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Press Conference May 12, 2004

Re: Amanda Menei and Christopher Fitzgerald

Ladies and Gentlemen, thank you for coming to today's press conference to receive Vermont Protection and Advocacy's investigative reports into the circumstances surrounding the suicide deaths of Ms. Amanda Menei on September 15, 2003 and Mr. Christopher Fitzgerald on August 8, 2003 at the Vermont State Hospital in Waterbury, Vermont. I will make a short presentation and then take questions. There are press packets available with information to take with you.

My name is Ed Paquin and I am the executive director of Vermont Protection & Advocacy, Inc. Here with me are : A.J. Ruben and Ginny McGrath, VP&A's attorneys and Paul Poirier, a VP&A advocate who worked on these reports. In addition, representatives from the Menei and Fitzgerald families are present.

VP&A is an independent, private, non-profit agency operating under federal mandate to investigate allegations of abuse, neglect and rights violations of people with disabilities and to provide them advocacy services.

Since 1986, VP&A has been advocating for Vermonters with mental health issues and monitoring their treatment both in hospitals and the community. The results of these investigations are relevant to concerns raised by clients, their family members and advocates, regarding the mental health treatment they receive at the Vermont State Hospital.

These reports identify failures on the part of the administration and staff at the Vermont State Hospital which created circumstances that may have contributed to Ms. Menei's and Mr. Fitgerald's suicides. The reports point to the absence of a written, comprehensive suicide prevention policy, lack of adequate staffing, lack of an appropriate physical environment and failure to ensure that important patient safety information was communicated to and among staff.

Ms. Menei was nineteen years old when she died. She had been admitted to the Vermont State Hospital six times. During her last admission, which began on July 14, 2003, Ms. Menei experienced 40 involuntary emergency treatment procedures ranging from involuntary administration of medication to seclusion and restraint. In the early afternoon of September 15, 2003, a treatment team meeting took place and a new treatment plan was drawn up for Ms. Menei that included the directive that all items in her possession that could be utilized for self-harm, including shoelaces, were to be taken from her. This treatment plan was not conveyed to Ms. Menei's new treatment team and the inventory of her possessions did not list shoelaces. At 5:15 pm on September 15th, the on-call physician was notified that Ms. Menei had abruptly left a group therapy session and he directed that she be placed on 15 minute checks. At 6:20 pm, the on-call physician was notified that Ms. Menei had self-harmed and he ordered Thorazine but did not increase her supervision. Ms. Menei was found hanging by a shoelace in the bathroom at approximately 7:15 pm. The on-call physician did not come in contact with, or personally evaluate, Ms. Menei on September 15th. The State Police investigation matched the shoelace that Ms. Menei used to hang herself with the other shoelace in her sneakers.

Mr. Fitzgerald was 39 years old when he died during his second admission at the Vermont State Hospital on August 8, 2003. He had previously received treatment at the Central Vermont Hospital and Northwest Counseling & Support Services. He was experiencing multiple stressors in his life and was expressing suicidal ideation at the time of his August 2003 admission. Mr. Fitzgerald was placed on 15 minutes checks when admitted yet, without explanation, these were discontinued within twenty-four hours. No record exists that a formal suicide assessment was made prior to his removal from 15 minute checks.

VSH records show that on August 7, 2003, Mr. Fitzgerald was subjected to restraint and involuntary medication by the VSH staff when he refused to get out of bed. He contacted VP&A and an advocate met with him that evening and took photographs of the injuries he said he had sustained as a result of his restraint. That evening, he covered his window with a sheet which he removed at staff's request. Later, he soaped his window and although VSH staff later claimed that it had been cleaned, photos taken by the State Police show the presence of soap on the window. Though VSH staff claimed that they were performing thirty minute checks on Mr. Fitzgerald through the night, Mr. Fitzgerald was found hanging in his room at approximately 7:20 am on August 8, 2003. His records indicate he was not checked between 6:30 am and 7:20 am. Mr. Fitzgerald left a suicide note which read, in part,: "NO MORE LIES, NO MORE PAIN! Today's assault is the last degradation I can endure.".

Vermont Protection& Advocacy's investigative reports into the deaths of Ms. Menei and Mr. Fitzgerald provide specific evidence of systemic failures which account for the environment and circumstances in which neither Ms. Menei nor Mr. Fitzgerald was provided adequate mental health treatment while at VSH. Our reports quote a letter sent by former medical director Bertolde Francke on August 7, 2002, a year prior to Mr. Fitgerald's suicide, to the VSH Governing Board, which specifically states: *"This letter will have achieved its purpose if we have substantiated the following points: The hospital is no longer a safe place for patients; we are not meeting our professional ethical standards of providing safe and individualized comprehensive treatment; this is not a temporary crisis that will resolve on its own and urgent help is needed".*

VP&A acknowledges that the Department and VSH have addressed some of the conditions that created the circumstances which resulted in these tragic deaths. However, we believes that more can and should be done by the leadership of the Department of Developmental and Mental Health Services as well as by the administration of VSH. Recommendations are made in the conclusions of both reports which, if implemented, may assist in preventing a reoccurrence of these tragic circumstances. Those recommendations include:

Assure that all staff are verifiably and continually trained to understand the policies and standards controlling their treatment of patients. All staff, from psychiatric technicians to the staff psychiatrists, must be well-versed in the formal policies relating to use of force, flow of patient information, suicide prevention, criteria for various levels of supervision and placement within the facility. These policies must be provided in writing, and where they do not yet exist, such as criteria for changing levels of supervision, they must be created with input from doctors, patients and advocates.

The administration must use all available resources to assure that VSH staff and patients have a voice that is respected regarding the physical and psychological environment of VSH. The administration should implement a process that documents the suggestions of these various groups and the actions taken in response to them.

Any staff that were negligent regarding the care and treatment of either Ms. Menei or Mr. Fitzgerald must be reprimanded and provided with additional, verifiable training relative to their individual failures identified by this report, the CMS report and any internal VSH investigation.

The administration must create a more comprehensive and insightful investigation protocol to review all instances of self harm, use of force, and suicide.

Formal apologies to the families affected and offer of compensation would be appropriate from the administration based on these findings.

You can refer to the complete investigation reports that are included in your media packets for more detailed information about specifics of the investigations and further elaboration on the recommendations.

Vermont Protection & Advocacy acknowledges the dedication and excellent work of much of the VSH staff. We also believe that leadership at the Department and at VSH have taken these events seriously and are working within their resources to remedy conditions that may have allowed these regrettable events to occur.

We hope that these detailed reports will assist the department in determining what areas of treatment for clients at VSH need to be improved.
I'll take questions at this point.

For further information please call me at Vermont Protection and Advocacy. My card with contact information is in the Press Package.

Thank you very much.