CROTCHED MOUNTAIN

December 31, 2013 (September 25, 2013 report with addendum)

Re: [redacted]

To Whom It May Concern:

My name is W. Carl Cooley, MD. For the past 14 years, I have worked as the medical director and then chief medical officer for the Crotched Mountain Foundation, a New Hampshire non-profit corporation providing health, educational, and community living supports to individuals with developmental disabilities and acquired brain injuries. I am a physician specializing in developmental pediatrics and licensed to practice medicine in the states of New Hampshire and Massachusetts. As a developmental pediatrician, I have 25 years clinical experience working with children, youth, and adults with developmental disabilities. In [redacted] 2012, I was asked by the Disabilities Rights Center of New Hampshire to assist as a medical expert in its review of the unanticipated death of [redacted] on [redacted], 2012, while he was a patient at the Lakeview Neurorehabiliation Center in Effingham, New Hampshire.

For the purposes of this process, I met by phone and in person with Attorneys Rosenberg and Ziegra, met by phone with and reviewed the report of NH Chief Medical Examiner, Thomas Andrew, MD, and reviewed medical and other records provided by the Disabilities Rights Center of NH.

At the time of his death, [redacted] was a 22[redacted] year old man who had been admitted on [redacted] to the Lakeview Neurorehabilitation Center following a two-week stay at the New Hampshire Hospital. Mr. [redacted] New Hampshire Hospital admission had come about following failed community living placements due to behaviors that were beyond the capacity of his community care providers to manage. He had attended the Crotched Mountain School as a boarding student from 2004 until [redacted] 2011 and then experienced an initially successful community family placement in [redacted] That placement eventually failed and was followed by other unsuccessful placements until his [redacted] admission to New Hampshire Hospital.

Mr. [redacted] records indicate developmental and intellectual disabilities since around three years of age at which time he had the onset of a significant seizure disorder associated with hospitalizations for status epilepticus. His early psychosocial development was reportedly affected by the death of his mother when he was [redacted] years old and by the irregular involvement of and alleged abuse by his father necessitating foster care arrangements with his grandparents and others and eventual residential placements from a young age. His

seizure disorder continued to require treatment with a variety of medications throughout his life and consultation with pediatric neurologists. His developmental challenges carried diagnoses that included intellectual disability and autism spectrum disorders. However, a consultation with Dr. Bryan King, a nationally recognized autism expert, in [redacted] 2002 disputed the latter diagnosis (autism) and suggested that his neurodevelopmental challenges may have resulted from his frequent and severe seizures as a young child.

Mr. [redacted] was admitted to New Hampshire Hospital (NHH) on [redacted] for evaluation and treatment of challenging behaviors felt to involve the risk of injury to himself and to others. Shortly after his admission to NHH, records suggest the impression that an acute adult psychiatric unit was not the most appropriate therapeutic environment for him. Efforts to identify an alternative placement began immediately and resulted in his transfer from NHH to Lakeview Neurorehabilitation Center on [redacted].

Upon his discharge from NHH, in addition to his neurodevelopmental diagnoses and his seizure disorder, he was diagnosed with major depression. His medications at upon admission to Lakeview Neurorehabilitation Center included:

Zonisamide 300 mg at bedtime (for seizures)
Senna 2 tablets daily (for constipation)
Risperidone 2 mg twice a day (antipsychotic used for explosive behaviors)
Loratidine 10 mg daily (allergies)
Fluvoxamine 100 mg at bedtime (for depression)
Divalproex DR 1500 mg at bedtime (for seizures)
Thera M daily (vitamin)
Buspirone 5 mg three times a day (for anxiety, agitation)
Diazepam 10 mg per rectum (as needed for seizure activity)

His admission history and physical examination at Lakeview conducted by Dr. Badman on [redacted] did not mention any specific diagnoses except for "neurodevelopmental and behavioral issues." His admission neuropsychological assessment conducted by Tracey Shannon, MS, MSCJ, and Stephanie Griffin, PhD, on [redacted] and [redacted] summarized his past history and current test results. Diagnoses included cognitive disorder NOS, autistic disorder, moderate "mental retardation," epilepsy, and "problems related to the social environment and problems with primary support group." Neither of these assessments mentioned major depression. No treatment plans for depression or for obesity were mentioned in either report other than the continuation of his admission medications.

