INVESTIGATION REPORT

INDICATE:
DPPC 19C/DMR Section 9: **X** DMR Section 9: DPPC 19C External:

CLIENT NAME: **V1**

PERSON COMPLAINED OF: **BRI**

INVESTIGATING AGENCY: **DMR** SERVICE-PROVIDING AGENCY: **BRI**

CLIENT'S GUARDIAN, CONSERVATOR, GUARDIAN AD LITEM, REP. PAYEE, PERSON WITH POWER OF ATTORNEY, IF ANY:

Name: **V1's Mother (Mother)**

Address: **12 Allens Neck Road, Dartmouth, MA**

Phone: **(508) 636-5218**

INVESTIGATOR: **Donna Cabral** Date of Appointment: **11/1/93 (DMR)**
3/4/94 (DPPC)

PHONE: **(508) 285-6321**

DATE THIS REPORT WAS COMPLETED: **January 3, 1995**

SENIOR INVESTIGATOR: **Rod Johnson**

REGIONAL DIRECTOR: **Richard O'Meara**

AREA OR FACILITY DIRECTOR: **Diane Rodriques/Randy Webster**

DATE OF ALLEGED: **Incident: 12/18/90; Death: 12/19/90**

PROVIDER AGENCY WHERE ALLEGED INCIDENT ALLEGEDLY OCCURRED: **Behavior Research Institute (BRI), currently known as Judge Rotenberg Educational Center[1], 240 Laban Street, Providence, RI and Frenier Street, Residence, Attleboro, MA**

SITE OF ALLEGED INCIDENT: **V1 died at Sturdy Memorial Hospital**

COMPLAINT: **On 12/18/90 at about 8:00 p.m. residential staff at the Frenier Street, residence in Attleboro became aware V1 was acutely ill. An ambulance was summonsed at 8:39 and V1 was transported to Sturdy Memorial Hospital. She died during surgery at 1:36 a.m., 12/19/90. This investigation focuses on circumstances and events prior to and surrounding her death.**

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[1] As this agency was known as BRI at the time of V1's death, it will be referred to throughout this report as BRI.

I. SOURCES OF INFORMATION

A. LIST OF PERSONS INTERVIEWED

SEE APPENDIX A

Registered/Certified Letters sent to:

1. 19C Access Forms:

   a. W4 (O.R. Physician)
   b. W4 (attending pathologist at autopsy representing BRI-No Response)
   c. Sturdy Memorial Hospital
   d. Bettina Briggs, Esq.
   e. James Weiner, M.D. (Medical Examiner)
   f. W2 (Consultant, Primary Care Physician for BRI - no response)
   g. State Crime Lab

2. Attempt/Notification of intent to interview:

   a. W5 (returned, unclaimed)
   b. W6 (returned, forwarding order expired)

B. CONSULTANTS

1. Carol Walsh, R.N.-C,.M.P.H. Health Services Consultant; **Report Attached as Appendix C.**
2. James M. Rabb, M.D., Board Certified in Gastroenterology & Internal Medicine; **Report Attached as Appendix F.**
3. Angela Duarte, Ph.D., Clinical Psychologist; **Report Attached as Appendix D.**
4. Deborah Dessaint, M.S., R.D., L.D.N.; **Report Attached as Appendix F.**

C. DOCUMENTS AND LITERATURE REVIEWED

SEE APPENDIX B

D. DEMONSTRATIVE EVIDENCE

1. (1) Polaroid (copy) photograph, taken by Det. W. Bennett, (Attleboro Police Dept.), depicting a blue discoloration to the face. Photograph taken at autopsy.

2. (10) 3x5 photographs, (copies), taken at autopsy by the medical examiners office. Bruises visible to both inner arms. Blue discoloration visible to the left side of the face. (Photo's taken at 12/19/90, on or about 11:30 am)

E. Physical Evidence

(2) Ammonia inhalants from the Frenier Street residence, in

Attleboro, MA

1. (1) was from a kitchen drawer, unsecured
2. (1) was from inside a vanity located in the bathroom, unsecured

(Both Inhalants were manufactured by James Alexander Corp.)

F. **Site Visits** Date(s) and time(s)

A site visit was conducted on 2/25/94, (both at the Institute Rhode Island, and the residence on Frenier Street, Attleboro, MA). Carol Walsh, (Nurse Practitioner) also toured both locations. A second site visit was conducted on May 13, 1994, (classroom B) by this investigator, Ms. Walsh, and Jim White (Dep. Director of Investigations).

II. NARRATIVE FINDINGS OF FACT AND CONCLUSIONS

A. **Background** (Regarding site, client, and/or alleged abuser, wrongdoer, if relevant.)

V1 was a 19 year old woman with Mental Retardation when she died. She was able to communicate with a few signs and gestures. She weighed 106 pounds and was 5'5" tall. Her provider/caretaker was the BRI of Rhode Island. She resided at the Frenier House, which is located in Attleboro, Massachusetts. The day program, was located in Providence, Rhode Island.

V1 was transported by bus daily to Providence where the day program is located. The bus trip took approximately 1 to 1.5 hours each way. The residence and the day program are both operated by BRI

1. **Overview of V1's placement and diagnostic history prior to admission to BRI (through 1984).** V1 was born on 2/23/71. Her mother, V1's Mother was her guardian. V1 resided at home from 1971-1978, attending the following day program:

1. I.H. Schwartz Clinic, New Bedford, MA (1974-1976)
2. Community Clinical Nursery, New Bedford, Ma (1976-1977)
3. Project Orient Nursery, Acushnet, MA (1976-1978)

The diagnosis for V1's first seven years included: impaired expressive and receptive language skills; psychosis; unspecified cerebral condition; developmentally delayed; severe mental-retardation.

From 1978-1984, V1 resided on the Autistic Unit, at the Bradley Hospital in Rhode Island. Medical problems were identified as seizures and hypothermia. Medications were Zonatin, Dilantin, Phenobarbital and Haldol. Allergies to Phenobarbital and Haldol were noted. A psychodiagnostic evaluation was conducted pm 5/28/82 by Bridgewater Psychological Associates who reported:

V1 is diagnosed as psychotic with unspecified cerebral conditions. She receives medication (Dexedrine) to control non-directed motor activity and restlessness. V1 verbalizes a few words and expressively uses approximately 15 signs. She only signs for the things that provide her with immediate gratification.

In a 12/10/82 psychological consultation, it was reported that: "V1 is a child with a multitude of developmental, behavioral, and emotional difficulties. She has been in residence on the Developmental Disabilities Unit at Bradley Hospital since September 1, 1978. Her current diagnosis is psychosis with several medical complications including a seizure disorder. She is presently taking Dilantin for the control of these seizures."

2. V1's admission, intake and early history at BRI

On 10/4/84, V1 was admitted to BRI. Psychological testing dated 11/84 stated:

Due to V1's limited cognitive and behavioral abilities, her behaviors were compared with Emotionally Disturbed Children in Residential Facilities. At the present time, V1's overall level of cognitive functioning appears to be consistent with Severe Handicap ranges. Projections: Since enrollment at BRI, many of V1's inappropriate behaviors have diminished. It appears that she may have benefited from consistent treatment. As V1's behaviors come more under control, program effort should be directed at improving her communication skills, living skills, and socialization skills. At this particular time more effort should be directed at developing V1's self-help skills.

Intake summary at BRI (dated 10/84) identifies that V1 was referred to BRI by the Town of Dartmouth, Public School System. The BRI psychologist found "V1 functioning at a 2 year old level with an I.Q. of under 30".

The BRI physician completed a physical examination on 10/10/84. "He has her on Dilantin 100 mg. to control her seizures."

In 3/85, V1 was seen at Mass General Hospital, on the Cardiac Unit for "additional thoughts concerning her cardiac status". The report concluded, " in the past she has been followed with the diagnosis of mild pulmonic stenosis. She was referred for a second opinion because of the question of duskiness. She does have skin discoloration, but it is not true cyanosis, nor is there clubbing. In summary, I do not find evidence for a significant structural heart problem. Most likely, her murmur is secondary to a functional flow-related phenomenon, which should there be a structural problem, it would certainly be minimal and not warrant further pursuit at this time."[2]

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[2] Richard R. Liberthson, M.D.

BRI's psychiatric evaluation completed in January of 1985 gave V1 a diagnosis of "Mental Retardation Severe".

3. Description of V1's behavioral program (12/89 -12/90, last year of her life) BRI grouped behaviors under major categories. For example, for V1 between 9/90 and 12/90 her behaviors were grouped under 8 such major categories, as follows:

1. Aggressive Behavior
2. Health Dangerous Behavior
3. Destroy
4. Health Dangerous Behaviors (Inappropriate U/D) U=Urine; D=Defecation
5. Non-Compliance
6. Education Socially (Ed/Soc)
7. Major Disruptive
8. Inappropriate Verbal

Included in the category of aggressive behavior was described as bite, hit, grab, to include grabbing when a consequence is being administered. If V1 displayed these behaviors in the day program or at the residence she would receive spatula spanks, finger pinches or ammonia. The category of Inappropriate Verbal included behaviors such as non-speech noises, silly laughing and nagging. If she displayed these behaviors, the consequences would include rotating taste aversives, vapor spray and ammonia.

The probate court in a substituted judgement determination approved the treatment plans proposed by BRI with some modifications. The orders afforded BRI flexibility in treating V1 by allowing BRI to use any consequence within the same category.

In April 1987, the court ordered BRI to provide notice of the change in treatment (using a new consequence within the same category or a category of lesser intrusiveness,) within one (1) week of the change. Also, restraint was allowed for non-aggressive, non-destructive, and non-self injurious behavior if the behavior interfered with educational development, social development, or was an antecedent or a weaker version of aggression, self injurious, or destructive behavior.

In reviewing V1's treatment plans, (1986-1990), her problem behaviors remained the same. The categories were subject to change. Existing topographies were shifted from one behavior category to another, making determinations about the effect of the aversive consequences or other forms of treatment very difficult. (Duarte Report p. 25)

Other elements of the treatment program were fines, loss of privileges, earning her calories (meals), and casual rewards such as verbal praise, a pat on the back, and/or pennies. See Duarte Report, for more details about V1's treatment.

B. FINDINGS AND CONCLUSIONS WITH RESPECT TO THE CHRONOLOGY AND EVENTS BETWEEN 12/11 AND 12/19/90

1. Introduction, including procedural history of investigation.

1. As previously noted, V1 died of a perforated ulcer at age 19 on December 19, 1990, at 1:36 a.m. at Sturdy Memorial Hospital.

2. The DMR's Division of Investigations, became aware of the death and allegations about some of the circumstances surrounding the death on October 13, 1993, during an interview of a former employee, W7.

3. Based on the information Ms. W7 provided, an investigation was initiated pursuant to 115 CMR 9.00.

4. Subsequently, on March 1, 1994, the matter was reported to DPPC as there was reason to believe based on the investigation that a reportable condition existed under MGL ch 19C.

5. The findings and conclusions below examine the circumstances and events of December 11 to 19, 1990 in detail as well as the circumstances and events prior to that period. The findings and conclusions are divided into four sections:

   a. Findings and conclusions concerning the chronology and relevant events and actions between 12/11 and 12/18/90, the last week of V1's life, and her death.

   b. Findings and conclusions relative to:

      1. V1's Contingent and Special Food Program
      2. Belt Feeder
      3. V1's Overall Behavioral Program

   c. BRI's Failure to Retain or Provide Documentation or Testimony Relative to this Investigation

   d. Other Findings

2. <u>Findings with respect to the chronology, events and actions between 12/11 and 12/19/90</u>.

1. Between December 11 and December 14, 1990, based on the evidence that was available and provided, V1 did not show any signs or symptoms of illness.

2. On December 12, 1990, V1's maximum caloric intake was increased from 1500 calories to 3000 as a result of orders from two different physicians approximately two and four weeks earlier, and a one inch height increase actually noted over two months earlier. (Walsh Report p. 6 and see below for

further discussion);

3. There is some evidence that possibly beginning on December 11 she was not eating all or part of her meals. It cannot be determined whether the possible lack of complete caloric intake from December 11 though December 14 was due to illness because the caloric recording sheets do not indicate why calories were thrown out.

4. On 12/15 and 12/16/90, V1 refused her dinner based on statements of direct care staff W9 and W1. They reported that V1 was not eating for two or three days prior to December 18, 1990; however, the caloric recording sheets provide contradictory evidence. The caloric sheets indicate that V1 received all her meals for those two days. On December 15, 1990, the caloric sheet depicts an even 1500 calories. However, the caloric recording sheets do not appear to be reliable for the following reasons:

   a. The sheets in use at that time only show what is allotted to the individual, not what is eaten.

   b. On December 12, 1990, V1's calories allotment had been increased from 1500 to 3000 calories. December 15 and December 16 were the only two days between December 12 and December 18, 1990 that the calories remained at 1500 and were not changed to 3000.

   c. While the total number of calories were increased, the minimum amount to be dispensed had not been changed. For example: 20% of 1500 was to be dispensed daily--300 calories. Even when the total amount of calories was increased to 3000, the minimum amount to be dispensed remained at 300 instead of 600 (20% of 3000). Prior to December 18, 1990 (12/12-17/90), BRI continued to use a 1500 caloric recording sheet, crossing out the 1500 and inserting 3000. (However, they failed to change the minimum caloric intake.) It was not until December 18, that a proper 3000 caloric recording sheet was used, identifying the minimum caloric intake to be 600.

5. It is evident that beginning on December 16, 1990, V1 began displaying signs of illness. This is based on accounts of W8, W9 and particularly W1 who worked with V1 five (5) days per week for almost two years. V1's behavior became unusual on December 16 in that:

   ". . . she refused snacks on the bus, and was getting out of her seat . . ."

". . . she was refusing to eat, or eating very little . . ."[3]

". . . she was acting fidgety, making unusual sounds . . ."

6. During the night of the 16th, it appears that direct care staff merely observed these signs, but did not notify a nurse/medical staff or case manager.

7. On the morning of December 17, 1990, W1 stated she advised a nurse that V1 was ill. W1 reported "V1 wasn't eating, that she always ate, and her behavior was unusual, she was acting fidgety." W1 does not remember whom she notified. None of the nursing staff recall the notification, and the documentary evidence does not indicate they were notified.[4]

8. On December 17th, on the bus ride home from school, V1 refused snacks, and later she refused all her dinner. Her condition deteriorated. Her behavior was described in the following ways:

". . . the evening before she died [December 17], she seemed fairly sick, . . . she looked white . . ."

". . . she looked pale and tired . . ."

". . . during the night she kept getting out of bed and walking to the door and going back to bed . . ."

". . . V1 never had out of bed behavior and was very lost, looking all around her like she didn't know where she was."

". . . she also kept going into the bathroom, she had attempts to vomit . . ."

". . . Her eyes were glassy, and V1 never slept . . ."
". . . Had been awake all night sticking fingers in her throat."

9. There is no evidence that the nursing staff became involved or checked V1 prior to the morning of the 18th outside of the normal routine body checks. There was no evidence they examined her because of or for any signs of illness.

10. Additionally, an examination of the nursing body check sheets shows inconsistencies and irregularities, to wit;

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[3] Based on staff interviews, it is clear that V1 had a very good appetite, always wanting to eat. She liked food.

[4] The lack of documentary evidence is not considered particularly dispositive on whether or not W1 in fact notified nursing staff given the general lack of adequate recordkeeping and record preservation at BRI regarding V1.

a. the body check sheets filled out by the direct care staff show bruises to V1's arms for the following dates: 12/12, 13, 14, 15, and 12/17/90. On the other hand, the nursing body check records did not record any bruises to the victim's arms. The existence of these bruises was in clear evidence in the autopsy photographs as well and were commented on by the emergency room staff.

b. the sheets are not signed by the person making the observations, but are merely signature stamped or left totally unsigned with the result that one does not know who filled them out or the wrong signature is placed on the document. In fact the 12/18/90 body check sheet, PC3 signature stamp is on it, but it was filled out by PC1.

