

Here is an account of what I experienced at the hospital November 13, 2005.

On November 13, 2005, I was taken to the Cooley Dickinson emergency room by my therapist, [REDACTED]. At Cooley Dickinson, after completing the paper work I was sent to one of the small rooms of the ER and told to wait. After some time, someone from Emergency Services spoke with me for a short while and as they left they told me to continue waiting. I waited for what felt like a long time. I remember feeling as if I had been forgotten about. Sometime during this time of waiting, I remember feeling better and deciding to go home. I walked out of the ER passing the front desk as I left. I remember feeling relieved to be going home. I walked down Elm Street getting as far as Smith College before a police car pulled up in front of me. I remember thinking that I had almost gotten home before he arrived. I felt surprise, I assumed that the hospital had forgotten about me. I was surprised that the officer had arrived to return me to the hospital. The officer got out of the car to ask me some questions, I don't remember the questions exactly but they had to do with his efforts to find someone (me) who had left the hospital. He told me to get in the car and he would drive me back to the hospital. I did not want to go and I told him so. I told him that I felt OK and that I would prefer to go home. He told me that he had to return me to the hospital. We returned to the hospital. They put me back into a small ER room. I told them that I wanted to go home but they told me that it was no longer voluntary and that I was considered to be "Section 12". I remember feeling frustrated with my circumstances. Then a staff person asked me to take an Ativan tablet. I told her that I did not want to take the medication because I wanted to be aware of what was happening to me. I also thought that I did not have to take it against my will. She said that I had to take the Ativan. I asked to see a patient advocate. I told them that I would take the pill if I had to but I wanted to know my rights and so I asked to see a patient advocate. The staff person told me that if I did not take the pill they would inject me with Ativan. At this point I remember there being a lot of people in the room. I remember repeating my request to see a patient advocate many times and on one occasion I was told to "shut up" and that they were going to inject me. The staff person asked for help to hold me down and to take my shirt off so that she could inject me. I remember someone, another female staff person, asking why I was being forced to take Ativan. I specifically remember her saying "why are you doing this? She's not out of control". At that point the staff person injected me with what I assumed was Ativan. Next, I was transported by gurney to a waiting ambulance to take me to Franklin Medical Center. At that point, the ambulance drivers put me into 4-point restraints. The drivers told me that, "we put all Section 12s into restraints". While I was restrained, the ambulance people asked me to sign some papers. I did not know what I was signing. I was medicated and unable to read the papers. I remember that the restraints made it very difficult to sign the papers. When we arrived at Franklin Medical Center they wheeled me into the Psych ward where they removed the restraints, stood me up, and turned me over to the Franklin Medical Center staff. I was taken to a room where I did not have a roommate.

The next morning Dr. Franklin came to my room. During this first visit I remember him reading from my medical record which, he said stated that the "patient was asking questions and so was injected". Dr. Franklin expressed his concern at my mistreatment and he recommended that I contact a patient advocate.

After being released from Franklin Medical Center I told my therapist, family and friends about this incident.

I am a survivor of sexual assault. Emergency Services recorded this fact while I was at the Cooley Dickinson emergency room on November 13, 2005. No one took this into account in regard to how they treated me. I found this experience at Cooley Dickinson emergency room retraumatizing. To this day, the memories of this hospital experience continue to disturb me profoundly.

April 2, 2007

Potential Life-Threatening Denial of Medical Care Results From Disability Prejudice

On or around September 2005, a woman went to her medical doctor reporting symptoms of chest pain and dizziness. Her medical doctor had been monitoring her for a heart condition, and immediately sent her to the medical unit of Cooley Dickinson Hospital for further testing and attention. The doctor specifically made arrangements to not go to the emergency room, because of the woman's past negative experiences at Cooley Dickinson.

On arrival for her appointment at the medical unit, she was examined by Dr. Russo and began to be monitored by staff. At some point her care changed abruptly and she began to be treated disrespectfully. Apparently based on seeing the woman's psychiatric records, Dr. Russo assumed there was no heart condition, and said to her, "This ain't no cardiac." Staff recommended she take psychiatric drugs, and her medical care related to her heart, including regular blood pressure tests, was discontinued and testing cancelled. When she examined her files a note said "Not cardiac - borderline." The woman asked to see the human rights officer but was denied.

After leaving Cooley Dickinson the woman went to Franklin Medical Center in Greenfield where testing revealed she did indeed have a pre-stroke condition as her medical doctor had originally suspected, which had led her to go to Cooley Dickinson in the first place. By not receiving proper testing and care promptly, the woman's life could have been put in danger.

Later, after complaining to the hospital, the woman received a general apology letter from the Cooley Dickinson CEO, but the letter referred inaccurately to her treatment in the ER, where she was not a patient, and no further action was taken by Cooley Dickinson.

This woman has experienced repeated psychiatric abuse prior to this experience, and this incident further damaged her trust in medical practitioners, significantly undermining her capacity to seek medical attention.

