Disability Rights California

California's Protection & Advocacy System
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Death of Jadeed at Napa--A Review of the Neglect, Restraint, and Death of Zouhair Jadeed at Napa State Hospital

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Note: When this report was originally published, we were known as Protection & Advocacy, Inc. (PAI). In October 2008, we changed our name from PAI to Disability Rights California.

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I. INTRODUCTION

This report presents Protection and Advocacy, Inc.'s (PAI's) review of the March 15, 1992, death of former Napa State Hospital (NSH) resident Zouhair Jadeed. Zouhair Jadeed, the son of Jano and Naaman Jadeed, was a 22-year-old young man with multiple disabilities. Zouhair Jadeed was found not breathing by NSH staff members in a seclusion room, following seven hours and forty-five minutes of physical restraint and isolation.

PAI is an independent, private, nonprofit agency which protects and advocates for the rights of persons with mental or developmental disabilities. Under federal and state law, PAI has the authority to investigate incidents of abuse and neglect of persons with mental or developmental disabilities. 42 U.S.C. §§ 6000 and 10801, et seq.; California Welfare & Institution Code (WIC) § 4902, et seq.

PAI's inquiry into Jadeed's death included:

- Reviewing Jadeed's clinical records.

- Reviewing NSH nursing, administrative, seclusion and restraint and other applicable patient care policies, procedures and directives.

- Reviewing Napa County Sheriff-Coroner autopsy, investigative reports and related documentary evidence.

- Reviewing NSH investigative and administrative reports concerning Jadeed's death.

- Consulting a board-certified psychiatrist/biologist/psychotherapist with over 15 years' experience in evaluating, prescribing, and monitoring the use of psychiatric medications.

- Consulting with a clinical psychologist/behavioralist/researcher with over 15 years' experience in evaluating behavioral programming and the use of physical restraint and isolation.

II. EXECUTIVE SUMMARY

One year ago, on March 15, 1992, Zouhair Jadeed, a young man who was sight- and profoundly hearing-impaired, as well as mentally and

developmentally disabled, died at Napa State Hospital (NSH). NSH is one of five such state hospitals run by the Department of Mental Health (DMH). Approximately 900 mentally disabled people reside at the facility.

Jadeed died alone in a locked seclusion room, his face tucked down into the mattress, following seven and three-quarter hours of physical restraint, unremitting agitation, and distress. According to the psychiatrist PAI consulted, Jadeed likely died from unrecognized and untreated neuroleptic malignant syndrome (a potentially fatal reaction to psychiatric medications) accompanied by a prolonged period of improperly monitored seclusion and restraint.

PAI reviewed the facts and circumstances surrounding Jadeed's death to determine what specific practices, if improved, would prevent such tragedies from occurring in the future. In its report, PAI identifies a number of deficiencies which, if corrected as recommended, would more effectively protect state hospital residents from the dangerous and unnecessary or excessive use of physical and chemical restraints.

Physical restraint or isolation is always a frightening and potentially dangerous procedure. When the risks of physical restraint are combined with adverse medication reactions and inadequate monitoring of individuals' conditions, the result too often proves fatal. Zouhair Jadeed's death is the fourth such death PAI has reviewed and reported upon publicly since it began investigating neglect-related deaths occurring in state hospitals in 1990. Jadeed's death demonstrates that the actions taken by individual state hospitals following the deaths of other similarly situated state hospital residents are inadequate. It is time that the dangers of physical restraint and adverse medication reactions, both individually and in combination, be addressed effectively and comprehensively by DMH so that related clinical practices can be improved substantially on a statewide basis.

FINDINGS AND CONCLUSIONS

A. Failure to respond to and follow up on persistent and potentially lethal medication reactions.

Jadeed experienced a number of increasingly troubling, adverse medication reactions during the month before he died. Although many of the symptoms of these medication reactions were documented, their significance was not appreciated by nursing or medical staff. Meaningful follow-up did not occur. Such symptoms included, but were not limited to, ataxia (unsteady gait), tremors, increasingly bizarre behavior, dizziness, confusion, oculargyric crises (prolonged fixation of the eyeballs in an upward position due to spasm), and, on the day Jadeed died, "lead pipe" muscle rigidity, and unremitting agitation. Despite these obvious signs of medication-related distress, the last physician's note indicating any concern about adverse drug reactions was charted on March 4, 1992, eleven days before Jadeed died.

B. Improper use of physical and chemical restraints as a substitution for a timely and appropriate, less restrictive behavioral plan.

The primary reason for Jadeed's admission to NSH on May 7, 1990, was to get him help for his problems of aggression toward others and property destruction (i.e., ripping/tearing/shredding of clothes and other materials). Instead of developing and implementing a timely and appropriate behavioral program to address Jadeed's individual behavioral needs, Jadeed's treatment team relied on the more restrictive and dangerous interventions of physical and chemical restraints. Seclusion and/or restraints are never an acceptable substitute for a less restrictive alternative form of treatment such as a nonaversive behavioral plan.

C. Inadequate care and monitoring during locked seclusion and bodily restraint.

The inattention to Jadeed's condition by nursing and medical staff while he was in restraints and seclusion on March 15, 1992, constituted neglect of a dependent adult, exposing Jadeed to significant dangers. Nursing staff failed to respond to clear signs of an impending medical crisis, including but not limited to flaring nostrils -- a cardinal sign of respiratory distress, incontinence, and "red" and "blue" extremities.

Although during the Coroner's investigation one staff person stated that Jadeed's vital statistics were taken during the seven and three-quarter hours of bodily restraints and isolation, none were documented as required by policy. And although a physician charted "no medical contradictions" to ongoing restraint and seclusion existed, no documentation explains how or why that conclusion was reached. Nor is it clear that the physician actually evaluated Jadeed.

In addition, on the day Jadeed died, NSH denied him needed access to basic hospital services by failing to accommodate his communication needs. Jadeed was profoundly hearing-impaired and could only communicate effectively through American Sign Language (ASL). In violation of NSH policy and antidiscrimination mandates, Jadeed reportedly was visited by a NSH staff member capable of communicating with him in ASL only four times during the entire time he was secluded and restrained. During the Coroner's investigation, this same staff member stated that she was working a double shift and was assigned to provide one-to-one supervision to another resident.

RECOMMENDATIONS

A. Preventing, identifying, and responding to medication reactions.

To promote the health, safety, and quality of life of state hospital residents, DMH and NSH should develop timely and effective review mechanisms which are triggered automatically when, as was the situation with Jadeed, medication regimens are not effective and adverse effects persist. Special attention should be given to identifying and responding to paradoxical reactions to medications. The dangerous assumption that behavioral deterioration is always the result of the individual's mental disability and that more medications are always the answer must be eliminated.

DMH should focus on strategies for ensuring that individuals at risk for developing potentially life-threatening medication reactions, such as neuroleptic malignant syndrome, are identified and appropriate preventive measures taken. Such strategies should include the greater individualization and data-based monitoring of treatment. More vigorous

ongoing training and supervision of care staff at all levels should also occur.

B. Developing and implementing appropriate and timely individualized behavioral plans.

DMH should ensure the timely development, implementation, and monitoring of appropriate behavioral plans at all of its state hospitals, including NSH; seclusion or restraints are never an acceptable substitute. DMH should streamline the process for obtaining behavioral consultations and psychological testing, and develop an effective mechanism for resolving interdisciplinary conflicts which adversely affect implementation of needed behavioral plans. DMH should also show greater leadership in deploying effectively its psychology and behavioral staff; such staff constitute valuable treatment resources to individuals who desire and need behavioral programs.

C. Improving seclusion and restraint care and monitoring practices.

Bodily restraint and seclusion is always an intrusive and potentially dangerous procedure. Risks can be ameliorated through close monitoring and supervision. Procedures should be modified to ensure that vital statistics and fluid intake are monitored more thoroughly and frequently. Ongoing staff training and education should emphasize that policies and procedures set minimum standards only, and that good care may require, as on the day Jadeed died, more intensive monitoring and evaluation. DMH and NSH should ensure, as required, that clinical assessments or "checks," whether by medical or by nursing staff, are always conducted face-to-face, never through the window of a locked seclusion room.

