

Investigation into the Death of A Resident
at the Serenity House Residential Substance Abuse
Treatment Center on December 11, 2010



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DRVT is the Protection & Advocacy System for the State of Vermont

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I. EXECUTIVE SUMMARY

This report presents the results of an independent investigation conducted by Disability Rights Vermont (DRVT) into the December 11, 2010 death of a resident at Serenity House, a residential substance abuse treatment facility located in Wallingford, Vermont. In order to protect the involved resident's confidentiality throughout this report, he will be identified as "Resident 1". Serenity House staff names and other residents' names have also been replaced with non-identifying pseudonyms.

Resident 1 had voluntarily admitted himself to Serenity House on December 8, 2010 and was found unresponsive in his room at the facility three days later. The Vermont Medical Examiner's Office found that the cause of Resident 1's death was suicide by hanging.

DRVT's investigation identified that Resident 1 did not display obvious signs of suicide during his short time at Serenity House. However, our review indicated that despite evidence that opiate detoxification was a significant issue, Resident 1 was not provided with detoxification assessment or treatment specific to opiate abuse and/or dependence while a resident at Serenity House. Serenity House's failure to fully consider the impact of opiate addiction and detoxification on Resident 1 and the failure to implement appropriate replacement therapy or facilitate a timely transfer to a facility that could provide the necessary services to meet Resident 1's opiate detoxification needs are omissions that may have contributed to Resident 1's untimely death.

DRVT provides this investigative report in furtherance of our federal mandate to protect and advance the rights of individuals with disabilities. This report is intended to illuminate areas of concern and promote improvement in future services, policies, and responses to individuals with disabilities throughout Vermont. DRVT wishes to acknowledge the cooperation received from Resident 1's family and Serenity House administrators during the course of our investigation.

II. BACKGROUND

A. Resident 1

At the time of his death, Resident 1 was a 27 year old Caucasian male, described by his mother as a very smart, charming, and polite young man. He had completed some college courses, was unemployed, and had most recently lived with family members. Resident 1 was on probation for criminal charges related to possession of narcotics at the time of his death. Resident 1 experienced a long history of poly-substance abuse/dependence and had previously completed residential substance abuse treatment at age 18 and outpatient substance abuse treatment at age 20. In the week prior to his admission at Serenity House, Resident 1 had sought inpatient treatment at the Brattleboro Retreat. He reported to Serenity House staff that he had been denied hospitalization at the Retreat because of insurance reasons.

Resident 1 participated in a pre-admission telephone screening with Serenity House on December 7, 2010 and was admitted for residential detoxification and treatment the following day, December 8, 2010. He was found dead in his room at Serenity House three days later, on December 11, 2010, of an apparent suicide by hanging.

B. Serenity House

Serenity House, located in Wallingford Vermont, is a private, non-profit residential substance abuse treatment center, operated by Recovery House, Inc. According to its website, Serenity House offers medically assisted detoxification services, medical consultation, individual counseling, group therapy, and other treatment and self-help services based upon individual needs (<http://www.recoveryhousevt.org/index.php/serenityhouse.html>). Serenity House serves individuals 18 years of age or older who are appropriate for residential detoxification and treatment as assessed using the Diagnostic and Statistical Manual for Mental Disorders IV (DSM IV) criteria for substance abuse/dependence and the American Society of Addiction Medicine (ASAM) placement criteria. Information provided to DRVT by Serenity House indicated that exclusionary criteria for admission may include, but is not limited to, individuals who are not cooperative with the screening or treatment process, individuals who are determined to be in need of intensive psychiatric or medical services, individuals who appear to be actively suicidal, and individuals who present a safety risk to the residence. Pre-screening of individuals seeking admission is done by telephone; newly admitted clients to Serenity House are assessed in person by the nurse on duty; group and individualized orientation are provided within three days of admission; and a more formal assessment used to guide treatment planning is completed within four business days of admission.

Although individualized to accommodate client-specific needs, Serenity House detoxification protocols for alcohol are reported to usually last 4 days and consist of Clinical Alcohol Withdrawal Scale (CIWA) assessments at regular intervals, Librium 25mg (1 capsule by mouth every 6 hours for withdrawal score less than 3; 1 capsule by mouth every 4 hours if withdrawal score greater than or equal to 3 but less than 6; 2 capsule by mouth every 4 hours for withdrawal score greater than or equal to 6); Thiamine (Vitamin B-1 100 mg 1 capsule daily for 7 days); and Multivitamin with minerals (1 capsule daily for 7 days).