11. While she was ill, according to BRI records, V1 received an unusually high number of aversives during the overnight of December 17. "[O]ver night V1 was spanked eight times, had muscle squeezes (no. illegible), was administered ammonia inhalants, and had taste aversives (vinegar mix, jalapeno pepper, or hot sauce?) administered several times." (Duarte report p. 22)

12. On the morning of the 18th, V1 continued to display unusual behavior, both at the residence and during transportation on the bus:

". . . in the morning she had inappropriate U(rine) and was very non-compliant. . ."

". . . she had inappropriate motion and was touching others . . ."

". . . I didn't give her self-care because I knew she was sick even though she didn't have a fever . . ."

". . . She was pulling the clothes at her stomach. She was touching her stomach (like she had menstrual cramps)... ."

". . . She was trying to tell us something. I honestly thought she had pain in her stomach . . ."

". . . She was bringing her feet up to her stomach, her knees to her chest, holding her stomach . . ."

". . . she looked pale, tired, and lethargic in the morning
. . ."

". . . She was limp, hanging on me on the bus. She got out of her seat and put her head on my shoulder. . ."

". . . She was holding her stomach. . ."

". . . She had 1-1 on the bus because she was sick. She does not require 1-1 on the bus. . ."

". . . On Tuesday morning, getting off the bus, she wouldn't move, she was looking around. Two of us tried to stand her up. [She was sitting in a puddle.] I told them to get someone to carry her in."

13. V1 was in fact carried into school on the morning of December 18.

14. On the morning of December 18, three staff (W1, and W10 W11) who observed V1 were of the opinion she was ill.

15. At least two staff (W1 and W11) advised nursing staff that V1 was ill, that she was not acting herself, that she was holding her stomach as if in pain. (Although there is no documentary evidence to support this notification, nursing staff agree they were notified she was ill.)

16. PC1 reported that she evaluated (performed a physical examination) of V1 shortly after she was notified at 9:00 a.m. and made observations until 3:00 p.m. V1 was allowed to rest on a pull-out couch for the day in the classroom, given frequent fluids, and placed on low demands,[5] no aversives were utilized between 9:00 a.m. and 3:00 p.m. She continued (uncharacteristically) to refuse to eat.

17. PC1 stated that she checked V1's temperature and abdomen, (which she stated was normal in both cases) her whole body and watched her face and looked into her ears. She also stated that she tried to look into her throat, but couldn't. She also stated that V1 was not having her period and was not constipated as she had a bowel movement. (Not noted by PC1 was the fact that it was an unusual time of day for V1 to have a bowel movement. Normally, she has it in the middle of the night. (W1).

18. However, there is no written documentation of a physical exam including of V1's abdomen at any time during the day of December 18. The only document that has any record of V1's physical condition is the aforementioned nursing body check sheet which is filled out routinely each day. That document states:

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[5]Low demands is a status at BRI where few if any academic demands are placed on the resident and only necessary activities of daily living are required. Being put on low demand status does not mean the person is taken off aversives. Aversives still would be used to consequate a behavior as prescribed in the treatment plan.

"V1 arrived at school pale and lethargic. Had been awake all night, sticking fingers in throat, temp. 98.4. Unable to see beyond wax in ears. Allowed to rest - giving frequent fluids."

19. With the exception of reportedly looking in the red communication book[6], (which was not provided) there is no other evidence that as part of the initial evaluation or as part of an ongoing assessment during the day of December 18, 1990, the nursing staff or the doctor inquired of the existence of signs or symptoms over the previous 24 to 72 hours. PC1 stated in her interview that she interpreted V1 sitting in a puddle and having to be carried into BRI from the December 18 morning bus ride as a behavioral problem rather than a sign of illness. PC1 reports that she contacted the physician (W2) by telephone, advising him of V1's condition. W2 corroborates PC1's statement that he received a telephone call; however, he does not remember what orders (if any) he may have given PC1. Neither remember the time of day the phone call was made.

20. There is an emergency room note made after V1 was taken to the hospital which stated that the "Nurse (PC1) did not feel pt. was acutely ill, but was acting sick" . . . vomited x 1 today. During this investigator's interview of PC1 on 4/26/93, she stated that she did not remember reporting this, however she felt comfortable with the report. Staff did not report that V1 vomited.

21. There are no progress notes by the nursing staff which would indicate how many times nursing observed V1 on December 18 and what they observed.

22. There is no written record of communication with W2 on this matter for December 18, nor are there any physician orders to nursing staff.

23. On December 18, responsible first shift personnel did not communicate to responsible second shift that V1 was ill.[7]

24. The nursing staff also did not communicate with the second shift staff and advise them of V1's status or provide instructions about whether or under what conditions to call them or other medical personnel.

25. The nursing staff did not check V1 after 3:00 p.m. even though she continued to be at the day program until about 5:00 p.m.

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[6] The communication book was requested by this investigator, but never provided.

[7] First/second shift changes are staggered during the afternoon.

when she embarked on a lengthy bus ride home.

26. The nursing staff did not at any time on December 18 direct that V1 be taken off aversives for medical reasons which they had authority to do.

27. By 5:00 p.m., permission was given by BRI administrative staff to allow the number of aversives to be increased to 95 for the day.

28. Because of lack of witness availability (e.g. W12) and documentation, it could not be ascertained why an increase in aversives was requested and whether inquiry was made as to the overall circumstances. As noted below, no aversives had been given between 10:00 and 3:52 p.m.

29. Between 3:52 p.m. and sometime prior to 8:00 p.m. on December 18, numerous aversive were administered to V1. As Dr. Duarte indicates in her report, punishment procedures were administered to V1 between 3:52 p.m. and sometime before 8:00 p.m. as follows:

> "At 3:52 p.m. she was administered an ammonia inhalant; between 4 p.m. and 5 p.m. she was spanked with a spatula 8 times, had 8 finger pinches, and was administered ammonia inhalants again. Each hour after that the punishing applications were continued, so that by 7 p.m. V1 had received 8 spatula spankings, 27 finger pinches and 14 muscle squeezes and several ammonia and taste aversive applications.
>
> At 6:45 p.m. staff had noted that V1 was not herself. Yet in the next hour (7 p.m. - 8 p.m.) she was spanked with a spatula 5 times, was finger pinched 2 times, was administered an ammonia inhalant at 7:40 p.m. and may have had other aversive applications (nature and number are illegible). Thus between 3:52 p.m. and 8 p.m. V1 had been physically punished at least 56 times (13 spatula spankings, 29 finger pinches, 14 muscle squeezes). She also received several ammonia applications of taste aversives and at least 5 inhalations.

The number of aversives administered to V1 between 3:52 and 7:00 p.m. is in contrast to no aversives during the 10:00 a.m. to 3:52 p.m. period, and was very likely a further indication that she was and continued to be ill.

33. The number of aversives administered to V1 on 12/18/90 (particularly between 3:52 and 8:00 p.m.) also stands in contrast to the number of aversives she received each day during the month of December 1990 (from 12/1-17/90) and recent

previous months. The following figures were obtained from a monthly recording sheet.

AVERSIVES ADMINISTERED DECEMBER 1-18, 1990

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17*	18*
AMMONIA	1				2			1						5	1		6	5
BCS																		
FP														2				29
MS				4	2	1	4		1	4	1	8	4		5	2	18	14
SP																		
WATER SPRAY 3																		
SPATULA SPANK	2	1	3	6		1	1	4	1		1		2	13	3	1	4	13
TOTALS	3	1	3	11	4	2	5	5	2	4	2	8	6	20	9	3	28	61

*Only 12/17 and 12/18/90 figures are from **daily** logs. Figures for all other days are taken from **monthly** logs. It appears that BRI's data sheets reflect 24 hour data recording cycles from 10 a.m. to 9:59 a.m. the next day.

34. 56 of the 61 aversives (indicated in chart above) were administered on 12/18/90 in an approximate period of 4 hours. The time frame for the other days is 24 hours. The total numbers for each day do not come close to the 61 or 56 figure, though the closest (28) happened the day before on the 17th. It should be noted that many or most of the 28 aversives were also administered when V1 was exhibiting signs of illness throughout the night of December 17th. (Duarte report p. 22)

35. The following staff who were on duty at the residence after V1 arrived at the residence on 12/18/90 at approximately 6:30 p.m.:

    a. W13 who had been on the bus ride home from the day program. She then left work early (between 6:30 and 7:00 p.m.) as she was injured.

    b. W1 who was occupied downstairs involved with food preparation. She was the residential supervisor and in charge. W1 had known V1 was ill the previous evening and had already informed nursing staff in the morning (at 9:00 a.m.) before she left work for the day, of V1's behavioral indicators. When she returned to work, she

received no further instructions from nursing or other staff.

c. W9 does not recall being involved with V1 during this time period.

d. W14 was on the bus ride home with V1 and was one of the direct care staff at the home.

e. The whereabouts of the remaining staff identified on the staff schedule for that time period is unknown and, therefore, they were not interviewed. Attempts to contact them were unsuccessful.

36. There is no explicit documentation of V1's condition and status from 6:30 to 8:00 p.m. with the exception that an inordinately high number of aversives were administered to her, demonstrating that she was exhibiting a number of behaviors for which she was getting consequated.

37. On or about 8:00 p.m. on December 18, W1 was called upstairs at the Frenier House by W14 or W6 stating that "V1 is on the floor and won't get up [and] that something was wrong with her."

38. Based on the testimony of W1, after she went upstairs, she noted that V1's eyes were glassy and that she was very pale. She had been to the bathroom to have her pajamas put on. She was sitting and/or laying on the bathroom floor which was out of character. She was "semi-responsive". Mr. W14 also confirmed that V1 was semi-responsive. He also stated that V1 had a bluish color to her skin. It took 2-3 people to carry her from the bathroom. W1 immediately called PC1 and told her that V1 was "very ill" and that "she has to go to the hospital."

39. PC1 directed that W1 should wait for W3, a medication certified administrator, who was to be arriving at the Frenier House to dispense medication. According to W3's handwritten report, she arrived between 8:20 and 8:30 p.m. After W3 checked V1, she called Rescue at 8:39 p.m. and PC1.

40. W3's note further indicates that she checked V1 and found "her extremities were blue/purple, she had labored breathing, her eyes were glassy, and felt a pulse rate of 110. I could not detect a radial pulse in either arm or a pedal pulse. I then went to the carotid artery and felt a pulse. Her rate was 110."

41. The Emergency Medical System's transportation sheet documents the time of receiving the rescue call and responding at 20:39 (8:39 p.m.). They arrived on location (at Frenier) at 20:45 (8:45 p.m.). They were enroute to the

hospital with V1 at 20:55.

42. V1 arrived by ambulance at 9:01 p.m. on 12/18, at the Emergency Room (Sturdy Memorial Hospital). Upon arrival, she had an acute abdomen, and was in shock. Blood pressure was zero upon arrival. She needed full resuscitation "with about five liters of intravenous fluids. Her extremities were cyanotic." Aggressive treatment was executed in the Emergency Room.

43. Laboratory tests, an electrocardiogram, an x-ray of the abdomen, and a portable chest x-ray were conducted. While she was getting ready to be taken to the operating room, "her blood pressure progressively became lower." This was despite "the rapid infusion of large amount of intravenous fluids that she was getting." The x-ray of the abdomen demonstrated "a large amount of free air in the abdominal cavity."

44. An authorization for medical/surgical treatment was signed by W3 on 12/18/90 @ 21:42 (9:42 p.m.). At or about 11:30 p.m. W4, (O.R. Physician), spoke to V1's stepfather on the telephone.

45. Subsequently, an authorization form was signed on 12/19/90 by PC1 for the procedure. A consent for anesthesia form was signed by W3, and witnessed by PC1. No time is documented on this form. At about 12:40 a.m., V1 was taken to the operating room. This was 3 hours and 39 minutes after V1 arrived at the hospital and almost exactly 3 hours from the time an authorization form was signed by BRI medical technician, W3. The pre-op diagnosis was "viscus rupture."

46. Anesthesia was administered at 12:45 a.m. Surgery (an "exploratory laparotomy") began at about 1:05 a.m. During surgery, V1 "arrested on the operating table." C.P.R. was administered, and she was "defibrillated several times." This was not successful. V1 passed away at about 1:35 a.m.

47. The post-op diagnosis was "Cardiac Pulmonary Respiratory Arrest, Gangrene 2/3 of anterior wall of stomach with massing peritonitis."

48. The medical examiner and the police were notified of the sudden death.

49. Medical Examiner, James Weiner, M.D. performed an autopsy on 12/19/90 @ 11:30 a.m. at Morton Hospital, Taunton, MA In attendance were: Wayne Bennett from the Attleboro Police Department, Bettina Briggs representing the Probate Court, and a pathologist consultant, W4 representing BRI.

The death certificate states: "Sepsis and Peritonitis[8] due to perforation of stomach, etiology unknown."

50. The medical examiner ruled the "manner of death is natural." His opinion, which is stated in the death certificate is, "death resulted from sepsis and peritonitis due to perforation of the stomach, etiology unknown." He further opined:

a) " . . . the enormous quantity of stomach contents removed at surgery may have caused or contributed to this event"

b) " . . . it cannot be ruled out that a foreign object may in some way have precipitated this . . ."

c) "the perforation of the stomach does not appear to be related to a caustic substance . . ."

d) " . . . the appearance of the stomach and the peritoneal cavity suggest this was a recent acute event, not more than 1-2 days of duration . . ."

51. Although the medical examiner determined the manner of death as "natural", issues or questions remain based on the aforementioned opinions a and b. Additionally, Dr. Weiner stated when he was asked by this investigator if the perforation may have been induced naturally. He stated, "he could not make a determination because of surgery."

a) A foreign object was not reported to have been found either at surgery or during autopsy. (There is no documentation that a foreign object was found during surgery. Nor is there evidence that V1 expelled a foreign object.)

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[8] Dorland's Illustrated Medical Dictionary, 24th Edition, W.B. Saunders Company

1. **sepsis:** Poisoning which is caused by the products of a putrefactive process, pg 1365.
   putrefactive: Pertaining to or of the nature of putrefaction
   putrefaction: Enzymic decomposition especially of proteins, with the production of four-smelling compounds, such as hydrogen sulfide, ammonia, and mercaptans, pg 1253.
2. **peritonitis:** Inflammation of the peritoneum; a condition marked by exudations in the peritoneum of serum, fibrin, cells, and pus. It is attended by abdominal pain and tenderness, constipation, vomiting and moderate fever. pg 1132.
   peritoneum: The serous membrane lining the abdominopelvic walls and investing the viscera (visceral p.) pg 1132.
   viscus: Any large interior organ in any one of the three great cavities of the body, especially in the abdomen. pg 1696.

b) Dr. Weiner concluded the perforation was not related to a caustic substance, based on microscopic examination (specimens). However, he did not take or preserve a tissue sample of the exterior of V1's face, where a blue discoloration could be observed (refer to autopsy photographs).

Dr. Weiner, during an interview, stated he had never observed these identifying marks prior to V1's autopsy. These marks were also referred to as "burn-like marks" by others who had observed them. Dr. Weiner was of the opinion "the marks were a discoloration".