In addition, NSH should provide qualified professionals to accommodate the communication needs of hearing-impaired individuals undergoing seclusion and restraint. On the day Jadeed died, this reportedly was not so. Consequently, he was denied access to basic hospital services, including adequate nursing and medical care. Signing competent staff should also receive more specialized training about the dangers of seclusion and restraints so that they can use their sign language skills to more effectively identify and evaluate at-risk individuals, such as Zouhair Jadeed.

III. CIRCUMSTANCES SURROUNDING THE DEATH OF ZOUHAIR JADEED

Zouhair Jadeed
S9: Unit for the Hearing Impaired
Antipsychotic Medications
Seclusion and Restraint

Zouhair Jadeed had multiple disabilities. He was profoundly hearing-impaired, probably as a result of Rubella Syndrome. Zouhair was also severely sight-impaired, and had the mental and developmental disabilities of intermittent explosive disorder and mild mental retardation. He communicated through the use of American Sign Language (ASL).

Zouhair Jadeed was born in Lebanon. His family moved to California when he was eight years old. He attended school programs for the deaf in Southern California. According to a clinical psychologist who recommended a more comprehensive mental health evaluation for Jadeed in 1989 due to his deteriorating behaviors at school: "Zouhair has difficulty sharing his emotions and understanding other individuals.... He acts aggressively only in times of severe frustration from lack of alternatives in expressing his emotional needs. There are no indications of emotionally inappropriate responses or psychosis."

Jadeed was admitted for psychiatric care and treatment to NSH's Unit S9 on May 7, 1990. S9: Unit for the Hearing Impaired

Unit S9 is licensed to provide an intermediate level of care for mentally disabled individuals with hearing impairments, ages 18-59. Individuals who are "actively violent" or who have physical conditions requiring a higher level of skilled nursing care are excluded from the unit.

While Jadeed resided on the unit, S9 housed 11 female and 22 male patients; it had two seclusion rooms. The unit's overall treatment goal is to "assist individuals in attaining maximum social function and in developing a sense of self-esteem and belonging in the Deaf Community." Treatment modalities include individual, family, group, and occupational therapy as well as medications, education, and vocational training.

Antipsychotic Medications

Zouhair Jadeed, like the vast majority of state hospital patients, received antipsychotic medications as part of his ongoing treatment. Antipsychotic or, as they are sometimes called, psychotropic or neuroleptic medications are "customarily used for the treatment of symptoms of psychoses and other severe mental and emotional disorders." California Code of Regulations (CCR), Title 9, § 856. These medications benefit many individuals by minimizing or eliminating psychotic symptoms such as hallucinations (seeing and hearing things which do not exist) and delusions (grossly inaccurate beliefs which are obviously contrary to fact). They are also intended to reduce excitability, anger, confusion and withdrawal.

Because of their effects on the nervous system, the class of drugs called neuroleptics (e.g., Navane, Stelazine, Mellaril) can produce neurological dysfunction, often called extrapyramidal symptoms (EPS). Symptoms of EPS include but are not limited to tremors, uncontrollable restlessness (akathesia), spasms of the face and neck muscles, involuntary protrusion of the tongue, difficulty swallowing (dysphagia), fidgeting, drooling, and shuffling movement of the feet. The use of neuroleptics has been associated with heart, breathing, and blood pressure problems, hyperthermia, death by neuroleptic malignant syndrome (implicated in the death of Jadeed as discussed in "B" below), and Tardive Dyskinesia (a condition which results in involuntary, potentially irreversible movements of the jaw, tongue, upper body, and extremities).

Seclusion and Restraint

As is the situation with a substantial minority of state hospital residents, Jadeed was subjected to physical restraint and locked isolation. According to the 1992 denial of rights/seclusion and restraint quarterly reports, NSH is one of the highest overall users of seclusion and restraint within the state hospital system.

Seclusion and/or restraint is always a humiliating and potentially dangerous procedure, but it is sometimes necessary for the physical safety of the individual or others. Risks include but are not limited to dehydration, exhaustion, fractures, muscle and kidney damage, self- mutilation,

strangulation, and a worsening mental condition as a result of being alone and isolated. The emotional impact of seclusion can be severe and some "debriefing" may therefore be necessary following removal from seclusion to mitigate against painful memories. Physical restraints (leather belts and cuffs are generally used to restrain individuals in state hospitals such as NSH) can also cause circulatory obstruction as well as aspiration if an individual is restrained on his or her back.

Under NSH policy, seclusion and/or physical restraint can only be used in emergencies. NSH defines an emergency as "behavior by a patient which signifies an imminent threat of conduct dangerous to the patient or others when less restrictive measures are not effective." NSH defines restraint as the "use of physical or mechanical means to control or restrict a patient's behavior, activity, or movement of all or a portion of the patient's body," and seclusion as the "use of physical, mechanical or psychological means to isolate a patient or to restrict a patient alone in a room by denying voluntary egress."

A. PATTERN OF NEGLECT PRIOR TO THE DEATH OF ZOUHAIR JADEED

As noted earlier, Jadeed's mental disability did not involve delusions or hallucinations; the primary reason for his admission and continued placement at NSH was his impulsive behaviors, which included the shredding of clothing and aggressiveness towards others. Despite numerous notes in the clinical records concerning the need for a comprehensive behavioral program to address Jadeed's behavioral needs and its forthcoming development, no appropriate and timely plan was ever implemented prior to Jadeed's death on March 15, 1992. Instead, as discussed below, NSH staff relied on the use of physical and chemical restraints to control Jadeed's behavior.

At the time of his death, Jadeed's regularly scheduled psychiatric medications included:

> Tegretol, an anticonvulsant also used as an antimanic -- 1600 mg. per day. Symmetrel, an anti-Parkinsonian medication (used to counteract the adverse neurological effects of antipsychotic

> medications) -- 200 mg. per day. Depakote, an anticonvulsant also used as an antimanic -- 2000 mg. per day. Navane, a neuroleptic and antipsychotic -- 60 mg. per day.

Navane was also prescribed for Jadeed on a PRN (as-needed basis), as was Ativan, an antianxiety medication.

In May, 1991, Jadeed was tested at NSH's Movement Disorder Clinic for signs of extrapyramidal symptoms (EPS). The evaluator observed that Jadeed had "a tremor of the tongue resting on the floor of the mouth and also protruded, and . . . minimal cogwheel rigidity" (arm muscle rigidity). The evaluator concluded that Jadeed showed no signs of involuntary muscle movement (dyskinesia), but that he did have minimal parkinsonism (rigidity and tremors).

Jadeed's treatment team developed a nursing plan for monitoring signs of EPS that required "immediate medical attention." According to the plan, these signs included: pain or tenderness in front of his ear; extreme dryness of his mouth; difficulty urinating; abdominal pain; a fast, pounding heart beat; and visual disturbances. In reviewing Jadeed's death, NSH noted that while nursing staff recorded symptoms consistent with adverse drug reactions, they did not appear to recognize their significance, as appropriate follow-through did not occur. NSH also commented on the lack of physician's notes after Jadeed's medications were increased.

In February of 1992, the month before Jadeed's death, two of his regular medications were increased. During this next month, six out of the seven times Jadeed received a total of 80 mg. or more of Navane within a 24-hour period, staff documented but failed to respond to symptoms of serious drug reactions. Such reactions included but were not limited to muscular rigidity and tremors, difficulty swallowing, disorientation, and behavioral deterioration. During five out of these six episodes, Jadeed ended up in physical restraints and locked isolation.

On February 20, 1992, Jadeed's Depakote was increased from 1000 to 2000 mg. per day. His psychiatrist documented that this increase was an "attempt to bring compulsive behavior under control" and "manage impulsiveness." Four days later, the Navane was also increased from 40

mg. to 60 mg. per day due to "periodic behavioral episodes" and "frequent shredding of clothing." Dr. D noted: "Mr. Jadeed is unable to discuss motivation for these acts even when addressed with signing interpreter.... Pt. has had frequent thiothixene (Navane) PRN's (as needed) will increase scheduled dose of this medication as well."

