DRVD
CONFIDENTIAL REPORT

AN INVESTIGATION INTO THE DEATH OF AR

Fifty-seven year-old male resident of Western State Hospital, dies after being struck by an oncoming tractor-trailer while walking along Interstate 81, near WSH, in Staunton, Virginia.

DRVD CASE# 96-4808M
Department For Rights of Virginians With Disabilities
Fishersville Field Office
Beth Chadwell, Advocate
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I. INTRODUCTION:

This report is a summary of the findings from the Department For Rights of Virginians With Disabilities' (DRVD's) investigation into the death of AR, a 57 year-old, white male, who was a resident at Western State Hospital (WSH) in Staunton, Virginia. AR was struck and killed by an oncoming tractor-trailer while walking along Interstate 81, near WSH, in the early evening at approximately 6:10 PM, on 6/5/96.

This investigation was undertaken as part of DRVD's responsibility pursuant to USC 42 10805 et.seq., to investigate incidents of abuse and neglect when reported or if there is probable cause to believe they have occurred.

DRVD's investigation has included the following:

1. Reviewing AR's medical records at WSH.
2. Interviewing WSH Risk Manager.
3. Reviewing WSH Security Report.
4. Reviewing Virginia State Police Investigative Report.
5. Reviewing Virginia Medical Examiner's Report.
6. Reviewing eyewitness testimony of the incident.

II. BACKGROUND:

AR was a 57 year-old, white male, who was transferred on involuntary status 4/24/96 to WSH from Prince William Hospital in Manassas, Virginia, where he had been a patient since 4/21/96. He initially went to Prince William Hospital

with a complaint of chest pain and received a complete cardiac work-up. AR was later transferred to WSH based on his need for further evaluation of psychiatric medications, exacerbation of his mental illness, and inability to care for himself.

AR had been disoriented, delusional and paranoid, and non-compliant with anti-psychotic medications, in the community, for sometime before his admission to WSH. His most recent psychiatric hospitalization was at NVMHI from 1/9/95-3/29/95 as a result of transfer from Northern Virginia Doctor's Hospital for evaluation and treatment of his bipolar disorder. AR had a long history of bipolar disorder with multiple psychiatric hospitalizations and noncompliance with treatment, dating back to the 1970's. He had been treated with Lithium since the early 1980's and had approximately 13 years of treatment with Haldol. AR's physical problems included muscular spasticity, dysarthia, and residual visual field deficits.

AR's wife resides in Manassas, Virginia, and maintained a somewhat close relationship with AR until his death. Prior to admission to WSH, AR had been evicted from his apartment due to delusional and paranoid behaviors, but AR's wife was allowed to stay. AR's wife was not planning for AR to resume living with her when discharged from WSH, although AR did not know this. She felt she was incapable of providing the supervision AR would need when discharged and was being pressured by her sister to leave her marriage to AR.

According to records from WSH, AR's psychiatric diagnoses were as follows:

1. Axis I: Bipolar I Disorder, Most Recent Episode Manic; R/O Schizoaffective Disorder.
2. Axis II: Deferred.
3. Axis III: H/O meningitis with residual visual field deficits, dysarthia, and spasticity of muscles.

His medication records as of June 1996 reflect that AR was being treated with the following medications:

1. Lithium 300mg q8am q4pm 600mg qhs
2. Children's Aspirin 2x per day
3. Valproic Acid 10 mg TID

III. CIRCUMSTANCES SURROUNDING THE DEATH OF AR:

A. Care Provided to AR at WSH

AR was transferred to WSH from Prince William Hospital as a result of exacerbation of his mental illness and inability to care for himself. Upon transfer to WSH, AR was admitted to Ward B1 Admissions Unit. He received treatment for his mental illness and had medical follow-up of his physical condition on B1 through 5/22/96. AR was then transferred to C1 Psychosocial Unit due to the his need for further stabilization. AR was compliant with both ward programs while a resident at WSH.

B. June 5, 1996 Sequence of Events

AR was last seen by WSH staff while eating his dinner on Ward C1/2, at approximately 5:00 PM on 6/5/96. Ward C1/2 staff stated that after AR finished his dinner, he left the ward. He had been approved, per his treatment plan, for unescorted, on-grounds privileges daily until 8:00 PM.

AR was next observed by the driver of the tractor-trailer, which struck him. The driver stated he was driving Southbound on Interstate I-81, near WSH, when he saw AR on the right southbound shoulder of the road. The driver then observed AR, in his rearview mirror, to appear to be waving at the truck and then lunged at the side of the truck. The driver stated he realized something was wrong when he noticed, in his rearview mirror, the driver of the small truck which had been behind him on the interstate, had pulled over to the side of the road.

The driver of the small truck behind the tractor-trailer, which struck AR, stated he saw AR walking Southbound on Interstate I-81. He stated AR jumped into the rear of the tractor-trailer, three-quarters way down the side of the tractor-trailer.

Another witness to the incident stated he saw AR walking down the shoulder of Southbound Interstate I-81 and then next in the middle of the interstate. He stated it looked to him that AR rolled out from under a pickup truck with a spare rig on the back.

AR was pronounced dead at approximately 6:15 PM, by the medical examiner and the body was transported to Augusta Medical Center in Fishersville, Virginia by the Staunton/Augusta Rescue Squad.

Interstate 81 South is straight and level with no defects in the roadway. It is a four-lane divided highway. There were no skid marks at the scene.

C. Investigations

The Virginia State Police was at the scene of the incident and conducted an investigation into AR's death. They ruled the death as accidental and no charges were brought.

IV. FINDINGS AND CONCLUSIONS:

There was a discrepancy in the documentation relating to AR's mental status at the time of his transfer to WSH from Prince William Hospital. The transfer form from Prince William Hospital listed suicidal ideation as one of AR's diagnoses for transfer, but the Prince William Community Services Board prescreening form completed prior to transfer to WSH, did not identify suicidal ideation as clinically indicated. There was no evidence found in the documentation reviewed from AR's WSH medical record, which indicated he was suicidal upon transfer or at any point in his hospitalization at WSH.

AR's wife reported to WSH staff after his death that AR had told her he was "going to meet his maker," during their phone conversation the night before his death. WSH had no knowledge of this conversation until after AR's death.

This investigation discovered no evidence that abuse or neglect was involved in either AR's care and treatment at WSH or in his death on June 5, 1996. AR had been deemed capable of handling unescorted, on grounds passes by his treatment team and physician. No recommendations were made to WSH due to the accidental nature of AR's death and lack of evidence substantiating abuse or neglect on behalf of Western State Hospital.

V. RECOMMENDATIONS:

Prince William Community Services Board and Prince William Hospital were informed of the discrepancy found in the documentation relating to AR's mental status at the time of his transfer to WSH.

WSH subsequently developed Hospital Instruction Number 4075 on June 21, 1996, which established parameters to assure patient pedestrian safety both on and off hospital grounds (See Appendix I).

Due to a lack of sufficient evidence substantiating either abuse or neglect it is recommended this investigatory case be closed.