Serenity House's detoxification protocols for opiates are reported to usually last 7 days and consist of Clinical Opiate Withdrawal Scale (COWS) assessments at regular intervals, Clonidine 1mg (every 4 hours for withdrawal score greater or equal to 10), Ibuprofen 600mg (every four hours as needed for aches and pains for 7 days), Immodium 2mg (as needed for loose bowel movements for 7 days), Trazadone 25mg (by mouth as needed 2 times a day for anxiety for 7 days), Trazadone 50mg (by mouth at bedtime daily for sleep as needed for 7 days), Bentyl 20mg (one tablet every 6 hours as needed for stomach cramps for 7 days), and a Lithium Taper (50mg 4 times daily by mouth for 48 hours, 50mg 3 times daily by mouth for 48 hours, 50mg 2 times daily by mouth for 48 hours, then 50mg 1 time daily by mouth for 24 hours).

C. Disability Rights Vermont

Disability Rights Vermont (formerly Vermont Protection & Advocacy, Inc.) is an independent, private, non-profit agency empowered by federal law to protect and advance the rights of individuals with disabilities. See Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801 et seq; 42 C.F.R. Part 51 et seq; Protection and Advocacy of Individual Rights, 29 U.S.C. § 794(e) et seq, 34 C.F.R. Part 381 et seq. DRVT has the authority to investigate allegations of abuse and/or neglect involving individuals with disabilities if the incident is reported to DRVT or if DRVT believes there is probable cause that an incident of abuse and/or neglect occurred. Id. DRVT is the State of Vermont's designated protection and advocacy system and is a member of the National Disability Rights Network (NDRN).

DRVT's investigation into Resident 1's death included an interview with his mother and step-father, brief telephone discussions with Serenity House administrators, a review of correspondence and contact notes provided by his family members, a review of his entire Serenity House record, a review of relevant Serenity House policies, a review of relevant Vermont State Police records, a review of relevant Office of the Chief Medical Examiner's records, and consultation with a medical doctor specializing in addiction treatment services.

III. CHRONOLOGY OF EVENTS AND DISABILITY RIGHTS VERMONT FINDINGS

Serenity House records document that a Pre-Admission Telephone Screening was performed with Resident 1 on December 7, 2010. At the time, Resident 1 reported no mental health or psychiatric treatment history, no self-harming behavior, no current medications, no suicidal thoughts within the last year, and stated that he was not under a doctor's care for any reason. Resident 1's mother also reported to DRVT that she was not aware of her son having expressed any prior suicidal ideation.

Resident 1 reported to Serenity House during his Pre-Admission Telephone Screening that his current substance use included daily IV heroin use at the rate of one bag a day for the past week and 5 bags a day over the last six months. His date of last use was recorded as December 6, 2010. He also reported daily alcohol use in the amount of one or more bottles of wine during the prior two weeks. Over the month leading up to his request for detoxification and treatment services, Resident 1 indicated to Serenity House that his opiate use had caused him not to meet his responsibilities, to use in unsafe situations, to need more to get high, to have withdrawal symptoms, to use more of or longer than he meant to, to have been unable to cut down or stop using, to spend a lot of time getting or using, to give up activities or cause problems, and to continue using despite medical or psychological problems. He also indicated that his alcohol use over the past month had caused him not meet his responsibilities, to have been unable to cut down or stop using, to give up activities or cause problems, and to continue using despite medical or psychological problems. Serenity House Staff Member 1 documented on the Pre-Admission Telephone Screening instrument that Resident 1 was experiencing "Dependence with Physiological Sx [symptoms]" related to his opiate use and "Dependence without Physiological Sx [symptoms]" related to his alcohol use.

