive Behavior in Child and Adolescent Psychiatric Institutions with Special Reference to Seclusion and Restraint” published by the American Academy of Child and Adolescent Psychiatry (2001, AACAP, p. 4). The Retreat's response to A.N.'s escalating behavior could have been substantially less traumatic had all potential treatment interventions by Retreat staff been adequately evaluated and attempted prior to the call for police assistance on October 10, 2003. A.N.'s initial treatment plan, developed on October 7, 2003, indicated general interventions regarding A.N.'s need for anger management treatment, including the setting of limits on aggressive behavior, medication intervention, assisting in the development of coping skills, and offering alternatives to manage his aggressiveness. Dr. Knorr's October 8, 2003 progress note indicated, in addition to medication intervention, the plan for A.N. was to participate in cognitive behavioral therapy, depression, and group therapy. However, the fact that A.N.'s chief complaint upon intake was stated as “(v)ery bad anger” and that he and his family were quite forthright in discussing specific examples of his long history of aggressive behavior, as well as his ineffective coping strategies, should have provided for a treatment plan that included more specific short-term techniques to be utilized to assist A.N. in managing his anger while receiving stabilization services at the Retreat. According to the aforementioned 2001 AACAP Practice Parameter, “(t)he treatment plan should include strategies to prevent aggressive behavior, de-escalate behavior before it becomes necessary to use restrictive interventions, and initiate psychological and psycho-pharmacological treatments for treating the underlying psychopathology” (p. 5).

Similarly, the intake information presented by A.N. and his family should have been more thoroughly utilized in developing a plan that would have incorporated a wide variety of non-physical staff responses to any potential display of aggression. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 2003 Hospital Accreditation TX.7.1.3

Standard states “(t)he initial assessment of each patient at the time of admission or intake assists in obtaining information about the patient that could help minimize the use of restraint or seclusion.” The initial assessment, per the intent statement of TX.7.1.3, should identify “...techniques, methods, or tools that would help the patient control his or her behavior...” Although a great deal of information was gathered from A.N. and his parents upon admission to the Retreat, especially of the recent and past circumstances in which A.N. had displayed aggressive tendencies, it is not evident that the information was used to formulate a specific plan, nor were specific techniques identified in the record, that could have helped him to better manage any potential aggressive behavior. Had the information presented upon intake been utilized to develop an individualized, targeted plan towards managing aggressive outbursts that could have realistically been anticipated, perhaps a more proactive approach could have been successfully implemented.

The development of specific non-physical intervention strategies based upon information presented in the initial assessment is particularly relevant to the events that occurred just prior to and upon entering the Quiet Room. As noted above, it is unclear from the record exactly what transpired between the time A.N. was breaking furniture in his room and the hallway and his entrance into the Quiet Room. The record does clearly indicate that once in the Quiet Room, A.N. became increasingly combative and began verbalizing explicit threats towards staff members (and police upon their arrival) rather than lashing out at objects of convenience prior to his move to the Quiet Room. It is very possible that the dramatic increase in agitation, leading to staff’s call for police intervention, had to do with staff’s attempts at or actual initiation of physical interventions at that particular point in time. Again, due to the lack of detailed documentation, there is insufficient information available to analyze this possibility. A specific statement by A.N. during the multidisciplinary assessment, had it been explored during the development of a more individualized plan of care to assist A.N. in the management of his behavior, may have provided for a completely different outcome. Specifically, he had reported previous aggressiveness to property but not to other people “unless they put hands on me first.” An individualized plan developed in conjunction with A.N., in anticipation of aggressive behavior, with a focus on a wide variety of non-physical interventions may have averted the crisis before it rose to the level that it did.

