

REPORT OF:

**THE CIRCUMSTANCES SURROUNDING THE SUICIDE DEATH
OF MS. AMANDA MENEI ON SEPTEMBER 15, 2003 AT THE
VERMONT STATE HOSPITAL IN WATERBURY, VERMONT**

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FINAL INVESTIGATIVE REPORT

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I. INTRODUCTION

This report presents the results of the investigation conducted by Vermont Protection & Advocacy, Inc (VP&A) into the circumstances surrounding the suicide death of Ms. Amanda Menei on September 15, 2003 at the Vermont State Hospital (VSH) in Waterbury, Vermont.

Since 1986, VP&A has existed as a statewide non-profit agency dedicated to advancing and protecting the rights of people with mental health and disability issues. The results of this investigation into the circumstances of Ms. Menei's suicide are relevant to concerns raised by many people with disabilities, their families, and advocates regarding the mental health treatment environment facing Vermonters today.

This report details systemic and individual failures that together created circumstances that led to Ms. Menei's suicide. This report focuses on policies and protocols adopted by VSH, many of which are unwritten as described by VSH staff. These policies and protocols are in place to protect patients and assure their humane and appropriate treatment. When these policies and protocols are violated or ignored, as they were in Ms. Menei's case, the consequences are tragic.

Based on continued monitoring of VSH, VP&A believes that weak enforcement of policies and protocols affecting patients continues to be a source of serious concern and an ongoing threat to patient safety.

II. BACKGROUND

A. Ms. Amanda Menei

Ms. Menei was a 19 year old, single, white female who was originally from the Philadelphia area. She moved to Vermont with her family. At the time of her first admission to VSH she had been living at the Safe Haven program in Randolph, Vermont. She was the oldest of three children. She had a good family relationship with her sisters and her parents. Her parents and two sisters survive her.

Despite Ms. Menei's young age she had a long psychiatric history extending back several years. She was sexually abused between the ages of 6 and 11 by a group of neighborhood boys. Her parents became aware of the abuse and attempted to have the boys prosecuted, but were unable to succeed in that effort apparently because the Statute of Limitations had already passed. Since those incidents, Ms. Menei had multiple admissions to various treatment facilities in Vermont and New Hampshire. According to medical records obtained from Central Vermont Medical Center, Gifford Memorial Hospital, Clara Martin Center, and VSH, Ms. Menei had a long history of attempted suicides. Ms. Menei suffered from hearing voices telling her to hurt other individuals and to kill herself. Ms. Menei was known to have suicidal ideations throughout her short life. Her most recent

diagnoses had included PTSD (Post Traumatic Stress Disorder), Severe Depression, Borderline Personality Disorder, and significant Polysubstance Abuse.

At the time of her admission on July 14, 2003, Ms. Menei had experienced five prior VSH admissions due to her inclination to self-harm. With the exception of a few unsuccessful pre-placement visits (PPV's), Ms. Menei remained hospitalized at VSH with limited rights from July 14th until her death at VSH on September 15, 2003. During her last hospitalization she was the recipient of approximately 40 involuntary emergency procedures, ranging from seclusion to restraint to involuntary medication. From Ms. Menei's first VSH admission in March of 2002 until her death in September of 2003, she received over 140 involuntary procedures.

B. Vermont State Hospital

The Vermont State Hospital is housed in a structure more than one hundred years old in the State Office Complex in Waterbury, Vermont. There are three hospital units within VSH, Brooks Rehab (BR), Brooks One (B1), and Brooks Two (B2).

The BR Unit is a 14-bed unit and it is the least restrictive unit in VSH. According to information obtained by VP&A through VSH staff interviews, patients who are housed on BR are considered safe to themselves and to others. There are no areas within the BR Unit for involuntary procedures. VSH staff reported during interviews with VP&A that if a BR Unit patient develops a crisis the patient is transferred to another unit. Staffing levels on the BR Unit are the lowest of the three units because the types of patients living there are often elderly or do not require intensive supervision. Access to the BR Unit is dependent upon one's behavior. Patients are expected to comply with treatment and must demonstrate that they are not a threat to themselves or to others in order to remain on the Unit. Apparently, none of the above referenced information about the BR Unit, which was obtained by VP&A interviews of VSH staff, is formalized into written policy or regulation by the VSH administration.

B1 is a 19-bed unit and is the most restrictive unit. B1 is the forensic unit of VSH. 18 men and 1 woman occupy B1. The unit is fully equipped to administer all forms of emergency involuntary procedures.

B2 is a 20 bed medium restrictive unit. The unit does use emergency involuntary procedures.

