

**REPORT OF:**

**AN INVESTIGATION INTO THE CIRCUMSTANCES  
SURROUNDING THE DEATH OF  
CHRISTOPHER FITZGERALD ON AUGUST 8, 2003  
AT THE VERMONT STATE HOSPITAL**

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**FINAL INVESTIGATIVE REPORT**

**May 12, 2004**

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## I. INTRODUCTION

Vermont Protection and Advocacy, Inc. (VP&A) is a federally funded, nonprofit agency that defends and advances the rights of people with mental health and other disability issues. VP&A has the authority to investigate incidents of abuse and neglect of persons with disabilities pursuant to 42 U.S.C. §10801 et. seq. and 42 U.S.C. §15001 et. seq. This report presents the results of the investigation conducted by VP&A into the circumstances surrounding the death of Christopher Fitzgerald on August 8, 2003 at the Vermont State Hospital (VSH) in Waterbury, Vermont.

Christopher Fitzgerald of Fairfax, Vermont was arrested on August 2, 2003 and charged with DWI #1 (Driving While Intoxicated). Mr. Fitzgerald was detained at Chittenden Regional Facility Center (CRCF) from August 2, 2003 until August 4, 2003. While in CRCF, two doctors prescribed the following medication for Mr. Fitzgerald: Neurontin, Valproic Acid, Klonopin, Naprosyn, and Zantac. He was taken for arraignment to the Franklin County District Court on August 4, 2003. The presiding Judge remanded Mr. Fitzgerald to the Vermont State Hospital (VSH) for a Court Ordered Observation. The admitting Registered Nurse (RN) at VSH noted on August 4, 2003 that Mr. Fitzgerald's "Presenting Problem" was "suicidal ideation, Code # 30<sup>1</sup> for DWI."

Mr. Fitzgerald originally contacted VP&A on August 6, 2003 requesting our assistance to get him released from VSH. On August 7, 2003, Mr. Fitzgerald again contacted VP&A and alleged the staff at VSH had unnecessarily restrained him. Mr. Fitzgerald reported he was restrained because he refused to get out of bed that morning. He stated he was simply too depressed to get out of bed. Mr. Fitzgerald maintained that during the course of the restraint, several of the staff had verbally and physically assaulted him, and coerced him into taking medication.

VP&A visited Mr. Fitzgerald at VSH on August 7, 2003 at approximately 6:00 p.m. to investigate his claims of abuse and mistreatment. Mr. Fitzgerald was angry and in disbelief of his current situation. He stated being restrained was "the most humiliating experience of my life." VP&A took photographs of his arms and ankles as Mr. Fitzgerald had redness and abrasions, allegedly from being improperly restrained on those areas.

On August 8, 2003 at approximately 7:20 a.m., Mr. Fitzgerald was found dead in his room having hung himself with a piece of nylon string. His suicide note began with the following statement: "No More Lies! No More Pain! Today's assault was the last degradation I can endure..."

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<sup>1</sup> Code 30 is defined as "Court Ordered Observation" by VSH Policy Manual dated 2003

## **II. BACKGROUND**

### **A. Christopher Fitzgerald**

Mr. Fitzgerald was a 39-year-old white male. He was a high school graduate and worked as a mechanic for much of his life. Several years ago Mr. Fitzgerald sustained an on-the-job back injury and since October 2001 he had received disability compensation. At the time of his death, he was involved in multiple court proceedings regarding the custody of his children. His four children, parents and two siblings also survive Mr. Fitzgerald. Per his report, some of his family members also had a history of depression.

Prior to his incarceration, Mr. Fitzgerald had received mental health treatment at Northwest Counseling and Support Services (NCSS). He was referred to Central Vermont Hospital (CVH) by NCSS on June 3, 2003 and was hospitalized on a voluntary basis. This was Mr. Fitzgerald's first known psychiatric hospitalization. At that time, NCSS noted Mr. Fitzgerald's suicidal ideation was increasing in intensity and he had prominent depressive symptoms. CVH noted Mr. Fitzgerald was overwhelmed by multiple stressors of relationship issues, financial problems, and legal issues involving custody of his children and domestic violence. He was treated with a mood stabilizer and discharged on June 5, 2003 with a plan to resume outpatient treatment at NCSS.

In June of 2003 Mr. Fitzgerald was living with his girlfriend and two of his daughters. His girlfriend had recently asked Mr. Fitzgerald to leave the household. On June 15, 2003 Mr. Fitzgerald made a serious suicide attempt by overdosing on multiple medications. Per CVH records, he had also planned to hang himself after taking these medications. He was admitted to the Intensive Care Unit of Northwest Medical Center, medically stabilized, and transferred to VSH. The Admission Certification performed by a staff psychiatrist at VSH noted that Mr. Fitzgerald had made a "potentially lethal suicide attempt" and had "significant recent psychosocial stressors." Mr. Fitzgerald was hospitalized at VSH from June 15, 2003 until June 19, 2003, at which time he was transferred to Central Vermont Hospital. He was diagnosed with Depressive Disorder and chronic lower back pain. Mr. Fitzgerald was treated with an antidepressant, a mood stabilizer, and medication for his back pain. He was discharged from CVH on June 24, 2003 with plans for follow up with his primary physician. The mother of his youngest daughter contacted Franklin District Family Court while Mr. Fitzgerald was hospitalized. The Franklin District removed one of his daughters from Mr. Fitzgerald's custody on June 16, 2003.