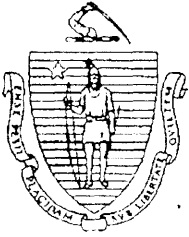
Question About Patients' Rights Met With Restraints and Forced Drugging

On or around November 13, 2005, a woman at the Cooley Dickinson emergency room was told to take ativan by a staffperson. The woman asked if she had the right to decline the medication. When staff did not answer her, she asked to speak with a patient rights advocate. She was then threatened with a forced injection of ativan if she did not comply. When she again asked what her rights were and to speak with a patient's rights advocate, she was physically restrained, her shirt removed, and forcibly injected. At the time of the injection, one ER staff said aloud so that she and several others could hear, "Why are they restraining her? She's not out of control."

The woman was then taken against her will to Franklin Medical Center. Ambulance drivers restrained her and, disoriented and confused by the injection she had just received, she was made to sign paperwork she did not understand.

At Franklin Medical Center she saw Dr. Franklin, who then read to her from her medical record, which said "Patient was asking questions and so was injected." Dr. Franklin expressed concern at her mistreatment and recommended she contact a patient advocate. She was released soon thereafter. The woman made notes about the incident in her journal and appointment book, and discussed what happened with several friends and her therapist.

The woman is a survivor of sexual assault and this incident significantly retraumatized her, with persistent intrusive symptoms afterwards and a significantly reduced trust in mental health care.



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April 9, 2008

Ms. Julie Nantais
Department of Public Health
Division of Health Care Quality, Complaint Unit
99 Chauncy Street
Boston, MA 02111

**RE: Complaint on behalf of Mary [REDACTED] regarding her treatment at
Cooley Dickinson Hospital**

Dear Complaint Unit Investigator:

I am writing to request that the Department of Public Health investigate issues that arose during Mary [REDACTED] visit to the Emergency Room at Cooley Dickinson Hospital on November 13, 2005.

On November 13th, Ms. [REDACTED] voluntarily transported herself to Cooley Dickinson Hospital, accompanied by her outpatient therapist secondary to thoughts of self-harm. Ms. Dean was initially evaluated by triage staff and then moved to a different area of the Emergency Department to wait for a second evaluation by the psychiatric emergency team. At this point, Ms. [REDACTED] outpatient therapist assumed she was being taken care of by hospital staff, so he left the hospital. Despite the hospital staff being aware of Ms. [REDACTED] thoughts of self-harm, the sole reason that brought her to the hospital, she was allowed to remain unaccompanied.

After waiting alone for a period of time, Ms. [REDACTED] believed that hospital staff forgot about her, and decided that she felt better than she did when she first arrived and walked out of the Emergency Department.

After Ms. [REDACTED] left the Emergency Department, hospital staff obtained an emergency restraint order, pursuant to M.G.L. Chapter 123, Section 12, and the police brought Ms. [REDACTED] back to the

hospital, where she was subsequently given a chemical restraint in a manner that exacerbated existing trauma.

FACTS

On November 13, 2005 at 3:35 p.m., Ms. [REDACTED] arrived at Cooley Dickinson Hospital Emergency Department.¹ Ms. [REDACTED] immediately reported to hospital staff that she felt as though she "should not be alive" and felt very desperate.²

Ms. [REDACTED] waited in the Emergency Department, in a secluded room, with [REDACTED], her outpatient therapist, until Emergency Services staff could conduct a follow up psychiatric evaluation.³ At 4:15 p.m., Emergency Services staff conducted an evaluation.⁴ At this point, Mr. [REDACTED] assumed she was being taken care of by hospital staff, so he left the hospital. Following the evaluation, Emergency Services staff left Ms. [REDACTED] unaccompanied despite their knowledge that Ms. [REDACTED] presented with serious thoughts of self-harm and acknowledge a need to provide Ms. [REDACTED] with a "higher level of care (more than what the CSU staff can provide) for safety and containment."⁵

Ms. [REDACTED] felt forgotten by hospital staff. She felt better than she did upon initial arrival to the Emergency Department and decided to leave the hospital. After Ms. [REDACTED] left the Emergency Department, hospital staff called the Northampton Police, and filed a request an emergency order pursuant to M.G.L. Chapter 123, Section 12.⁶ One hour later, at 6:10 p.m., Ms. [REDACTED] returned to the Emergency Department via police escort and was placed on 1:1 observation.⁷

At 7:00 p.m. Ativan was offered to Ms. [REDACTED], which she refused because she wanted to remain alert. Ms. [REDACTED] has taken Ativan before on an outpatient basis making her aware of its side effects.⁸ At 7:45 p.m., the hospital staff with assistance from hospital security, had Ms. [REDACTED] remove her shirt prior to injecting her with Ativan.⁹ In Ms. [REDACTED]'s evaluation with Emergency Services Staff, she told the interviewer that she had a history of sexual assaults yet the ED staff still removed her shirt to administer the chemical restraint further traumatizing her.¹⁰

At 8:00 p.m. Ms. [REDACTED] was transported to Franklin Medical Center.