C. Vermont Protection & Advocacy, Inc.

Vermont Protection & Advocacy, Inc (VP&A) is an independent, private non-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; Protection and Advocacy for Individuals with Mental Illness, 42 U.S.C. § 10801 et seq; 42 C.F.R. part 51 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 has jurisdiction to conduct investigations of alleged abuse and/or neglect in the following settings: hospitals, nursing homes, community facilities, board and care homes, homeless shelters, jails and prisons, and in the community. 42 U.S.C. §10802(3); C.F.R. §51.2.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF MS. MENEI

A. Sixth Admission through September 13, 2003

Ms. Menei was admitted to VSH on July 14, 2003. This was her sixth admission to VSH within eighteen months. During this admission Ms. Menei was allowed pre-placement visitations (PPV's) but they ended quickly and she was returned to VSH because of her dangerous behavior in the community.

Ms. Menei was placed on a PPV on September 11th to the Clara Martin Center in Randolph, Vermont. At 6:00 a.m. on September 12th she was re-admitted to VSH because of dangerous behavior in the community. Ms. Menei had apparently attempted to jump off a second story porch at the Clara Martin residence and explained to VSH staff that she "wanted to fly." Once admitted, Ms. Menei was assigned to the B2 unit. By 1p.m. on September 12, 2003, a decision was made to move Ms. Menei to the BR Unit. The BR Unit is apparently intended only for patients who do not need special restrictions or supervision. The BR Unit is populated by elderly, physically disabled, trauma survivors, and low-risk patients. There is no formal document specifying the criteria or characteristics for patients admitted to the BR Unit, however VSH staff consistently identified the BR Unit as intended for the purposes and patients stated above.

There was no specific documentation in Ms. Menei's VSH records acknowledging the lower level of supervision she would receive in the BR Unit, nor the medical rationale for reducing the level of supervision by transferring her to the BR Unit. According to interviews of VSH staff, Ms. Menei was moved to the BR Unit because the staff on B2 felt Ms. Menei's presence created a serious safety problem as two other patients on B2 at the time were very demanding of staff resources and maintaining all three patients in the same unit was likely to result in injury to one or more of them. On Saturday, September 13, 2003 at 12:45 p.m., the doctor responsible for BR Unit patients verbally ordered that Ms. Menei be placed on 15-minute checks because she reported "feeling unsafe."

B. September 14, 2003 Events

On Sunday, September 14, 2003 at 9 a.m. a VSH staff person whose name is not legible in Ms. Menei's records removed Ms Menei from 15-minute checks. The progress notes for this action do not indicate any specific reasons for reducing Ms. Menei's supervision. She gradually regained her unit rights as she became compliant with her behavioral plan.

At approximately 11:45 a.m. on September 14th VSH records demonstrate that Ms. Menei was given medication for agitation and medical treatment for recently self-inflicted wounds. At 12:00 p.m. on the 14th Ms. Menei notified staff that she felt unsafe. BR Unit staff contacted a doctor and he ordered Klonopin and more direct observation of Ms. Menei, but did not reinstitute 15-minute checks. There was no information in Ms. Menei's medical record indicating that the doctor referred to any VSH policies or protocols to determine what level of supervision should be applied to Ms. Menei due to her behaviors. Investigation of VSH Policies determined that there is no VSH policy on when and under what circumstances 15-minute checks are ordered or rescinded.

C. September 15, 2003 Warning Signs

Ms. Menei telephoned VP&A and spoke with an intake specialist on Monday morning, September 15, 2003. During this call, Ms. Menei expressed concern that VSH was discharging her that day and she did not feel safe. The intake specialist called a VP&A advocate who was working at home and that advocate contacted Ms. Menei by telephone at about 12:00 p.m. on the 15th. Ms. Menei reported she felt suicidal and did not want to be discharged from the hospital. Ms. Menei reported that she felt she would get into trouble in the community leading to criminal charges if she were discharged. She felt that her treatment team was not listening to her concerns about her safety. The VP&A advocate assured Ms. Menei that the advocate would contact members of Ms. Menei's treatment team and advocate for her safety.

The VP&A advocate telephoned Ms. Menei's social worker, and informed her that Ms. Menei reported she felt she would kill herself or someone else if she was discharged from the hospital that day. The social worker was notified that VP&A considered Ms. Menei's threat to be very serious and was documenting the warning that was being relayed in that telephone call. For her part, the social worker made references to Ms. Menei's unsuccessful attempts at community living and stated that she cannot "live in the hospital."

The VP&A advocate then called the Medical Director responsible for VSH operations, and told him of her conversation with the social worker and Ms. Menei. He reported to the advocate that Ms. Menei had told him that she would blow her head off if she were discharged that day.