On August 2, 2003 Mr. Fitzgerald called the crisis hotline at NCSS and expressed suicidal ideation. NCSS notified the Franklin County Sheriff's Department so they could drive to Mr. Fitzgerald's residence and transport him to a hospital. In the interim, Mr. Fitzgerald, who had allegedly been drinking, got into his car and drove a short distance from his home. Mr. Fitzgerald reported he had a long and acrimonious relationship with the Franklin County Sheriff's Department, and when he realized they would be responding to his crisis, he decided to try to leave his house. The Franklin County Sheriff's Department apprehended Mr. Fitzgerald, charged, and jailed him for Driving Under the Influence (DUI).

One of the arresting officers noted in his DUI Affidavit that Mr. Fitzgerald repeatedly made both suicidal and homicidal threats during the course of his arrest. On August 4, 2003, the Franklin District Court ordered an on-site (at the court) mental health evaluation, performed by a crisis worker from Northwest Counseling and Support Services. Based on the conclusions of this mental health evaluation, the Judge remanded Mr. Fitzgerald to VSH for a Court Ordered Observation, which is an evaluation to determine competence to stand trial.

#### **B. Northwest Counseling and Support Services**

Northwest Counseling and Support Services provides outpatient and residential mental health services to persons residing in the Northwest region of Vermont.

#### **C. Central Vermont Hospital**

CVH is located in Berlin, Vermont. It is a private hospital with a psychiatric unit designated by the Commissioner of Developmental and Mental Health Services to accept involuntary patients.

#### **D. Vermont State Hospital**

VSH is located in Waterbury, Vermont. It is exclusively a public psychiatric hospital. In general, it treats the most acute psychiatric patients in the state of Vermont. Both patients requiring treatment and those being evaluated for criminal court proceedings are housed at VSH.

### **III. CIRCUMSTANCES SURROUNDING THE DEATH OF MR. FITZGERALD**

#### **A. VSH Admission: August 4, 2003**

A staff psychiatrist at VSH examined Mr. Fitzgerald on August 4, 2003. In his Psychiatric and Admission Note (Observation Cases Only)<sup>2</sup>, this doctor noted that Mr. Fitzgerald stated “I’m not trying anymore...I’ve lost my kids...my ex-wife saw to that.” This note indicates the doctor was aware of Mr. Fitzgerald’s legal situation and his call to the suicide hotline prior to arrest. The doctor’s note also stated “[H]e [Mr. Fitzgerald] was referred to VSH today for forensic observation, presumably as a suicide risk...Mr. Fitzgerald has reportedly made many suicidal threats to family members and mental health personal [sic]...” The doctor’s Admission Certification Report noted Mr. Fitzgerald had been hospitalized at VSH approximately six weeks prior to this current

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<sup>2</sup> An additional form that is apparently required upon admission if the case is a Court Ordered Observation. The VSH Manual section titled CERTIFICATIONS TO HEAD OF HOSPITAL F-2 states, “In order to be admitted to the Vermont State hospital as either a Voluntary or Involuntary patient, an individual must be mentally ill as defined by Vermont Law. The one exception to this is an Observation case. For policies regarding this type of admission, see “Observation Cases.” Despite repeated attempts VP&A was unable to locate “Observation Cases” in the VSH Manual.

admission. During the August 4, 2003 examination, the doctor identifies Mr. Fitzgerald's Admission Problem #1 as "Depressed mood and anger issues; Stressor=loss of child custody/contact; DUI charge and court ordered exam..."

On August 4, 2003 this doctor diagnosed Mr. Fitzgerald with Depressive Disorder NOS, Possible Alcohol Abuse or Dependence, Borderline Personality Disorder and chronic back pain. The goal of the hospitalization as stated in the doctor's Admission Care Plan was "[P]revent suicide, restore outpt. treatment system." The doctor fails to identify suicidal or homicidal thoughts under the Admission Problems section, despite stating in his report that "[T]he current stressors are severe...This patient shows quite serious safety issues...He also presents a significant suicide risk, and he has just gotten news that his last connection with his children may be ending..." The doctor noted Mr. Fitzgerald's impulse control and judgment are "poor" and "impaired", respectively. The doctor did note under the "Special Precautions" section of the Admission Care Plan "Suicidal Risk: poss." and placed Mr. Fitzgerald on 15 minute checks upon admission.

The VSH Nursing Needs Assessment completed on August 4, 2003 by the admitting RN noted under "Presenting Problem (Why has the person come to VSH?)" "Suicidal ideation, code #30 for DWI." The nurse filled out a checklist and indicated mild suicide risk (other choices are low and high). The RN also noted that a safety plan had not been completed with the patient, and the patient did not have the plan, although a safety plan was "done verbally with MD 10 PM 8/4/03" (presumably with the initial doctor, as per the record, this is the only M.D. with whom he spoke, and this doctor performed the Admission Certification that evening). On the Nursing Needs Assessment there is a section which instructs the nurse to "Ask for and list the activities that calm the patient when (s)he becomes upset." When asked this question Mr. Fitzgerald responded "talking, being alone."

The VSH Social Services Department performed an Initial Social Assessment; this form is signed by two licensed social workers, and the initial doctor. This assessment notes Mr. Fitzgerald's admission date as 8/4/; however, the Initial Social Assessment is dated August 8, 2003 (post-mortem). Thus, the Initial Social Assessment neither indicates when this assessment was actually performed, nor whether the social workers actually spoke with Mr. Fitzgerald. The social workers wrote in the Assessment, "[I]nformation for this note is taken primarily from the certification." The Assessment states, "[H]e reports chronic suicidal thoughts, he states his current suicidality is 'not bad', no active plan."

On 8/4/03 (no time noted), an R.N. (signature illegible) noted, "[U]pon admission pt. was served with papers by Franklin County Sheriff's Office regarding child custody. Pt. became upset after hearing news and refused to comply with admission interview and vs [vital signs]. He was shown to Rm 119 where he began hitting window screen, causing two knuckles on R hand to bleed. Dr. [ ] on the scene. Pt. quickly calmed down..."