Serenity House records indicate that Resident 1 stated during the Pre-Admission Telephone Screening that he had gone through detoxification previously, at home, and had experienced prior withdrawal symptoms of being tired and having back pain and back spasms. He had previously completed residential substance abuse treatment at Maple Leaf Farm at age 18 (9 years prior) and outpatient substance abuse treatment at Day One in Burlington at age 20 (7 years prior). He stated that he had sought inpatient treatment at the Brattleboro Retreat on December 3, 2010 but was denied due to insurance reasons. He reported that he was currently on probation for possession of narcotics and had prior charges and/or convictions for DUI, possession of marijuana, and unlawful mischief. In response to the question “why do you want to come to Serenity House”, Resident 1 reportedly replied, “I just really want a place to detox, away from everything I know, so I don’t screw up and call someone when I’m sick. I used to have a very good support network, now I have lost it. My sober friends used to help me out a lot.” Serenity House agreed to admit Resident 1 to their residential detoxification and treatment program the following day, December 8, 2010 at 10:30 a.m.

Resident 1 arrived at Serenity House on December 8, 2010. He was driven there by his mother who reported that, upon arrival, Resident 1 met privately with LPN 1 for approximately 20 minutes. Resident 1’s mother also reported to DRVT that she had inquired about 24 hour nursing and medical access/detoxification services and that LPN 1 confirmed that Serenity House provided 24-hour health access and medical detoxification. Resident 1’s mother stated to DRVT that she was led to believe that her son “was under acute medical supervision.”

Serenity House records indicate that LPN 1 performed a Nursing Triage Assessment on December 8, 2010 at 10:10 a.m. Resident 1 reportedly stated during the assessment that he was not currently experiencing any withdrawal symptoms; that he had no problem associated with detoxification (i.e. history of convulsions, dt’s, seizures, blackouts, etc.); that he had no suicidal ideations and no mental illness. He did respond positively to questions about GI problems, specifically “diarrhea”, and neuropsychiatric problems, “anxiety”.

As documented on the Nursing Triage Assessment, Resident 1 reported his recent substance use as follows: Drinking 1 and a half bottles of wine daily with last use the day before admission, Cannabis “a few hits monthly” with last use 2 days prior, Klonopin 1mg every 2 weeks with last use a week prior, Morphine 60mg weekly with last use 2 weeks prior, Oxycontin 120mg daily with last use 3-4 months prior, and Ativan 12mg every 2 weeks with last use 2 weeks prior to his admission.

Although LPN 1 noted on the Nursing Triage Assessment that Resident 1 had “needle tracks” on his arms and the Pre-Admission Telephone Screening recorded that Resident 1 had reported daily IV heroin use at the rate of one to five bags daily over the past six months, there was no documentation related to any heroin or other IV drug use on the Nursing Triage Assessment.

LPN 1 wrote in her 10:10 a.m. through 10:40 a.m. Progress Note on December 8, 2010 that verbal orders were obtained for “alcohol detox protocol” from Serenity House Physician 1.

Serenity House Staff Member 2 documented an Intake Note at 10:15 a.m. through 10:45 a.m. on December 8, 2010 stating that Resident 1 arrived as planned, had a nursing triage assessment

performed by the nurse on duty, had an unsupervised UA, and completed all intake paperwork (including paperwork indicating that his participation in treatment was voluntary and that he may elect to terminate participation in treatment at any time). Staff Member 2 wrote that Resident 1 was polite and made good eye contact.

Based upon documentation from Resident 1's Pre-Admission Telephone Screening Instrument and Nursing Triage Assessment, DRVT is concerned that opiate detoxification protocol was not initiated for Resident 1, in addition to the alcohol detoxification protocol. Serenity House Detoxification Protocols policy states: "...If the new admission is at risk for withdrawal from drugs/alcohol the nurse on duty will then complete the indicated substance withdrawal scoring sheet...The indicated detox protocol will be initiated by the nurse on duty, and the appropriate detox forms will be used for monitoring the new admission's progress..." Additionally, the Serenity House policy related to Triage Assessment states the following: "...If, using Nursing Judgment, the nurse assesses that the new admission needs to be designated Detox the Medical Director, or designee, will be contacted for orders..." Although LPN 1 did contact Serenity House's Physician 1 for orders, the orders were specific only to the alcohol detoxification protocol. In addition, while Physician 1 did sign the Nursing Triage Assessment form two days after Resident 1's admission, on December 10, 2010, the documentation does not identify the level of oversight Physician 1 employed regarding LPN 1's assessment of Resident 1's needs and status.

DRVT notes that LPN 1 was a Licensed Practical Nurse (LPN), which is a credential that does not allow the holder to be responsible for assessing patients. While an LPN's scope of practice may include "contributing to the assessment of the health status of individuals" pursuant to 26 V.S. A. § 1572 (3)(A)(i), a Registered Nurse (RN)'s scope of practice actually includes "assessing the health status of individuals" per 26 V.S.A. § 1572 (2)(A).