Ingestion of a substance which causes corrosion on contact is ruled out by examination of the mouth and esophagus. The blue marks on V1's face remain unidentified.

c) The police officer, in his report, wrote, ". . . some chest cavity fluid was placed on her leg to see if there would be any reaction. At the end of the autopsy, the fluid was washed away and red streaks could be seen." The officer stated, "Dr. Weiner did not comment on it, neither did he mention it in his report."

d) Both the police officer and V1's mother cite the imminent concern of the operating physician regarding "the condition of V1's stomach."

e) The medical examiner did not note any observation which may include or negate any anatomical abnormality of the stomach.

f) There is a question as to whether the microscopic examination included investigation into H. pylori. This is the bacterium which is associated with ulcer disease. See Rabb Report, p 2.

52. BRI staff, when interviewed by this investigator, reported being questioned and asked to submit reports to BRI Administration immediately after V1's death regarding incidents relevant to 12/17 and 12/18/90.

53. These reports/statements were reportedly requested and provided to W4, a forensic pathologist who was retained as a consultant to BRI and attended the autopsy. He prepared a report concerning the death which was also requested by this investigator pursuant to M.G.L. 19c §5. Neither BRI nor W4 would provide it, nor would BRI provide any written statements of staff.

54. Also requested was a video tape of V1 dated either 12/17 or 12/18, the existence of which remains in question. BRI did not provide the tape, and neither would they confirm or deny if such a tape exists.

55. It should be noted that W3's handwritten incident report was typed up by BRI. In the process, it was reconstructed and put in the third person. Important information was omitted, such as:

"The nurses tried to get a B.P. [blood pressure] and couldn't get one in either arm. They put the electronic cuff on her arm and still couldn't get a B.P. They put a heart monitor on her and her pulse was 178. V1 was also beginning to turn purple on her body. They asked about the bruises . .

3. Conclusions with respect to the chronology, events and actions between 12/11 and 12/19/90

1. Between December 11 and 14, 1990, based on available evidence and recollections of witnesses, on balance there was no reason to suspect that V1 was suffering from a gastrointestinal illness.

   a. This conclusion is reached notwithstanding the possible conflicting evidence that V1 was not eating all or part of her meals beginning on December 11, and the fact that it cannot be determined from BRI's recordkeeping whether V1's lack of eating during this period was because she was ill or because of her behaviors. For example, the calorie recording sheets which record the amount of calories do not indicate why the student is eating less than their full allotment. The reliability of the calorie recording sheets is open to question for other reasons discussed above. See Findings 4 a-c. Additionally, daily behavior tally sheets are not preserved.

   b. Thus, the possibility exists that V1 was not eating because of illness as early as 4 to 7 days before her marked deterioration on December 18, 1990. However, the overwhelming weight of the witness accounts (including V1's mother on December 15), was that there were no overt signs or symptoms which during December 11-14 would raise the index of suspicion that V1 was ill.

2. Beginning on December 15, 1990, V1 began showing signs and symptoms of illness, which as detailed in findings, and summarized below, became progressively worse on December 16 and 17.

3. BRI nursing staff did not check V1, concerning these signs and symptoms until shortly after 9:00 a.m. on December 18, 1990, two to three days after onset. (It is undetermined whether or not W1 notified nursing of V1's illness in the morning of December 17. While she believes she may have, there is no record of the notification and nursing staff do not recall being notified. (see note 2)

4. That the first contact due to this illness did not occur by nursing personnel until shortly after 9:00 a.m. on December 18, 1990, constitutes an unacceptable delay in initiating observation and/or monitoring by nursing staff given:

   a. V1's presentation beginning on December 15 or 16, when she began refusing her dinner and other meals, which was of concern to staff since V1 "always ate" (W1).[9]

   b. On December 16, she began displaying other signs of illness to include such uncharacteristic behavior as: refusing snacks on bus, getting out of her seat on the bus, acting fidgety, making unusual sounds.

   c. On December 17, there was a continuation and worsening of the above mentioned uncharacteristic signs. At night staff noted she appeared sick and looked pale; and during the night she kept getting out of bed and walking to the door and going back to bed. "V1 never had out-of-bed behavior and was very lost, looking all around her like she didn't know where she was." She attempted to vomit but couldn't, and "her eyes were glassy". "She was awake all night sticking fingers in her throat."

   d. During the night/early morning hours of December 17/18, staff administered an uncharacteristically high number of aversives to V1 (relative to recent period(s)) for presentations interpreted as target behaviors, including spatula spanks, muscle squeezes, ammonia and taste aversives.

   e. V1's cognitive and communication limitations, precluded clear communication of her distress, mandating that staff err on the side of caution by seeking hands-on medical evaluation.

5. It is concluded that 1) PC1 after receiving notification at approximately 9:00 a.m. on December 18, promptly examined V1, and 2) subsequent to the examination most likely in the morning, telephoned W2.

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[9] Direct care staff interviewed all unanimously spoke of V1's strong desire for food she liked to eat.

6. However, the assessment initially and during the day were deficient in the following ways.

   a. No written documentation of a physical examination was made.

   b. The only information about a physical examination was on the daily nursing body check sheet which indicated that the nurse apparently looked in V1's ears for wax, and noted that "she was pale" and her temp was 98.4. There was no information about an abdominal exam. (Nurse body check sheets are filled out routinely regardless of whether an individual is sick. This sheet was not properly signed and had other deficiencies. (See Findings 10 a & b)

   c. PC1 did not obtain from staff a sufficient history of V1's course over the previous 24 to 72 hours or when the staff began noting changes in presentation. The only written information provided by PC1 on the previous period was that V1 had "been awake all night sticking fingers in throat." Thus the duration, severity, type and amount of signs and symptoms over the past 24 to 72 hours do not appear to have been obtained or considered by PC1.

   d. While PC1 contacted W2, there is no record of the call or when it was made, whether and what signs and symptoms were conveyed to W2 or what orders (if any) he may have given PC1. The aforementioned body check sheet, only indicates that V1 was to be "allowed to rest and be give frequent fluids".

   e. PC1 also interpreted what little information she obtained as symptoms of V1's behavior rather than illness; e.g. sitting in the puddle and having to be carried in. While there is some historical information to indicate that such an explanation was possible, the overwhelming weight of the evidence available then, indicates that this and other behaviors were uncharacteristic of V1, particularly when taken together with the behaviors on the immediately preceding vehicle ride[10], the night and 2-3 days before.

7. As Consultant Walsh concluded: "In discussion with PC1, RN, and PC3, LPN, they both verbalized their concerns re an ongoing abdominal process. However, the only written documentation was a note regarding wax in V1's ears. There

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[10] In addition to the presentations on the December 16-17, in the morning on the 18th, V1 continued to display unusual behavior, inappropriate urinating, inappropriate motion and touching of others, pulling clothes at her stomach, touching and holding her stomach, bringing her feet to her stomach, knees to chest, acting tired and lethargic.

is no written evidence that V1 received the ongoing attention described. These are errors of omission." This appears to be an underlying problem at BRI as:

-- Formal nursing documentation policies are non-existent at BRI. Id. at 13.

-- Adherence to acceptable standards for nursing documentation are non-existent. Id.

8. Consultant Walsh also found that PC1 "never participated in any formal physical assessment course for nurses. Given the length of time from nursing school graduation [approximately 40 years] and her current clinical responsibilities, such a course should have been mandatory." Id.

9. Nursing staff's interventions and other actions were not adequate during the course of the day. According to the nurse body check sheet, V1 was allowed to rest and to be given frequent fluids. However, despite the accumulative evidence and the fact that V1 had to be carried into the school in the morning after uncharacteristically sitting in a puddle, and her continuing to refuse to eat:

a. She was merely placed on low demands and not taken off aversives, which nursing staff had authority to do.

b. Nursing staff did not check V1 after 3:00 p.m. even though she continued at the day program until 5:00 p.m. when she left for home.

c. Nursing staff nor responsible first shift personnel communicated with second shift personnel about V1's illness. See also Walsh report, p. 12, ¶ 1. Nursing staff did not, for example, provide instructions about whether or when to call them or other medical personnel.

10. As a result of this lack of communication and coordination, when signs and symptoms occurred after 3:00 p.m. (and V1's illness was actually worsening), direct care and supervisory staff continued to interpret her presentation as behavioral and not of distress as a result of illness, until approximately 8:00 p.m., though they did note "she was not herself". Thus between 3:52 and 7:00 p.m. 56 physical aversives administered -- 13 spanks with a spatula, 29 finger pinches and 14 muscle squeezes and 5 odor aversives, while she was sick and very likely in consequence for behaviors resulting from deteriorating medical condition and pain.

a. The staff on second shift not being aware of previous symptoms or V1's course during the day and/or not having

been alerted by nursing staff, were not in a position to fully and accurately assess V1's situation and take necessary steps in a timely manner.

b. No one person was in a position to view and assess V1's problems longitudinally. Staff were not alerted to the problem and nursing was not monitoring the situation after 3:00 p.m. As found by Consultant Walsh: Moreover, despite the "reappearance" of old "behaviors" in the face of an acute illness, staff continued to prescribe aversive therapies to an obviously ill young woman rather than to consider other possible etiologies. PC1's lack of information transfer to the second shift staff regarding V1's illness **delayed** medical attention as behaviors, rather than illness, were treated during the late afternoon and evening hours. (Emphasis added.) Id. at 14-15.

11. This lack of communication and coordination between shifts, lack of instruction and/or nurse monitoring after 3:00 p.m.:

a. constitutes omission on the part of BRI administration and nursing staff,

b. resulted in a delay in treatment, and

c. was a contributory cause to V1's demise.

As found by Dr. Rabb (p. 4):

> Unfortunately, in this case it appears from available data that no one at the residence was informed of the necessity for observation, that competent staff was not available, that there was a significant delay in recognition of the evidence of a critical situation, and that once the nature of the emergency had been identified definitive surgery was not performed within a reasonable period of time.
>
> Thus, if the evidence as described is confirmed the care provided to V1 failed to conform to standards prevalent in the community and may have contributed to her death.

12. When staff person W1 called PC1 at 8:00 p.m. and nursing contact was finally re-established, given the severity of V1's condition[11] and duration, for PC1 to direct W1 to wait

[11] V1's condition at the time included the fact that she was semi-responsive or semi-conscious. She was glassy eyes, and was sitting or laying on the bathroom floor; her skin color was bluish and she had to be carried to bed by two staff.

for W3 to arrive as opposed to immediately obtaining emergency medical intervention constituted poor judgement and was contrary to good health care practice. As stated by Dr. Rabb (p.3): "Inexplicably she [PC1] delayed the ambulance call until the arrival and corroboration of someone she believed had more expertise or authority. It is my impression that she had been employed to perform such tasks."

a. The medical technician did not arrive until 20 to 30 minutes later and did not contact emergency medical services until 8:39 p.m., thus PC1's actions/omission resulted in approximately a 40 minute delay in the activation of EMS services from the 8:00 p.m. point.

b. Waiting for and the relying on the judgment of a person certified to give out medication is no substitute for nursing, medical or EMT evaluation which was clearly and immediately needed, given the description of V1's condition at 8:00 p.m. "PC1's request for staff to await W3 further delayed acute care instructions". Id. at 16.

13. As put by Consultant Walsh a contributing factor to the 8:00 - 8:34 delays was: "From discussions with staff, there is no differentiating between licensure and the clinical ability/responsibilities that perceive "clinical nursing staff". In my discussions with staff there was no ability to differentiate PC1's role from that of the other nursing/LPN staff. Moreover PC1, when contacted by direct care staff as to an acute presentation by V1, requested the staff to wait for W3, a certified medication administrator. Such a delay was unnecessary and unwarranted." Id. at 13-14.

14. Another contributory factor in the above omissions and Mrs. V1's death is BRI's lack of policies or procedures which provide instruction to staff on when and how to notify nursing or medical staff when a consumer appears ill. The lack of such policy and procedures caused or contributed to staff (nursing, supervisory, and direct care) to erroneously interpret her signs of illness as behaviors. This resulted in V1 receiving punishment instead of treatment for her illness both on the overnight of December 17 and during the late afternoon or early evening of December 18.

"The lack of policies and procedures to assist staff in the differentiation of signs or symptoms of illness from "behaviors" (some in this case not in evidence for several years) can be construed as having a significant impact upon the proper diagnosis, treatment and outcome of this unfortunate death." See also Rabb Report, p.2.

15. Such lack of policies and procedures persist at BRI. This is both dangerous and inhumane as consumers at BRI continue to be:

a. placed at risk of not having acute or emergency care medical needs met.

b. being punished rather than treated when they show signs of distress resulting from illness.

As noted by Consultant Walsh despite requests: (p.14)

This consultant was not provided any policy, procedure, or information indicative of BRI's cognizance of current acceptable standards of nursing practice.

16. The promptness with which the Emergency Medical System arrived, assessed the situation and transported V1 to the hospital is in accord with acceptable emergency medical practice.

17. Despite the fact that she was clearly ill on the night of December 17 and through the day of December 18, V1 was forced to endure lengthy bus rides to and from the day program and remain at the day program all day. While there is no evidence that these circumstances exacerbated her condition, forcing V1 to travel to and from school and attend all day while she was ill constitutes inhumane treatment.[12]

18. As Consultant Walsh also found: "Students who are deemed 'ill' are allowed to rest in their classroom, a situation which could be extremely problematic in the case of communicable disease." [13]

19. Subjecting V1 to aversives on December 17 and December 18 while she was ill and in consequence for behaviors resulting from her deteriorating gastro-intestinal condition and pain, constituted abuse under M.G.L.A. 19c §1 et seq and mistreatment under 104 CMR 20.07(1). In addition to violating these laws, BRI's actions toward V1 in this regard violated the most basic codes and standards of decency and humane treatment. This was a young woman, seriously and obviously ill, and particularly vulnerable,

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[12] As stated in the findings, V1 once at the day program was allowed to rest and was placed on "low demands." Nevertheless, lack of provisions to permit a student to stay at home when ill is inappropriate.

[13] In this connection Consultant Walsh also expressed concern "that there is no specific area for examination by the physician. An empty classroom is utilized as an examination room." Id. at 13.

due to her disabilities, who when she displayed signs of illness and nonverbally communicated pain, was spanked with an implement, subjected to muscle squeezes and finger pinches, and forced to inhale ammonia and ingest vinegar mix, jalapeno pepper or hot sauce. Her disability also made her unable to effectively protest. Practices at BRI also meant that her attempt at protestation or any noncompliant behavior would, and very likely did result in further aversive consequences.

In sum, these egregious actions are inhumane beyond all reason and constitute violations of the above mentioned legal standards as well as universal standards of human decency. At fault were:

a. The direct care staff for administering the painful aversives although their actions are mitigated by the factors in b, c, d, below.

b. The nursing staff and PC1 in particular for not ordering V1 off aversives and not notifying second shift staff about her condition.

c. W12 for granting approval for a staff request for an increase of aversives above the normal limit of 40 to 95 without an adequate or possibly [14] any inquiry.

d. BRI administration for not having clear policies and instructions to staff on differentiating between behaviors to be consequated and signs of illness and the appropriate action to take in case of the latter, and for maintaining and fostering such one-dimensional behavioral orientation that personnel view and treat pain and illness presentation with punishment rather than with appropriate nursing or medical care. As was also concluded by Dr. Duarte:

Most disturbing of all was that a high number of punishment procedures were administered to V1 just prior to her death, after staff had already formally reported that she appeared to be ill for two consecutive days. Id. at 25.