## **B. Failure to Assess Suicidality: August 5 and 6, 2003**

According to the progress notes, a different staff psychiatrist discontinued the 15-minute checks on August 5, 2003 at 3:05 p.m. However, there is no record of any 15-minute checks after 1:45 p.m. on that date on the form used to document the 15-minute checks. It is unclear when those checks actually ceased. This doctor wrote in the record “D/C 15 checks”, and then in the right margin “pt. adjusting to ward.” There is no documentation from this doctor regarding why less than 24 hours after Mr. Fitzgerald was assessed as being a “significant suicide risk” by the first doctor, the second doctor determined that he was no longer in need of some special level of observation. VP&A could not locate in the VSH Manual an actual policy or procedure outlining guidelines for 15 minute checks and terminating that status.

By way of comparison, VP&A obtained Central Vermont Hospital’s policy titled Observation of Psychiatric Patients. This policy states the following:

*Policy Statement: Patients shall be monitored in accordance with their current mental status, behavior, and safety needs. Each patient’s status shall be reviewed at least once every 24 hours by the attending psychiatrist and treatment team. In addition, the Charge Nurse shall have the responsibility to ensure that each observation level is warranted based upon assessment of each patient’s mental status, behavior, and safety needs...*

Specifically regarding 15 minute checks, their policy states in part:

*Fifteen-minute checks are ordered by the physician or instituted by nursing when a patient exhibits symptoms that warrant increased monitoring. Orders for 15-minute checks must be renewed every 24 hours and can only be discontinued by the physician after consultation with the Charge Nurse.*

*If the suicidal ideation/intent/plan is the reason for the checks, the patient’s room, belongings, and clothing may be searched by two staff members for potentially dangerous articles. Those articles will be removed from the patient’s possession.*

The CVH policy also includes the policy and procedure for “Constant Observation” (“1 to 1”), which, in part, states the following:

*When a patient’s behavior becomes too erratic or unpredictable, continuous observation is warranted to prevent patient self harm, harm to others, or risk of elopement.*

*Specifically, constant observation may be used for, [inter alia],:*

- 1. Patients who express current suicidal ideation and are ambivalent about contracting for safety;*
- 2. Patients currently verbalizing a clear intent to harm themselves or who have attempted suicide in the past;*
- 3. Patients with poor impulse control;*
- 4. Patients at risk of elopement, coupled with any of the above symptoms.*

The lack of information in Mr. Fitzgerald's record regarding the circumstances under which his observation status was changed on August 5, 2003, combined with the lack of any policy on the subject, points to a failure on the part of staff and administration to adequately protect and treat suicidal patients at VSH.

Mr. Fitzgerald was also seen by the psychologist (signature not legible) at VSH on August 5, 2003 (no time noted). The psychologist completed the Initial Psychological Assessment form and noted under Treatment Focus and Recommendations: "[A]ssess for Suicide Prevention." He also identified Mr. Fitzgerald's impulse control and judgment as "poor." There is no evidence in the record that an assessment for suicide as recommended by the unidentified psychologist actually occurred.

According to a note that is dated "8-5-03 PM 3 day note", written by a Psychiatric Technician III [PT III] on August 5, 2003, Mr. Fitzgerald told staff he planned "to be out of here in 48 hours one way or another." Mr. Fitzgerald reported to VP&A that on August 5, 2003, during the night shift, he exited his room to report suicidal ideation to staff. He reported the staff "yelled" at him, ordered him back to his room, and did not even give him an opportunity to tell them he felt suicidal. Mr. Fitzgerald said that upon admission he was instructed to tell staff if he felt suicidal (apparently the safety plan that was verbally done with the initial doctor on 8/4/03). He reported feeling angry about the staff's behavior, and in his chart there is a note from Mr. Fitzgerald alluding to this incident: "I kept up my end. Too bad you and the Doc didn't."

Mr. Fitzgerald contacted Vermont Protection & Advocacy on August 6, 2003 to complain about being involuntarily hospitalized. He was agitated and confused about why he was being held in the hospital. Nursing notes from August 6, 2003 indicate Mr. Fitzgerald became loud and belligerent at one point, demanding to be released from the hospital.

There is no record of any formal suicide assessment of Mr. Fitzgerald after the second doctor deemed him safe to take him off special observation status.

### **C. Inappropriate Restraint and Lack of Monitoring: August 7<sup>th</sup>**

On August 7, 2003, Mr. Fitzgerald telephoned VP&A at approximately 5:30 p.m. He was outraged and reported earlier in the day he had been assaulted and restrained by the staff at VSH. VP&A visited him at the hospital, interviewed him, and took photographs of abrasions on his ankles and arms (which he maintained were from the restraint process).

Mr. Fitzgerald reported that the incident began due to his desire not to get out of bed that morning. Mr. Fitzgerald reported he told the staff person this and the staff person told him if he didn't get up "we'll come in there and make you get up." According to Mr. Fitzgerald, about 6 staff members returned to his room with the restraint bed (a bed in which a person is placed in 5 point restraints, with hands, legs, and mid-section being restrained so the person's freedom of movement is severely restricted). Mr. Fitzgerald reported the restraint bed was placed in his full sight in the hallway. Mr. Fitzgerald reported that he continued to maintain he was depressed and just wanted to be alone. He contended that staff came at him to physically drag him out of bed, with the express intention of restraining him.

Mr. Fitzgerald stated he was verbally abused, kicked in the groin, slammed in his back, put in a choke hold, and then ultimately put in 5-point restraints. He said staff members made comments such as “[I]t’s all your fault. All you had to do was get out of bed.” He reported he was then coerced into taking medication in a crushed form with the threat from staff “[O]r we’ll shoot you up with Haldol.” Mr. Fitzgerald stated he only took the medication because he was terrified of Haldol.