During the month of [redacted] Mr. [redacted] was transported on two occasions to the Huggins Hospital emergency room for the treatment of prolonged seizure activity that had not responded to the usual measures (administration of rectal diazepam). Prior to these events, Mr. [redacted] seizures had been under good control for an extended period of time. On both of these occasions, he was sent back to Lakeview after his emergency room consultation. At the time of the [redacted] emergency room visit, laboratory work showed no remarkable findings.

At some point shortly before (while still at NHH) or shortly after his Lakeview admission, Mr. [redacted] began refusing food and refusing or resisting his medications. Initially these behaviors could be overcome and averted at times, but during [redacted] and [redacted], staff notes indicate that he became increasingly resistant to any food intake even when offered preferred foods and special treats. During this time, the available records indicate that he was weighed on only two occasions – for the admission history and physical on [redacted] and at the time of a medical consultation with Dr. Badman on [redacted] four days prior to his death.

[redacted], 2012

275.8 pounds (NHH admission)
269 pounds (Lakeview pre-admission notes)
262 pounds (Lakeview admission physical exam)
222 pounds (Lakeview Medical Note)

A Huggins Hospital Emergency Room visit on [redacted] indicated a weight of 269 pounds, but it seems likely that this weight may have been provided by Lakeview records or staff rather than resulting from actually weighing Mr. [redacted]. [redacted]

Overall, Mr. [redacted] appears to have lost over 50 pounds between [redacted] and [redacted] 2012. On that date, Dr. Badman was asked to see Mr. [redacted] because of a concern about dehydration. Dr. Badman found no evidence of dehydration, and did not comment about weight loss or the presence of "large ketones" in Mr. [redacted]'s urine. In the absence of diabetes, which Mr. [redacted] did not have, "large ketones" in the urine suggests a metabolic state of starvation. It should also be noted that a state of ketosis such as this has an appetite suppressing effect. [redacted]. Laboratory studies obtained at the time of the [redacted] evaluation were generally unremarkable except for slightly decreased sodium, potassium, and chloride levels. Anticonvulsant medication levels were not obtained with these laboratory studies. Mr. [redacted]s records do not indicate that his rapid weight loss and state of starvation were recognized as problems or connected with a specific, on-going plan of care.

On [redacted] 2012, Mr. [redacted] was evaluated by psychologist, Stephanie Griffin, PhD, at the request of his occupational therapist because of a suicidal statement. He stated that he was sad and wanted to return to live in [redacted]. He mentioned thoughts of dying and that he would "shoot himself with a gun" if he could. Dr. Griffin concluded that he did not have access to a gun and did not "appear capable of formulating a coherent plan to self-harm otherwise." However, she did order that his status be changed to "5 minute checks."

While at Lakeview, Mr. [redacted] was seen twice by Dr. Badman, for his admission history and physical on [redacted] and for the medical visit due to suspected dehydration on [redacted]. He also had "Monthly Health Services Reports" on [redacted] for the period from [redacted] to [redacted], on [redacted] for the period from [redacted] to [redacted] and on [redacted] for the period from [redacted] to [redacted]. The latter two reports mentioned the fact that Mr. [redacted] "continues to eat

1/ date admitted to New Hampshire Hospital (2 weeks before admission to Lakeview)

2/ 68 days after his admission to Lakeview

minimally" and "continues to eat little," but no mention is made of weight loss or of a plan of action and no weights are recorded.

On the morning of his death on [redacted], 2012, Mr. [redacted] was noted by a staff member to be naked on the floor of his room sitting in a pool of urine. He responded initially to the staff member, but shortly afterward when the staff member returned, the staff member indicated in an interview with Attorneys Rosenberg and Ziegra that he was not able to elicit a response from Mr. [redacted] However, there is no evidence that an attempt was made to further evaluate his status or seek assistance. It was not until sometime later when nurse Rachel Emery arrived to administer his medications that he was confirmed to be unresponsive without pulse or respiration. At that time CPR was initiated and a 911 call was placed. Mr. [redacted] was eventually transported to Huggins Hospital where he was pronounced dead on arrival.