The VP&A advocate understood at the end of these conversations that VSH staff were aware of the serious nature of Ms. Menei's threats to harm herself and would not discharge her into the community against her wishes. The advocate conveyed this

information to Ms. Menei at about 12:30 p.m. on September 15th. Ms. Menei seemed reassured and thanked the advocate for her intervention.

D. The September 15, 2003 New Treatment Plan

On September 15, 2003, Ms. Menei's behavior plan was amended during a treatment team meeting held at approximately 12:30 p.m. on the Brooks 2 Unit. At that meeting, a staff psychiatrist, the Head Nurse from Brooks 1, Ms. Menei's social worker, the Head Nurse for BR Unit, and Ms. Menei were present. The new treatment plan included a new behavior plan that was drafted at that meeting. The new behavior plan included a new requirement that staff search Ms. Menei's possessions for items, including shoelaces, which she could use to harm herself and take those possessions away from her. Shoelaces are specifically identified in the new plan as items to be removed from her possession. The new behavior plan also required one-on-one supervision to commence immediately and to recommence if Ms. Menei's behavior warranted it. See Attachment A, Behavioral Plan for Amanda Menei, September 15, 2003.

After the treatment team meeting on September 15th, Ms. Menei returned to the BR Unit. According to the Nursing Notes for that afternoon, Ms Menei attended a group therapy session in the BR Unit but left the session before it was concluded. According to Physician's Orders, at 5:15 p.m. a doctor ordered that Ms. Menei be placed on 15-minute check status for "safety reasons." At 6:20 p.m., the doctor was notified that Ms. Menei had a self-inflicted wound on her left arm. The doctor ordered that Thorazine be administered to Ms. Menei but did not order that the level of observation increase to a one on one situation. Again, there is no indication in the medical record that the doctor referred to any VSH policy or protocol, or any other standard of medical practice, to guide him regarding what level of supervision was appropriate for Ms. Menei at that time. An interview with that doctor confirmed that at no time on September 15th did he come into contact with or personally evaluate Ms. Menei.

According to an interview with a Psychiatric Technician (PT) on the BR Unit, that night Ms. Menei went to the bathroom on the BR Unit at approximately 6:45 p.m. The PT then spoke with her at her room at approximately 7:00 p.m. as part of the 15-minute check. The PT reported that he invited her to come out to the porch for a smoking break, but she refused to go. After the smoke break, at approximately 7:15 p.m., the PT rechecked her room and did not find her. He and the head nurse started searching for her and eventually found her hanging by a shoelace inside the locked BR Unit bathroom. VSH records demonstrate that while a property inventory was done sometime on September 15th, the presence of shoes with shoelaces in Ms. Menei's belongings was not identified.

Interviews with staff who were working that day revealed that BR Unit staff was not aware of the new behavioral plan even though Ms. Menei's treating doctor entered the new plan into the physician notes at 1:30 p.m. on September 15th. The actual new plan was not provided in those notes. A PT on the BR Unit noted the fact that there was a new plan at 3:05 p.m., but there is no evidence that anyone on the BR Unit ever reviewed the actual plan itself with its new warning to secure shoelaces from Ms. Menei.

VSH has a policy that requires a property inventory search for each patient when they are transferred from unit to unit. This is another unwritten policy that interviews with VSH staff revealed. A list of personal belongings is taken and all potential self-harming materials are removed and stored until a patient is discharged. In examining the numerous lists of Ms. Menei's belongings, there is no record of her having a pair of white sneakers with shoelaces. The Vermont State Police (VSP) investigation report lists a pair of white sneakers found in the victim's room. According to the VSP report of September 15, 2003, a pair of white sneakers with one lace missing was found in Ms. Menei's room. The missing lace matched the lace used by Ms. Menei to commit suicide.

IV. INVESTIGATIONS INTO THE CIRCUMSTANCES SURROUNDING MS. MENEI'S DEATH

VSH Investigation: VSH produced a one-page list of recommendations in response to Ms. Menei's death. The recommendations do not clarify any systemic or individual failures responsible or contributing to Ms. Menei's death. The recommendations focus on the need to create a comprehensive suicide prevention policy at VSH.

VSP Investigation: VSP concluded that Ms. Menei's death was a suicide by hanging from a shoelace in the bathroom. It did not review any VSH policies or protocols that may have been violated prior to Ms. Menei's death.

Medical Examiner: The Medical Examiner concluded that Ms. Menei's death was a suicide by hanging from a shoelace in the bathroom. The Medical Examiner apparently did not review any VSH policies or protocols that may have been violated prior to Ms. Menei's death.