The Certificate of Need filed in this incident states “[M]ore staff came to room to show a show of force and he refused to get out up + out of his room...He continued to lay in his bed and refused to come out. Staff proceeded to remove the covers from his bed and approach him. He became combative and started swinging at staff. It was necessary at that point to restrain him and place him in 5 point restraints to protect the - - 9 - - staff.” The initial doctor notes at 9:30 a.m. (while Mr. Fitzgerald is in restraints) “#suicidal/behavioral dyscontrol.” This doctor also noted “[H]e has been speaking about elopement and asking for privileges several X this wk.” He does not re-institute 15 minute checks on Mr. Fitzgerald or recommend Constant Observation at this time.

VSH records do not reflect that Mr. Fitzgerald had any supportive/therapeutic contacts with the VSH staff once he was released from restraints until his death, save for a seemingly perfunctory interaction at 10:35 a.m. immediately upon his release from restraints. A RN (name illegible) completed a Monitoring of Seclusion/Restraint/Involuntary Timeout form. The nurse engaged Mr. Fitzgerald to complete this form. The content is as follows: “What is the patient’s understanding of why the involuntary procedure was necessary?”--- Mr. Fitzgerald response, “Staff like to show their power”; “What interaction or event led to the loss of behavioral control and risk of harm?”---Mr. Fitzgerald’s response, “Just want to be left alone”; and “What would help prevent future risk of harm”—Mr. Fitzgerald response, “Don’t let Dr. [ ] treat patients.”

A Licensed Practical Nurse (LPN) note signed 8/703 (with no time, but it was after Mr. Fitzgerald’s release from restraints at 10:35 a.m.) says he “refused all prescribed medication.”

There was no documentation of Mr. Fitzgerald’s meeting with VP&A on the evening of August 7, 2003 found in any records reviewed by VP&A.

#### **D. The Final Hours: Evening of August 7 to Morning of August 8, 2003**

Mr. Fitzgerald’s record indicates he was awake the entire night of August 7, 2003 and the entire morning of August 8, 2003. A Psychiatric Technician IV (PT IV) (who worked the 11:00 p.m. to 7:00 a.m. shift on August 8, 2003) wrote in his note dated (but with no accompanying time) “8/7-8/03” that Mr. Fitzgerald put a sheet over his window, which Mr. Fitzgerald removed per the PT IV’s request. The PT IV’s notes that later in the morning staff did find his door window covered with soap, and, “[P]t was also awake all NOC [night].” There is no documentation in Mr. Fitzgerald’s record indicating the soap was removed. Pursuant to an apparently unwritten VSH practice, 30 minute checks are supposed to be done of patients in Mr. Fitzgerald’s unit, Brooks 1. While it is very

troubling that no such formal written policy on 30 minute checks exists at VSH, it is even more troubling to consider how 30 minute checks were performed in this case if Mr. Fitzgerald's window was opaque with soap. VSH records state clearly that Mr. Fitzgerald was not checked on for 50 minutes between 6:30 a.m. and 7:20 a.m. on August 8, 2003, when he was found dead by hanging.

Mr. Fitzgerald's suicide note included the words "NO MORE LIES, NO MORE PAIN! Today's assault was the last degradation I Can endure." VP&A believes Mr. Fitzgerald was likely referring to the restraint, involuntary medication, and assault by the staff at VSH in this portion of his suicide note.

#### **IV. INVESTIGATIONS INTO THE DEATH OF MR. FITZGERALD**

##### **A. CMS Investigation**

The Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) conducted an investigation and issued a report on the circumstances at VSH during 2003 that discussed the death of Mr. Fitzgerald. They cited the following deficiencies that were relevant to Mr. Fitzgerald's suicide:

1. "A hospital must protect and promote each patient's rights. This CONDITION is not met...Based upon observations, interviews, and record review, this Condition of Participation is not met."
2. "9 of 17 patient rooms observed had wall-mounted shelves with gaps ranging between ¼ inch to ½ inch between the shelves and walls, which created a safety hazard for patients at risk for self harm. These shelves also had hooks that did not move with ease when attempts to move them were made."
3. "...no evaluation was conducted of Patient #1's changes in behavior symptoms during the night shift on 8/7/2003 into the morning on 8/8/2003. Findings include:  
On 8/8/2003 between 12:00 a.m. and 12:30 a.m., Patient #1 was observed placing a sheet to cover the window of the door to this patient's room during a 30-minute ward check. The sheet was removed from the window when two psychiatric technicians (#1 & #2) intervened. This incident was reported to supervising nurse #1. At 4:30 a.m., psychiatric technician #1 observed the same window had been "soaped" decreasing visual access to Patient #1. This was reported to supervising nurse #1. Psychiatric technician #1 who made the observation of the "soaped" window also reported the patient appeared to be "hiding" next to the shelves in this patient's room. Psychiatric technician #1 reported that no intervention occurred because of concern the patient would become assaultive. At 6:30 a.m., psychiatric technician #3 observed the patient in front of the shelf 'staring off.' This was reported to supervising nurse #1. No staff intervention took place...no nursing evaluation was conducted when these observations were reported on 8/8/2003 by psychiatric technicians #1 & #3. Supervising nurse #1 reported observing Patient #1 upon arrival at 7:00 p.m. for a 12-hour shift on 8/7/2003, but did not see Patient #1 during the remainder of the shift."

4. "...although 30-minute checks are conducted on the night shift on Brooks 1, there is no written policy and procedure for these checks."