Similarly, an individualized plan for the appropriate use of more restrictive interventions in accordance with the Retreat’s Behavioral Emergencies Policy should have been developed, based upon historical information presented by A.N. and his family. It is unclear from the records why Retreat staff chose not to utilize physical interventions in an attempt to manage A.N.’s aggressive and threatening behavior if in fact they believed he was an imminent danger to himself or others. It is possible, although not mentioned in the Retreat’s records, that his stature was not taken into consideration until the staff found themselves in the midst of an explosive crisis involving A.N. The records indicate that upon admission, a limited physical exam was performed by a nurse who recorded A.N.’s height as 5’8” and weight as 216 pounds. Perhaps his size, in conjunction with his aggressive acting out and destruction of property, raised the concern by staff that they were potentially unable to safely manage a physical intervention should they have chosen to begin one. Rather, they called the police instead of exhausting all possible interventions, including MOAB-approved techniques that the staff were trained and certified in. The 2001 AACAP Practice Parameter states that an important part of planning for an

individual's potential aggressiveness is the assessment including the patient's physical characteristics. "For example, on an inpatient unit, a 6-foot, 350 pound patient in the midst of a manic episode could create a potentially explosive and dangerous situation. Children and adolescents who are larger, taller or developmentally different than those in their peer group pose a similar difficulty. This situation should be foreseen by the intake assessor and addressed by developing special staffing and treatment programming, or by referral to an alternative treatment facility, if possible" (p. 25).

Also related to the Retreat's apparent failure to adequately evaluate alternative interventions prior to seeking police involvement is the seemingly heavy reliance on the use of medication as the primary means to have diffused A.N.'s agitated behavior, as indicated on both the patient and staff debriefing forms. Specifically, the answer recorded on the October 10, 2003 patient debriefing form, in response to "(i)dentify alternative interventions to reduce the potential for additional episodes" was "take prns – follow staff direction." A.N.'s records reflect that PRN medications were offered but refused, and staff direction was given, but ignored. As A.N. did not respond to such "interventions" during the incident under investigation, there is no reason to suggest the same would work more effectively as a de-escalation tool in a possible future episode.

The Seclusion/Restraint Staff Debriefing form included a similar question: "(h)ow could it have been managed differently?" The answer recorded was "n/a Refused PRN meds." Although medication may have been one option in an attempt to help A.N. regain control of his behavior, a wider spectrum of possible interventions should have been considered, prior to calling the police and shooting A.N. with a Taser weapon. Additionally, during the staff's debriefing, there should have been consideration for a more effective and less traumatic response in the future. It is noted that in addition to staff's attempts to redirect A.N., to set limits on his behavior, and to offer him PRN medication, the "SPECIAL PROCEDURES" form indicated that staff interventions included "calming techniques." As mentioned previously, the lack of detail found in the record makes determination of the specific calming techniques utilized impossible.

C. Brattleboro Retreat's Reliance on Police Intervention

Following an exhaustive review of the Retreat's records, it remains unclear exactly why the police were summoned by Retreat staff to contain A.N.'s agitated and threatening behaviors. Certainly A.N. is not the first juvenile patient who has broken furniture, has insulted and verbally threatened staff, or has refused PRN medication. Once in the Quiet Room, A.N. reportedly refused to cooperate with the "contraband" requested by staff in which he would have been required to remove specific pieces of clothing, shoes, belts, and any other items that potentially could cause injury to himself or staff. He was also making explicit threats towards staff, specifically: "I'll bash you in every orifice...and shove that needle into your eye socket!" The Brattleboro Police records indicate that A.N. had broken the lock on the Quiet Room door, was pounding the walls, doing "air kicks" and was continuing his verbally threatening statements towards staff and the police, specifically stating he would kill them if they came in the room. It is not evident from the record that upon entering the Quiet Room A.N. was an imminent danger to himself or others or that he had the means to carry out his verbal threats of significant harm. Although Dr. Knorr did report in his October 10, 2003 progress note that once in the Quiet

Room, A.N. refused to cooperate with the “contraband” and Mr. Palmisano further elaborated on that issue in his December 4, 2003 letter to Mr. N., there is no staff report found that indicated the potential for imminent harm as a result of A.N.’s refusal to be contrabanded. VP&A also notes that in Dr. Knorr’s initial assessment of A.N. on October 8, 2003, he reported A.N.’s tendency to exhibit “...much bravado as he was talking about his problems...” There is no evidence in the record demonstrating that A.N. was doing anything in the Quiet Room other than exhibiting that same tendency.