On February 26, 1992, Dr. D documented that Jadeed's antipsychotic medication could not be reduced and that there was no abnormal movement disorder present. The symptoms of adverse medication reactions that Jadeed had been experiencing since December, 1991, which were noted in the chart, included but were not limited to muscle rigidity, tremors, soreness, restlessness and pacing, weight loss, and incontinence, as well as the findings of the movement disorder evaluator in May, 1991, went unmentioned. On March 5, 1992, Dr. E, an independent reviewer, approved these medication changes.

On February 27, 1992, at 5:20 PM, Jadeed was put in seclusion and restraints for hitting another patient who was in a side room for "time out." Dr. B ordered Jadeed restrained and secluded for a period not to exceed 12 hours. Jadeed could be released earlier if he was "calm and able to follow directions and no longer threatening."

At 5:50 PM, a half-hour after being restrained, Jadeed began breathing rapidly and his muscles turned tense. His eyes were wide and glaring, and he was not responsive to communication. These symptoms of distress appeared three days after the Navane had been increased and within one hour and fifty minutes of Jadeed having received his 4:00 PM dose of Navane, for a total of 80 mg. of Navane over a 24-hour period. Just five minutes later, at 5:55 PM, Jadeed was offered another PRN of 20 mg. of Navane in liquid form. He refused it and was given 10 mg. of Navane by injection. Jadeed remained in bodily restraints and locked isolation until 5:00 AM, for a total of more than 11.5 hours.

On March 3, 1992, at 5:35 PM, Jadeed started tipping tables and chairs over and yelling in the dining room for "no apparent reason." Staff responded by putting him in restraints and locked seclusion. At 6:15 PM, staff documented that Jadeed had a pulse of 116 (or tachycardia, a heart rate over 100 beats per minute), a temperature of 99 , and that his body

was "very tense." These symptoms, again noted while Jadeed was restrained and isolated, occurred two hours and fifteen minutes after he received his 4:00 PM dose of Navane, for a total of 80 mg. of Navane within a 24-hour period.

This time, Dr. B authorized restraints and seclusion for a period not to exceed six hours. Criteria for early release included being "able to express why he is in S/R and able to resume ward routines." Jadeed was released from restraints and isolation nearly four hours later at 9:15 PM.

By the following day, March 4, 1992, Jadeed was in a state of severe physical distress and panic. At 6:00 PM, direct care staff observed Jadeed trembling, disoriented, and experiencing oculargyric crises (prolonged fixation of the eyeballs in an upward position due to spasm). These disturbing observations were documented two hours after Jadeed received his 4:00 PM dose of 20 mg. of Navane, for a total of more than 80 mg. of Navane within a 24-hour period. Staff charted that Jadeed was:

> ". . . wrapped in blanket under bed, body trembling. Asked him why under bed, signed 'scared.' He was offered PRN which he accepted but missed his mouth dribbling on to blanket, slopping on to floor. Zouhair's eyes looked glazed then rolling back into the top of his head. This writer yanked him out from under bed still wrapped in blanket. Zouhair continued to try and tear blanket with his teeth, try to pull in body into fetal position."

At 6:10 PM, staff documented that Jadeed had "fine tremors on hands," and appeared "tensed and very confused." At 7:00 PM, staff noted that Jadeed was alert but disoriented, had a rapid pulse, an unsteady gait and was "staggering a bit."

Over the next several hours, Jadeed's entire body became tense; he was trembling. His pulse continued to rise, going as high as 132 beats per minute. His behavior became increasingly bizarre. At 9:45 PM, staff observed Jadeed sitting quietly in the day room; he then put a sheet into his mouth and slowly tipped over a wooden table. Before staff could take Jadeed's vital signs, his "eyes glazed, biting sheet, pt. [patient] VERY SLOWLY stood and climbed onto pool table, threw flowers at peer, jumped

down, staff proned him c [with] much difficulty -- pt. very tense ... transported pt. via gurney to 5 pt. R&S [five-point restraints and seclusion], attempted to verbally calm pt. -- pt. not responding c signing [eye contact only]...." (Emphasis in original.)

At 10:00 PM, Jadeed complained that his head hurt. His eyes were grimacing, and he was "hollering as if in pain, trembling." He was visited by the medical doctor on duty, who questioned whether Jadeed was suffering from catatonia, seizures or extrapyramidal symptoms (EPS). The doctor also noted that "earlier he sustained a slight wound on head w/[with] moderate bleeding. He was disoriented w/[with] gait unsteady . . . Pt. [Patient] was pointing to his head as if in pain. He looks very anxious." Jadeed was given 2 mg. of Ativan. Direct care staff were then ordered to and did take Jadeed's vital statistics and check his neurological status every two hours for the next twenty-four hours. According to the psychiatrist PAI consulted, the significance of documented observations, however, went unappreciated and follow-up did not occur. Such observations included sluggish pupils, dizziness, disorientation, and a rapid heartbeat.

According to NSH records, although "quiet with his eyes closed" from 11:00 PM on, Jadeed remained, per his own request, in waist restraints and "open" (i.e., unlocked) seclusion until 6:00 AM the following morning, for a total of 8.25 hours. At 10:30 AM the following day, March 5, 1992, Jadeed complained of being dizzy. Jadeed's pulse continued to race, remaining over 100 beats per minute for more than 21.5 hours. It finally fell below 100 at 4:30 PM.

By 4:00 PM on March 5, 1992, Jadeed had again received a total of 80 mg. of Navane within a 24-hour period. Jadeed was seen by Dr. F around 4:30 PM, who wrote: "He appears calmer today. He is alert this afternoon. Events of yesterday were reviewed with him and he was able to discuss little that was disturbing him. Impression is his anxiety was diminished with Ativan."

At 5:50 PM, staff observed Jadeed's "eyes roll upward" and his "upper lip curled into a grimace" for a period of one to two minutes. After this, Jadeed appeared disoriented. Between 6:30 and 10:55 PM, Jadeed complained that his eye and face hurt. He received a PRN of Tylenol. At 11:45 PM,

staff heard Jadeed scream. Jadeed requested something to help him sleep. Dr. G noted that Jadeed complained of insomnia and that Jadeed received 30 mg. of Restoril for sleep. This was the last charting by a physician until Jadeed's death, ten days later.

On March 9, 1992, staff charted that Jadeed had "several bright scratch marks in linear-oval shape under both eyes; other staff report these have been there for several days, but barely noticeable. Today they are much brighter red...." After Jadeed's death, staff told the Coroner's investigator that days before his death, Jadeed developed the new behaviors of scratching at his eyes and digging at himself.

On March 10, 1992, five days before Jadeed's death, his psychologist noted: "Recently has been very labile and regressed. Behavior program for shredding developed this month by referral to BCT (Behavioral Consult Team) from psychologist; to be implemented soon...."

On March 13, 1992, at 9:00 PM, Jadeed was "acting very bizarre, laying in a fetal position, then tearing clothes with his teeth and choking on cloth." Staff offered and Jadeed attempted to swallow a PRN of 20 mg. of Navane. Jadeed choked on it so he was given the Navane by injection. This injection brought his Navane total to 80 to 90 mg. within a 24-hour period. At 9:05 PM, he was observed "sitting in his locker making a pill-rolling motion with hands" (a classic medication-related neurological effect).

At 9:30 PM, Jadeed "continued chewing on rags, laying on floor, eyes rolling, scratching face. Help called and put into five-point restraint and seclusion for self-injurious behavior. Patient continued to stick his fingers in his eyes and scratch at his face so wrists were put below his waist...." At 9:45, staff observed: "continues rhythmic pill rolling movement of hands."

Jadeed was seen by the psychiatrist on duty at 10:15 PM, who authorized continued seclusion and restraints for a period not to exceed 12 hours. The psychiatrist stated that Jadeed could be let out of restraints early if he was "cooperative" with staff and had "self-control." According to the psychiatrist's notes, Jadeed had "tried gouging his eye out after shredding his clothes ... states doesn't remember what happened ... states he doesn't know why he hurt himself & states he couldn't stop...."

At 11:00 PM, Jadeed's face and right eye were reddened and slightly puffy. There was a small amount of dried blood under his nose and around his mouth. At 12:45 AM, Jadeed "requested and was given a drink of water. Patient appeared to have difficulty swallowing a small amount of water and choked twice." Jadeed remained in restraints and locked isolation until 6:45 AM the next morning, March 14, 1992, for a total of 9.25 hours. (Emphasis added.)