## **B. Vermont State Police Investigation**

The VSP report included photographs of Mr. Fitzgerald's room, the still-soaped window of his door (through which staff make their visual checks on the patient), his suicide note, and the implement with which he hung himself. The report noted that among other things:

1. Mr. Fitzgerald hung himself using a "web belt with two D rings at one end for a buckle" and "the belt was forcibly slid between the space of the wall mounted book shelf and the wall."
2. "She [an R.N.] advised that the soaped window was cleaned up so that the checks could be continued."
3. "[The R.N.] advised that all of the patients on Brooks 1 are on 30 minute checks."
4. "[A PT] advised at the 6:30 check victim was on the side of the room by the bookcase...[The PT] described victim's facial expression as being blank with no emotion, just staring. [The PT] advised that the victim was 'zoning out' with no expression."
5. "As a result of viewing the body, this writer was of the opinion that victim appeared to have died as a result of a hanging...This writer should point out that the minor abrasion to victim's forearms and legs were consistent with abrasions that would be caused by 5 point restrains [sic]...This writer did observe an abrasion on the back of the victim's ankle."
6. "As a result of this writer's investigation into this death, this writer feels that the manner of death is in fact a suicide. The preliminary autopsy results indicate that the cause of death was asphyxia due to hanging."

## **C. State of Vermont Medical Examiner's Office**

The Office of the Chief Medical Examiner concluded Mr. Fitzgerald died of hanging, and the manner of death is classified as suicide. The Medical Examiner noted the same abrasions on Mr. Fitzgerald as did VP&A.

## **D. Vermont Protection and Advocacy Inc.**

Vermont Protection and Advocacy's own investigation included a review of the following:

1. Chief Medical Examiner's Autopsy Report
2. Vermont State Police Investigation and supporting documents and photographs
3. CMS Investigative Report dated August 20, 2003

4. VSH Policies and Procedures Manual
5. VSH Medical Records
6. CVH Medical Records
7. Department of Corrections Medical Records
8. Death Certificate
9. Suicide Note
10. Floor Plans, Brooks I, VSH
11. Ambulance and CVH Emergency Room Report Post-Mortem
12. Office of Public Defender Franklin and Grand Isle County documents
13. Franklin County Sheriff's Department Police Reports
14. Interview by VP&A with Mr. Fitzgerald August 6 and 7, 2003
15. Review of photographs taken by VP&A August 7, 2003
16. Interview with Mr. Fitzgerald's parents
17. Interview of a patient who interacted with Mr. Fitzgerald before his death and with VSH staff after Mr. Fitzgerald's death

## **V. FINDINGS AND CONCLUSIONS**

### **A. Findings**

1. Despite Mr. Fitzgerald's prior admission to VSH on June 15, 2003 for a "near lethal" suicide attempt, Mr. Fitzgerald's repeated suicidal statements to arresting officers on August 2, 2003, the court remanding Mr. Fitzgerald to VSH for Observation, the initial screening psychiatrist's statement that Mr. Fitzgerald "presents a significant suicide risk" and noting Mr. Fitzgerald's impulse control and judgment were impaired, the initial doctor did not place Mr. Fitzgerald on Constant Observation (one-on-one observation), whereby a staff member would be assigned to continuously observe Mr. Fitzgerald, but instead placed him on 15 minute checks. Mr. Fitzgerald's possessions with which he could harm himself were not removed. At the time of his death, he was in possession of his shoelaces and a web belt with which he hung himself. Using Central Vermont Hospital's policy as a standard, Mr. Fitzgerald met the criteria for Constant Observation (his behavior was erratic and unpredictable: he hit the wall, he recently made a "near lethal" suicide attempt, he recently made suicidal and homicidal statements to both the crisis hotline and to arresting officers, and he had poor judgment and impulse control). The failure of VSH to have an effective Suicide Prevention Policy or for staff at VSH to implement standard suicide prevention practices, similar to those detailed in CVH's manual, are among the main contributing factors in Mr. Fitzgerald's successful suicide attempt.
2. Mr. Fitzgerald's 15-minute checks were discontinued on August 5, 2003 at 3:05 p.m., less than 24 hours after his admission to the hospital. The second doctor discontinued these 15-minute checks. Prior to the discontinuation of the 15-minute checks, the record does not reveal Mr. Fitzgerald was re-evaluated for suicidal ideation, suicidal plans, or suicidal intent, despite the psychologist's Treatment and Focus Recommendation on August 5, 2003 stating "[A]ssess for suicide potential". The record simply notes "pt. adjusting to ward" with no other clinical justification or observation for determining Mr. Fitzgerald was no longer, as the initial doctor determined less than 24 hours before, a "significant suicide risk." Using Central

Vermont Hospital's criteria, Mr. Fitzgerald would likely have been placed on Constant Observation because he met the criteria (i.e. the initial doctor stated he presents as a "significant suicide risk", the fact he demonstrated poor impulse control by hitting the window, and his recent suicide attempt).

3. Per Mr. Fitzgerald's record, a PT III wrote in his note dated "8-5-03 PM", "Pt. did state that he was going to be out of here in 48 hrs. one way or another." This statement indicates Mr. Fitzgerald was thinking about elopement and/or suicide, as this is a commonly used phrase by people who are contemplating suicide. This statement should have resulted in a suicide risk assessment or increased observation level. He was not placed on 15-minute checks or Constant Observation.
4. Mr. Fitzgerald's account indicated the staff at VSH treated him in a punitive, brutal manner and did not provide humane or therapeutic treatment for his problem of depression. The Orientation Booklet for Patients/Clients ostensibly given to each patient upon admission states, "[I]f you are frightened at night, make sure that you tell this to staff and they will help you with a plan to feel more comfortable." Mr. Fitzgerald reported the staff yelled at him to return to his room on August 5, 2003 when he attempted to honor his safety contract with the initial doctor by telling staff he felt suicidal. He says this incident eroded his ability to trust the staff.
5. On August 7, 2003 at 9:30 (not clear if this is a.m. or p.m., as at 9:30 a.m. Mr. Fitzgerald was in restraints, though the note does not refer to this), the initial doctor noted in Mr. Fitzgerald's record "#suicidal/beh. dyscontrol" and "[H]e has been speaking about elopement and asking for privileges several x this wk." Despite this, per his progress note dated August 7, 2003, this doctor does not perform a suicide risk assessment or place Mr. Fitzgerald on Constant Observation or even 15 minute checks. The doctor's note focused on Mr. Fitzgerald's anger, and in part says, "[P]t. difficult to direct on wards and in intvs. [interviews] rambles about injustices done to him; dramatic manner. So far, has never allowed that he contributed in any way to his difficulties... P. [Plan]-Court Assessment, likely return to NCSS..."