20. The aforementioned acts and/or omissions by BRI and its staff (including the cited lack of BRI's policies and procedures) constitute mistreatment under 104 CMR 20.07 and abuse under M.G.L. c 19 §1, which contributed to V1's death. These acts and omissions include, but are not limited to:

[14] There was no written evidence of an inquiry and attempts to reach W12 for an interview were unsuccessful.

a. failure of nursing staff to conduct and document a proper physical assessment both earlier and in a complete and proper manner.

b. failure to initiate observation and monitoring earlier.

c. failure to treat her signs of distress as illness, rather than as behaviors to be punished.

d. failure of nursing staff to consistently monitor V1's condition, including at and after 3:00 p.m. before they went off shift.

e. failure by nursing and/or supervisory staff to communicate to direct care staff to include especially second shift personnel that V1 was ill and to provide instruction regarding same, thus causing or contributing to a delay in earlier, possibly life saving medical intervention.

f. delaying in obtaining appropriate nursing, medical or emergency services evaluation after 8:00 p.m. on December 18.

21. Conclusions with regard to the chronology and events once V1 arrived at Sturdy Memorial Hospital at 9:01 p.m. on December 18, are deferred pending an examination by the Medical Board of Registration and the Department of Health to which agencies a referral of this matter should be made, though it should be noted that Dr. Rabb found that "definitive surgery was not performed with a reasonable period of time", "once the nature of the emergency had been identified." p.4.

22. Dr. Rabb's finding regarding the post-mortem examination should be noted. The etiology of the ulcer was not determined by the autopsy and is still unknown. "Important inadequacies mar the post-mortem examination". Id. 2. Dr. Rabb points out that:

There are no observations which might include or rule out any anatomic abnormality of the stomach. Was there torsion along gastric ligaments? Was there a periesophageal hiatus hernia? There is no mention of investigation into H. pylori in the microscopic examination. That is the bacterium which is associated with ulcer disease. Even now a pathologist might be able to distinguish on microscopic examination a "stress ulcer" from one associated with H. pylori or an ischemic insult caused by one of the anatomic abnormalities mentioned above. Blood, peritoneal fluid and gastric fluid were not tested for any of the ulcerogenic noon-steroidal anti-inflammatory drugs (NSAIDs). The patient has a prescription for Naproxen reported in her record. It is

not clear whether or not she had used that medication in the near past. Id.

He recommends "that an independent consultant pathologist interview the original pathologist with regard to gross findings, review the microscopic material and retest any available blood or fluid for NSAIDs to attempt to discern an etiology". Id.

4. Other Findings and Conclusions

1. BRI did conduct an internal investigation regarding V1's death which apparently included a) questioning by and taking statements from staff by PC2, b) having W4 attend the autopsy, and c) preparation of a report by W4 and/or BRI administration.

   - BRI denied requests of this investigator for these statements and report. The denial constitutes obstruction with the investigation. (BRI in at least one other case provided a DMR investigator with a complete copy of an internal investigation report of alleged wrongful staff conduct, log # 05-92-TNTN-005).

2. Despite the derelictions on the part of staff which were evident in this case and which contributed to V1's death, BRI administration took no corrective or disciplinary action against PC1 or other staff at BRI.

3. Additionally, a change in policy precipitated by V1's death which BRI represented to the court-appointed guardian ad litem, Bettina Briggs, Esq. was never implemented.

   a. Bettina Briggs attended the autopsy and prepared a final report to the court, and wrote to PC2 indicating concern about the "long term chronic administration of a noxious state aversive such as vinegar on a silent stomach condition?" A response dated August 1, 1991 from W2 stated:
   "PC2 asked me to respond to your letter of April 23 regarding taste aversives. I do not believe that taste aversives could cause or "exacerbate a silent stomach condition" under the regimen at BRI.
   As you know, the ammonia aversive can only be administered 3 times within a one hour period. **After meeting with BRI staff, we have decided to implement the same limitation for the use of taste aversives (Louisiana Hot Sauce, Jalapeno peppers, and Vanilla and Vinegar).** [It had been 20 per hour]

   b. A "Two week training manual" was obtained from the agency, dated 1993. The manual was never changed to reflect the reduction from 20 to 3 taste aversives per

hour. The manual reads:"**All students are limited to 20 tastes per hour, the student may receive more taste aversives at the next o'clock.**"

c. Staff when interviewed were not aware of any reduction to 3 per hour.

d. When W2 was interviewed, he was allowed time to review the letter he forwarded to Ms. Briggs. He did not recall the letter. He also did not recall if he instituted the 3 per hour limit for administration of ammonia.

Thus, the limitation of taste aversives were never changed from 20 per hour to 3 per hour. It is undetermined whether BRI misrepresented this policy change to Bettina Briggs, who was preparing a report to the Court, or if they were negligent in failing to implement the change.

4. PC3 who began working for BRI in September 1990, stated in her interview that she was licensed in Rhode Island but not Massachusetts. She stated she does at times work in Massachusetts, "it's part of the job." She described working under the supervision of the RN PC1, doing body checks, passing out medications, paper work, "doing everything the RN does, but I can't make a decision without PC1." The Board of Registration in Nursing in Massachusetts was contacted regarding the necessity of licenses in this state. They stated a license is required, it is illegal to practice without it. A review of PC3's personnel file also shows that she does not possess a certification from Rhode Island as a school nurse/teacher.

3. RN PC1's personnel file was also reviewed. In it was an expired certification from the State of Rhode Island, Department of Education, Special Education Unit for school nurse/teacher, as well as a letter stating this certification needed to be renewed (1991). Rhode Island Department of Education confirmed that PC1's certification expired in August 1991 and that PC3 was not certified as an emergency school nurse/teacher. This information was followed up by contacting the Director of the Special Education Unit in Rhode Island, Ben Effreom. He stated, "the regulations in Rhode Island require the certification of an emergency school nurse/teacher at a private special education facility. A person needs to be properly certified." He requested a copy of this report when it is completed.

5. As found by Consultant Walsh, "There is no system in place to insure familiarity with the unique clinical needs of BRI students by local medical providers. W2, whose office is located in Springfield, MA is considered the "primary care physician". He is extremely dependent upon the observations of PC1, who as noted previously, has had no formal training

in physical assessment. Id. at 14. As she concludes (p. 16): "The lack of acceptable standards for nursing practice and the lack of proximity of familiar medical care providers will continue to place BRI students at significant medical and nursing risk."

C. FINDINGS WITH RESPECT TO ELEMENTS OF V1'S PROGRAM

1. Finding and Conclusions

1. Because V1's death was gastroenterological in nature and related to ulcers, elements in the behavior program that pertain to her gastroenterological or digestive system were examined; e.g. the specialized food program, taste aversives, ammonia. The overall program was examined as well. This part of the investigation was initially concerned with whether the programs or elements thereof may have contributed (either as stressors or physiologically) to the ulcers and ultimate perforation. Dr. Rabb concluded that:

> The record in my possession gives no compelling evidence that the attempts to feed her or that any of the agents used in aversive therapy or the therapy itself contributed to her demise.
>
> Despite popular belief, the scientific literature has not conclusively connected pepper oils or ammonia with ulcer disease. The concept of stress as an etiologic factor outside the intensive care of neurologic unit settings is vague and has numerous definitions and connotations. One can not definitely show that emotional stress, punishment or food deprivation per se, are ulcerogenic factors for the stomach in human beings. p.2

Ms. Walsh concurred. As she concluded "From this consultant's perspective, as well as a thorough discussion with gastroenterology consultant, Dr. Rabb, the use of prescribed aversives did not subsequentially contribute to V1's demise." Id. at 11.

2. In reviewing these areas, other concerns and ultimately findings arose about V1's program and certain practices at BRI. These are set forth below.

2. Additional Findings and Conclusions with Respect to Contingent and Specialized Food Program

1. Under the Contingent Food Program a student earns his/her meals by:

a) passing a DRO contract, or
b) successfully working on the computer.

2. V1 was on a less-than-a-day DRO contract. When she was first put on the program, the interval was for five (5) minutes (1986). By 1989, it had increased to one hour, and again in 1990, it was increased to two hours.

3. The idea is that the student should constantly be attempting to meet the less-than-a-day contract. For completing a less-than-a-day contract a student is rewarded by earning his/her mealtime food and one or more nickels. A new contract is set with the student after the reward is received. If the contract is not met, the student will not receive that portion of his/her meal and the food will be thrown away. There is a loss of privilege period after the student breaks his/her contract. The failed contract is not reset again until the time the student should have passed elapses.

4. BRI's policy as described in the Permission Packet for Restrictive Procedures signed by V1's mother described the regular contingent food program and specialized food program as follows:

> **"Contingent Food":** The student earns his/her caloric intake by means of many small portions of food earned throughout the day, rather than in three large meals. These small portions are earned by the student when he/she shows certain specified appropriate behaviors or by not showing specified inappropriate behaviors.
>
> If the minimum daily total of calories has not been earned by 7:00 p.m., then the balance necessary to bring the total staple food calories eaten to the desired target will be dispensed in the form of non-preferred staple food starting at 7:00 p.m.[15] Alteration in the time and manner of staple-food make-up may be made, with the approval of a consulting physician. (p.43)
>
> **Specialized food:** If special treatment considerations require it, the provision of staple food make-up may not be made, with the approval of a consulting physician, provided however, that the individual shall always receive at least 20% of his/her caloric target which is set by the nutritionist. BRI will provide all necessary medical safeguards to ensure that the health and well-being of the individual is not jeopardized." Id.

Under the specialized food program, a student must only reach 20% of his/her minimum caloric intake. Thus, a student on

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[15] A make-up meal (LOP food) consists of bland chicken, mashed potatoes and spinach. Preferred staple food is basic menu food, excluding desserts.

the specialized food program who earns 22% of their daily caloric intake by bedtime will not receive any LOP food. If the same student only earned 16% of the caloric intake by bedtime, then that student will need to be offered 4% of caloric intake in LOP food.

5. The permission packets also describes the following safeguards with respect to aversive procedures generally, including: (p. 7)

   - A nurse inspects each student who receives daily restrictive procedures to insure that any adverse side effects are minimized, and that good health is at all times maintained.
   - A physician visits the program **several** times each month and is on call at all times. (emphasis added)
   - Informed, written consent is obtained from the parents for all restrictive procedures, and this consent is renewed annually." (page 8)

   Page 88 states: "Student Weight: BRI's medical staff will establish a desired target weight for each student, appropriate for his/her height, weight, age and program, and will make its best efforts to keep the student's average weight at this level."

   Page 7 states: #7: "We employ a wide variety of safeguards to insure that all procedures--both rewards and restrictive procedures--are carefully used by a well-trained staff, and that the human rights and dignity of the students are at all times respected. Some of these safeguards are listed:

6. Page 8 states: ". . . Each form describes, in some detail, a single restrictive procedure, including how it is administered and, where relevant, the to-be expected side effects." The permission packet which parents or guardians sign for informed consent, including the one signed by V1's mother, did not describe any potential side effects that may occur specific to the food program, and medical or nutritional safeguards were not provided.

7. Despite the permission packet and a 12/8/89 order of Judge Rottenberg with regard to V1 requiring an examination by a qualified physician at least every two weeks", physicians visits occurred only once a month.

8. While the BRI policy and the above mentioned permission packets require daily inspections of students on aversives by nurses, with the exception of about 3 weeks worth of sheets documenting such checks in 1990, the daily body check sheets by nurses have been destroyed. Thus it cannot be determined from documentation that the daily examinations occurred.

9. Moreover as noted above, there are deficiencies and irregularities concerning these sheets including use of stamped signatures by individuals who did not actually fill them out, and questions about the adequacy or completeness of the information.

10. Despite the fact that permission packets filled out by parents state that students on the specialized food program will be maintained at proper weight and a 7/13/84 Court Order with regard to V1 requiring that her weight not fall below 90% of her ideal body weight (red-line figure), BRI by policy and practice allowed V1 and other students' weight to fall below 90% of ideal weight to as low as 80%, as confirmed by the following:

    a. On 3/29/89, W16's records indicate on a medical contraindication form, to continue the red-line @ **90% min.** for V1,

    b. However, on 2/27/90, W2's general order was if a student is below **80%** they should return to 85% and maintain it for 3 days before going back on food program,

    c. On 3/20/90, W2's general order indicates he should be notified if any student is at or below 85% of ideal weight, and if a student reached 80% of ideal weight h/she goes off program.

    d. On 8/12/90, 9/18/90 and 11/13/90, another physician, W17, maintains continuity of the red-line @ **80%**.

11. Additionally it appears that the requirement of the 90% red-line was not communicated to relevant staff. The nutritionist who was employed at BRI stated that she was not aware of the Court Order to be at 90%, and PC1 stated that she thought the Court approved red-line was for 80%.

12. Caloric recording sheets were maintained for students on the food program in order to monitor the students caloric intake of food. However, most of these recording sheets were not retained for V1. BRI provided only 30 days of caloric recording sheets, (November-December 1990). In addition, the sheets provided do not indicate how many calories were offered and how many were consumed.

13. If a full allotment was not received, the reason is not indicated. For example, a check mark indicates all calories were recorded. If instead of a check-mark, the recording sheet depicts a 1/2, it does not provide any information as to why 1/2 was not received; e.g. she did not complete her computer task, she had a behavior and was being consequated, or she refused the portion.

14. Staff reported (in 1989-1990) that they routinely monitored and recorded students' ketone[16] levels. This practice was implemented in order that a student did not lose weight and become ketotic (breaking down his/her proteins). Staff were not able to recall specifically if this was done for V1. The ketone test results for V1 were not provided. PC1, R.N. could not locate them.

15. In an April 6, 1989 Order (Docket No. 86P1161) relative to V1, the Court approved a plan that she receive a minimum of 2500 calories per day. However, from that point and up to December 1989, when BRI received approval to implement the specialized food program, BRI decreased the calorie intake to 2000 then to 1800 and then to 1500.

16. On 12/7/89, BRI filed a motion to amend the V1's treatment plan, to include the use of the Specialized Food Program for a ninety day period, stating ". . . V1 is presently refusing to evacuate the building independently during a fire drill. . ." In this proposal they represented that they had been providing 2500 calories per day, when in fact they had only been providing as low as 1500.

17. In granting the Motion for a 90 day period, the Court said that V1 shall be examined by **a qualified physician at least every two weeks,** and lab work shall be conducted as medically indicated. **Documentation of the exams and the lab work shall appear in the medical records."** (Emphasis added) On March 15, 1990 a motion for continued authority to use this special Food Program was granted. The Specialized Food Program meant that twenty percent of V1's staple food calories (300) must be dispensed between 7:00 a.m. and bedtime each day. If, by bedtime the student has not yet eaten at least 300 calories, the balance will be dispensed non-contingently (without conditions).

Her records further stated that: IF V1'S WEIGHT FALLS TO 108 LBS. OR BELOW, PLEASE NOTIFY HER CASE MANAGER!

18. However, as aforementioned, physician's records, weight graphs, and statements indicate the red-line was not maintained at 90%, V1's weight fell below 108 lbs., and she was not seen by a physician every two weeks as the court ordered.

19. Several notations are made by W2 during the last two months of V1's life concerning her diet and weight. These are reflected in the records and noted by Consultant Walsh in

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[16]A ketone is any of three related compounds including acetone which is found in the blood and urine when there is excessive oxidation of fatty acids by the liver, as during starvation or pregnancy, or in diabetes.

her report followed by her comments:
-- "On 10/18/90 and 11/1/90 W2 stated: " 'V1 is doing well on special food program.' No weights were documented."
-- "On 11/13/90 he saw V1 and stated 'Special food red line 100 [lbs]. Present weight 104.'"

20. Only two weeks later on 11/28/90, W2 noted that V1's red-line was 113 lbs., and that her weight was 107. Therefore he ordered an increase in calories.

21. W17 on 11/13/90 had ordered an increase in calories as well.

22. However, it was not until 12/12/90 that the diet was increased from 1500 to 3000 calories, which was two and four weeks, respectively after the physicians' orders to increase the calories and two months after a 1" height increase was noted, which in part triggered the need for the calorie increase.