The Retreat’s Behavioral Emergencies Policy, under the heading “ADDITIONAL SUPPORT REQUIRED DUE TO PRESENCE OF WEAPON, ETC.” states it may be necessary to call the police if a situation is determined to be too dangerous for the staff to handle without additional support. However, there was no indication in A.N.’s records that he possessed a weapon at the time of the incident, or again, that he possessed the means to carry out his threats of harm against staff or police. It is unclear whether A.N. broke the Quiet Room door lock before or after the police were called, however, regardless of the timing, there was no indication in the notes that A.N. was attempting to leave the Quiet Room, rather he was stating rather aggressively that he would cause serious harm to anyone who attempted to enter the room where he was located. Additionally, VP&A surmises that the indication on the “SPECIAL PROCEDURES” form that A.N. was physically threatening to peers was a result of his throwing of furniture prior to entrance into the Quiet Room. The records do not reflect any further potential for harm to other patients upon his placement in the Quiet Room. In fact, on occasion, the records actually report A.N.’s concern and empathy towards his co-patients. The reasons why staff chose not to allow A.N. to continue his verbal tirade inside the Quiet Room, while observing him from the window outside the door to ensure that he did not cause harm to himself, are not evident. The record does not clearly identify what it was about this particular situation that resulted in staff’s determination that it was too dangerous to handle themselves, leading to the call for police intervention and subsequent use of the Taser weapon on A.N.

Questions remain as to whether this was an isolated incident or one in a pattern of systemic failures on the Tyler 3 Unit. The possibility that the treatment environment had a role in the call to police and use of the Taser weapon against A.N. is supported by information discussed during VP&A’s telephone consultations with both the Division of Mental Health (DMH) Acute Care Program staff and the Brattleboro Chief of Police. While reviewing the events surrounding A.N.’s treatment at the Retreat, VP&A was informed that DMH did have some concern of a possible “over-reliance on police” by the Retreat at the time of the incident under investigation. Similarly, Brattleboro Police Chief Martin stated that his department had “responded to several out of control patients” at the Retreat around the time of the Taser shooting and agreed “that some time ago the frequency of calls to the Retreat was of concern.” Since this incident, it appears that efforts have been made to address such concerns. Specifically, DMH staff have indicated that administrative personnel from their Acute Treatment Program and Child and Adolescent Services Program have been meeting monthly with Retreat staff to discuss their inpatient program status and prepare for quality review work by DMH that will begin in 2005. Similarly, Tyler 3 clinical staff and administrative personnel have held at least two meetings with members of the Brattleboro Police Department since the October 10, 2003 incident to discuss issues of concern related to past requests for police assistance within the treatment milieu, to

clarify roles, and to develop collaborative and informed efforts to ensure the most appropriate handling of crisis situations by both Retreat staff and police responders when called.

D. Brattleboro Police Department's Use of Force on A.N.

In addition to VP&A's concerns regarding the Retreat's decision to call the police, we are also concerned about the police decision to utilize a level of force involving the Taser weapon to subdue A.N., the effect of which involved serious traumatic consequences. While discussing the incident by telephone with VP&A, Brattleboro Police Chief John Martin explained that often the mere presence of police in response to agitated patients at the Retreat has provided for immediate de-escalation. Such was not the case in the October 10, 2003 incident. In fact, it appears that the police presence had just the opposite effect on A.N., causing his level of aggressive, threatening behavior to escalate with increased physical defensiveness and posturing noted.

Chief Martin informed VP&A that the protocol utilized by the Brattleboro Police in response to patients at the Retreat is dependent upon the situation, but generally the officers first make verbal contact by asking the patient to comply. The patient is informed that there is the chance they will use force if non-compliant and the officers utilize "lateral force" so that medication can be administered and the situation de-escalated. The Taser is "very low on the use of force continuum" according to Chief Martin, and "...as compared to pepper spray and batons, it is the best method in terms of non-injury and no lasting effects..." for both the subject and the officers involved. Chief Martin stated that the most danger from the use of the Taser is the potential of a fall from a standing position. He further indicated that hands-on struggling with a patient is not recommended, as it often results in injuries to either or both the patient and the officers. Additionally, Chief Martin stated, "(o)ften times, just bringing it (the Taser) out is enough to gain compliance."

The officers' narratives indicate the decision to utilize the Taser occurred as a result of A.N.'s non-compliance with direct orders issued by the police after he persisted in threatening the staff and the officers "...if we came into the room." Again, VP&A questions the reasons why the need was thought to be so great for anyone, including the police, to enter the Quiet Room against A.N.'s very clearly expressed wishes to not come near him, especially in the absence of any indication that he was attempting to harm himself or to flee that space.