Per the American Psychiatric Association "Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors, "...suicide risk assessment is a process and never simply an isolated event." In particular, per Table 2, "Circumstances under Which A Suicide Assessment May be Indicated Clinically", a suicide assessment should be made "[B]efore a change in observation status...abrupt change in clinical presentation...lack of improvement...anticipation or experience of a significant interpersonal loss or psychosocial stressor (e.g. divorce, financial loss, legal problems, personal shame or humiliation...)." Despite Mr. Fitzgerald's change in clinical presentation and his expressed humiliation over being restrained on August 7, 2003, the doctor did not perform another suicide risk assessment.

6. Mr. Fitzgerald reported he was assaulted, restrained, and coerced into taking medication when he felt depressed and did not wish to get out of bed on the morning of August 7, 2003. The hospital clearly violated its own policy titled "RULES GOVERNING THE USE OF: INVOLUNTARY MEDICATION, SECLUSION, MECHANICAL RESTRAINTS AND GRIEVANCE PROCEDURES AT THE VERMONT STATE HOSPITAL." This policy states: "[W]hen necessary, these

measures shall be utilized in the least intrusive and restrictive manner for the least amount of time consistent with good medical practice.” As previously noted, Mr. Fitzgerald informed the staff that when upset, “talking, being alone” were effective in calming him. The Orientation Booklet for Patients/Clients states “...if restraint is necessary it will be done in a safe and respectful manner...if you know that certain things calm you, when you are upset, please share this with your nurse for your safety plan.” The VHS staff’s actions did not adhere to the practices required in the policy above, and in fact were just the opposite.

7. The staff’s actions also violated Regulations for Hospitals, 42 C.F.R. § 482.13(f) (Conditions of Participation [COP’s]) which is a federal requirement pertaining to the use of restraints and seclusion. It states:

*“Emergency use only—In the context of behavioral management, the rule specifies that R/S [restraint/seclusion] may only be used in emergency situations if needed to ensure the patient’s safety and less restrictive interventions have been determined to be ineffective. Can not use for discipline, staff convenience or as a substitute for active treatment, and no PRN’s.”*

Mr. Fitzgerald stated he was not offered any verbal interventions, other than threats. He stated the staff skipped this more appropriate level of intervention and even the next two levels of intervention. These levels fall under VSH’s Time Out policy in its Policies and Procedures Manual:

*“Time out is a separation of a patient from the rest of the group to a quiet place for a period of time. The purpose is to reduce stimulation and defuse an escalating situation, in order to allow the patient to regain self-control and prevent further loss of control that may lead to dangerous situations.”*

The first level of Time Out is Quiet Time:

*“The patient chooses, or a staff member suggests, a break in the room away from others...The room may be the patient’s bedroom...If it extends beyond fifteen minutes, the staff member will check on the patient and attempt to converse about the event.”*

In Mr. Fitzgerald’s case, Quiet Time could have been easily achieved by all the staff leaving his room for a period of time. This simple act would have very likely defused the situation and prevented the violent restraint incident. The second level of Time Out is Enforced Time Out (seclusion), and that was not used either. Instead, after he was given two chances to get out of bed, the staff used a “show of force.” Mr. Fitzgerald says he was dragged out of bed, kicked in the groin, choked, slammed in the back, verbally abused, put in 5 point restraints and coerced into taking medication. He described these events to VP&A as “most humiliating experience of my life.”

In fact, there was no emergency requiring the use of restraints until the staff started using force.

8. It appears that the use of involuntary treatment, the restraint on August 7, 2003, was also in violation of VSH policy on use of emergency interventions. VSH policy, as

imposed by consent decree in Doe v. Miller, requires an emergency to exist before involuntary treatment can be implemented. The VSH Mechanical Restraints policy states “[I]nvoluntary placement of a patient in mechanical restraints is a valid procedure that may be used only in emergency circumstances.” The actions attributed to Mr. Fitzgerald, i.e. lying in his bed, do not rise to the level of an “emergency” as defined by the VSH manual, which requires a danger to self or others, a requirement that was not present in this instance. Section C-14, which defines “emergency” regarding use of restraints, was not in the VSH Manual of 2003.