¹ Cooley-Dickinson Hospital, Inc. Emergency Department Outpatient Record, written by Gary Mantano, M.D., printed Wednesday, November 16, 2005, pg. 1, see also Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 15:35.

² See Id, Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 15:35.

³ Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 16:00.

⁴ See Id at 17:15, see also Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg. 1.

⁵ See Id at 15:35, see also Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg. 2.

⁶ See Id at 17:15.

⁷ See Id at 18:10.

⁸ Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg. 2.

⁹ Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 19:45.

¹⁰ Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg. 2, see also Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 19:45.

CONCERNS

MHLAC requests that DPH investigate the possibility that Cooley- Dickinson Hospital ED staff failed to provide adequate 1:1 observation of Ms. ██████ resulting in the inappropriate use of a chemical restraint.

I. Cooley Dickinson Hospital staff failed to provide adequate 1:1 observation of a patient known to be in need of safety watch protocol.

1. At 3:35 p.m., when Ms. ██████ arrived at the ED, she immediately reported to hospital staff that she felt as though she “should not be alive” and that she was very desperate.¹¹
2. At 4:15 p.m., when the Emergency Services Evaluation was conducted, the evaluator acknowledged that Ms. ██████ “will require a higher level of care for safety and containment” due to her recent suicidal thoughts.¹²
3. Emergency Services Staff thought Ms. ██████ was such a safety concern that they issued a Section 12 after she fled the hospital grounds.

Cooley-Dickinson Hospital staff knew that Ms. ██████ was a patient in need of safety watch protocol and failed to provide such care. A 1:1 sitter should have been observing Ms. ██████ from the time the staff identified her as a safety concern, at 3:35 p.m. If Ms. ██████ had been observed since 3:35 p.m., she would not have been able to leave the Emergency Room and not been subjected to a chemical restraint.

II. Cooley Dickinson Hospital staff inappropriately subjected Ms. Dean to a chemical restraint.

1. Hospital staff failed to utilize least restrictive alternatives prior to the chemical restraint. Restraint may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm and the record must indicate this.¹³

The record does not indicate that a less restrictive intervention was ever offered to Ms. ██████. Secondly, if the hospital staff had monitored Ms. ██████ with a 1:1 sitter, this would have been a less restrictive intervention and the restraint would have been avoided.

2. A chemical restraint may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others.¹⁴ The mere refusal to consent to medication and a

¹¹ See Id, Cooley-Dickinson Hospital, Inc. Emergency Department Nursing Assessment Sheet, dated 11/13/05, at 15:35.

¹² Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg.2, subsection “Formulation/Rationale For Plan.

¹³ See 42 CFR 482.13 (e)(2) and 42 CFR 482.13 (e)(16)(iii).

¹⁴ See 42 CFR 482.13 (c).

transfer, and asking questions of hospital staff does not justify the use of a chemical restraint.

Less restrictive alternatives of restraint should always be utilized before subjecting a patient to this type of forced treatment.

III. Cooley Dickinson Hospital staff inappropriately removed Ms. [REDACTED]'s shirt during the chemical restraint, a patient with a known sexual assault history.

During Ms. [REDACTED]'s evaluation with the Emergency Services Staff, Ms. [REDACTED] disclosed a history of sexual assaults.¹⁵ The hospital staff proceeded to force Ms. [REDACTED] to remove her shirt during the chemical restraint causing her to be retraumatized.

REQUESTS

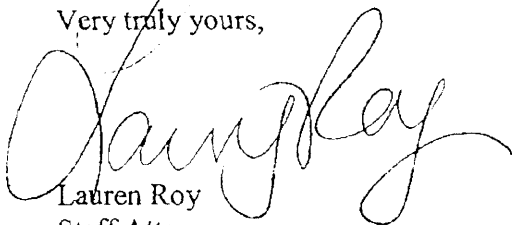
Cooley-Dickinson Hospital ED staff failed to employ least restrictive alternatives to restraint by failing to appropriately monitor a patient in need of safety watch protocol, thus subjecting Ms. [REDACTED] to an unnecessary and illegal chemical restraint.

Mental Health Legal Advisors asks the Department to take action to mandate training of the ED staff at Cooley- Dickinson Hospital to address the above mentioned concerns, and to create a policy that remedies these types of situations so to avoid future harm of patients. Passage of the new proposed Emergency Room Rights Bill (House Number 2042) would prevent such incidents as described in this complaint from recurring.

[REDACTED]
[REDACTED] I can be reached at 617-338-2345, ext. 26 or lroy@mhlac.org.

Thank you for your attention to this matter.

Very truly yours,



Lauren Roy
Staff Attorney
Mental Health Legal Advisors Committee

Enclosures

Cc. [REDACTED]

¹⁵ Services Net, Emergency Services Evaluation Form dated 11/13/2005, pg. 2.