Despite the fact that the Retreat staff may have requested police involvement to lessen the likelihood of injury to themselves or to A.N. rather than to use more traditional means of crisis de-escalation, including therapeutic hold when necessary and appropriate, and despite the fact that the police may believe the use of the Taser weapon is less likely to result in injury than other methods of crisis intervention, VP&A remains concerned about the decisions made in response to A.N.'s agitated behavior and the traumatic consequences suffered as a result. Edward Kaufman, M.D., board certified by the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association, provided an affidavit in the *Coleman* case (noted above at page 5) in which he stated: "...it is certainly possible that the 'non-lethal' taser or rubber pellet could seriously injure a prisoner by hitting the head or eye. In every such incident, psychological injury to the mentally ill inmate, damage to any existing therapeutic

relationship, and a reduced prospect of successful mental health treatment in the present and future are almost certain... The appropriate method for restraining a violent or agitated psychiatric patient is to use clinical and custodial personnel, trained in management of assaultive behavior... Properly trained professionals use no weapons... Frequently, appropriately trained mental health professionals will avoid an incident by not reacting to a patient who is acting out or by talking calmly to the patient. They do not risk escalating the conflict by demanding compliance with an 'order'."

A review of the current national and international literature regarding Taser use by police also presents grave concerns. There is ongoing debate about the safety of the Taser technology. As recently as November 26, 2004, the *New York Times* published an article entitled "Claims Over Tasers' Safety Are Challenged." Alex Berenson wrote: "(t)he growing use of Tasers is disconcerting because their risks have not been properly studied, biomedical engineers say. More than 70 people have died since 2001 after being shocked with Tasers, mainly from heart or respiratory failure. Taser International says the deaths resulted from drug overdoses or other factors and would have occurred anyway... Taser has performed only minimal research on the health effects of its weapons..." There is no indication that Taser has studied the effects of its weapons on children or adolescents, let alone on children or adolescents on psychotropic medications. In fact, Alex Berenson wrote in a July 18, 2004 *New York Times* article entitled "As Police Use of Tasers Rises, Questions Over Safety Increase" that Taser International's "...primary safety studies of the M26, which is far more powerful than other stun guns, consists of tests on a single pig in 1996 and on five dogs in 1999. Company-paid researchers, not independent scientists, conducted the studies, which never published in a peer-reviewed journal."

Although A.N.'s father, in his October 30, 2003 complaint letter to the Retreat, questioned whether the extreme sedation exhibited by A.N. following the events of October 10, 2003 was attributed to the involuntary medication administered (a suggestion dismissed by Mr. Palmisano in his response letter), it is possible that the effects of the Taser, alone or in conjunction with the medication he was given, in addition to the overall physiological and/or psychological effects of the entire incident, produced such an effect on A.N. Without empirical research on the effects of Taser use on juvenile psychiatric patients with medication in their system, VP&A suggests the use of such weaponry cannot be considered safe. Furthermore, the traumatic event of being shot with a Taser weapon had different, and potentially more detrimental, psychological effects on A.N. than a traditional restraint hold utilized in accordance with the Retreat staff's MOAB training.

The question of the appropriateness of the use of the Taser, especially against an unarmed subject, is raised in the current investigation as well as current literature on the subject. According to a November 20, 2004 Media Briefing by Amnesty International entitled "USA/Canada: Excessive and lethal force? -- AI's concerns about deaths and ill treatment involving police use of tasers – Facts and Figures", Tasers are less lethal than weapons of deadly force, and "...are promoted as a safer alternative than firearms or impact weapons when dealing with dangerous suspects. However, in practice they are used as a routine force tool against people who do not pose a serious threat. They are frequently used in situations where use of firearms, or even batons, would never be justified... AI has found use of tasers in many instances violate international standards which require that officers should only use force as a last resort,

after exhausting non-violent alternatives, and in proportion to the threat posed...” Chief Martin suggested that the use of the Taser against A.N. at the Retreat provided for a lower likelihood that those involved, including A.N., would be injured than had the police or staff utilized physical interventions. However the use of such a powerful weapon seems out of proportion to the actual threat represented by a juvenile psychiatric patient in a locked ward with nearly a dozen trained staff and police officers present. It is possible that PRN medication was viewed by Retreat staff as the most effective way to manage A.N.’s aggressive acting out behavior, and the only way to administer it was through involuntary means, thereby resulting in the need to incapacitate him long enough to give him a shot. If the goal of the staff and the police was to quickly and safely incapacitate A.N. so they could forcibly medicate him, then that position should have been clearly stated in the Retreat’s records.