At 2:10 AM on the day of Zouhair Jadeed's death, March 15, 1992, staff noted that Jadeed complained of pain in the throat area. At 12:30 PM, Jadeed was given a PRN of 20 mg. of Navane for a "scowling facial affect, glaring at staff and peers." Two hours and fifteen minutes after receiving this PRN, Jadeed ran out of a side room during a staff meeting, asking if he could be let out. He was then secluded and restrained for verbally threatening a staff member who told him that he would be let out when staff told him he could be let out. (The events of March 15, 1992, are discussed more fully in Section B below.)

During the restraint procedure, staff observed but failed to document and follow-up on the facts that Jadeed was extremely rigid ("like a piece of concrete") and that his lower arms turned "bright red and blue."

At 4:45 PM, Jadeed told staff he was calm, but staff disagreed because he was "snarling and growling, resistive to his scheduled medications at 1600." According to staff, when range of motion of his limbs was attempted, he jerked on the restraint. Over the next two hours, Jadeed scratched at his eyes and face and clawed into the mattress with his toes and fingers; his body was extremely rigid.

At 8:00 PM, Jadeed received 20 mg. of Navane, which brought the total received to 80 mg. within a 24-hour period. One hour and forty-five minutes later, at 9:45 PM, Jadeed was given 2 mg. of Ativan because "he has not been able to relax, clawing nails into bed rails.... Nostrils flaring, attempting to claw face...."

At 10:30 PM, March 15, 1992, Jadeed was found with his face tucked down into the restraining bed, not breathing.

All of the above symptoms described in Jadeed's record for the month preceding his death -- muscular rigidity and tremor; tachycardia (pulse rate over 100 beats per minute); ataxia (unsteady gait); oculogyric crises (fixed upward gaze); disorientation; dizziness; behavioral deterioration; dysphagia (difficulty swallowing) and complaints of throat pain; motor restlessness leading to insomnia; incontinence; agitation; anxiety; and panic -- are all consistent with potentially dangerous medication reactions.

Jadeed's clinical records also clearly reflect that NSH staff failed to develop and implement, as required, a timely and appropriate individualized plan to address his behavioral problems. Instead, he was subjected to physical and chemical restraints. According to the psychiatrist PAI consulted, the failure to implement potentially more effective and less restrictive treatment interventions, such as comprehensive behavioral programming, "appeared to rest on the dangerous unwavering assumption that more medication would yield better results; paradoxical reactions were therefore not adequately considered."

The behaviorist PAI consulted echoed this concern, stating:

> "The use of documented efficacious behavioral interventions does not appear to have been attempted. There was little, if any, systemic evaluation of treatment efficacy for either medical or behavioral interventions. And appropriate review or oversight mechanisms regarding Mr. Jadeed's treatment failed to respond to an increasing pattern of behavioral disturbance which was not responded to with sound behavioral interventions but with increasing dosages of medications."

On March 17, 1992, two days after Jadeed's death, his treating physician wrote in the "Release Summary":

> "During Mr. Jadeed's time at Napa State Hospital, his behavior continued in the same way that it had prior to hospitalization. Property destruction, especially the shredding of clothing, continued as a problem. Typically he would rip into small pieces four to five outfits of clothing per day. Physical assaultiveness continued, and typically he would require emergency intervention

> of seclusion and restraint somewhat more often than once a week for paroxysmal assault against peers or staff. Efforts were made to engage Mr. Jadeed in group and individual therapy. While he would attend various activities including deaf culture and anger management, he would rarely participate in either group.... Mr. Jadeed was experiencing some of the same impulsive and assaultive behaviors seen in our other congenitally deaf patients with known rubella encephalopathy.... We attempted pharmacotherapy similar to that which has been helpful in other cases...." (Emphasis added.)

B. MARCH 15, 1992: SEQUENCE OF EVENTS

In the early morning of Sunday, March 15, 1992, NSH staff observed that Zouhair Jadeed had been up to the bathroom twice within a half hour. Staff asked Jadeed if anything was wrong. Jadeed signed "Pain" at his throat area and asked for and received Tylenol. On the two previous nights, Jadeed had experienced difficulty swallowing, choking on even a small amount of water. This night, however, staff documented no such swallowing problems. After taking the Tylenol, Jadeed reportedly was in bed with his eyes closed for the rest of the shift.

At 8:00 AM, Jadeed received his morning medications. At noon, he again received his scheduled medications. Staff noted nothing unusual during that morning. Then, at 12:30 PM, after displaying a "scowling facial affect" and "glaring at peers and staff," Staff Person No. 1 (SP #1) gave Jadeed a PRN ("as needed" dose) of 20 mg. of Navane (an antipsychotic medication) in liquid form. Staff Person No. 2 (SP #2) stated during an interview with Deputy A, Napa County Sheriff-Coroner investigator, that she thought Jadeed had been "angry in the morning." SP #2 also stated that she was the only "bilingual" (capable of communicating in sign language) staff available during the entire period Jadeed was in restraints and isolation (seven and three-quarter hours), that she was working a double shift (AM & PM), was assigned to provide "one-to-one" supervision to another patient for the second shift, and that she went in to check on Jadeed approximately four times. (Jadeed's clinical records indicate nothing about these four "bilingual" checks.)

At 1:30 PM, SP #1 noted that Jadeed appeared calmer and was smiling. Twice during shift report (a meeting between AM and PM shifts for exchanging information, which occurs around 2:30 PM), Jadeed came out of a side room where staff had isolated him for "time out." According to Staff Person No. 3's (SP #3) statements to Deputy A, when Jadeed stated he wanted to come out of the side room, a staff member responded that he would have to stay in the room until staff told him he could come out. SP #1 stated during his interview with Deputy A that the second time Jadeed came out of the side room he was really angry and attempted to hit a staff member. Various staff then documented that Jadeed came out of the side room with clenched fists, yelling, stomping his feet, and signing "Hit. Hit you."

Staff responded at 2:45 PM by placing Jadeed on his abdomen in five-point (referring to all four extremities plus waist) leather restraints in a locked isolation room.

Staff made several observations while restraining Jadeed. These observations were later discussed with Deputy A following Jadeed's death. SP #2 observed that while Jadeed was being placed into restraints, "the whole time he was rigid." Another staff member told Deputy A that Jadeed was "like a piece of concrete." This same staff member also stated that as she was holding Jadeed's legs (his arms were unrestrained at the time), she saw his arms turn "bright red and blue" from the elbow down to the tips of his fingers.

Although such observations forewarned an impending crisis, they were not even documented in Jadeed's clinical records. Nor were they apparently reported to supervisorial or medical staff. In fact, the physician who authorized the restraint, Dr. A, documented that there were "no medical contraindications" to placing Jadeed in five-point restraints and isolation. The records do not reflect whether Dr. A conducted a face-to-face evaluation of Jadeed, as required, to determine the clinical appropriateness of bodily restraint and seclusion. In addition, one of the conditions imposed by Dr. A for Jadeed's release from restraint and seclusion was punitive: "can comply with treatment program." (Restraint and seclusion can only be used in emergencies; it cannot be used as punishment or to force compliance with a treatment program.)

From 2:45 PM to 4:30 PM staff observed that Jadeed was "pulling on his belts [restraints]," "sneering," and "yelling." At 4:30 PM, he was "resistive" but given his regular medications. He was also visited by Staff Person No. 4 (SP #4), who documented that the restraints were applied properly, were nonconstricting, and that Jadeed's central nervous system was "OK."

At 5:15 PM, Jadeed was observed scratching at his face. Still restrained on his abdomen, his hands were then placed back into the leather wrist restraints down at his waist. Between 5:30 PM and 6:45 PM, staff observed Jadeed digging his toes into the mattress, clawing at the sheets with his fingers and clawing at the restraints with his feet. Jadeed eventually took a piece of sheet into his left hand and began tearing the sheet with his teeth. At 6:15 PM, Staff Person No. 5 (SP #5) removed the sheet from the restraining bed, repositioned Jadeed "with difficulty," and adjusted the restraints. SP #5 documented that "it took staff a full five minutes to get the sheet away from him. His body is extremely rigid and he will not relate to staff except with threatening gestures and yells -- clenched fists." During this time, staff documented that Jadeed's circulation and respirations were "OK." (Emphasis added.)