9. The Vermont State Police (VSP) Report, the Medical Examiners Report, and photographs taken by VP&A substantiate the presence of an abrasion on Mr. Fitzgerald’s ankle, as well as abrasions on his arms. These injuries were likely caused by his 5-point restraint, which Mr. Fitzgerald described to VP&A as particularly brutal and included allegations the staff continued to tighten the restraints when not necessary. VSH apparently violated its own policy found in the VSH Policy and Procedures Manual regarding Mechanical Restraints requiring that “[R]estraints are to be applied in a manner which provides padding and protection of all parts of the body where pressure areas might occur by friction and shall:...Allow the patient as much freedom as possible under the circumstances.”
10. Mr. Fitzgerald’s description of being assaulted by staff on August 7, 2003 conforms to the definition of a simple assault, a criminal act. No effort was made by VSH or other investigators to pursue information regarding this potentially criminal use of restraint by VSH staff.
11. Verbal abuse as described by Mr. Fitzgerald is contrary to VSH Policy Manual: Client-Employee Relationship, which states, “[P]hysical, sexual or verbal abuse or neglect of clients or exploitation of clients will not be tolerated and such staff behavior will result in serious disciplinary response up to and including dismissal...” The manual defines “verbal abuse” as any action, including incitement of others to act, which vilifies, intimidates, degrades or threatens a client with harm. An employee will be guilty of verbal abuse even if the client did not understand what the employee said.”
12. Mr. Fitzgerald alleged staff coerced him to take medication by threatening to give him a shot of Haldol if he didn’t accept the medications offered. Such behavior by VSH staff violates Federal statutory and regulatory protections regarding restraint and seclusion. Specifically, 42 C.F.R. §482.12 (f) (CoP’s) states under DRUG USED AS A RESTRAINT: “[I]s a medication used to control behavior or to restrict freedom of movement and is not a standard treatment for the patient’s condition?” Haldol is not a medication that is standard treatment for Mr. Fitzgerald’s condition, Depression, as Haldol is not an antidepressant. The alleged coercion also violates VSH Policies and Procedures Manual policy Involuntary Procedures which states “Everyone is interested in preventing coercive procedures...”
13. A PT noted on the early morning of August 8, 2003 that Mr. Fitzgerald had covered his window with a sheet (which he took down at the PT’s behest), but then later covered his window with soap. The Vermont State Police photographs of Mr. Fitzgerald’s room document that his window still had soap on it after his death. Thus,

if the window was covered with soap, the staff could not conceivably perform accurate 30 minute checks. This contradicts the RN's statement to the State Police that the soap was washed off the window prior to the discovery of Mr. Fitzgerald's dead body.

The fact that Mr. Fitzgerald was trying to cover his window and eventually succeeded in covering his window should have caused the staff to become more hypervigilant about his safety. The staff should have instituted Constant Observation or at the very least 15 minute checks. Instead, despite the Charge Nurse's and Psychiatric Technician's knowledge of the obscured window, no action was taken to remove the soap and staff could not perform proper safety checks. These very serious failures to act essentially gave Mr. Fitzgerald the opportunity to commit suicide.

14. The record indicates the VSH staff failed to perform 30-minute checks on Mr. Fitzgerald. The record indicates he was checked at 6:30 a.m., and then not again until 7:20 a.m. when he was found dead by suicide. And, given that Mr. Fitzgerald's window was obscured by soap, the time of death could have been prior to 6:30 a.m.
15. Once released from restraints at 10:30 a.m. on August 7, 2003 until he was discovered dead at 7:20 a.m. August 8, 2003, Mr. Fitzgerald was largely neglected by the staff, as there are no notes indicating any substantive therapeutic contact, despite his enraged mood and "speaking about elopement". In fact, Mr. Fitzgerald's entire record is devoid of any therapeutic interventions to treat Mr. Fitzgerald's depression and suicidal thoughts (aside from the administration of medication).
16. A review of the VSH Policy and Procedure Manual dated 2003 does not contain any specific policies or protocols for suicidal patients. When carefully reviewed, this Manual's attention to other important policies regarding the care and treatment of its patients is disturbingly sparse. When VP&A interviewed employees during the course of another recent death investigation, staff gave various responses when asked if the Manual contained a specific, written policy regarding suicidal patients. Most staff were not clear if it did contain such a policy, and others definitively stated the Manual did contain such a policy. This demonstrates the staff did not have a written policy to refer to when dealing with suicidal patients, and that they were not trained to respond in a consistent manner when confronted with suicidal patients.
17. At the time of his admission to VSH on August 4, 2003 and throughout his stay, Mr. Fitzgerald manifested symptoms which were consistent with the doctor's diagnosis of Major Depressive Disorder.

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition provides guidance for diagnosing Major Depressive Disorder, including the existence of persistent anger, a tendency to respond to events with angry outbursts or blaming others, allusions to committing suicide, hypersomnia (oversleeping), and tiredness and fatigue. Further, per the American Psychiatric Association's Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, Mr. Fitzgerald's clinical presentation was consistent with almost all of the conditions which the American Psychiatric Association identifies as factors which make a person a serious suicide risk. These factors include:

- Caucasians commit suicide at rates greater than any other ethnicities;
- Mr. Fitzgerald was single, which made him twice as likely as a married person to commit suicide;
- He had a psychiatric disorder and depression, and “[M]ood disorders, primarily in depressive phases, are the diagnoses most found in suicide deaths”;
- Mr. Fitzgerald had a history of alcohol abuse or dependence, and “alcoholism is associated with an increased risk for suicide, with suicide mortality rates that are approximately six times those of the general population”;
- Mr. Fitzgerald was diagnosed with Borderline Personality Disorder, and “individuals with personality disorders, concurrent depressive symptoms or substance use disorders are seen in nearly all individuals who die by suicide” and further, “borderline personality disorder and antisocial personality disorder confer an added risk of suicide attempts”;
- Mr. Fitzgerald had a “comorbid psychiatric diagnoses” which increases suicide risk”;
- Mr. Fitzgerald expressed obvious hopelessness, and “hopelessness is well established as a psychological dimension that is associated with increased suicide risk”;
- Mr. Fitzgerald had a recent history of a near lethal suicide attempt, and “[I]ndividuals who have made a suicide attempt constitute a distinct but overlapping population with those who die by suicide”;
- Mr. Fitzgerald reported to VSH that he had been physically abused as a child and history of childhood physical and/or sexual abuse has been associated with increased rates of suicidal behaviors;
- Mr. Fitzgerald had a history of having domestic assault charges, and “[M]en with a history of domestic violence toward their partners may also be at increased risk for suicide”;
- Mr. Fitzgerald had a history of being hospitalized for a suicide attempt, and “...as a general rule, a past history of treatment, including a past history of hospitalizations, should be viewed as a marker that alerts the clinician to increased suicide risk”;
- Mr. Fitzgerald suffered from a back injury which made him unable to work and the APA states, “[B]eyond the physical illness itself, functional impairments, pain...increase suicide risk”;