In addition to the potentially unknown physical consequences due to the lack of scientifically validated research regarding the use of the Taser on adolescents, also of significance are the unknown emotional consequences. While the use of traditional seclusion and restraint techniques, as stated in the JCAHO 2003 Hospital Accreditation Standards, “...poses an inherent risk to the physical safety and psychological well-being of the patient and staff...” it does not appear that the Retreat possessed scientific or professional data demonstrating that the use of a Taser gun that may result in death or physical injury, creates any less risk of “psychological” damage to a patient, especially a juvenile patient. The trauma reportedly experienced by A.N. as a result of the October 10, 2003 incident, and the subsequent Acute Stress Disorder diagnosis and accompanying troublesome symptoms demonstrate that more attention must be paid to the question of whether the patient or the police are better served by the use of the Taser weapon. The HCRS and Harbour House records reviewed suggest that the newly formed symptoms experienced by A.N. directly following his discharge from the Retreat were unequivocally related to the Taser incident. Additionally, A.N.’s symptoms did not quickly dissipate, rather he continues to identify disturbing flashbacks and intrusive thoughts about having been shot with a Taser by the police at the present time.

E. Brattleboro Retreat’s Poor Physical Plant Characteristics

VP&A is concerned about the possibility that faulty environmental aspects of the Tyler 3 unit may have contributed to the Retreat’s decision to seek police intervention rather than manage the crisis themselves. It is of concern that the walls and the lock of the Quiet Room were such that a patient could damage them. It is unclear exactly in what state of disrepair the walls of the Quiet room may have been prior to A.N.’s presence there. A.N.’s father wrote that when he and A.N.’s mother arrived on the unit to see their son, they observed pieces of plaster all over the Quiet Room floor and plaster actually stuck to A.N.’s face, hands, arms, and feet. He further wrote that a nurse informed him that although A.N. had kicked the lock open on the Quiet Room door, the walls had been damaged by a previous patient and not yet repaired. Upon review of the Retreat’s Tyler 3 maintenance work orders for the time surrounding the incident, VP&A found that on September 29, 2003 the maintenance department received a report of a hole in the wall of the Quiet Room and recorded an entry indicating the wall was repaired that day. Maintenance also recorded an entry on October 6, 2003 indicating that the quiet room walls needed repair, however there were no entries indicating that repairs were actually performed to the Quiet Room until October 15 and October 16, 2003. This certainly raises the question of what condition the

Quiet Room was in when A.N. was placed there and, if indeed it was damaged at the time, why staff would utilize a potentially hazardous space for A.N. to be contained within.

Additionally, it is reported that A.N. broke the lock on the Quiet Room door. However, there is no indication that he was attempting to leave that room, rather he was quite explicit in his demands that staff not enter the room, as he did not want to be injected with medication. It is possible the situation may have been de-escalated had staff been more willing to preserve A.N.'s autonomy once he was located in the Quiet Room by taking a non-intrusive observational stance from outside the door. Although not noted in the record, had A.N. attempted to leave the Quiet Room, there is no indication why the eight to ten staff members who were present for the Show of Support could not have safely and adequately managed such an attempt by simply blocking the doorway.

VP&A's observation of the layout of the Retreat's Tyler 3 Unit is that the Quiet Room is located in the same wing as the younger children's unit, and in fact directly across from some of the youngest patients' bedrooms, thereby presenting potentially dangerous physical plant circumstances should there be an unintended "escape" from the Quiet Room. At the same time, however, it is our observation that during situations resulting in a show of force by staff, in accordance with the Retreat's behavioral emergency policies, typically other available staff members move any non-involved patients away from the area in which the episode is occurring. The lack of detail in the Retreat's records about the possibly inadequate environmental aspects which may have given rise to a potentially more dangerous situation again raises questions about the justification for staff's reliance on police intervention rather than allowing the situation to diffuse itself over time and without the threat of restraint and forced medication.

