

Mr. GOLDMAN

OA-501 12-67

COMMONWEALTH OF PENNSYLVANIA

December 7, 1972

CC:SS

SUBJECT: Death of Raymond Hellman at Polk State School and Hospital

TO: Mr. Frank S. Beal - Executive Deputy Secretary for Operations  
Mr. Edward R. Goldman - Commissioner - Office of Mental Retardation  
Mr. Robert Vogt - Director - Meadville Office  
James H. McClelland, M.D. - Superintendent - Polk State School and Hospital  
*Ralph L. Meador*  
Ralph L. Meador - Commissioner Mental Health and Mental Retardation -  
Western Region

Enclosed for your information is a follow-up report concerning the death of Raymond Hellman. The purpose of this follow-up was to determine if there was negligence involved in this death.

Miss Patricia Gishbaugher and Mr. Robert Vogt did this follow-up visit on November 3, 1972.

Mr. Vogt will be assigned responsibility to follow-up on the recommendations and see that they are carried out.

*Bill Meador*  
October 24, 1972

Mr. Norman Taylor - *Western  
Region*

Frank S. Beal

I have read Mr. Meador's report concerning the death of Raymond Helman.

While the report was preliminary, I have a strong feeling that there was gross negligence involved on someone's part. I would like to have the case investigated in depth by someone outside of the institution. If negligence is involved, the negligent person must be disciplined to the fullest extent that the circumstances justify.

cc: Mrs. Wohlgemuth  
Mr. Goldman  
Mr. Leopold

COMMONWEALTH OF PENNSYLVANIA

October 27, 1972

SUBJECT: Death of Raymond Helman

TO: Mr. Robert L. Vogt - Director  
Miss Pat Gishbaugher - Institutional Standards RepresentativeFROM: *Ralph L. Meador*  
Ralph L. Meador - Commissioner Mental Health and Mental Retardation - Western Region

Attached for your information and action is a copy of a memorandum from Mr. Frank S. Beal to Mr. Norman J. Taylor.

I share similar concern particularly with Dr. McClelland's statement that one of the attendants left a long piece of tie cloth hanging beside Raymond's bed after re-tying him. This is the piece of cloth or cord which was around Raymond's neck. Please investigate this jointly and report back to us.

RLM:fz

cc: Mr. Norman J. Taylor

November 13, 1972

SUBJECT: Death of Raymond Hellman at Polk State School and Hospital

TO: Mr. Norman J. Taylor - Deputy Secretary - Western Region

FROM: Patricia A. Gishbaugher - Institutional Standards Representative I

November 3, 1972 Mr. Vogt and I visited Polk State School and Hospital to investigate the death of a resident, Raymond Hellman on October 16, 1972.

Records of the deceased and the resident suspect were reviewed. Dr. McClelland then accompanied us to the dormitory where the death occurred. Mr. Wertz, the Child Care Aide, who found Mr. Hellman's body, demonstrated the exact conditions that he found the morning of October 16, 1972 at 5:58 A.M. when he arrived to awaken the residents.

A resident was used as the victim and a sleeveless jacket that laced up the back was applied. The long restraining cotton strap was threaded through the laces and the resident laid down on the bed. The strap was then pulled through and one end was shorter than the other. Both ends were then tied to the bed rails. When questioned if this is the way he was taught to apply the restraint, Mr. Wertz replied he had not been taught. He is a new employee and has not had the Child Care Aide Training Course as yet. Another attendant was there and he was asked to demonstrate the way he was taught to apply the restraint and this was done satisfactorily. Mr. Martin, the Child Care Aide who worked 10:00 P.M. to 6:30 A.M. on October 16, 1972 was then called in and asked to demonstrate how he was taught to apply the sleeveless jacket restraint. This was done satisfactorily and during conversation, Mr. Martin stated that at no time was it necessary for him to re-apply the restraint on Mr. Hellman. At 5:15 A.M. when he made the dorm check, he found Mr. Hellman standing on the left side of the bed but restraining strap was only loose from the right side of the bed. This would have been the short end of the strap. Mr. Martin stated he put Mr. Hellman back to bed and re-tied the loose end of the restraining strap and returned downstairs. At 5:40 A.M. he returned to awaken another resident to take him to the dispensary for a blood sugar. Nothing seemed to be awry at that time. Mr. Wertz came on duty early and went to the dorm to awaken all residents and found Raymond Hellman sitting on the floor on the left side of the bed and the end of the restraining strap wrapped around his neck several times. Since Mr. Martin had at no time completely re-applied the restraining strap, it was then necessary to talk with the 2:00 P.M. to 10:30 P.M. Child Care Aides. Mr. Carter was asked to demonstrate the application of the jacket and it was obvious that he did not know how. When questioned, he too replied that he is a new