23. "Of paramount concern" to Consultant Walsh was "the use of Special Food Program and the constantly changing parameters for 'red line' weights"(Id. at 10), and as Consultant Walsh went on to state:

> "[There was] [s]ignificant weight loss resulted from the use of this program. The December 1989 weight of 125 pounds for a height of 64" is well within the acceptable range. I find no grounds for dietary modification based on this weight. By 11/30/90 weight had dipped to 104#. However, the Program Description of 9/26/90 outlined in bold letters that the case manager should be contacted if weight fell to 108$ or below.
> Not all laboratory tests mandated by the court for the Special Food Program are available. Of note, however, is a December 1989 Annual Medical Evaluation noting a hemoglobin of 14.1 and hematocrit of 42.5. Nutritional consult of January 1990 noted a hemoglobin of 13.5 and hematocrit of 39.5. Although these laboratory changes may be statistically irrelevant, given the type of diet V1 was receiving and her continued physical growth, a formal discussion between the physician and dietician should routinely have taken place. Id. at 10-11.

Due to the complexity of the nutritional and medical issues regarding the food program, consultant Deborah Dessaint, M.S., RD, L.D.N., was retained to assist in the investigation. Her report is attached as Appendix E. She found:

a. The program did not guarantee that V1 was provided enough kilocalories to maintain her health.

b. . . . V1 would have needed at least approximately 1737 calories (1) and 39 grams of protein (2) per day to

maintain her red-line of 108 lbs. . .

c. . . . It is not recommended that any one consumer receive less than 1000 calories per day, or to do so without vitamin and mineral supplementation. . .

d. It is impossible to meet the RDA on 300 calories.

e. That there even existed the slightest possibility that V1 would not receive enough calories to meet daily needs over periods of time is a serious flaw in the design of the Special Food Program.

f. . . . all clients should be provided with adequate calories, regardless of behavior. . .

g. . . . V1 was on a safeguard provision called 'make-up' . . . this provision should not have been removed . . .

h. Nutritionally, 87.5% of ideal body weight is low. To strive for a percentage of IBW (ideal body weight) that is normally associated with mild nutritional depletion is inconsistent with optimal nutritional status.

i. Ketone testing is not routine, and is usually done only when it is suspected that someone is not getting enough calories. If ketones build up in the blood, they could cause the blood to become too acidic; leading to possible coma and death. That BRI tested for ketones indicates an awareness of the potential side effects of the Specialized Food Program.

j. The method by which BRI dispenses food through a belt-feeder is a serious concern with regards to sanitation and food safety.

24. Staff stated V1 did not realize the relationship between getting the right answer on the computer and receiving food. She did not generally know how to get the right answer on the computer and thus did not get rewarded for food. "If she didn't earn her food, it was thrown out. She got real thin, she was skinny."

25. The BRI nutritionist stated: "I have never approved 20% of 1,500 calories to 300 calories. That is not adequate."

26. Finally, as Consultant Dessaint stated (p.6):

I regard a number of practices that BRI engaged in regarding the nutritional well being of V1, with grave misgivings. In light of the information brought forth in this report, it is my professional opinion that a review of the way BRI uses food as a behavior modifier, by Registered Dietitians and Physicians, be undertaken

to ensure the nutritional well being of BRI's clients. I also feel that a dietitian/nutritionist that is there 3 hours a week would not have sufficient time to thoroughly follow such high nutritional risk clients as those that are on the Specialized Food Program.

3. Additional Findings and Conclusions with Respect to Belt-Feeder

1. The belt feeder is part of the food program. It is a vending type machine, holding/storing food that is to be dispensed to the student upon task completion. The unit has 46-48 shelves. The shelves are approximately 4 inches wide, 2 inches high, and 4 inches deep. The unit is not refrigerated. In 1990, food was stored for the breakfast period from 9:00-11:30 a.m., and for lunch from 11:30 a.m. until approximately 3:30 p.m.

2. Computers and rewards (meal portions) are set up prior to the student sitting at the computer in a belt-feeders. The belt-feeders were not (in 1990) and still are not refrigerated. The food items (in 1990) remained in the feeder for specific times. For example: breakfast was earned, and food was stored from 9-11:30 a.m., lunch was earned and stored from 11:30 a.m. to 3:30 p.m., (approximate times according to staff interviewed). Students also earned pennies for computer completion.

3. Staff interviewed were consistent in statements relative to never having received training regarding the dividing of portions of food to be stored both in 1990 and when interviewed for this investigation.

4. Staff stated it was difficult to determine exactly how many calories to calculate on the recording sheets because as many as 40 portions may have been in the belt-feeder.

5. As stated above, one could not tell from the food sheets whether food is thrown out because the meal time period was ending or if the student broke the contract. Recording the amount of calories a student ate was further compounded by the fact that there was no way to precisely measure the amount of calories in the portions of food put on the belt-feeder. Staff cut up the portions and had to estimate the amount of calories in a sliced portion and then determine how many calories in that portion. As one staff person put it: "We would put food on wax paper, eggs, meat, etc. You'd have to be a good guesser (visually) as to how many slices to break it into.

6. Staff further reported they received no training regarding the sectioning of food to be stored in the unit, the counting of calories relative to portions of food dispensed or thrown out, the types of food that could/couldn't be

stored, or the amount of time that was acceptable to store the food. Gloves were available for staff to use, however staff reported this issue was not addressed in training. They stated gloves were not worn because BRI does not employ food preparation staffing in the classroom. They further stated they could be doing several other things at the same time, such as administering an aversive.

7. Current sanitation public health issues were uncovered in this investigation relating to the belt-feeder:

   a. Perishable food such as milk and milk products, eggs, meat were kept unrefrigerated on the belt-feeder for over one hour and up to four hours, increasing the risk of food poisoning.

   b. There are some staff who reportedly put only a limited amount of portions on the feeder (e.g. 10 versus the full 20) so that the food does not get cold or unhealthy; however, this sometimes results in the food reward being delayed after the positive behavior is exhibited.

8. The above problems, including lack of refrigeration, continue to date. However, they were pointed out as far back as 1990. W18, a former BRI nutritionist in a 10/29/90 memorandum to the nursing staff stated the following:

   "I have discussed with W19 [BRI administration] the possibility of having the belt-feeder refrigerated to help prevent food poisoning. Michael is having this looked into. In the meantime, **perishable food** including meat, eggs, milk and milk products **should not be left in the belt-feeder or at room temperature for more than 1 hour.** If perishable food items are left any longer than this, there is an increased risk of food poisoning."

9. The Board of Health Agent in Rhode Island was contacted regarding inspections, (rules/regulations and/or applicable laws). State Inspector Ed Wardyga stated they do not perform inspections every year on a regular basis. He stated the last inspection for BRI was in 1989. (As noted below, Rhode Island Department of Health recently conducted an unannounced visit to BRI.) He stated he only inspected the kitchen relative to food. When asked why the classrooms were not also inspected (pertaining to the belt-feeders), Mr. Wardyga stated he did not have prior knowledge of the belt-feeders. Mr. Wardyga forwarded to this investigator a copy of the codes for the State of Rhode Island, and a copy of BRI's inspection. Relevant provisions of the code include:

   1. The term food-service establishment shall mean any non-profit organization or institution routinely

serving food.

2. Perishable food shall mean any food of such type or in such condition as may spoil.

3. Potentially hazardous food shall mean any perishable food which consists in whole or in part milk or milk products, eggs, meat, poultry, fish, shellfish, or other ingredients capable of supporting rapid and progressive growth of infectious or toxigenic microorganisms.

4. F2.2 Food Protection: All food while being stored shall be protected from contamination. All perishable food shall be stored at such temperature as will protect against spoilage. All potentially hazardous food shall be maintained at safe temperatures (45°F or below, or 140° or above) except during necessary periods of preparation and service.

5. Compliance (a2): Conveniently located refrigeration facilities shall be provided as needed to assure the maintenance of all food at required temperatures **during storage.**

6. Preparation c(5): Meat salads, poultry salads, potato salad, egg salad, cream-filled pastries, and other potentially hazardous prepared food shall be prepared (preferably from chilled products) with a minimum of manual contact, and on surfaces and with utensils which are clean and which, prior to use have been sanitized.

7. Cleanliness F3.2(a)1: All employees shall thoroughly wash their hands and arms with soap and warm water before starting work, and shall wash hands during work hours as often as may be required to remove soil and contamination, as well as after visiting the toilet room.

8. F3.2(b)2: Hair nets, headbands, caps, or other effective hair restraints shall be used by employees engaged in preparation and service of food to keep hair from food and food contact surfaces.

10. These rules, at the time V1 attended this facility, were not adhered to. The belt-feeder currently remains a non-refrigerated unit. Classroom staff are without food preparation training. (Rules and Regulations of the Department of Health, State of Rhode Island, pgs. 63-65).

11. Many of these problems were still found to exist by the Rhode Island Department of Health, who visited BRI on August 24, 1994. Their report is attached hereto as Appendix I.

12. The health risks to BRI residents as a result of the lack of refrigeration was described by consultant Dessaint (see Appendix E):

> "When food is allowed to sit out, two critical components of microorganism growth come together: time and temperature."
>
> ". . . foods being maintained at room temperature do not meet regulations. . ."
>
> "When those foods sit at room temperature for more than 45 minutes to an hour, optimal conditions for food microorganism growth occur."
>
> "There exists a wide variety of food-bourne pathogens. They cause a variety of highly unpleasant side effects, and some can lead to death, especially in a person whose health is already compromised in some way."
>
> "It is critical that food safety regulations be followed at all times."
>
> "It is my professional opinion that a review of the way BRI uses food as a behavior modifier . . . be undertaken to ensure the nutritional well being of BRI's clients."

4. Additional Findings and Conclusions with Respect to the Behavior Program Overall

1. Due to the complexity of V1's program, Dr. Angela Duarte, a behavior consultant, was retained to assist in addressing the issues. In performing this consultation and in reviewing V1's overall treatment program, she made a number of findings and conclusions with respect to the appropriateness and effectiveness of BRI's interventions.

2. Some of these findings and conclusions may constitute a violation of Department regulations and are contrary to basic professional practice. As these practices continue and are relevant to other students, they warrant review by and are hereby referred to the Regional Director pursuant to 115 CMR 9.07(6). The following is a synopsis of Dr. Duarte's major findings. Her full report is attached as Appendix D for review.

3. Based on a review of V1's history at BRI, Dr. Duarte concluded that "[p]unishment procedures were introduced a few weeks after V1's admission to BRI, targeting a wide range of behaviors that might have responded well to positive approaches if those had been attempted for a reasonable period of time. (The charts examined did not show formal positive approaches being attempted to address

V1's behavior problems prior to the introduction of punishment.)" (p. 24)

4. For example, by the end of October 1984, less than three weeks after V1 arrived, BRI had already introduced water spray aversive (for tearing paper and throwing or spilling objects off the table); and by November 22, 1984, taste aversives and ammonia were added. (p.10) This despite the fact that V1's inappropriate behaviors had been showing a decelerating trend. Id. By January 1985 after three months at BRI, BRI increased the number of taste aversives, and added spank, muscle squeezes, finger pinches, hand squeezes, wrist squeezes and brief cold showers. (pp. 10-11)

5. Subsequent to the addition of aversives in 1984, V1's inappropriate behaviors increased, suggesting that a return to the previous intervention and/or reusing the use of positive procedures. "Instead as noted BRI increased the variety and severity of the aversives in January, 1985, which after a brief decrease was followed by a "drastic increase" in inappropriate behaviors". Id.

6. Neither BRI's policy nor its practice in choosing behaviors to be consequated by Level III and other aversives follow DMR's regulations which permit the use of such aversives only for seriously dangerous behaviors. BRI's own policy (p. 4) allows Level III consequences for merely embarrassing behaviors. As noted by Dr. Duarte: "Punishment procedures are typically used to address severe behavior problems. The vast majority of V1's behaviors targeted for treatment with punishment did not appear to be severe enough to warrant such intrusive form of treatment". Id. at 24. BRI allowed aversives in V1's case for such things as drooling, spitting, nagging, stopping work, refusing, silly laughing. She was deprived of food for merely having the wrong answer on the computer.

7. Documentary evidence indicates that punishment procedures might have actually produced an increase in V1's inappropriate behavior (see generally pp. 13-20). By way of one example from Dr. Duarte's report:

> Figure 5 shows that the total number of inappropriate behaviors were temporarily reduced ... in January through April 1985. [However], by May/85 the number of inappropriate behaviors began increasing again to reach a level 500% worse than baseline: 3077 in May/85; and 5586 in June/85; 10,055 in July/85; and 31,627 in August/85 (p. 14).
>
> Apparently, in September of 1985, BRI was prohibited from using physical punishments such as Finger Pinches, Muscle Squeezes, Spank, Hand Squeezes, and Wrist Squeezes. Figure 5 also shows that as these forms of

physical punishment were dropped from treatment, the frequency of V1's inappropriate behaviors decreased substantially. These effects suggest that the punishment procedures might have been producing the increase in the frequency of inappropriate behaviors. This would be consistent with the literature in applied behavior analysis ... (p. 15)

8. Both of the above phenomena--the lack of seriously dangerous behaviors and the minimal and even aggravating effect of the aversive consequences--was supported anecdotally from staff testimony as well:

A. "She would attempt to bite someone when they put her on the board. When V1 would become aggressive, it was always when staff attempted to apply an aversive. I never remember aggression by V1 without an aversive. V1 was very low level, not intense, just in response to people coming at her. She would bite herself, lightly, or pick her fingers, but all they (the students) have to do is do it once and it will be consequated. The parents would come in and have really no idea what's going on. He's (PC2) the biggest manipulator I've met." (W11)

B. "V1's behaviors were not that bad, she was one of the best students, she was happy, she liked to rock, out of 12 kids, she was in the top three." (W1)

C. "She was happy, she'd rock to music and dance, her most major behaviors were pinching her inner thigh, picking her gums, or biting herself, but not severely, minor. She'd typically click her tongue, or have hand play." (W39)

D. "I didn't see her as violent, in general, the only behaviors I remember she had was she would clutch another student. She would try to steal someone else's food." (W9)

E. Most of her behaviors were twitty little ones. She would grab people in a situation that was scary to her. Sometimes she would bite herself, but no enough to leave a mark, not to break the skin. I took her to Rocky Point, on a ride, she grabbed me, not to hurt me, she was scared. She'd tap everything and pinch her inner thigh." (W21)

F. "She wasn't BRI material. She had hand play manipulation. She'd bite her hand, not hard. PC2 doesn't believe you can make allowances, you consequate. (W10)

G. "V1 would hoard things, in her pockets or underwear.

She would have to be checked before getting on the bus. If you took her behind the screen to check her, she knew, she knew she'd get into trouble for putting something in her underwear. If it was time to check her, she'd grab you. She would steal food, put things in her mouth." (W22)

H. "It was a fight to give V1 Ammonia. She'd be in a panic and try to get away from you. It used to break my heart, she'd panic and grab me. She would mouth things. Mouth to object. Not swallow it. She'd headbang, not like other students, just shake her head. When she was scared, she would grab your shirt." (W7)

I. "She was very happy, aware of everyone around. If someone was going to get ammonia, she would get nervous, and grab the person next to her. She was pleasant, friendly, not aggressive or violent, only if she saw ammonia. She would grab out of reaction, in response to the aversive--ammonia." (W8)

J. "If she received an aversive, she was aggressive, she would grab you to stop you. The only time I saw her aggressive was when she got an aversive. We had to put her on the board to give her ammonia. There were cuffs on the board. Four (4): two for the feet and two for the hands. She would be laying on the board, you would squat at the head, brace the head in between your knees, put goggles on her, and from the top of the head quirt into each nostril. She would bang the front of her computer. She wasn't a runaway, the group she was in was slow, V1 was very mobile. She was paces ahead, she could walk fast. She would steal food and stick pennies in her pockets. She'd put things in her mouth." (W13)

9. The data collection and reporting system in use at BRI makes it difficult to determine what effect, if any, their treatment procedures had on V1 and other clients. As found by Dr. Duarte:

> V1's records indicate that BRI's data collection and date reporting system (categorization of behaviors and subsequent switching of behaviors across categories) make it impossible for the provider, clinicians, internal or external monitors, to thoroughly evaluate the effect, if any, of aversive and non-aversive treatment on each of the client's target behavior.
>
> Such practice would be disturbing independent of the form of treatment used, but it is even more so when punishing procedures as intrusive as those V1 received, are being used. Id. at 25.