DRVT concludes that the lack of an appropriate assessment by an appropriately trained and certified health care professional, an RN versus an LPN, and the failure to compare the telephone pre-screening information with the information obtained in person may have contributed to the apparent failure to identify opiate detoxification as an important concern for Resident 1's treatment.

On December 8, 2010, between 11:50 a.m. and 12:05 p.m., LPN 1 documented on a Nursing Note that Resident 1's CIWA score was 4 due to an elevated pulse rate of 102 and tremors felt. He reported anxiety to LPN 1 and he was medicated with Librium 25mg. The documented plan was to continue the alcohol detoxification protocol.

Between 4:15 p.m. and 4:30 p.m. on December 8, 2010, RN 1 documented that Resident 1 had a CIWA score of 2, that he complained of mild agitation and hand tremors could be felt. He was medicated with Librium 25mg with a plan to continue the detoxification protocol.

On December 8, 2010, between 10:15 p.m. and 10:30 p.m. RN 1 documented that Resident 1 scored a 5 on the CIWA assessment and that he complained of nausea, sweating/chills and feeling restless and fidgety. He was medicated with Librium 25mg and Phenergan 25mg for "nausea" according to his Medication Administration Record (MAR).

On December 9, 2010, between 8:15 a.m. and 8:30 a.m., LPN 1 wrote a Nursing Note stating that Resident 1's CIWA score was 3 due to tremors felt and clammy skin. He also reported experiencing nausea and was medicated with Librium 25mg.

LPN 1 wrote another Nursing Note between 12:15 p.m. and 12:30 p.m. that day indicating that Resident 1's CIWA score was 5 due to an elevated pulse rate of 97 and visible tremors. He reported experiencing nausea and anxiety, and was medicated with Librium 25mg.

At 4:30 p.m. on December 9, 2010 RN 1 documented in a log note that during her detoxification check with Resident 1 he indicated that he wanted to transfer to Maple Leaf Farm as he wanted to be on the Suboxone program and that he wanted to call them in the morning.

Resident 1's mother reported to DRVT that she received a phone call from her son in the evening of December 9, 2010 stating that he wanted to get into another detoxification/rehabilitation facility because his needs were not being met by medical staff at Serenity House. He reportedly did not feel that he was receiving appropriate treatment to assist him through his withdrawal and detoxification process. He told his mother that he was going to make calls about arranging for a transfer.

On December 9, 2010, between 8:30 p.m. and 8:45 p.m., RN 1 wrote a Nursing Note stating that Resident 1's CIWA score was 5 and that he complained of sweating and had visible hand tremors. He was medicated with Librium 25mg.

At 8:45 p.m. that evening RN 1 wrote in the staff log that she performed another detoxification check with Resident 1 and that he "now thinks he is going to try and stay at SH."

At an unknown time on December 9, 2010 RN 1 completed a "Request for Doctor Consultation" form regarding Resident 1's "[A]nxiety +++ - opiate detox symptoms."

In response to RN 1's request, a Doctor's Progress Note without date or time was documented by Serenity House Physician 1 stating:

In alcohol detox – on meds. Anxiety is expected – on Librium.

Plan: 1. Await eval re anxiety after he has completed detox.

2. May have Nicotine Patches.

3. Use Hydroxyzine 25-50 mg Q 4h PRN for Anxiety.

DRVT notes that on the second day of Resident 1's admission to Serenity House, RN 1 identified that Resident 1 was suffering from opiate detoxification symptoms and although she made an appropriate referral for consultation by the Serenity House physician, no further action was taken to address the opiate detoxification concerns or initiate more appropriate treatment at this time.

On December 10, 2010, between 12:15 a.m. and 12:45 a.m., LPN 2 documented that Resident 1 participated in a 30-minute "acudetox" session. LPN 2 wrote, "[A]fter a short introduction 5 pins were inserted into each ear. [Resident 1] fell asleep during the session, and later said that it made

him think he would sleep well.” LPN 2 later documented that at 12:45 a.m. Resident 1 scored a 2 on the CIWA scale and received 25 mg of Librium.

At 3:45 a.m. on December 10, 2010, LPN 2 documented that Resident 1 “woke up drenched in sweat and is now taking a shower.”