At 7:45 PM, nursing staff obtained a new telephone order for keeping Jadeed in five-point restraints and seclusion, noting: "Continues to attempt to claw his face, bite straps, shred sheets, and yell. Continuation order secured as he is still out of control." Jadeed's restraints were adjusted and staff documented that his circulation and respirations were "OK." At 8:00 PM he received his regular medications. Staff noted that he was "yelling and threatening."

SP #4 assessed Jadeed for the second time at 8:20 PM. She determined that Jadeed was not ready for release and secured the restraints, noting that they were nonconstricting and that Jadeed's central nervous system was "OK." SP #4 documented that Jadeed had a "slight laceration sustained in both nostrils bilaterally" and that she notified the medical doctor on duty. Jadeed's clinical records do not indicate whether the medical doctor on duty responded. Nearly two and a half hours later, after Jadeed's death, Dr. C noted: "There was old blood around nose as he earlier was attempting to 'scratch eyes out' and that was the reason for seclusion, restraint...."

NSH nursing procedure requires that during seclusion and restraint: "... The patient's vital signs [blood pressure, pulse and respirations] are to be taken at the beginning of each shift and recorded in the Vital Signs Record." Twice during her interview with Deputy A, SP #4 stated that she checked Jadeed's vital signs. However, Jadeed's clinical records do not contain any entries by SP #4 or any other staff member documenting Jadeed's vital signs that day.

Dr. B made an 8:45 PM entry in Jadeed's record indicating that Jadeed was not ready for release, stating: "Remains hostile, out of control -- attempts SIB [self-injurious behavior] and property destruction." Dr. B's log entry stated: "[Ward] S-9 -- stat [meaning 'give now'] Ativan -- agitated." The records, including Dr. B's shift log, do not indicate whether these conclusions were reached following a face-to-face medical evaluation.

Between 8:45 PM and 9:25 PM, Jadeed was "picking at bed," "pulling at belts," and "yelling and pulling." At 9:25 PM, consistent with the log entry above, Dr. B ordered a PRN of 2 mg. of Ativan (an antianxiety medication) for Jadeed. The order specified that if the Ativan was refused orally, it was to be given by injection. Staff Person No. 6 (SP #6) charted that she gave the Ativan in pill form. In SP #6's interview with Deputy A, she related that Jadeed was "real tense," so she gave him the PRN and tried to get him to relax. SP #6 further stated that she turned Jadeed's head to one side. By that time, the PM shift was almost over. According to SP#6, Staff Person No. 7 (SP #7) then continued checking Jadeed every fifteen minutes, as required.

At 9:45 PM, SP #7 documented: "unable to reduce patient" (i.e., use less restraint) and that range of motion was given to Zouhair's legs when his clothes were changed, as he had been incontinent. According to SP #7, Jadeed was "very resistive -- attempting to scratch staff and himself" and that "staff was trying to get him to breathe slowly in and out but unable to follow directions." Although SP # 7 noted: "Nostrils flaring, attempting to claw his face and staff when checking his nails and restraints," SP #5 documented Jadeed's respirations as "OK." (Emphasis added.)

At 10:00 and 10:15 PM, SP #5 documented that Jadeed's eyes were "closed," and that his circulation and respirations were "OK." In her

interview with Coroner Deputy A, SP #5 stated that she too had been assigned to supervise another resident on a one-to-one basis, but that she checked on Jadeed "periodically." SP #5 also stated that Jadeed had not been feverish and that he had received plenty to drink, adding: "If anything, he maybe wasn't warm enough -- but we couldn't cover him because we were afraid he'd shred and ingest it [the sheet].... We were very busy, but for most of the day, I checked him. We never go in there alone -- at least two or sometimes three people go in there...." (These statements are not corroborated by documentation in Jadeed's clinical records.) SP #5 further said that bedtime was at 10:00 PM and that at approximately 10:15, she went by and checked "the dorm," observing: "He looked like he was settling down."

At 10:30 PM, SP #6 saw Jadeed's face tucked down into the restraining mattress. She told Coroner Deputy A: "I went in and tried to feel for breathing." In her interview with Deputy A, SP #5 told the deputy, "SP #6 found him; SP #2 took charge." During SP #2's interview with Deputy A, she stated that after she heard SP #6 scream, she called for the paramedics and contacted her supervisor. SP #2 further stated that she picked Jadeed up by herself, placed him on the floor, and that she and another staff member then began administering CPR and the Ambubag.

The special incident report stated: "When staff was making scheduled checked [sic] -- she opened door -- another staff yelled don't open that door by yourself -- she said I don't think he is breathing -- staff ran discovered face down on mattress -- not breathing. Cyanotic -- removed from restraints placed on floor cpr started immediately -- emergency help called. Fire Dept. responded.... Medical Doctor and Psych Doctor -- Hospital Police also responded."

Upon arriving at the death scene, paramedics noted that Jadeed's skin was moist, pale and cyanotic (turning blue from lack of oxygen); his temperature was cool; his pupils were dilated and fixed. He was unresponsive and not breathing. The fire department continued CPR until Jadeed was pronounced dead.

At 10:50 PM, after Dr. C arrived, Jadeed was intubated and given Epinephrine 1 mg. intravenously. A suction tube was used to clear vomit out of the endotracheal tube.

Dr. C could find no pulse rate, no respiratory rate, and no muscle or pupil reflexes.

At approximately 10:52 PM, March 15, 1992, Dr. C pronounced Zouhair Jadeed dead.

C. FOLLOW-UP INVESTIGATIONS

A NSH Police Officer conducted a preliminary investigation of Zouhair Jadeed's death. DMH Division of State Hospitals' Special Order #7 requires that the Senior Special Investigator be requested to be present at any death scene in which the cause of death, as was Jadeed's, is unclear, unusual or unexpected. Although NSH's records reflect that the Senior Special Investigator was contacted within ten minutes of Jadeed's death, there are no indications that he responded to the scene. After Deputy A conducted his preliminary investigation, Jadeed's body was transported to the Napa County Sheriff-Coroner's Office for autopsy.

An autopsy was conducted by a forensic pathologist the following day, March 16, 1992, at 2:30 PM. Autopsy results were essentially unremarkable, noting some lung congestion. The Napa County Sheriff-Coroner's Office conducted an independent investigation and interviewed direct care staff who were on duty during the PM shift when Jadeed died. Specimens of Jadeed's body fluids were sent to a toxicologist. Lab testing did not reveal any toxic levels of medications. (These lab findings are consistent with the potentially lethal drug reaction of Neuroleptic Malignant Syndrome, which, according to the literature, is not necessarily related to toxic overdoses.)

On May 17, 1992, the Napa County Sheriff-Coroner's Office concluded that Jadeed died from "probable exhaustion after hyperactivity" with the manner of death ruled as "undetermined."

On October 21, 1992, PAI received a copy of NSH's Senior Special Investigator's "Final Report of Death," dated September 17, 1992. The Senior Special Investigator limited the scope of his investigation primarily to the restraint procedure itself. The report merely reiterated clinical records entries from the day of Jadeed's death, findings from the autopsy and toxicology reports, and the findings of NSH's death review. The Senior Special Investigator made no findings of fact, conclusions or recommendations for corrective action concerning the neglectful facts and circumstances underlying Jadeed's death. There were no indications that the Senior Special Investigator conducted any staff interviews. Nor was there evidence that he made use of the interviews conducted by the Coroner's Office. This superficial NSH "investigation" violated DMH Division of State Hospitals' Special Order #7, which specifies that "unusual, suspicious, or unexpected" deaths receive "intensive, prompt, objective, and adequate" investigation.

IV. FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

A. PATTERN OF NEGLECT PRIOR TO THE DEATH OF ZOUHAIR JADEED

FINDINGS AND CONCLUSIONS

NSH staff neglected Jadeed by failing to respond and follow up on persistent medication reactions.