10. As further explained by Dr. Duarte in the body of her report (p. 8).

> "An assessment of the effects of treatment on individual behaviors is not possible. Even though baseline data was collected on 36 individual behaviors, in January of 1985 all behaviors were grouped in 9 categories: Aggression; Destroy; Inappropriate Motion; Inappropriate Verbal; Non-Inappropriate U/D; Inappropriate Verbal; Non-compliance; Self-abuse; Stereotypic Behaviors; and Work Interference.
> From the moment the behavioral categories were created (e.g., Health Dangerous Behavior), it appears that BRI ceased data collection of the frequency of each specific behavior, and began to report totals for the sets/categories of behaviors. The problem with this practice is that it does not allow the identification of improvements or worsening of each behavioral component over time.
>
> The problem is aggravated by the fact that throughout the years, new behavioral categories were added, some categories were renamed or dropped, new behaviors were identified and added to the existing categories, or a new one was started, and old or new behaviors were switched from one category to another for unspecified reasons.
>
> Such unsystematic changes make it impossible to determine which specific behavior was or was not being affected by treatment.

D. BRI's Failure to Retain or Provide Documentation or Testimony Relevant to the Investigation.

1. BRI's denial of access to relevant documents

1. On December 2, 1993, BRI agreed to make available to this investigator and Consultant Walsh all records pertaining to V1 and all personnel records required by the investigator on a planned December 6, 1993 visit.

2. When this investigator and consultant both arrived on December 6, two cardboard boxes containing V1's records were provided. This investigator and the consultant spent most of the day reviewing the material in the boxes. We then determined that not all of the records were provided--only those for 1984-1988. This was pointed out to the staff representative from BRI, W25, who subsequently discovered that 1990 records were in the possession of another BRI staff person. Those records were then provided and photocopied.

3. After the additional material was received, it was still determined that relevant information was missing. Only a few documents were provided for 1990, a critical year in this investigation. Several verbal requests were made over a period of time to W25 for additional records. W25 stated she was having difficulty locating the records, and eventually stated that the request should be made in writing.

4. Thus, on February 2, 1994, this investigator sent a memorandum to W25 with a 54-item list. (Attached as Appendix G) Several additional telephone conversations ensued between W25, W23 (also of BRI) and this investigator. Only two of the 54 documents were provided during the next two months. Then on or about April 4, 1994, now four months after the original request, BRI informed this investigator a new policy was in effect regarding copying documents and further that the request again be put in writing. The new policy stated:

> BRI would be now charging 20¢ per copy and would only copy less than 10 pages on site--providing the copy machine was available, staffing permits, and payment is made. All other requests for copies would be contracted with an outside agency and would only be released after payment is made.

5. This investigator made another written request to BRI for documents on April 5, 1994. (Attached as Appendix H). As a follow-up to the April 5 letter, this investigator notified W23 verbally that on April 8, 1994, Dr. Angela Duarte (consultant to DMR) would be at BRI on another matter, and would pick up the requested material for this investigator. However, when at BRI, Dr. Duarte was informed that 20¢ per page had to be paid in advance. She was not provided with the requested material.

6. After learning of the preceding encounter, the Director of Investigations, Richard Cohen, addressed the BRI document copying policy in an April 8, 1994 letter, stating that the DMR investigator was entitled to unimpeded access to the documents and that BRI could bill DMR for copying costs.

7. On 4/11/94, W23 was able to locate additional records of V1 "in the basement of a vacant apartment" utilized by BRI for storage. W23 was notified that this investigator would arrive at BRI on 4/15/94 to obtain the records that she (Fravel) found. W23 stated this notification had to be made in writing. The written notification was made in memo form, addressed to W23 and W24 (4/12/94).

8. When enroute to BRI (4/15/94), this investigator was beeped and contacted by W24 (BRI) via car phone. He indicated if

payment was not made for the documents already received, BRI would not provide the requested material. Thus, BRI again denied production of the documents.

9. On 4/26/94 Attorney Flammia (representing BRI) proposed that a request for the documents be made directly to him. He stated the material in question should be requested in writing. Again, Mr. Cohen requested the records in written form on April 29, 1994. No response was received from BRI until July 22, 1994 when Attorney Flammia wrote confirming that the documents had been received. The documents had not and still have not been received. Mr. Cohen wrote to Flammia on December 6, 1994 indicating that if any material surfaces or is provided in the future, it will be reviewed.

10. Examples of records requested but not provided are mentioned throughout this report and they include:

    a. Written statements of staff submitted to PC2 pursuant to an internal inquiry conducted by BRI administration shortly after V1's death. Not only was this information requested under DMR regulations, but also under DPPC statute (19C S5).

    b. Pursuant to DPPC statute, W4's report of V1's death was also requested pursuant to M.G.L. c9 §5. BRI refused to submit this report, citing attorney/client privilege.

    c. Ketone tests results routinely administered in 1990 were never provided.

    d. Nursing notes were requested for the period of 12/89 to 12/90. Six months of nursing notes were missing during this period.

    e. PC1, R.N. stated she wrote an incident report (aka a therapy note) on or about 12/19/90, regarding the events of 12/18/90. This record was never provided.

11. Also mentioned in the report is incomplete or inadequate records, or records which were not preserved, including the following examples:

    a. PC1 stated she assessed/evaluated V1 on 12/18/90. PC1 gave a description of the physical examination she performed (i.e. checking the stomach, etc.). PC1 stated V1 was not having her menses, nor was she constipated. She (PC1) further commented she contacted the physician regarding V1. The daily nursing body check sheet merely states, ". . . arrived @ school pale & lethargic. Has been awake all night sticking fingers in throat. Temp 98.4. Unable to see beyond was in ears. Allowed to rest - giving frequent fluid." Neither this record, nor are there other records which provide information

regarding:

1. Checking V1's stomach

2. Contacting W2 and/or his orders

3. V1 taking a bath @ the school

4. The last time V1 was checked for the day before she left the building.

b. The nursing body check sheets are not consistent with the direct care staff's body check sheets. (Direct care staff documented bruises to the arms of V1 (which were confirmed in autopsy photos, nursing did not.)

c. V1's service program (treatment plan) was incomplete in description: It failed to identify which behavior was being consequated. For the same reason, it is impossible to determine which behaviors V1 was being consequated for on 12/18/90.

1. The behaviors are grouped into categories, for example: the **aggressive category** includes eight behaviors; bite, hit, kick, grab, etc. The daily recording sheet will identify that a consequence was administered, and the type of consequence. However, one cannot determine which behavior is being consequated. See also Duarte Report, p. 8.

d. BRI fails to retain daily recording sheets. They convert the daily forms into weekly/monthly sheets. Only the daily forms have the time (hour) the aversive was administered. As in V1's case, the time was an essential factor. Over fifty aversives were administered in a relatively short period of time before she was transported to the hospital. (Between 4-5 p.m., she received 16 aversives that is 1 every 3.75 minutes, between 5-6 p.m. she received 24 aversives, that is 1 every 2.5 minutes.)

(1) Furthermore, some aversives such as ammonia have a procedural limit (3 per hour). There is no way to monitor the administration of ammonia on a weekly/monthly sheet. If the record indicates 4 for example, one cannot determine if that was over a 24 hour period or in one hour.

e. Incident reports (also known as therapy notes) are condensed when they are typed, omitting valuable information and then destroyed. W3 wrote a 3-page handwritten incident report relative to 12/18/90. Information provided by W3 such as the time she arrived at the Frenier Street residence, and V1's pulse rate

upon arrival to the E.R. were deleted when it was typed. This policy continues today and raises an obvious concern that the best of freshest documentary account of the incident is not available and the possibility of an inaccurate presentation of the facts exists. This practice is in violation of DMR regulation 115 CMR 9.16 which requires the person who witnessed and/or observed the incident to write the report which is filed with the service coordinator, head of the provider, and the family or guardian.

12. Lack of accurate record keeping and preservation of records was especially consequential in this investigation where several of the key witnesses could not be located or would not testify. The failure to provide or preserve records or record information adequately or completely had several other harmful consequences, including:

a. This investigator is unable to determine if V1 was ill during the months preceding her death.

b. It is unknown if routine lab tests were conducted in December 1990 (6 month check) or what the results were if they were conducted.

c. It is unknown if ketone tests were monitored.

2. Other findings regarding noncooperation or obstruction with investigation

1. During an interview with PC2, he was asked if he operated a facility in California. His attorney (Flammia) objected to the line of questioning. Mr. Flammia was advised by Mr. Cohen (Director of Investigations) that this investigator also intended to question who the licensing agency in California was, and if that licensing agency had ever received any complaints. Mr. Flammia reiterated his objection. Mr. Cohen then advised Mr. Flammia that refusal to answer questions would constitute non-cooperation with this investigation. Mr. Flammia did not allow the questions to be answered.

2. Prior to interviewing PC2, this investigator had the occasion to interview V1's Mother (mother of the victim). V1's Mother was accompanied by her attorney, Ann McGuire. Attorney McGuire asked this investigator if she had observed the video of V1 of December 17 or 18, 1990. This investigator's response was of surprise, as I had been informed by W25 the video tapes had been recycled. (BRI) employs video surveillance on the students, both at the residences, and the educational/vocational facility. Attorney McGuire then stated it was her understanding that a video tape of V1 did exist, however she had not yet viewed

it because BRI needed to review the tape for confidentiality purposes and possibly edit it. Attorney McGuire stated she did not know if V1 was on the tape for 15 minutes or 15 seconds. Attorney McGuire further commented this information was provided to her by Attorney Ritenberg.

During an interview with PC2, he was asked if a video tape of V1 existed. PC2 stated he did not know. This investigator then presented the question to both attorneys present, Flammia and Ritenberg. Ms. Ritenberg became angry, stating that she "was not going to answer that question." To date, this investigator is unaware if such a video tape of V1 exists.

3. Conclusions regarding BRI's denial of access to relevant documents and non-cooperation or obstruction with investigation.

1. A number of records as aforementioned, were incomplete or inaccurate in violation of 104 CMR 30.12(1) which states: Client records maintained ... by providers ... shall contain client information which is accurate, complete, timely, pertinent, and relevant to the client's needs and services.

2. The instances of lack of recording of physician-ordered treatments for V1 on December 18 is in violation of 104 CMR 20.54 which states: "Upon instruction by a physician, each client's program record shall document ... physician-ordered treatments ..."

3. BRI's failure to provide or to delay access by Investigations to relevant documents and records violates:

   - 104 CMR 20.11(c) which states: The head of the program or a designee shall provide, as necessary and appropriate, access to a client's record by persons authorized by the Department to monitor the quality of services offered to the individual, including the Human Rights Committee.

   - 115 CMR 9.08(3) which states: As part of the investigation the investigator shall review and shall have the right to obtain copies thereof, all pertinent documents, including but not limited to:
   -- medical or clinical recordings pertaining to any injury, if obtainable;
   -- any incident report filed pursuant to 115 CMR 9.15(c).
   Relevant portions of the case records of any individual served and involved in the allegation;
   -- any relevant policies, procedures or guidelines of the Department and the provider involved or employer of the person complained of;
   -- any other document deemed appropriate by the investigator, if obtainable. **Providers shall make all**

records available to the investigator. (Emphasis added).

4. Condensing and destruction of the therapy note by a third person (violates 115 CMR 9.16(2)) which provides: The staff person observing the incident must complete a written report of the incident within two hours of its occurrence, and file with the service coordinator(s) assigned to the involved individual(s).

5. Failure to retain numerous client records of V1 enumerated above, (e.g. daily tally sheets, nursing notes, body check sheets etc. in 1990) violates the Standard Master Service Agreement Department has with providers. Section VII(D) provides that "[A]ll records ... shall be kept for a period of six (6) years". The purpose of such retention is to allow for "Inspection and review of client records must be conducted in accordance with Sections V(D) and VII(B)... for the following purposes ... (B) to assure that services are being provided as specified in the service contract, (C) to evaluate the quality and effectiveness of those services, (D) to monitor the maintenance of such files, (e) to comply with ... service delivery standards ...

The general failure by BRI to either provide or retain relevant documents violates the aforementioned purposes (B-E) of the Master Agreement as well as the purpose of Department Regulations pertaining to records, which is to:

- "provide a basis for accountability in the provisions of services" 104 CMR 20.31(2) "...
- "to meet the legitimate service needs of the client and the documentation needs of the Department ..." Id. at (§)3)

Failure of PC2 to answer legitimate relevant questions during the interview, as aforementioned, constitutes obstruction and non-cooperation with the investigation in violation of 104 CMR 9.08(2)(c) and 9.14(2).

E. Other Findings

1. To determine whether there was any research on the efficacy or risks of ammonia capsules as used by BRI, the research departments of OSHA and NOISH were contacted, as well as several manufacturing companies of ammonia inhalants, (i.e., Burrown Welcome, Eli Lilly, Consolidated Midland Corp., Newton Laboratories, and the James Alexander Corp.) All concluded they have never conducted studies of ammonia inhalants. BRI uses ammonia inhalants manufactured by the James Alexander Corporation. The President of the Corporation, Frances C.F. Davidson, was contacted and asked if testing had ever been conducted for the purpose of side effects regarding the inhalants. Ms. Davidson's reply was negative and she forwarded a letter to this investigator.

Excerpts of the letter included:

> The inhalants are intended to be used solely to treat or prevent fainting. This particular product has no other medicinal or therapeutic value.
>
> We consider the alternate use of this product, ... the control of the behavior of retarded individuals by exposing them to the pungent odor of the ammonia inhalant, to be totally inappropriate.

Issues observed during a site visit to the residence were the following:

2. Alarms and monitoring cameras were observed throughout the dwelling. The tour guide stated the students residing in this dwelling now do not exhibit severe behaviors as the students did when V1 lived there. The first floor bathroom did not have a monitoring device in case (as was stated) a staff member had occasion to use it. If a student were to use this rest room, "the door must remain open." The issue of privacy should be addressed.

3. A door located in one of the bedrooms did not appear to be a closet door. Upon further examination, this door was found to lead to an exit, (bulkhead area). The door does not have a locking mechanism. Immediately outside this door on the floor was a 2′ x 3′ opening into the concrete, exhibiting a subpump that was submerged in water. There was nothing covering the device or the hole containing water. A closer examination determined the door was monitored by an alarm. An alarm does not prohibit a student from opening the door and being exposed to the sump pump, electrical cord, or the water. An alarm does notify staff that the door is opened; however, it does not guarantee a staff person has the ability to respond in time prior to an injury being sustained by a student.