Between 6:45 a.m. and 6:55 a.m. on December 10, 2010, LPN 2 documented in a Nursing Note that Resident 1 was seen in his room and was easy to wake. He scored a 2 on the CIWA scale and received Librium 25mg. The plan documented by LPN 2 was to continue the alcohol detoxification protocol.

At 11:20 a.m. on December 10, 2010 LPN 1 documented in the MAR form the administration of Hydroxine 25mg for anxiety to Resident 1. However there was no associated Nursing Note provided to DRVT by Serenity House about this encounter.

Between 1:15 p.m. and 1:30 p.m. on December 10, 2010, LPN 1 documented in a Nursing Note that Resident 1’s CIWA score was 7 due to an elevated blood pressure of 141/83, an elevated pulse rate of 99, visible tremors, and clammy skin. He also reported nausea and anxiety. The records documented that Resident 1 was medicated with Librium 50mg and Phenergan 25mg.

Records indicate that Serenity House Counselor 1 interviewed Resident 1 at an unknown time on December 10, 2010. Counselor 1 documented that during the past 30 days Resident 1 reported using alcohol 25 days; alcohol to intoxication 17 days; heroin 30 days; methadone 2 days; opiates/analgesics 10 days; cocaine 3 days; and cannabis 15 days. He reported spending \$300 on alcohol and \$2,500 on drugs during the past 30 days. Counselor 1 noted that Resident 1 “sees a slight need for alcohol treatment and an extreme need for drug treatment.”

Regarding his psychiatric status, Resident 1 reported to Counselor 1 that he had experienced serious depression, serious anxiety or tension, hallucinations, and trouble understanding, concentrating, or remembering over the past 30 days. He said he had not experienced any serious thoughts of suicide in the past 30 days and had not attempted suicide during this time period or at any other time in the past although he did report experiencing serious thoughts of suicide at some point during his lifetime. Resident 1 said he had been prescribed medication for a psychological/emotional problem during his lifetime although no other details were available in the records. He reported being considerably troubled by psychological or emotional problems in the last 30 days and he expressed a considerable need for treatment for these problems. He reported experiencing auditory hallucinations at times, the last incident two weeks prior to the interview in which he described hearing someone calling his name. Resident 1 also reported being dissatisfied with his current living situation and extremely bothered by family problems over the past month, particularly with conflicts with his father and grandparents.

Given the information obtained by Serenity House Counselor 1 related to Resident 1’s significant heroin and other opiate use, his fragile psychological status, and his identified need for treatment of these serious problems, DRVT is concerned that there was no indication that any treatment planning and/or detoxification protocol changes were implemented as a result of this information. As evidenced in his Serenity House records, Resident 1 simply remained on the alcohol detoxification protocol until his untimely death.

DRVT found that Resident 1 exhibited many of the symptoms of opiate withdrawal, as well as alcohol withdrawal, and in fact had stated to staff his desire for additional opiate detoxification treatment that was not offered at Serenity House. Serenity House's failure to identify Resident 1's opiate addiction and to provide appropriate replacement therapy (or the facilitation of a transfer to a facility that could provide replacement therapy) is in contradiction to what may be considered best practices in the field of opiate addiction services.

On December 10, 2010, between 5:15 p.m. and 5:30 p.m., RN 1 wrote a Nursing Note documenting that Resident 1 had a CIWA score of 6. She noted that his pulse rate was 106, respirations were 16 and his blood pressure was 146/85. He complained of agitation and had visible hand tremors. He was medicated with Librium 50mg.

Resident 1's mother reported to DRVT that she spoke with Resident 1 on December 10, 2010 by telephone (time unknown). She reported that he told her he was willing to try to stay at Serenity House.

Between 9:15 p.m. and 9:30 p.m. on December 10, 2010 RN 1 documented Resident 1's CIWA score as a 3 and wrote in a Nursing Note that Resident 1 had no complaints at the time of this assessment. She also wrote that visible hand tremors persisted. Resident 1 was medicated with Librium 25mg and the documented plan was to continue detoxification protocol.

Resident 1's MAR documented that he was given Melatonin 3mg for "sleep" by RN 1 at 10:30 p.m. on December 10, 2010. However there was no associated Nursing Note provided to DRVT by Serenity House about this encounter.