NSH violated Zouhair Jadeed's rights to reasonable training and habilitation by failing to develop and implement an appropriate and timely individualized behavioral plan.

NSH violated Jadeed's fundamental rights to be free from excessive bodily and chemical restraints.

NSH staff neglected Jadeed by failing to respond and follow up on persistent medication reactions.

During the month preceding his death, Jadeed experienced a number of troubling symptoms consistent with adverse drug reactions. These

symptoms included but were not limited to difficulty swallowing, muscle rigidity and body tremors, a shaky and unsteady gate, confusion, increasingly bizarre behavior, rapid heartbeat, and increased motor restlessness leading to insomnia. Although these symptoms were observed and documented by direct care nursing staff, their clinical significance was not appreciated. Meaningful follow-up did not occur.

Nor did NSH medical staff analyze and respond appropriately to these documented, distressing symptoms. Despite the fact that such repeated medication reactions corresponded with increases in the dosages of medications, including the neuroleptic Navane, they were accepted as routine and clinically insignificant. The last physician's note indicating any concern about adverse drug reactions was charted on March 4, 1992, more than ten days before Jadeed's death. As observed by the psychiatrist PAI consulted:

> "On March 4, 1992, the medical doctor on duty appropriately ordered checks for suspected medication-related neurological dysfunction; but then the ball was dropped. Once the twenty-four hour checks were done, unit staff simply didn't follow up, which should be part of routine monitoring. This omission fell below acceptable standards of care and ultimately placed Mr. Jadeed in unnecessary danger."

NSH violated Zouhair Jadeed's rights to reasonable training and habilitation by failing to develop and implement an appropriate and timely individualized behavioral plan.

The primary reason for Jadeed's admission to NSH on May 7, 1990 was to get him treatment for his impulsive, aggressive behaviors, including the shredding of clothing and assaultiveness towards others. If these behaviors improved, he could then be released to live in a less restrictive and more normalized environment. Before coming to NSH, he lived with his family and attended the California School for the Deaf in Southern California. Despite his known and ongoing behavioral problems, Jadeed was never evaluated comprehensively by a qualified behavioral specialist. Instead of developing and implementing a sound, individualized behavioral plan that

could reasonably be expected to address Jadeed's behavioral needs, NSH staff relied on bodily and chemical restraints.

Although two "behavioral" plans were developed by NSH staff, they were unsound, failing to meet the most minimum professional standards. According to the behavioralist PAI consulted, the plans failed to address basics, such as assessing and specifying problem behaviors and evaluating treatment efficacy.

In July, 1990, staff noted that a "behavioral" treatment plan was implemented to increase his shredding, tearing, and ripping of material all day when he was not otherwise involved in scheduled activities. This plan evidenced a lack of behavior analysis and expertise. The behavioral consultant observed: "Why else would you try to increase a patient's negative behavior, "shredding," for nearly a year and then say [as documented in Jadeed's chart] that the patient can't leave the hospital until the problem hasn't occurred for 3 months?" (Emphasis in original.)

The second "behavioral" plan, characterized by the behavioralist PAI consulted as "painfully inadequate," was noted as implemented in August, 1991. It used a "thin" schedule of reinforcement at the end of the AM and PM shifts (e.g., praising attendance at groups). The plan, according to the behavioralist, failed to, among other things, assess and specify the severity of problem behaviors with regard to frequency, intensity, form, duration, and appropriateness of context, including environmental factors. Short-term goals and treatment plans to address functional deficits and enhance participation and coping skills were also not addressed.

Despite numerous references to the need for behavioral program development and notes concerning requests for consultations, psychological testing, and the forthcoming implementation of a revised, comprehensive behavioral treatment program, nothing further was done prior to Jadeed's death on March 15, 1992.

According to the behavioral specialist that PAI consulted:

> "The use of documented efficacious behavioral interventions does not appear to have been attempted by Mr. Jadeed's treatment

> team.... It appears that the use of restrictive alternatives ... [PRNs, and seclusion and restraint on an emergency basis] were not being consistently joined with positive or proactive behavioral treatment programs in this case. Furthermore, the restrictive alternatives utilized with Mr. Jadeed were not implemented according to accepted standards of professional care."

NSH violated Jadeed's fundamental rights to be free from excessive bodily and chemical restraints.

NSH violated Jadeed's constitutional and statutory rights to be free from harm, including unnecessary or excessive physical restraint, isolation or medication. Youngberg v. Romeo, 457

U.S. 307, 324 (1982); WIC §§ 4502, 5325.1. Instead of providing Jadeed treatment in ways that were least restrictive of his individual liberty, NSH resorted to the increasingly restrictive use of medications and physical restraint and isolation.

The obligation to develop and implement a less restrictive appropriate behavioral plan to address Jadeed's individual treatment needs was not met. NSH thus violated a basic tenet of California law: "[s]eclusion and/or restraints shall never be used ... as a substitute for a less restrictive alternative form of treatment...." CCR, Title 9, § 865.4. Moreover, restraints and isolation were not only used in lieu of a professionally developed treatment program, they were also, at times, used punitively, unreasonably, and for the convenience of staff (e.g., ordering that Jadeed not be released from restraints and seclusion until he was "cooperative" with staff and had "self control").

RECOMMENDATIONS

> DMH and NSH should develop and implement effective strategies for ensuring that ongoing medication reactions are responded to appropriately and not treated as routine.

DMH should develop effective mechanisms for ensuring that its state hospitals develop appropriate and timely individualized behavioral plans.

NSH should implement more effective quality assurance programs for protecting individuals from excessive or inappropriate bodily and chemical restraints.

DMH and NSH should develop and implement effective strategies for ensuring that ongoing medication reactions are responded to appropriately and not treated as routine.

Although a basic nursing plan was developed to identify extrapyramidal symptoms (EPS) requiring "immediate medical attention," it was not followed. As noted by NSH following Jadeed's death, direct care staff documented numerous observations consistent with drug reactions but did not appreciate their clinical significance. In addition, the inattention to Jadeed's medication-related problems by medical staff, especially following the increase in the dosage of Navane and Depakote, constituted active neglect (i.e., neglect that exposed Jadeed to significant health risks).

DMH should develop more effective proactive quality assurance mechanisms to improve medication prescribing and monitoring practices. To protect the health, safety, and quality of life of state hospital residents, timely and effective review mechanisms must occur automatically when, as was the situation with Jadeed, medication regimens are not effective and adverse effects persist.

All direct care, nursing and medical staff should receive more vigorous training in identifying, monitoring, responding to and communicating about medication reactions. More attention should be given to ensuring that direct care and medical care staff do not accept medication-related reactions such as agitation, tremors and increasingly bizarre behavior as routine or as manifestations of the person's disability. Special attention should be given to improving the capacity of all clinical staff to identify, communicate about and respond meaningfully to potentially dangerous paradoxical reactions to medications, especially when increasing amounts of medication are being given in an attempt to control compulsive or

potentially assaultive behavior. Such training, education, and oversight should, as emphasized by the psychiatrist PAI consulted, effectively counteract the dangerous assumption that behavioral deterioration is always a product of the individual's mental disability and that more medication is always the answer.

The psychiatrist PAI consulted concluded that the failure of unit medical staff to follow up on Jadeed's medication-related neurological problems fell below acceptable standards of care and placed him in unnecessary danger. DMH and NSH should take all necessary steps to protect patients whose physicians deviate from acceptable standards of care for monitoring and responding to the adverse effects of medications. This includes conducting effective peer review, providing needed individualized training and education, imposing appropriate discipline administratively at the local and departmental levels, and referring matters of suspected unprofessional conduct that threatens the health and safety of state hospital residents to external regulatory authorities.

DMH should develop effective mechanisms for ensuring that its state hospitals develop appropriate and timely individualized behavioral plans.

To safeguard disabled individuals' liberty rights to habilitation and training, appropriate individualized behavioral plans should be developed and implemented by qualified staff for all state hospital residents who need them. The consequence of failing to do so, as was the situation with Zouhair Jadeed, may be unnecessary reliance on more restrictive and aversive measures, such as chemical and physical restraints.