4. Staff conducting the tour stated at the time V1 resided at Frenier Street, the beds were also alarmed. A motion detector device was described as having been attached to the bed, and being made audible if a student sat up in bed, or got out of bed. The alarm was made audible to determine the volume. The beam/motion detector to activate the alarm was moved, and relocated to project a different angle, (in the corner of the room). Staff working on the alarm reported when he moved the beam, "I can box someone in the corner." W33 (DMR licenser) stated monitor devices were authorized by the court. However the devises are not mentioned in the permission packets signed by parents, BRI program descriptions or student ISP's or behavior programs.

II. CONCLUSIONS

A. GENERALLY, AND UNDER 115 CMR 9.00 WHEN APPLICABLE.
set forth in body.

B. UNDER M.G.L. 19C AND DPPC REGULATIONS 118 CMR ET. SEQ. WHEN APPLICABLE.
Set forth in body.

[THE REST OF THIS FORM IS USED AND FILLED OUT IN DPPC CASES ONLY.]

III. RECOMMENDED PROTECTIVE SERVICES

In as much as the victim, V1, is deceased protective services would not be applicable. The Regional Director and the Department's central administratiion's attention is called to the referrals and other recommendations set forth in the body of this report.

IV. ADDITIONAL RECOMMENDATIONS

Donna Cabral 1/3/95
INVESTIGATOR (Print or Type) (Investigator Signature)

Richard A. Cohen 1/3/95
DIRECTOR OF INVESTIGATIONS (Print) (Signature)

Rod Johnson 1/3/95
SENIOR INVESTIGATOR (Print or Type) (Signature)

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V. DATA SUMMARY

A. POSSIBLE INDICATORS OF ABUSE BY ACT OR OMISSION (Check all which apply and include discussion of these in the Findings of Fact.)

1. FOCUS ON VICTIM

a. PHYSICAL INJURY(IES) TO VICTIM

1. (x) BRUISES, WELTS
2. ( ) SPRAINS, DISLOCATIONS
3. (x) BURNS, POSSIBLY SCALDING
4. ( ) ABRASIONS, LACERATIONS
5. ( ) WOUNDS, CUTS, PUNCTURES
6. ( ) FRACTURES
7. (x) INTERNALINJURIES
8. (x) OTHER (Specify) Discoloration on face
9. ( ) NONE

b. EMOTIONAL INJURY(IES) TO VICTIM

1. CHANGES IN:
   a.(x) SLEEPING PATTERNS
   b.(x) ANXIETY LEVEL
   c.(x) IRRITABILITY
   d.(x) EATING HABITS
   e.( ) FUNCTIONING LEVEL
   f.( ) OTHER
2. ( ) SUICIDAL THOUGHTS OR COMMENTS
3. ( ) SHAKING, TREMBLING, CRYING
4. ( ) DEPRESSION
5. ( ) APATHY
6. ( ) OTHER (e.g. CHANGE IN AFFECT) (Specify)
7. ( ) NONE

c. POSSIBLE INDICATORS OF SEXUAL ABUSE

1. ( ) INTERCOURSE
2. ( ) PHYSICAL FORCE USED
3. ( ) ORAL SEX
4. ( ) FONDLING
5. ( ) PROSTITUTION/EXPLOITATION
6. ( ) ANAL SEX
7. ( ) PHYSICAL INJURY
8. ( ) OTHER (Specify)
9. ( ) NONE

d. PHYSICAL CONDITION OF VICTIM:

1. ( ) DIRT, FLEAS, LICE
2. ( ) SKIN RASHES
3. ( ) SORES
4. ( ) MALNUTRITION
5. ( ) DEHYDRATION
6. ( ) INAPPROPRIATE CLOTHING
7. ( ) FECAL/URINE ODOR
8. ( ) UNEXPLAINED WEIGHT LOSS
9. ( ) POOR GENERAL HYGIENE
10. (x) OTHER (Specify) Shock, Cyanotic, Ulcers; Perferation of Stomach
11. ( ) NO PROBLEMS

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2. FOCUS ON ALLEGED ABUSER:

a. ACTIONS BY ALLEGED ABUSER:

1. ( ) VERBAL ABUSE
2. ( ) THREATENED, COERCED
3. ( ) CONFINED, ISOLATED
4. ( ) ATTEMPTED TO HARM
5. ( ) THREW OBJECTS
6. ( ) PUSHED, GRABBED
7. (x) SLAPPED, HIT, KICKED
8. ( ) THREATENED WITH WEAPON
9. ( ) USED WEAPON (GUN/KNIFE)
10. (x) OTHER (Specify) Squeezes, pinches, forced inhalants & taste aversives
11. ( ) NONE

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b. OMISSION BY ALLEGED ABUSER:

Failure to Provide:

1. ( ) SHELTER
2. ( ) PERSONAL CARE
3. ( ) SUPERVISION
   a.( ) CL.TO CL. PHYSICAL INJURY TREATMENT
   b.( ) CL.TO CL. SEXUAL ASSAULT (RESULTING
   c.( ) PHYSICAL, EMOTIONAL, SEXUAL NEEDS)
   (e.g. sibling, other family member)
   d.( ) CL. SELF-INJURY

4.BASIC MEDICAL/PSYCHOLOGICAL NEEDS:
   a.( ) PRESCRIBED MEDICATION
   b.( ) MEDICAL EQUIP. OR AIDS
   c.(x) ACCESS TO MEDICAL/PSYCH.

5. ( ) FINANCIAL MISAPPROPRIATION IN FAILURE TO PROVIDE DAILY LIVING

6. ( ) OTHER (Specify)
7. ( ) NONE

B. CONCLUSIONS:

1. Did physical and/or emotional injury occur as a result of **physical abuse?** [x] YES [ ] NO [ ] UNDETERMINED

2. Did physical and/or emotional injury occur as a result of **emotional abuse?** [x] YES [ ] NO [ ] UNDETERMINED

3. Did physical and/or emotional injury occurred as a result of **sexual abuse?** [ ] YES [x] NO [ ] UNDETERMINED

4. Did physical and/or emotional injury occur as a result of **omission?** [x] YES [ ] NO [ ] UNDETERMINED

5. Did **death** occur as a result of an act or omission? [x] YES [ ] NO [ ] UNDETERMINED

6. Is there **risk** of injury in the future? [x] YES [ ] NO [ ] UNDETERMINED
To Other Students

IF FURTHER INVESTIGATION IS NEEDED: Check here if unable to determine if abuse is indicated in c.19C time frame and further investigation initiated [ ]. Investigation Log #: _____

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C. PROTECTION CONSIDERATIONS
(IF ABUSE IS INDICATED, PLEASE COMPLETE THE FOLLOWING)

1. Frequency of abuse: [ ] Once only [x] More than once (specify)_____ [ ] Ongoing

2. Was hospitalization required as a result of injuries from abuse? [ ] YES [x] NO

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3. Suspected Cause(s) of Abuse (Check all that apply.)

a. ( ) LACK OF SUPPORTIVE SERVICES (e.g. PCA, RESPITE, CASE MGMT.)
b. ( ) ALCOHOLISM/OTHER SUBSTANCE ABUSE BY VICTIM
c. ( ) ALCOHOLISM/OTHER SUBSTANCE ABUSE BY ABUSER
PROCEDURES
d. ( ) ECONOMIC FACTORS
e. ( ) CULTURAL FACTORS
f. ( ) STRESS
g. ( ) ISOLATION
h. ( ) FEAR OF RETALIATION FOR REPORTING
i. ( ) HISTORY OF GENERATIONAL ABUSE
j. ( ) MENTAL HEALTH PROBLEMS-CARETAKER
k. (x) CARETAKER'S LACK OF KNOWLEDGE REGARDING DISABILITY
l. ( ) USE OF IMPROPER RESTRAINT
m. (x) UNMET CLINICAL NEEDS (e.g. behavior program)
n. ( ) OTHER (Specify)

4. Other Support Services Currently Received by Client

	Contact	Tel No.
a. ( ) Personal Care Attendant/Home Health Aide		
b. ( ) Visiting Nurse		
c. ( ) Homemaking/chore		
d. ( ) Physical/Occupational/Speech Therapy		
e. ( ) Psychotherapy		
f. ( ) Physician/Other Medical Provider		
g. ( ) Day Program		
h. ( ) Supported Employment		
i. ( ) Vocational Rehabilitation		
j. ( ) Transportation		
k. ( ) Other (specify)		

5. Does abuser have continued access to the victim? N/A [ ] YES [ ] NO

6. Is there a continued risk of abuse to the disabled person? N/A [ ] YES [ ] NO

7. Does the victim appear to have the capacity to knowingly accept or refuse protective services? N/A [ ] YES [ ] NO

8. If answer to preceding question is yes, does the alleged victim desire protective services? N/A [ ] YES [ ] NO

9. List emergency protective services provided, provider, location, date initiated, and

duration. N/A

10. List Protective Services offered to victim and refused by victim.
N/A

11. Is there a risk of abuse to other disabled persons, children, or elders at the same location:

[x] YES [ ] NO

12. If yes, list action(s) taken:

Action Plan being developed.

13. Was law enforcement involved? [x] YES [ ] NO
Explain:

14. Person responsible for protective services:

NAME:_____ TITLE:_____

LOCATION:_____ PHONE:_____

15. Contact person for Protective Services follow up (if different from above):

NAME:_____ TITLE:_____

LOCATION:_____ PHONE:_____

APPENDIX A

LIST OF PERSONS INTERVIEWED

NAME	AGENCY	POSITION	DATES(S)INTERVIEWED
1. W25	BRI		Diverse Dates
2. W23	BRI		Diverse Dates
3. David Nolan	DMR	Attorney	Diverse Dates
4. Ralph Calderaro	DPPC	Attorney	Diverse Dates
5. O.S.H.A.			4/6/94
6. NIOSH (National Institute Occupational Safety Health)			4/7/94
7. Food and Drug Administration			4/7/94
8. Gwen Sullivan	DPH	Attorney	4/6/94
9. Edward Wardyga	DPH (R.I.)	State Inspector	4/6/94
10. Bettina Briggs, Esq.		GAL Attorney	Diverse Dates
11. Ann McGuire		Lubin & Merer, P.C.	Diverse Dates
12. Melissa White		Lubin & Merer, P.C.	Diverse Dates
13. Paul D. Sylvia		Probate Court Attorney	(refused interview)
14. PC2			11/23/93, 4/26/94
15. Donna Birtz		Probate CRT (Aster) (Att)	4/6/94
16. W4	O.R. Physician		4/4/94
17. Dr. Weiner		Pathologist (M.E.)	3/29/94
18. Dept. of Education		MA	3/28/94
19. Dept. of Education		R.I.	4/4/94
20. W10		BRI Former Staff	3/24/94
21. W3		BRI Former Staff	3/22/94
22. W26		DMR Psychologist	4/11/94
23. W22		BRI Former Staff	3/21/94
24. W27		BRI Former Staff	3/21/94
25. W28		SMR (Records)	3/21/94
26. W29		DMR (ARC)	3/21/94
27. Board of Registration of Physicians			3/19/94
28. W30		BRI Former Staff	3/17/94
29. W7		BRI Former Staff	3/16/94
30. Jerry Elmer		Attorney for W7	2/28/94
31. W8		BRI Former Staff	3/17/94
32. W32		EMT Ambulance Att.	3/16/94
33. W13		BRI Former Staff	3/15/94
34. W33		DMR	Diverse Dates
35. Wayne Bennett		APD Police Dect.	Diverse Dates
36. Paul Zambella		State Police Crime Lab	3/7/94
37. Jose Gonsalves	D.A. Office	SGT. CPAK	11/18/93;3/7/94;4/11/94
38. W34		BRI	2/25/94
39. Escort to BRI Residence		BRI	2/25/94
40. W21		BRI Former Staff	3/10/94
41. W9	BRI	Former Staff	3/12/94
42. W1	BRI	Former Staff	3/10/94
43. Dan Pratt		State Police Crime Lab	3/7/94
44. Alan Auglis	BRI	Former Staff	3/7/94
45. W11	BRI	Former Staff	3/7/94
46. W35	BRI	M.H.A.	3/2/94
47. W36	BRI	C.E.C.	3/2/94

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NAME	AGENCY	POSITION	DATES(S) INTERVIEWED BRI	R.C.
48. W37			3/2/94	
49. W38	BRI	A.A.	3/2/94	
50. W39	BRI	C.T.C.	3/2/94	
#'s 46, 47, 48, 49, & 50 were represented by BRI's Attorney				
51. V1's Mother w/Attorney, mother of victim			3/15/, 4/25/94	
52. Hopkins Medical Lab			2/94	
53. Physicians Medical Lab			2/94	
54. Dartmouth Public School System SpEdDept			11/18/94	
55. R.I. Dept. of Health			4/6/94	
56. R.I. Division of Food Protection			4/6/94	
57. R.I. Facilities Regulations			4/6/94	
58. Poison Control			4/6/94	
59. Division of Health Care Quality, Public Health Licensing R.I.			4/6/94	
60. W40	DSS		11/18/94	
61. W41	DMR	Pharmacist	4/13/94	
62. Tom Hales	NIOSH	Medical Dept.	4/13/94	
63. PC1	BRI	RN	4/26/94	
64. PC3	BRI		4/26/94	
65. PC2	BRI		4/26/94	
(#'s 63, 64, & 65 were represented by (2) BRI Attorneys				
66. W18	BRI	Former Staff	4/18, & 5/1/94	
67. Burrows Welcome		(Manufacturer of Ammonia Inhalant)		4/13/94
68. Eli Lilly, Corp.		(Manufacturer of Ammonia Inhalant)	4/13/94	
69. James Alexander Corp.		(Manufacturer of Ammonia Inhalant)		4/13/94
70. Consolidated Medland Corp.		(Manufacturer of Ammonia Inhalant)		4/13/94
71. Newton Lab Industries		(Manufacturer of Ammonia Inhalant)		4/13/94
72. W14		Former BRI	12/94	

APPENDIX B
DOCUMENTS AND LITERATURE REVIEWED

1. Emergency Fact Sheet
2. Admission Form
3. Psychodiagnostic Evaluation (5/29/82)
4. Psycho Educational (end of year) Report (6/22/82)
5. Psychological Consultation (12/10/82)
6. Pediatric Neurological Evaluation (9/3/82)
7. BRI Intake Summary 10/4/84
8. BRI Psychological Testing (11/84)
9. Cardiac Status Exam (3/19/85) (MA General Hospital)
10. BRI Speech and Language Screening (4/85)
11. BRI Social Summary Update (9/15/87)
12. BRI Social Summary (11/12/94)
13. BRI Medical Intake Questionnaire
14. BRI Agency Contact Forms (23) for "Notification of Death"
15. Permission Forms for Restrictive Procedures at BRI (1990) (1985)
16. Consent Forms-various: Tetanus/Booster, Gynecological, Neurological, etc. (3/22/90)
17. Parent Agency Contact Forms
18. Assorted Monthly Statements: (Billing), (Dental), etc.
19. Consent Forms for Administration of Medical Care: (1986) (1987) (Measles, Mumps, Rubella, etc.)
20. BRI & Dartmouth Public School Agency Agreement (Tuition Schedule, 1985-1986)
21. Human Rights Committee Approval for Treatment (5/89)
22. Peer Review Committee Student Review (10/90)
23. Human Rights Committee Approval (Special Food) not dated
24. Variance Request (1/19/86)
25. Staff Schedules (12/90)
26. Various Correspondence from M. Flammia (Law Office of Eckert Seamans Cherin and Mello II) representing BRI re: release of information, medical records, etc.
27. (I) Program Description (Service Plan) 12/89:
    A. Program Update 1/13/90
    B. Program Update 4/14/90
    C. Program Update 7/14/90

    (II) Program Description (Service Plan) 9/90
    A. Program Update 10/13/90
    B. Program Update 12/19/90
    C. Program Update, period ending 10/14/89
    D. Program Update, period ending 6/25/88
    E. Proposed Program (6/23/86)