Records indicate that Resident 1 was checked by LPN 2 at 1:15 a.m. on December 11, 2010 and scored a 2 on the CIWA assessment at that time. He reportedly had slept briefly but could not get back to sleep. He went out for a cigarette that morning at 1:25 a.m. At 3:00 a.m. he was noted to be asleep on the couch.

At 7:15 a.m. on December 11, 2010 LPN 2 documented that Resident 1 scored a 4 on the CIWA assessment. LPN 2 wrote in a Nursing Note that he had been awake most of the night, sleeping short periods on the couch or in the chair. He received Librium 25mg plus Ibuprofen 400mg for a headache. The documented plan was to continue detoxification protocol.

Resident 1's mother reported to DRVT that around 8:00 a.m. on December 11, 2010 she received a call from her son stating that he needed to transfer to another facility so he could get proper medical detoxification. She offered to make some calls to that end but Resident 1 said he would try to make the calls himself. She asked him if staff would let him make the calls and he told her he was not sure. Resident 1's mother also reported that her daughter, Resident 1's sister, received a call from him that morning that went to her voicemail. On his message, he reiterated that he was not getting the help he needed. Additionally, Resident 1's mother provided DRVT with a copy of an undated letter that Resident 1 had sent during his stay at Serenity House, stating: "...I am having a really tough time staying here. I thought that they had a suboxyn (sic) or methadone

program here, but they don't...I am at my wits end, and I don't want to leave against medical advice. I am desperate to make this work, but I am not getting any help from the medical staff..."

On December 11, 2010, between 11:15 a.m. – 11:30 a.m., RN 2 documented that Resident 1 scored a 5 on the CIWA "due to continued lack of sleep, elevated pulse, mild tremors and generalized anxiety and restlessness. Trying to locate physician who will prescribe Suboxone." He was given Librium 25mg po and then 1 oz. of pepto bismol after lunch. The plan documented by RN 2 was "ETOH detox protocol."

At 11:30 a.m. on December 11, 2010 Serenity House Counselor 2 wrote in the staff log that she allowed Resident 1 to make phone calls to the Brattleboro Retreat and to Maple Leaf Farm. Her note stated, "[Resident 1] reports being extremely uncomfortable in his detox and that 'the Librium isn't touching anything.' He has been interested in getting on a suboxone program."

Based on the records provided to DRVT by Serenity House, it appears that the only assistance provided by staff to address Resident 1's need for opiate detoxification on the day of his death was to allow him to use the telephone to make phone calls to facilities that could have provided the desired, and perhaps more appropriate, opiate replacement therapy.

According to staff incident reports and Vermont State Police records, at about 1:15 p.m. on December 11, 2010 Resident 1 was found by his roommate hanging from a sprinkler pipe in his room with a belt tied around his neck. CPR was performed by staff, 911 was called, rescue responded, and he was pronounced deceased at the scene.

A Vermont State Police Detective wrote that during his investigation he found no evidence of a struggle and no one at the house reported hearing any suspicious sounds from the room. A roommate of Resident 1, who stated he was asleep in their room at the time of Resident 1's death, was characterized as a petite male whose size would contradict him being able to forcibly hang the victim. The State Police Detective wrote that he felt the incident was a suicide and no further action would be taken.

In addition to the above, the State Police Detective wrote that Resident 1's roommate stated that Resident 1 was having a difficult time with detoxification. The roommate advised that Resident 1 did not sleep at all and was always in the day room at night. He said that Resident 1 wanted sleeping medication, but the nurses refused to give him any. The roommate also advised that Resident 1 was having severe withdrawals and wanted to obtain some heroin. He stated that Resident 1 never mentioned killing himself in their conversations.

A Vermont State Police Trooper interviewed another roommate who stated that Resident 1 had been upset and sick and told him he wanted to leave because he felt like things weren't working for him there. The second roommate advised that Resident 1 wanted medication to help him with the way he was feeling, but the staff would not give him any. He said that Resident 1 was going through withdrawals, was "dope sick", and was not sleeping much. He stated that Resident 1 spent most night pacing back and forth. The roommate told the Vermont State Police Trooper that Resident 1 had a girlfriend that recently left him and he was a little upset about that. He said

that Resident 1 never told him he wanted to kill himself, but did say that he was now happy, because he was leaving soon to go to another place. The roommate stated that he didn't think that Resident 1 meant that he was going to kill himself, rather that he was going to another rehabilitation facility. The roommate said that he saw Resident 1 just after lunch in their room and that Resident 1 was sitting on his bed listening to an iPod. He advised that Resident 1 did not say much, and that he (the roommate) left the room to get a drink.