- Mr. Fitzgerald learned on the day of his admission he was losing the last connection with his children and “family discord, other relationship problems and social isolation may also increase risk;
- Mr. Fitzgerald expressed strong suicidal ideation two days before he was admitted to VSH, and the APA states that “suicidal ideation is an important determinant of risk because it precedes suicide...patients may report thoughts of death that may be nonspecific (“life is not worth living”)...individuals with suicidal ideation will often deny such ideas even when asked directly...the presence of suicidal ideation indicates a need for aggressive intervention.” ; and
- Neither Mr. Fitzgerald’s shoelaces nor the nylon belt with which he hung himself was removed from his possession and the APA requires that “clinicians should recognize the potential lethality of other suicide methods to which the patient may have access”.

18. VP&A has obtained a letter from the former Medical Director of VSH (he was also the director at the time of Mr. Fitzgerald’s death) sent to the Members of the Governing Body at the Vermont State Hospital, which included the following people: Jane Kitchel, Secretary, Agency of Human Services Susan Besio, Commissioner, Dept. of Developmental and Mental Health Services. This letter is of particular significance because it is dated August 7, 2002 (almost a year to the day before Mr. Fitzgerald’s death), and in the letter the former Medical Director 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 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 doctor’s suggestions, and failed to remedy serious safety and treatment issues he raised. One might reasonably believe that if these members had responded last year to this letter that described the hospital as being in a “crisis” and other reports and warnings of a failed system, Mr. Fitzgerald may have received adequate treatment for his depression and suicidality.

## **B. Conclusions**

The conclusion of this report is that practice at VSH tolerated an unnecessary show of force in Mr. Fitzgerald's case that is inconsistent with proper emergency procedures. VP&A finds that VSH records do not indicate that an emergency existed consistent with the definition laid out in the Doe v. Miller consent decree nor in CMS regulations. This show of force, as well as the lack of subsequent monitoring, contradicts the humane and therapeutic practices desirable to treat and alleviate the pain and suffering which accompanies mental illness. These circumstances could well have set the stage for the tragic death of Mr. Fitzgerald.

Mr. Fitzgerald exhibited all of the risk factors of being suicidal, and the staff had ample red flags regarding Mr. Fitzgerald's risk to commit suicide. VP&A counts seven occasions Mr. Fitzgerald exhibited signs he needed to be on observation, and seven times the staff failed to institute 15 minute checks or Constant Observation. In fact, they failed to take any actions to prevent his suicide. The conclusion of this report is that the VSH staff exacerbated Mr. Fitzgerald's condition each day by failing to provide him with adequate or proper treatment. The most attention Mr. Fitzgerald received from the staff was the unlawful restraint process, and this incident clearly drove Mr. Fitzgerald to become angrier and hopeless, and was on his mind just before his suicide as evidenced by his suicide note that began with "No More Lies! No More Pain! Today's assault was the last degradation I can endure..."

## **VI. RECOMMENDATIONS**

- The Agency of Human Services should acknowledge the failure in leadership, supervision, and professionalism that resulted in an environment at VSH that allowed for Mr. Fitzgerald's untimely death. While it is clear that the obvious failings included a lack of suicide prevention protocol and allowing an unnecessary and brutal restraint to go uninvestigated or unresolved, both these issues have their roots in the failure of leadership, supervision, and professionalism. The letter from the former Medical Director to the administration a year prior to Mr. Fitzgerald's untimely death indicates that the problems identified in this report were not unknown to the staff and administration, yet no substantial action was taken to improve services and the environment. Far from being just a hollow gesture, a public and sincere apology by the Agency to the patients and families who were negatively effected by Mr. Fitzgerald's death and poor provision of services will demonstrate that the Agency has the strength, honesty, and resolve necessary to assure that similar, avoidable tragedies do not occur in the future. The failure of the Agency to make such a public acknowledgement would signal the opposite.
- VSH should immediately establish a comprehensive suicide prevention protocol with attention paid to ensuring adequate evaluation and analysis of patient status. This protocol, as well as all other policies relevant to keeping patients safe and

properly cared for, must be imparted to all levels of the staff in a verifiable, effective, and repetitive manner to assure complete compliance.

- Individual staff involved in the unlawful use of force should be investigated thoroughly in regard to their activities on the morning of August 7, 2003. The investigation should address their failure to adequately notify superiors of the use of force, and any other use of force they have been involved with which may have been inappropriate.
- VSH staff and administration should be required to participate in an intensive program on the reduction of seclusion and restraint and VSH reporting policies.
- As a part of a system-wide training mandate, all staff should be made aware of the appropriate definition of “emergency” which is the one imposed by the Doe v. Miller consent decree and CMS regulations.
- VSH should reach out and support augmented peer support and outside community participation for patients at VSH. The aggressive promotion of peer support and recovery programs that utilize outside, non-VSH staff resources will help bring both a sense of hope and connection to patients that desire such contact. In addition, the presence of outside support people will assure that circumstances inside the hospital are observed and remedial action taken before a crisis situation develops. VSH should provide.
- VSH should provide VP&A with written documentation that the recommendations made in this report are implemented.