28. Student Summary Sheet (6/5/89) (5'4" 125 lbs.)
29. (I) IEP (10/-1/89 - 9/30/90)
    Amendment to IEP (4/1/90 - 9/30/90)
    6 month Addendum to IEP (4/90) (passed fire alarm)
    (II) IEP (10/1/90 - 9/30/91)

30. Quarterly Report (2/89) (less than day contract 1 hour)
31. Nutritional Consultation Report (1/90)
32. Program Ops (112/18/90) (incomplete)
33. U/D Recording Sheet (12/18/90) (incomplete)
34. Procedure Change Forms:
5/15/89 inapp verbal from T/AS/Am-T/Am;8/7/89 inapp verb add scream; 8/7/89 inapp verbal add nagging; 8/7/89 non-compliance add remove clothes in public; 8/7/89 self injury rename HDB (other); 8/7/89 stereo type rename ed/soc; 8/8/89 ed/soc add VS; 8/7/89 work interfere rename ed/soc interfere; 6/5/89 HDB (other) change in make up caloric period from calorie make up target times of 4pm & 7pm to just 7pm; 12/30/89 HDB (other) from spank to spatula spank "functional analysis conducted on this behavior was inconclusive; 1/26/90 aggressive behavior from rotate FP/SS to SS "functional analysis was in conclusive; 1/26/90 HDB (steal) add hoarding; 1/26/90 HDB (steal) from rotate VS/T to AM; 1/30/90 HDB (other) add pick fingers; 3/16/90 add grabbing when consequence is given; 4/6/90 aggressive add multi-day contract; 4/23/90 HDB (other) add scratch self; 4/23/90 HDB (other) add pick scabs; 4/24/90 destroy change from less day contract 1 hour - 2 hours; 4/24/90 aggressive behavior change from less day contract 1 hour - 2 hours; 4/24/90 HDB (other) change from less day contract 1 hour - 2 hours; 6/20/90 HDB (other) pick fingers on objects; 7/9/90 HDB U/D inapp from VSII to SS

35. Graphs of Behaviors
36. BRI description of "Nurse Position"
37. BRI description of "Director of Nursing"
38. BRI Policy on "Student Illness Accident and Death
39. BRI Brief Program Description (3/12/92, 6/24/88)
40. BRI Policy "Administration of Medications"
41. "Special Features of the BRI Program" (3/12/92, 7/20/89)
42. BRI Policy for Copying Materials and Observing Students
43. Daily Medication Records (6/90-12/90)
44. Nutritional Consultation Report (9/89)
45. Nurses Note Dated 12/18/90
46. Nurses Note (not dated) re: V1's calories need to be elevate, Dr. W2 will reevaluate in 1 week
47. Medical Summaries: (10/84, 12/85, 10/86, 12/87, 12/88, 12/89, 11/88)
48. Cardiac Program R.I. Dept of Health Report (8/13/85)
49. Psychiatric Evaluation (1/85, 1/89)
50. Semi-Annual Seizure Update (2/87)

51. EEG Report (11/21/88)
52. Neurological Consultation (11/16/88)
53. Orthopedic Report (4/12/89)
54. Dental Report (5/2/89)
55. Speech Language Screening (7/88) (4/90)
56. BRI Medical Reports: 10/30/86, 1/22/87, 5/19/88, 12/2/88, 2/2/89, 12/27/89, 1/4/90, 1/5/90, 1/17/90, 2/2/90, 2/23/90, 2/27/90, 3/2/90, 3/8/90, 3/20/90, 3/20/90, 3/30/90, 5/25/90. 6/13/90, 6/23/90, 7/10/90, 7/27/90, 8/7/90, 8/8/90, 8/21/90, 9/5/90, 9/18/90, 10/5/90, 10/7/90, 10/13/90, 10/18/90, 11/1/90, 11/13/90, 11/15/90, 11/28/90, 12/11/90

57. Medication Charts
58. Medical Information Sheet 9/90
59. Residential Information Sheet 9/90
60. Weight Charts 10/89-12/90
61. Hopkins Medical Lab Reports: 1/89, 4/89, 6/89, 11/89, 5/90. 6/90
62. Physicians Laboratory Service Reports: (3/85, 10/85, 6/85, 12/85, 7/86)
63. Audiology (8/8/90)
64. Medical Contraindication Forms: (3/89, 11/2/88, 2/7/86, 2 not dated, 10/84, 11/86)
65. Neurological Contraindication Form (3/29/89)
66. Graphs (Behavior) 1990 (weekly, monthly, yearly)
67. Tally Sheets of Behavior (monthly) 1984-1990
68. Behavior Analysis Form 3/89
69. Incident Reports: 12/18/90, 12/18/90, 4/18/90, 5/3/90, 5/5/90, 3/25/89, 3/26/89, 4/8/89, 5/2/89, 5/2/89, 5/10/89, 5/15/89, 5/16/89, 6/20/88, 8/2/88, 10/2/88, 2/20/87, 3/2/87, 3/23/87, 3/31/87, 4/1/87, 4/6/87, 5/13/87, 5/14/87, 5/22/87, 6/4/87, 6/2/87, 7/9/87, 1/7/86, 1/8/86, 1/8/86, 1/11/86, 1/12/86, 4/2/86, 4/21/86, 4/24/86, 4/25/86, 4/28/86, 4/29/86, 5/3/86, 5/11/86, 6/5/86, 6/11/86, 7/18/86, 7/24/86, 7/29/86, 7/30/86, 7/31/86, 8/1/86, 8/2/86, 8/3/86, 8/19/86, 8/21/86, 8/27/86, 9/16/86, 11/30/86, 12/3/86, 12/4/86, 12/16/86, 11/29/86, 11/16/86
70. Calorie Procedure change form 6/5/89
71. Human Rights Approval (6/89)
72. Student Caloric Meal Portions (2/94) of: 1500 Calories
    A: W42 B: W43
    Breakfast: Caloric Itemization
    Lunch: Caloric Itemization
    Dinner: Caloric Itemization
73. Caloric Daily Charts (L.C.) 11/18/90 - 12/18/90
74. Staff Schedules 12/90
75. Hand written, unsigned incident report of 12/18/90
76. Nursing Log dated 12/18/90 (unsigned)
77. Nursing Log (noted dated) of:
    A. List of 8 students to be removed from the Special Food Program until weight up to 87.5%

    B. List of 9 students who may remain on Special Food Program but need to increase calories
78. Body Check Sheets (Nurses) 12/90
79. Incident Report (aka) Therapy Note 12/17/90 (W1)
80. Weight Graphs (1/89 - 12/90)
81. Episode/Behavior Recording Sheets 12/16, 12/17, & 12/18/90
82. Agency Contact Form: Record of telephone conversation with Dr. Weiners Office (M.E.) 1/25/91
83. Agency Contact Form: Record of telephone conversation with B. Briggs (GAL)
84. Death Certificate dated 2/14/91 (copy)
85. Birth Certificate (copy)
86. Attleboro Police Department Report
87. E.M.T. Transport Sheet 12/18/90
88. E.R. Admission Form 12/18/90 (Sturdy Memorial Hospital)
89. Autopsy Report

90. Sturdy Memorial Hospital Records:
Discharge Summary, Progress Notes, Admission Report, Physical Examination/Admitting Diagnosis, Patients Therapy Record, Electro Cardiogram, Imaging Report: (Exams Chest (Port Exam) Abdomen), Hematology Cumulative Summary, Electrotypes, Routine Chemistry, Urine & Body fluids, Bacteriology, Blood Cultures, Consent Form for S.M.H. signed by BRI staff, Anesthesia Report, O.R.: (Exploratory Laparotomy, Insertion of Double Lumen Central Line Catheter), Instrument Count Abdominal, O.R./R.R. Medication Intravenous Solution Record, Antibiotic Order
91. Memo to BRI file from S.R.D. (Eckert Seamans Cherin and Mellott) dated 12/21/90, re: W4's (forensic pathologist retained by ESCM on behalf of BRI) opinions and observations at autopsy
92. Probate Court file Docket # 86P1161
93. Letter(s) to B. Briggs from D.Mr. (3/1/94, 11/29/93, 3/21/94)
94. Letter to K. Murdock (Counsel DMR) from B. Briggs (3/10/94)
95. Inspection of BRI by R.I. DPH 3/16/89
96. Graphs by A. Duarte (consultant)
97. Rules and Regulations Pertaining to Food Establishments, R.I. Dept of Health
98. BRI's Training/Orientation Policy
99. Report of B. Briggs (GAL) to the Probate Court re: Autopsy attendance
100. BRI's Results of 1986 Follow-Up Study (3/12/92)

101. Documents marked **exhibits** produced by BRI to DMR re: research

A. Food: Exhibit 7-12

1. Browning Robert M. Treatment Effects of a Total Behavior Modification Program with Five Autistic Children. Behavior Research and Therapy, 1971, Vol9 319-327
2. Risley, Todd R. The Effects and Side Effects of Punishing the Autistic Behaviors of a Deviant Child. Journal of Applied Behavior Analysis, 1968, 1 21-34.
3. Tate, B.G. Case Study: Control of Chronic Self-Injurious Behavior by Conditioning Procedures, Behavior Therapy, 1972,3,72-83

B. Ammonia: Exhibit_____

1. Clarke, C.J., Thomason S., Case Study: The use of an Aversive Smell to Eliminate Autistic Self-Stimulatory Behavior, Behavior Therapy, 1983, Vol5 (3)
2. Dixon M.J., Helsel W., Rojahn J., Cipollone R., Lubetsky M., Aversive Conditioning of Visual Screening with Aromatic Ammonia for Treating Aggressive and Disruptive Behavior in a Developmentally Disabled Child, Behavior Modification Vol13,No1 pg 91-103
3. Tanner B., Zeiler M., Punishment of Self-Injurious Behavior Using Aromatic Ammonia as the Aversive Stimulus, Journal of Applied Behavior Analysis 1075, 8, 53-57
4. Baumeister A.A., & Baumeister A.A., Suppression of Repetitive Self-Injurious Behavior by Contingent Inhalation of Aromatic Ammonia, Journal of Autism and Childhood Schizophrenia, Vol8,No1 1978p71-77
5. Doke L., Wolery M., Sumberg C., Treating Chronic Aggression 'Effects and Side Effects

of Response-Contingent Ammonia Spirits, Behavior Modification Vol17 No4 pg531-555
6. Singh N.N., Aversive Control of Breath-Holding. Behavior Therapy & Exp. Psychia. Vol10 pp147-14
7. Singh N.N., Dawson M.J., Gregory P., Suppression of Chronic Hyperventilation Using Response-Contingent Aromatic Ammonia, Behavior Therapy II
8. Rojahn J., McMonigle J.J., Curcio C., Dixon M.J., Suppression of Pica by Water Mist and Aromatic Ammonia, A Comparative Analysis, Behavior Modification Vol II p6570

103. Cutler E.C. (M.D.F.A.C.S.), & Harrison J.H. (M.D.), Phlegmonous Gastritis, 22.34-240 Dolloff Medical Library
104. Bruanwalde, A.B., M.D., M.A. (Hon) M.D. M.H. (Hon), Isselgacher K.J., A.B., M.D., Petersborf R.G. A.B. M.D. M.H. (Hon) Wilson J.D., Martin J.B. M.D., Ph.D., F.R.C.P. (C), M.A. (Hon), Fauci A.S. M.D., Harrison's Principles of Internal Medicines, Eleventh Edition Ch 236 p1259 Gastritis and Gastroenteric
105. Kissane J.M., Anderson's Pathology 8th Edition Vol II pp1061
106. Harris Benedict Equation: The Ross Medical Nutritional System
107. Chronic Peptic Ulcer Disease Diet, Manual of Clinical Dietetics, American Dietetic Association pp341-342
108. Fenian and Ney Applications of Clinical Nutrition Practice Hall (1988), pp192, 1993, Nutritional Care of Patients with Diseases of the Esophagus and Stomach
109. Whitney, Cataldo, Rolfes, Understanding Normal and Clinical Nutrition, West 1987, 1983 Metropolitan Height and Weight Tables
110. 105 CMR 590.000 State Sanitation Code Article X, Minimum Sanitation 590.034 (E) 1
111. Whitney, Cataldo, Rolfes, Understanding Normal and Clinical Nutrition, West 1987, Recommended Dietary Allowances (RDA)
112. Literature obtained from N.I.O.S.H. (National Institute for Occupational Safety & Health
    1. Anhydrous Ammonia (National Safety Council)
    2. NIOSH Recommended Standard for Occupational Exposure to Ammonia
    3. Safe Handling of Anhydrous Ammonia
    4. Chemical Hazards of the Workplace
    5. chemical Hazard Summary
    6. Emergency First Aid Treatment Guide for Ammonia
    7. Abstracts:
        a. #00055474/Radionuclidic Lung Imaging Procedures in the Assessment of Injury due to Ammonia Inhalation
        b. #00207248/The Effect of Ammonia on the Respiratory Nasal Musosa of Mice. A Histological and Histochemical Study
        c. #00001785/Physiological Response of Man to Ammonia in Low Concentrations
        d. #00001792/Chronic Toxicity of Ammonia Fumes by Inhalation
        e. #00016014/A Case of Near Fatal Ammonia Gas Poisoning
        f. #00001786/Changes in Blood Following Exposure to Gases Ammonia
        g. #00071178/Fatal Anhydrous Ammonia Inhalation
        h. #00093160/Ammonia Inhalation Toxicity in Cats: A Study of Acute and Chronic Respiratory Dysfunction
        i. #00094401/Mass Ammonia Inhalation
        j. #00095103/NH3 Concentrations in the Expired Air of the Rat: Importance to Inhalation Toxicology
        k. #00126833/Acute Inhalation Toxicity of Ammonia in Mice
        l. #00126856/Acute Inhalation Toxicity Study of Ammonia in Rats with Variable Exposure Periods
        m. #00015235/The Combines Effect of Carbon Monoxide and Ammonia

on Man
n. #00169257/Acute Inhalation Injury
o. #00027682/Toxic Gastritis
p. #0002791/The Toxicity of Ammonia
q. #00027694/Effects of Ammonia Inhalation on Respiration Rate of Rabbits
r. #00027696/Experimental Ammonia Gas Poisoning in Rabbits and Cats
s. #00027705/Respiratory functional Sequelae of Ammonia Poisoning (about 8 Cases)

113. Literature Obtained from O.S.H.A. (Occupational Safety & Health Administration:
1. Industrial Exposure and Control Technologies for OSHA Regulated Hazardous Substances
2. Chemical Infogram Ammonia
3. Occupational Safety and Health Guide for Ammonia

114. Bantam Medical Dictionary, New York, Bantam 1990, ketosis, ketonuria
115. General Diet, Manual of Clinical tics, American Dietetic Association
116. Nutrition in Hypermetabolic Conditions, Zemen, Clinical Nutrition & Dietetics 2nd Edition Macnullan 1991
117. Assessment of Nutritional Status, Manual of Clinical Dietetics, American Dietetic Association p203-219
118. The Economics of Fasting, Whitney, Caraldo, Rolfes, Understanding Normal & Clinical Nutrition, West
119. The Response to Stress, Whitney, Cataldo, Rolfes, Understanding Normal & Clinical Nutrition, West
120. Letter from W2 to B. Briggs, dated 8/1/91 re: Taste Aversives
121. Letter from Frances C.F. Davidson, (President) of the James Alexander Corp. re: Proper use of Ammonia Inhalants
122. Letter from W18 R.D., to PC2, W2, and Nursing Staff re: Janine Casoria
123. Documents from L. W18, R.D. re: J. Valez