LPN 2 noted the following in a December 12th Progress Note (the day after Resident 1's death): *"[Resident 1] participated in alcohol detox. He last used alcohol in the amount of a bottle of wine on 12/7/10 at 4pm and had been using at that rate for 2 weeks. In addition he reports using Oxycontin 125mg po daily for 3-4 months and 1-5 bags of heroin daily for the last 6 months. During detox, [Resident 1's] blood pressure ranged from 108/67 to 146/85 and he received 16 doses of Librium. [Resident 1] was able to tolerate fluids and food well from day one of detox and was able to attend programming on day one. He was able to perform activities of daily living without difficulty. He tolerated detox with mild withdrawal symptoms, mainly tremors, insomnia and some agitation. During the course of detox, [Resident 1's] disposition was low key. His level of participation in programming would be best described as variable and demonstrated poor recognition of the severity of the substance-related problem."*

DRVT finds that there was ample evidence available to Serenity House staff to indicate a need for Resident 1 to be considered for opiate detoxification protocols and to be provided with additional treatment specific to his opiate addiction, yet there is no evidence that Serenity House identified this concern as relevant to his detoxification and treatment needs or his untimely death. The fact that he was documented to have demonstrated poor recognition of the severity of his substance-related problem may have been due in part to Serenity House's failure to actively identify and treat the opiate-related issues of his detoxification process.

IV. CONCLUSION AND RECOMMENDATIONS

Resident 1's suicide was an unnecessary tragedy. Although he displayed no obvious signs of suicidal ideation during his admission to Serenity House, the question remains as to whether his death may have been prevented had he received the apparently necessary opiate detoxification and treatment services he sought, with appropriate nursing assessment, medical oversight, and replacement therapy for his serious opiate addiction. Serenity House records demonstrate that Resident 1 made staff aware of his daily use of heroin in the months prior to his admission as well as other significant opiate use, that he displayed obvious signs of opiate withdrawal, and that he expressed his concerns on more than one occasion to staff that the treatment he was receiving at Serenity House was inadequate to meet his needs. Although one nurse did in fact refer him for a consultation with the Serenity House physician because of concerns she had about opiate withdrawal symptoms, the only detoxification protocol that Resident 1 was placed on during his short stay prior to his death at Serenity House was the alcohol detoxification protocol, and that did not include important opiate detoxification and treatment options.

Furthermore, DRVT's follow-up with Serenity House administrators during the course of our investigation revealed that Serenity House's own internal examination of Resident 1's death found no errors or omissions during Resident 1's admission. The Serenity House administration stated their belief that they had followed all of the policies in place at the time, and indicated that they had not taken any steps in the wake of Resident 1's suicide to address the fact that residents' bedrooms contained very obvious ligature risks.

Based upon our findings in this investigative report, DRVT recommends the following:

1. Serenity House should ensure that Registered Nurses, rather than Licensed Practical Nurses, perform all new admissions' Nursing Triage Assessments to ensure adequate assessment and evaluation of residents' detoxification and treatment needs;
2. Serenity House should revise its Detoxification Protocol policies to ensure that residents who are in need of co-occurring detoxification protocols are placed on the proper protocols and receive the proper treatment, including opiate replacement therapy when clinically indicated;
3. Serenity House should revise its Screening and Treatment Protocols to ensure that if a resident's clinically indicated level of treatment is not able to be provided at Serenity House then appropriate referrals and/or a transfer to a more suitable treatment center is facilitated by Serenity House staff;
4. Serenity House should provide additional training to staff about the need to review information obtained and documented during all aspects of a resident's care, including the Pre-Admission Telephone Screening, to determine appropriate detoxification and treatment planning; similarly, when new information is obtained during the course of a resident's stay at Serenity House, treatment plans should be updated accordingly; and
5. Serenity House should take all reasonable measures available to remove ligature risks from residents' rooms, bathrooms, and other areas of the facility to which residents have access.

For questions or concerns regarding DRVT's independent investigation into the December 11, 2010 death of a resident at Serenity House, please contact A.J. Ruben at 1-800-834-7890.