Based on a telephone conversation with NH Chief Medical Examiner, Dr. Andrew, on [redacted] 2012 and review of his final report, Mr. [redacted]'s gross autopsy findings were generally not revealing of a manner and cause of death. [redacted] Post mortem laboratory findings were of interest for [redacted] (similar to ketone) indicative of a state of starvation. [redacted] The medical examiner concluded that the cause of death was his seizure disorder [redacted] The manner of death was suggested as natural.

Conclusions

Mr. [redacted]'s cause of death remains uncertain though it seems likely that his long-standing refusal to eat and frequent refusal of his medications may have led to increased seizure activity as evidenced by the two emergency room visits in [redacted] after a long history of good seizure control. While staff members acknowledged that they could not force Mr. [redacted] to eat or take his medications, available records suggest no recognition of the seriousness of Mr. [redacted]'s condition as a result of these refusals or the development of any plan for intervention beyond a few behavioral management suggestions. There were no apparent efforts to monitor Mr. [redacted]'s weight or caloric intake, and no coordinated approach involving a combination of medical and psychological consultation and planning. Mr. [redacted] had at this time what has to be called an eating disorder, which may or may not have been a conscious effort to end his life or at least necessitate a transfer from the Lakeview facility. It does not appear that Mr [redacted]'s guardian was apprised completely of this problem. According to Dr. Badman, the major domains of health care at Lakeview (medical, psychiatric, and neurologic) are compartmentalized with little exchange of

information, discussion, or interaction among the doctors responsible for each of these disciplines. This lack of coordination may have led to a failure to recognize a connection between Mr. [redacted]'s diagnosis (at NHH) of major depression and a pattern of behavior that reflected a somatic symptom of that diagnosis if not an active attempt to end his life. In addition, the lack of coordination of the neurologic management of his seizure disorder with the fact of his frequent medication refusal (and the undetectable level of one of his seizure medications on his autopsy) did not seem to identify the seriousness of this situation or result in an aggressive or coordinated plan of action. In his final hours, Mr. [redacted]'s status did not seem to be the subject of a high level of concern by his direct care staff in spite of the recent institution of "5 –minute checks" due to concerns about suicidality on the part of his psychologist. Given the medical and behavioral complexity of some of the patients at Lakeview, leaving a residence for a group of patients attended by only one staff member especially with one patient on an every 5- minute suicide watch does not constitute safe practice. Even without final certainty of the exact cause of death, Mr. [redacted] appears to have suffered from a systemic lack of coordination among members of his health care team, a lack of sufficient concern about his nutritional status to even weigh him regularly or regard it as a serious medical problem and determine plans of action, a failure to continue to monitor and adjust the treatment of major depression in the face of serious symptoms, an insufficient staff to patient ratio at the time of his death, and uncertain responsibility for assessment and intervention in the face of an unresponsive patient. Communication with his responsible guardian regarding these problems seems to have been limited, inexplicit, and at times absent.

Addendum December 31, 2013:

On or about December 10, 2013, an additional post mortem report [redacted] was received from the medical examiner's office. [redacted] In my opinion, this analysis does not materially change the conclusions of this report though it does corroborate some its findings.

[redacted]

[redacted] At his prescribed dose of 1500 mg per day of valproic acid (Depakote), his blood level should have been in the 50 – 100 mcg/ml range. Actual pre-mortem blood levels of valproic acid obtained during [redacted] ranged from 60 to 110, which would be expected levels on his dose of Depakote. [redacted]

[redacted]

[redacted] is consistent with ketoacidosis associated with either an uncontrolled diabetic condition or with significant and prolonged fasting – in either case constituting a potential medical emergency. Since there is no evidence that Mr. [redacted] had diabetes, it must be concluded that ketoacidosis in his case was due to extreme fasting in keeping with the prior conclusions in this report.

Respectfully submitted,

W. Carl Cooley, MD
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