E. Brattleboro Retreat's Failure to Identify Precipitating Factors

Also of great significance to VP&A's investigation is the Retreat staff's apparent failure to adequately identify and evaluate factors that may have contributed to A.N.'s agitation and aggression on October 10, 2003. The "Seclusion/Restraint Staff Debriefing" form asked specifically: "(w)hat led to the incident." The response recorded on the form was: "Pt agitated, threw furniture, + threatened staff + co-pts." Whether sufficient detail was missing from the form or whether any discussion of possible precursors to A.N.'s disruptive behavior actually occurred among staff is a question that remains unanswered from the information found in the records. VP&A suggests that the nurse's statement in the October 10, 2003 progress note describing A.N.'s agitation and subsequent staff and police response, "Pt was extremely disruptive during another patient's show of force..." merits significant attention by staff in their processing of the incident. Somewhat telling as to the Retreat's failure to acknowledge any precipitating factors in the larger context of what should have been considered a breakdown within the therapeutic milieu is Mr. Palmisano's statement in his December 3, 2003 response letter to A.N.'s father: "I hope that (A.N.), can over time, understand and accept how his behavior and continued escalation resulted in the events of the day." This statement, in essence, places blame solely on A.N. for the unsettling and traumatic events experienced. It is more probable that witnessing a show of force on another patient triggered some significant emotional reaction to previous trauma experienced as identified by A.N. during the intake process. It is possible that the only familiar means A.N. had to process such an emotional reaction were deregulated and aggressive

behaviors, the same that led to his need for inpatient hospitalization in the first place. It is possible that staff's reaction to A.N.'s escalated verbal and aggressive behavior may have been substantially different had there not been a separate show of force on the unit just prior to A.N.'s acting out. It is also possible that factors associated with two back to back shows of force, such as staff's emotional and/or physical exhaustion, frustration with what may have been perceived as a loss of control of the unit, and the desire to more quickly manage what may have become a disturbingly chaotic environment, resulted in staff's reliance on police intervention rather than less drastic measures. VP&A finds that these are all questions that should have been identified, evaluated, and addressed in an attempt to debrief the incidents of October 10, 2003 and to plan appropriately for the prevention of a similar pattern of events, whether specific to A.N. or any other patient on the unit. Unfortunately, VP&A's investigation revealed that these issues were not adequately addressed by the Retreat.

F. Brattleboro Retreat's Peer Review Process – This Section Redacted

VIII. RECOMMENDATIONS

VP&A acknowledges that the Brattleboro Retreat is diligently working towards providing a treatment environment that is restraint and seclusion free. The effort to minimize and eventually eliminate the use of such coercive and potentially harmful practices has been spearheaded by the Retreat's Tyler 3 Unit Clinical Manager, in conjunction with the Tyler 3 Medical Director and Therapeutic Activity Services Manager. The Retreat's Executive Team and Board of Trustees have unanimously voted in support of this philosophical shift in the provision of inpatient psychiatric services and a plan has been developed with the goal of implementing this initiative by 2006.

The current initiative is commended by VP&A but raises an obvious concern that the therapeutic environment and the Retreat staff will need to be much better equipped to manage potential aggressive outbursts by patients, without resort to the police. Not only will the organization be required to undertake a complete paradigm shift, but front-line staff will need to do so as well. Adequate training and utilization of non-physical crisis de-escalation techniques, such as those that were not well reported in the Retreat's records concerning their response to A.N.'s escalation on October 10, 2003, will need to be employed to the utmost extent.

VP&A may have come to substantially different conclusions had sufficient information been provided in the records allowing for a definitive determination that staff's response to A.N.'s behavior on October 10, 2003 was appropriate and/or optimal. Of significant concern is VP&A's knowledge that this incident was not an isolated one, rather there have been additional reports of the Retreat's request for police intervention and the subsequent use of the Taser weapon on at least one other juvenile patient at the Retreat. Given our findings and conclusions related to the October 10, 2003 incident, VP&A hereby recommends the following:

A. The Brattleboro Retreat administration and staff should place a greater emphasis on individualized treatment planning that incorporates specific techniques and interventions to prevent behavioral emergencies, to de-escalate crisis situations when they arise, and to minimize the use of involuntary procedures.