Center for Medicaid and Medicare Services (CMS): CMS is the federal regulatory agency responsible for funding and regulating state facilities utilizing federal medicare or medicaid funds. CMS conducted an on-site investigation on September 16, 2003 through September 18, 2003 in response to Ms. Menei's suicide. Based upon observations, record reviews, and staff interviews, CMS determined that a situation of imminent jeopardy existed based on VSH's failure to implement additional interventions for patients who verbalized and /or carried out threats of self-harm.

CMS issued a report that discussed the circumstances surrounding Ms. Menei's death. The CMS report concluded that inventories of Ms. Menei's belongings were not done when required and when done, did not identify the presence of shoes with shoelaces in Ms. Menei's possession. The report revealed that the staff of the BR Unit was not familiar with Ms. Menei's special needs or characteristics when she was placed in that unit. The report concluded that the new behavioral plan for Ms. Menei created on September 15, 2003 was not followed by VSH staff and, in fact, they did not know of its existence.

VP&A: During the course of this investigation, VP&A interviewed the following VSH staff:

- 1) B2 Lead Nurse
- 2) B2 Social Worker
- 3) BR Lead Psychiatric Nurse
- 4) BR Psychiatric Nurse
- 5) BR Psychiatric Technician IV
- 6) BR Psychiatric Technician IV
- 7) BR Psychiatric Technician III
- 8) BR Psychiatric Technician I
- 9) BR Psychiatric Technician II
- 10) VSH Staff Psychiatrist #1
- 11) VSH Staff Psychiatrist #2

The following reports were examined and are referenced in this report:

- 1) State Police investigative report
- 2) Central Vermont Medical Center patient records
- 3) Medical examiner's report
- 4) VSH patient file
- 5) Waterbury Ambulance report
- 6) Gifford Memorial Hospital patient records

V. CONCLUSIONS

Based on the foregoing investigation, VP&A concludes that Ms. Menei died of suicide by hanging while a patient at VSH. VP&A concludes that serious errors and omissions were made by VSH staff that contributed to Ms. Menei's suicide.

Primarily, the failure of VSH to have a comprehensive suicide prevention plan in place and known to its entire staff was a critical omission contributing to Ms. Menei's death. A comprehensive suicide prevention policy would have a requirement that items that could be used for self-harm or suicide be routinely removed from patients exhibiting the characteristics displayed by Ms. Menei in the days and hours leading up to her death. A comprehensive suicide prevention plan would have a requirement that supervision be increased over a patient who exhibits risk signs, such as vocalizing suicidal intentions, self-harming, disruptive or despondent behavior.

VP&A concludes that the VSH staff failed to ensure that important safety information, i.e., removing Ms. Menei's shoelaces, was communicated effectively to the BR Unit staff responsible for caring for Ms. Menei. This failure to ensure proper communication systems around patient safety issues is deplorable. A system to insure that new information be accurately and consistently transmitted to all staff having contact with the patient at risk was obviously not in effect at the time of Ms. Menei's death.

VP&A concludes that staffing at the BR Unit was inadequate at the time of Ms. Menei's suicide. On the evening of Ms. Menei's death there were approximately 14 patients on the BR Unit with seven VSH staff people assigned to that unit. At the time of her death, at least one staff person was off the unit with another patient, one was on her break off the unit, one was in the nursing station, and the remaining staff appear to have been on the smoking porch or otherwise out of sight from the bathroom door. No staff person was assigned to monitor Ms. Menei, despite her recent self-injurious behavior, verbalization of suicidality, and disruption of the group therapy session earlier in the day.

In addition, the physical layout of the BR Unit prevented sufficient observation of the bathroom. A site review by VP&A advocates revealed that staff seated at the nursing station could not view the corridor and bathroom door, thereby preventing adequate supervision of that potentially dangerous area.

Finally, VP&A concludes that Ms. Menei's death on September 15, 2003 could have been prevented. If VSH staff had known about a comprehensive suicide prevention plan and implemented it, if VSH staff had successfully communicated the new treatment plan to BR Unit staff, if VSH staff had appropriately responded to Ms. Menei's increased difficulties during the evening of September 15th, and if VSH administration had assured appropriate staffing, physical plant and supervision, this tragedy could have been prevented.