DMH should develop effective strategies for ensuring the timely development, implementation, and monitoring of appropriate behavioral plans. Timely data-based quality assurance monitoring mechanisms should be implemented so that treatment efficacy is evaluated properly and behavioral plans modified as needed. DMH and NSH should streamline the process for obtaining behavioral consultations and comprehensive psychological testing, develop an effective mechanism for resolving interdisciplinary conflicts which adversely affect timely implementation of needed behavioral plans, and improve substantially the competency,

training and supervision of direct care staff expected to carry out such behavioral plans.

NSH should implement more effective quality assurance programs for protecting individuals from excessive or inappropriate bodily and chemical restraints.

NSH should develop and implement more effective quality assurance programs to monitor and increase compliance with seclusion and restraint requirements. Attention should be given to ensuring that restraint and seclusion is not used as punishment, for the convenience of staff, or in lieu of a professionally developed individualized treatment or behavioral program, as it was with Zouhair Jadeed.

More effective oversight is also needed to ensure that criteria for release from seclusion and restraint is objective, nonpunitive, reasonable, and related specifically to physical safety needs. Although NSH policy states that individuals are to be restrained for the shortest time possible, training, supervision, and quality assurance mechanisms are not addressing this requirement sufficiently. The result, as with Jadeed, may be that restraint is used not for physical safety, but coercively or unreasonably, especially given the individual's disabilities (e.g., "able to express why he is in S/R [seclusion and restraint] and able to resume ward routines.")

More vigorous competency-based training should occur on a regular basis. Training programs should always demonstrate directly, exactly how to restrain and/or seclude an individual. Studies show that competency-based training in managing aggressive behavior reduces staff and patient injuries significantly. Such training programs should also focus more intensely on teaching staff how to develop, utilize, and evaluate sound de-escalation techniques to meet the goal of avoiding the use of seclusion or restraint.

In addition, policies, procedures and training should be modified to protect individuals with mental and developmental disabilities from locked seclusion. Title 17, CCR § 50515(a). If applicable California regulation had been followed, Jadeed would have never been subjected to locked seclusion.

Effective systemic evaluation of treatment efficacy for both medical and behavioral interventions should be developed and implemented so that treatment can be individualized to the maximum extent possible. Had appropriate and timely review or oversight mechanisms been in place, Jadeed's increasing pattern of behavioral disturbance could have been addressed with sound behavioral interventions instead of with physical restraint, isolation, and increasing doses of medications.

B. MARCH 15, 1992: SEQUENCE OF EVENTS

FINDINGS AND CONCLUSIONS

NSH staff neglected Zouhair Jadeed while he was secluded and restrained by failing to provide him adequate medical and nursing care.

NSH staff failed to recognize and respond to a potentially life-threatening medication reaction.

NSH denied Jadeed access to basic hospital services by failing to accommodate his communication needs adequately while he was in bodily restraints and seclusion.

NSH staff neglected Zouhair Jadeed while he was secluded and restrained by failing to provide him adequate medical and nursing care.

People with disabilities confined to facilities such as NSH possess constitutional and statutory rights to reasonably safe conditions, including adequate medical and nursing care. Youngberg v. Romeo, supra; WIC § 5325.1. On the day Jadeed died, these fundamental rights went unprotected. The medical and nursing care provided Jadeed fell far below acceptable standards. The inattention to Jadeed's condition while he was in restraints and seclusion constituted neglect of a dependent adult, exposing him to significant dangers. WIC § 15610(d). According to the psychiatric expert who reviewed the clinical circumstances surrounding Zouhair Jadeed's death, such inadequate care and monitoring contributed to or caused Jadeed's death on March 15, 1992.

Nursing staff failed to respond to clear signs of medical crisis, including unremitting agitation, "lead pipe" muscle rigidity, flaring nostrils -- a cardinal sign of respiratory distress, incontinence, and "red" and "blue" extremities. Although during the Coroner's investigation one staff person stated that Jadeed's vital statistics were taken during the seven and three- quarter hours of bodily restraints and isolation, no clinical documentation corroborates that assertion as required by existing NSH nursing policy.

According to the psychiatric expert PAI consulted, "under the circumstances, Jadeed's vitals, including his body temperature and blood pressure, should have been monitored and recorded more frequently by nursing staff until he was cleared medically."

Although a NSH physician documented that there existed "no medical contradictions" to ongoing seclusion and restraint, that judgment is not supported adequately by the record. In the face of clear symptoms of extreme agitation and other distress, a far more careful evaluation of the ongoing medical risks of restraint and seclusion should have occurred. The psychiatric consultant stated: "Had Jadeed been evaluated thoroughly by a qualified physician, he likely would have been monitored more closely and provided a more appropriate level of nursing and medical care which could have saved his life."

NSH staff failed to recognize and respond to a potentially life-threatening medication reaction. Although the precise manner in which Jadeed died may never be known, his death, according to the psychiatrist PAI consulted, was likely the consequence of Neuroleptic Malignant Syndrome (NMS), accompanied by a prolonged period of improperly monitored seclusion and restraint. NSH staff ignored numerous indicators of a potentially lethal drug reaction. Even though Jadeed remained in a state of uncontrolled agitation over a period of hours, was clawing at the bed, had flaring nostrils, "lead pipe" muscle rigidity, extremities that had turned "red" and "blue," and was incontinent, his vital statistics were not taken and documented accurately. Nor was a qualified physician summoned to assess his medical condition more closely.

NSH concluded that Jadeed's death was "probably medication-related, with dystonia [difficult or painful muscle spasms] affecting respiration a probable

terminal event." A Napa County forensic pathologist concluded that the cause of death was "probable exhaustion after hyperactivity" with the specific manner of death "undetermined." The psychiatrist PAI consulted concluded: "there is a strong possibility that unrecognized and untreated neuroleptic malignant syndrome caused Jadeed's death."

Neuroleptic malignant syndrome (NMS) is a relatively uncommon but life-threatening complication of treatment with antipsychotic medications. Its prevalence ranges from as low as 0.5% to as high as 2.4%. NMS is fatal 20-30% of the time. Common causes of death include respiratory failure, cardiovascular collapse, and kidney failure. Its core features include elevated body temperature, muscular rigidity, and fluctuating consciousness. The extreme muscle rigidity experienced by patients suffering from NMS is often described, as it was on March 15, 1992 when Jadeed was put in restraints, as "lead pipe." The syndrome can occur at any time following the administration of antipsychotic drugs. Its onset is apparently not related to the duration of drug exposure or to toxic overdoses. See Guze, Baxter, Medical Intelligence Current Concepts Neuroleptic Malignant Syndrome, The New England Journal of Medicine 313:3, 163-166 (1985); Addonzio, et al., Symptoms of Neuroleptic Malignant Syndrome in 82 Consecutive Inpatients, American Journal of Psychiatry 143, 1587-1590 (1986).

Jadeed had many of the predisposing risk factors for developing NMS. Hospital staff should have known that he was at increased risk for NMS and should have monitored him accordingly. These known risk factors included physical exhaustion from agitation, organic brain disease, and the fact that Jadeed was young and male. Indeed, the known mortality from NMS in brain-damaged individuals such as Jadeed, is nearly three times greater than in individuals with functional psychoses. Lazarus, Neuroleptic Malignant Syndrome and Preexisting Brain Damage, The Journal of Neuropsychiatry and Clinical Neuroscience, 4:185- 187 (1992).

The treatment for NMS is "prompt discontinuation of neuroleptics and intensive medical and nursing care." Lazarus, Should Neuroleptic Malignant Syndrome be Treated in a Private Psychiatric Hospital or a General Hospital? General Hospital Psychiatry 12, 245-247 (1990).

NSH denied Jadeed access to basic hospital services by failing to accommodate his communication needs adequately while he was in bodily restraints and seclusion.

NSH violated its own policy on sign language services, Section 504 of the Rehabilitation Act of 1973, the newly-enacted Americans With Disabilities Act, as well as Jadeed's rights to humane, dignified and accessible care by failing to provide him with necessary communication services during the seven and three-quarter hours of physical restraint and seclusion preceding his death on March 15, 1992. According to NSH staff, Jadeed was visited by signing competent staff only four times during this entire time period; this was grossly inadequate and unreasonable under any standard. These infrequent visits violated explicit NSH policy which requires that "all clients having significant hearing deficits be treated in an environment which allows them to communicate in sign language with at least one staff member at all times." (Emphasis added.)