There is currently an initiative underway to eliminate the use of seclusion and restraint at the Retreat. It is acknowledged that members of the Retreat's administration and staff have engaged in a significant amount of best-practices research and networking with other behavioral health care professionals both in state and nationwide. Some changes have been made since the October 10, 2003 incident with regard to better use of intake information and individualized treatment planning in an effort to reduce the need to resort to emergency procedures. One example is a new "Patient Reported Therapeutic Interventions Survey" that is completed upon admission to the Tyler 3 Unit. This form asks specifically what actions and interventions have been helpful and what has made situations more difficult for the patient when upset or having a hard time. It is this type of practical application that is strongly advocated by VP&A to ensure that more proactive therapeutic strategies are developed and attempted prior to the escalation of behavior resulting in the need for restrictive interventions. Similarly, the Retreat is in the process of proposing a change in the curriculum and training provided to staff regarding the management of behavioral emergencies. VP&A supports the proposed changes which have been described by Retreat staff as having a primary focus on de-escalation techniques rather than the use of physical interventions. VP&A recommends that the Retreat administration and staff continue to evaluate alternative practices that will contribute to a healthier therapeutic milieu as well as alternative interventions which may be applied on an individualized basis. VP&A remains concerned regarding the seemingly heavy reliance on the use of PRN medication as the primary means to effectively contain a patient who has not demonstrated cooperation with staff's attempts at de-escalation. VP&A recommends that the Retreat address this issue as a part of its restraint and seclusion free initiative as well as its ongoing performance improvement processes.

B. The Brattleboro Retreat administration should take a greater leadership role and provide improved staff training to ensure that its "BEHAVIORAL EMERGENCY" policies are strictly adhered to.

The policy currently in place regarding behavioral emergencies addresses the Retreat's philosophy, purpose, and procedures regarding the use of restrictive measures such as restraint and seclusion. However, VP&A advocates that the facility's administration should place a greater focus on ensuring that when such interventions are used, the policies are appropriately followed. This includes, but is not limited to: using non-physical interventions as the first choice of crisis de-escalation; utilizing strategies which emphasize preventing the use of seclusion and/or restraint; and utilizing the least restrictive intervention when necessary in an emergency situation where there is an imminent risk of physical harm. Again, necessary resources must be invested in training and quality assurance to achieve this goal.

C. The Brattleboro Retreat administration should take all necessary steps to ensure that patient records and "SPECIAL PROCEDURES" forms contain sufficient documentation and provide a complete and actual representation of the events that occurred before, during, and after a behavioral emergency.

Noted areas for improvement include the recording of specific circumstances leading to and contributing to the escalation of dangerous behaviors, the specific de-escalation measures attempted prior to the initiation of emergency procedures and by whom, the specific patient response to each attempted de-escalation measure, and the specific benefits of the utilization of emergency procedures as opposed to non-physical interventions. VP&A suggests that complete and accurate records will allow for the comprehensive internal administrative review of behavioral emergencies and will not unnecessarily impede investigations performed by external oversight agencies. VP&A welcomes the opportunity to provide feedback on any proposed changes that may be made to the “SPECIAL PROCEDURES” form in the future at the Retreat.

D. The Brattleboro Retreat administration should take a greater oversight role and provide improved staff training to ensure that patient and staff debriefing following a behavioral emergency is completed in a comprehensive and analytical manner.

VP&A recommends that behavioral emergencies at the Retreat should be more adequately evaluated by involved staff and administratively reviewed with a focus on performance improvement elements. Staff and administration should thoroughly consider precipitating factors that may have led to a behavioral emergency, any improvements in responses that could have been made, strategies that could have possibly averted the need for emergency procedures, and the safer implementation of emergency procedures when used.

E. The Brattleboro Retreat administration should take all necessary measures to ensure a safe and adequate physical treatment environment.