This conclusion is even more tragic in light of the fact that the VSH Administration had ample warning that conditions were at a crisis state in their facility well before Ms. Menei's untimely death. VP&A obtained a letter dated August 7, 2002, written by a former VSH Medical Director during the time that Ms. Menei was a patient there, that was sent to the members of the Governing Body of the Vermont State Hospital. The letter clearly outlines a dire situation at VSH:

This letter is to make you aware of the growing crisis at Vermont State hospital in which patients can no longer receive adequate treatment and neither patients or staff can be assured of reasonable safety...The hospital is no longer as safe place...In addition to the primary concern about the safety and treatment, we are also concerned about malpractice liability...A survey by HCFA at this time would find the hospital in noncompliance with the following standards: The patient's right to receive care in a safe setting, staffing and delivery of care, individualized active treatment for all patients, exceeding certified census.

The letter from the former Medical Director continues to provide proposals to remedy these deficiencies, and then concludes his letter with the following:

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.

Unfortunately, the members of the Governing Body failed to implement the former Medical Director's suggestions, and failed to remedy the serious safety and treatment issues he raised. One might reasonably believe that if the Governing Body had responded more effectively to this warning letter, or to other signs and reports identifying the "crisis" situation at VSH, Ms. Menei may not have had the opportunity or motivation to commit suicide while a VSH patient.

VI. RECOMMENDATIONS

VP&A acknowledges that, in the aftermath of Ms. Menei's suicide, the suicide of another patient close in time to Ms. Menei's death, the decertification of VSH by CMS, and the public and legislative pressure applied because of these facts, VSH has implemented many remedial policies and practices to avoid reoccurrence of the failures that lead to Ms. Menei's suicide. These remedies have included hiring an architect to assure the facility is not amenable to suicidal actions like hanging; creating and distributing a comprehensive suicide prevention policy; and requiring two staff people to note acknowledgment of a change in the physician's orders to assure that such changes are not overlooked by relevant staff. VP&A supports these changes, as well as efforts by VSH to reduce the use of involuntary procedures such as seclusion and restraint, which played an important role in Ms. Menei's experience as a patient at VSH. However, ongoing concerns of lack of adequate staff training, lack of an appropriate physical environment, and lack of appropriate treatment for individuals with significant trauma history, create a situation in which VSH must demonstrate in a quantifiable manner that the efforts to remedy the various failures identified have been made and are being followed by VSH staff.

VP&A considers the implementation of remedies after the fact to be only part of the required actions necessary to address this tragedy. VP&A recommends that the VSH staff involved in Ms. Menei's treatment while a patient, and the VSH administration, must make a genuine and public acknowledgment of the errors that contributed to Ms. Menei's death. VSH should then make a formal and public apology to Ms. Menei's family, and to all the patients and their family members, who have been detrimentally impacted by Ms. Menei's suicide and the other failures identified in this and the CMS report. Finally, the State of Vermont should contact the Menei family privately and offer financial compensation for their loss, without forcing the family to use the legal system to vindicate their rights.

Vermont Protection and Advocacy, Inc. continues to monitor conditions at VSH and to work with VSH administrators, staff and patients to improve treatment and protect the rights of individuals receiving care at VSH.

ATTACHMENT A

9/15/03

Behavioral Plan for Amanda Menei

1. Upon admission, Amanda will be given hospital garb so that she can remove all her clothing, including her underwear. Clothing may be returned when search is complete.
2. All clothing and possessions will be thoroughly searched for any objects she could potentially harm herself with, including sharps, jewelry, belts, and shoelaces, anything she may use for self harm. All items except clothing ~~with~~ that cannot be used for strangulation will be sent to admission and will be returned to her on discharge, except jewelry which may be returned after 8 hours, as per protocol.
3. Upon admission to the ward:
 - *Amanda will be place on 1:1
 - *After 2 hours without threats to self or others, self harm or assaultive behavior and not causing any disruption to the ward, she will be able to be out of her room and go into the Activity Room.
4. If Amanda is able to maintain control of her behavior on the ward, while on 1:1 (without threats to self or others, self harm or assaultive behavior and not causing any disruption to the ward):
 - *After 4 hours, she may smoke on the porch
 - *After 6 hours, she may go into the TV room
 - *After 8 hours, she may have her jewelry returned
 - *After 24 hours her 1:1 may be discontinued after assessment by MD

When Amanda comes off 1:1 she will be assigned a point person familiar with DBT.

If Amanda displays behavior that necessitates quiet time, the protocol starts again, at step #3.

If Amanda requires an Emergency Procedure (requiring a CON), the Brooks 2 Unit Safety Protocol will be followed with the exception that Amanda may be on the porch in 12 hours rather than 24 hours. The 1:1 status may have to be reinstated based on Safety Assessment. Also, if not safe (requiring a CON) she will start the above protocol from Step #1.

Amanda will not be allowed to shave or to go into the yard. She will be restricted to the Brooks Building.

[Handwritten Signature] 9/15/03