Jadeed was in considerable distress. He needed to be evaluated thoroughly, both objectively and "subjectively." Had Jadeed been communicated with in a thorough and appropriate manner, staff could have learned more about his deteriorating condition. Instead, he was denied access to basic NSH services, including appropriate nursing and prompt medical care and monitoring. NSH staff failed to document the most basic communication information in Jadeed's clinical records:

When the four "bilingual" checks occurred.

Whether Jadeed's hands were untied so that he could sign. Whether Jadeed was given his eyeglasses so that he could see.

The nature and extent of communication between staff and Jadeed, if any.

RECOMMENDATIONS

To minimize unnecessary risk of harm, NSH should ensure that individuals undergoing seclusion and restraint receive appropriate medical and nursing care.

The Department of Mental Health (DMH) should develop more effective systemic strategies for monitoring and responding to potentially life threatening medication reactions such as Neuroleptic Malignant Syndrome.

NSH should provide qualified professionals to accommodate the communication needs of hearing-impaired individuals undergoing seclusion or restraint.

To minimize unnecessary risk of harm, NSH should ensure that individuals undergoing seclusion and restraint receive appropriate medical and nursing care.

Bodily restraint and seclusion is always an intrusive and potentially dangerous procedure. Known risks can be ameliorated through close monitoring. Monitoring should always be conducted face-to-face, as required by NSH policy, and never through the window of a locked isolation room. To improve patient safety, NSH should modify its Behavioral Seclusion and Restraint Policy (Administrative Directive #761). Adequate requirements for the monitoring and documentation of vital statistics (including temperature, pulse, respirations, and blood pressure) and fluid intake should be specified. NSH policy should also address potential contraindications for the use of restraint or seclusion. Seclusion, for example, may be contraindicated medically when, as was the situation with Jadeed, an individual is suffering a paradoxical reaction to neuroleptics or is self-abusive. See, Tardiff, et al., Seclusion And Restraint: The Psychiatric Uses (Report of The American Psychiatric Association Task Force on the Psychiatric Uses of Seclusion and Restraint) (1984). Such policy should also make clear that the physician must conduct a thorough face-to-face clinical assessment to determine if seclusion and restraint is justified and specify criteria for determining whether the indications for its use outweigh the risks.

In addition, the practice of placing individuals with developmental disabilities in locked seclusion must cease and be prohibited clearly by policy. Had appropriate procedures been followed on March 15, 1992,

Jadeed would not have been in locked seclusion and he would have been supervised on a one-to-one basis throughout the seven and three-quarter hours of bodily restraint and isolation. (Per agreement reached with the U.S. Department of Justice, all NSH residents in "open" (i.e, unlocked) seclusion must be supervised on a one-to-one basis.)

NSH should also provide a far more aggressive, ongoing program of staff training and active supervision to ensure that basic nursing and medical interventions are carried out and documented adequately in individuals' clinical records. This training should emphasize that even the best policies and procedures explicate minimum standards only, and that patients' individual conditions may, as on the day Jadeed died, require far more intensive evaluation and monitoring.

The Department of Mental Health (DMH) should develop more effective systemic strategies for monitoring and responding to potentially life threatening medication reactions such as Neuroleptic Malignant Syndrome.

The tragic death of Zouhair Jadeed is the fourth medication-related death that PAI has issued a public report on since it began investigating such neglect in 1990. Three of these four deaths, including Jadeed's, involved inadequate care and monitoring during isolation and/or restraint in a state hospital. See also, "Investigation Of the Circumstances of the Deaths Of C.C. and K.C. at Patton State Hospital and J.V. at Camarillo State Hospital" (Sept. 1991).

Clearly, it is time for DMH to develop more effective systemic strategies for improving state hospitals' response to potentially life-threatening medication reactions such as NMS. Applicable nursing, medical and quality assurance policies, procedures and protocol should be overhauled on a state-wide basis at the Departmental level. DMH should also develop and implement a far more vigorous ongoing state-wide program of education, training, and active supervision.

DMH should focus on strategies for ensuring that at-risk individuals, such as Jadeed, are identified and appropriate measures taken: "Further efforts must therefore be directed toward prevention. Individuals with preexisting brain damage and CNS [central nervous system] abnormalities . . . should

be recognized as high risk candidates for NMS. Neuroleptics should be used carefully in such individuals, at the lowest possible doses, and only for specific target symptoms." Lazarus, Neuroleptic Malignant Syndrome and Preexisting Brain Damage, The Journal of Neuropsychiatry and Clinical Neuroscience, 4:185-187 (1992).

Special attention should also be given to educating state hospital staff about the combined risks of seclusion and restraint and potentially dangerous adverse medication reactions. In addition, DMH should develop an effective oversight mechanism for reviewing the deaths of all state hospital patients where the combined risks of seclusion and/or restraint and medication reactions are implicated.

NSH should provide qualified professionals to accommodate the communication needs of hearing-impaired individuals undergoing seclusion or restraint.

Zouhair Jadeed died on a unit specializing in the care of hearing-impaired individuals. According to NSH policy and antidiscrimination mandates, he had a right to expect that at least one staff person competent in American Sign Language (ASL) was available to communicate with him at all times necessary to ensure access to NSH services. This reportedly was not so on the day he died in seclusion and five-point restraints on NSH's Unit S9.

Access to critical services and programs for hearing-impaired individuals with mental or developmental disabilities must be guaranteed at all times. NSH should ensure that it has adequate numbers of signing competent staff on duty at all times to meet the communication needs of all deaf and hearing-impaired individuals.

Signing competent staff should also receive more specialized training about the dangers of persistent agitation, adverse medication reactions, and seclusion and restraint so that communication with at risk individuals addresses these health and safety dangers more effectively. Policies and procedures should also be modified to emphasize the importance of documenting accurately the nature and extent of sign language communication between staff and patient. Staff who are not proficient in ASL should receive more competency-based training and supervision on

how and when to utilize the skills of other signing competent staff. Deaf and hearing-impaired individuals should be involved in developing such communications training.

C. FOLLOW-UP INVESTIGATIONS

FINDINGS AND CONCLUSIONS

> NSH failed to investigate the facts and circumstances surrounding Jadeed's death adequately.

NSH failed to investigate the facts and circumstances surrounding Jadeed's death adequately.

As discussed in this report, Zouhair Jadeed likely died because of a series of acts and omissions by NSH and its staff that constituted active neglect. Considerable evidence suggests that the care provided Jadeed departed so substantially from the standard of care that it violated his constitutional rights. (This report has been forwarded to the U.S. Department of Justice.)

Instead of investigating the salient neglect issues underlying the facts and circumstances of Jadeed's death, the Special Investigator merely summarized observations contained in the clinical records, focusing primarily on those related to the imposition of seclusion and restraint. No documentation indicates that witnesses were interviewed or their statements taken. Despite the fact that the Special Investigator was notified of Jadeed's "unexpected" death which, according to DMH policy, required "intensive, prompt, objective and adequate investigation," he did not even go the death scene or utilize the information gathered by the Coroner.

RECOMMENDATIONS

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The internal investigation of the facts and circumstances surrounding Zouhair Jadeed's death was inadequate. In PAI's experience, internal investigations conducted by state-run facilities too often, as in this situation, fail to be conducted in an objective, thorough and effective manner. A primary reason for the problem is that investigators face a serious conflict of interest: they are responsible for investigating neglect that may properly be the subject of adverse personnel action or civil or criminal liability on the part of their employer. Inadequate training is also a problem.

The interests of those individuals suffering the neglect must be paramount. The existing internal system for investigating neglect-related state hospital deaths invites divided loyalty and thwarts needed reforms. DMH should take all necessary steps to resolve this conflict of interest so that vulnerable disabled individuals, such as Zouhair Jadeed, can be more fully assured the protection to which they are entitled.

Disability Rights California is funded by a variety of sources, for a complete list of funders, go to http://www.disabilityrightsca.org/Documents/ListofGrantsAndContracts.html.