VP&A acknowledges that the Retreat is currently in the process of making significant architectural changes to its physical layout with the proposed addition of a Tyler 4 Unit. VP&A advocates that the Retreat develop the proposed Tyler 4 Unit as a distinct and separate treatment environment for the youngest patients rather than the co-mingling of children and adolescents on one unit as is currently the case. Even in the absence of the ability to provide a different unit for different age groups, VP&A strongly recommends that the Retreat change its physical layout to ensure that the Tyler 3 Unit Quiet Room is not directly across from or next to patient bedrooms and/or dayrooms where patients frequently congregate. Additionally, the Quiet Room should be constructed with materials that can withstand damage by agitated and physically aggressive patients to prevent the potential for a dangerous situation to become even more hazardous due to inadequate and unsafe environmental aspects.

F. The Brattleboro Retreat should limit its reliance on police intervention to situations where there is an objective and quantifiable imminent threat of physical danger to patients and/or staff, only after all other reasonable alternatives have been exhausted.

VP&A acknowledges that occasional aggressive behavior by patients may occur in psychiatric treatment settings, however we strongly advocate that law enforcement personnel should not be expected to provide psychiatric patient management services within a behavioral health care setting. Rather, the hospital staff should have adequate training in alternative methods for managing crisis situations and limit the use of police intervention to extreme emergencies where

the imminent threat of physical danger remains after all other attempts at crisis de-escalation have been unsuccessful.

VP&A also acknowledges that the Tyler 3 staff have revised the informational packet provided to parents/guardians upon admission since the October 10, 2003 incident. There is now a statement that indicates police may be called “(i)n the event all staff interventions have been ineffective and a crises situation still exists...” VP&A strongly advocates that the Retreat only employ such drastic measures after staff have exhausted all other available options and have made the determination that patients and/or staff are in immediate jeopardy of physical harm, such as that involving the presence of a weapon.

G. The Brattleboro Retreat administration should develop policies that prohibit the use of Taser weapons against individuals with psychiatric disabilities in their facility, except under circumstances that would otherwise require the use of lethal force.

The use of Taser weapons on a locked, inpatient psychiatric unit poses potential hazards to patients, both physically and psychologically. VP&A suggests that the presence and use of such weaponry jeopardizes the provision of safe and humane treatment for individuals experiencing acute psychological distress and should not be utilized in any therapeutic milieu except as a last resort when the only other appropriate alternative is the use of lethal force.

H. The Brattleboro Police Department should immediately suspend the use of Taser weapons until proven to be safe through empirical research.

VP&A strongly advocates that the Brattleboro Police Department heed the recommendations issued by Amnesty International, specifically the suspension of Taser use pending a rigorous, independent, and impartial inquiry into their use and effects. Should the Brattleboro Police Department be unwilling to suspend their use of the Taser technology as an option in the continuum of force, VP&A recommends that policies be developed to prohibit Taser use on children, individuals with psychiatric disabilities, and people under the influence of drugs except as a last resort when the only other appropriate alternative is the use of lethal force.

IX. RECOMMENDATIONS REGARDING THE BRATTLEBORO RETREAT’S PEER REVIEW PROCESS – THIS SECTION REDACTED

X. ACKNOWLEDGEMENTS AND SUMMARY

Vermont Protection & Advocacy wishes to acknowledge the assistance and cooperation showed to us by all involved parties during our investigation into the events leading to the Taser shooting of A.N. on October 10, 2003, including A.N., his family, his treatment providers, the administration and staff of the Retreat, the staff of the Division of Mental Health, and the Town of Brattleboro’s Chief of Police. VP&A believes this detailed analysis of the events leading up to the Taser shooting and the responses to the incident can be used by all parties involved to better understand what happened and why, and to assist all parties in creating an environment where

the resort to the significant use of force by the police and the Taser weapon can be avoided. VP&A believes that the strict adherence to reporting and documentation requirements is imperative in order to assure that actions taken in regard to juvenile psychiatric care and treatment on the Tyler 3 Unit are appropriate if not optimal. Without adequate, individualized treatment planning and the use of alternative interventions that are appropriately evaluated and analyzed, efforts to improve services and avoid trauma to juvenile patients on Tyler 3 will be significantly impeded. A.N. and his family turned to the Retreat for help with a very difficult set of problems in October 2003. Their experience at the Retreat has further complicated A.N.'s path to a healthy future, but it is hoped that this report and attention to its recommendations may pave the way for increased success for both A.N. and future patients at the Brattleboro Retreat.