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employee and had not had the Child Care Aide Training Course. He also stated that Raymond Hellman had a habit of having the jacket put on when he got ready for bed but the restraining strap would be applied just before lights out and this was usually applied by another one of the residents. James Ivory was the resident that applied the restraining strap on October 15, 1972. Mr. McVey, the other Child Care worker that was on duty October 15, 1972 when the residents were put in bed, was then questioned. He stated he had gone to the quiet room at 9:00 P.M. to check Mr. Washington and returned to the dorm about 9:10 P.M. The lights were out but he did a bed check and remained in the dorm until Mr. Martin came on duty.

All of the Child Care Aides were questioned as to whether they saw any excess strap on the floor when they checked the restraints and the answer was "no". They also felt that any excess strap laying on the floor would have caught their attention.

It was also brought out that Raymond Hellman was capable of releasing the restraining strap himself as his arms were free and had done it in the past. Raymond Hellman was also spastic and frequently he would call out in the night and ask one of the residents to help him to the bathroom. One of the residents told Dr. McClelland and the police that on the night involved, James Ivory had either taken Raymond Hellman to the bathroom or had found him there and put him back to bed.

The Staff ratio the night of the unfortunate incident was:

2:00 P.M. to 10:30 P.M. ----- 3 Aides

10:00 P.M. to 6:30 A.M. ----- 1 Aide

Also one Supervisor of North Side and one Supervisor of entire male service

Resident capacity was sixteen (16) men.

PERTINENT FACTS

- 1.) Body of Raymond Hellman discovered by Mr. Wertz at 5:58 A.M.
- 2.) Pronounced dead at 6:15 A.M. by Dr. Rood
- 3.) Body removed to dispensary at 9:00 A.M. and autopsy was done by Dr. Robert Griffin and Coroner Jonathan Hutchinson
- 4.) Body taken to Robert M. Jones Funeral Home
- 5.) Doctor's order for sleeveless jacket was originally ordered over a year ago but the order was renewed each month

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6.) Cause of death was asphyxiation by strangulation

7.) Attached are:

- (a) Autopsy report
- (b) Job descriptions
- (c) Class schedules and training outline
- (d) Psychological report of suspect

PG:fz

cc: James H. McClelland, M.D.  
Superintendent  
Polk State School and Hospital

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Death of Raymond Hellman - Polk State School and Hospital - Possibility of Negligence

Mr. Norman J. Taylor - Deputy Secretary

Ralph L. Meador - Commissioner of Mental Health and Mental Retardation - Western Region

This is in response to the report of Pat Gishbaugher concerning the above subject. Pat and Bob Vogt visited Polk State School and Hospital at my request following receipt of a memorandum from Mr. Frank S. Beal requesting a re-visit. Mr. Beal was questioning the possibility of staff negligence and need for a reprimand from the Regional Office.

If anything should be reprimanded, it is our entire lousy system; however, it is obvious that attendant staff is not trained or instructed on how to apply the sleeveless jacket restraint. This would raise the question as to whether or not instruction has been given in the use of any mechanical restraint. Dr. James H. McColland should be instructed to provide such instructions immediately.

Mr. Vogt informed me that the night attendants stay on the first floor, in the dayroom, while the sixteen (16) residents sleep on the second floor. Unless there is some exceptionally good reason for this, it would be better for the attendants to have a desk and telephone on the second floor.

I do not feel that the attendant who was on duty can be held at fault for negligence. It is my understanding that this attendant has since resigned his job.

RIM:fs

bcc: Pat Gishbaugher

November 30, 1972

SUBJECT: Death of Raymond Hellman at Polk State School and Hospital

TO: Mr. Norman J. Taylor - Deputy Secretary - Western Region

FROM: Patricia A. Gishbaugher - Institutional Standards Representative I

RECOMMENDATIONS:

- (1) New employees should attend the 100-hour Child Care Aide Training Course prior to being responsible for Resident Care.
- (2) All Child Care Aides should have refresher Course.
- (3) Job descriptions should be more explicit.
- (4) Dormitory check should be made frequently and not at specified times.
- (5) Perhaps the door to the dormitory and the door to the First Floor could be propped open during the night. Some better system of coverage must be developed.
- (6) All restraints should be checked on restrained residents during each dormitory check.
- (7) Supervisors of Male Services and North Side should make at least one dorm check a night in all of the dormitories that come under his supervision.
- (8) Manual should be re-written to describe the proper application of restraints and include pictures of the various steps of application.
- (9) Restraints should only be applied or released by trained Child Care Aides or Nurses.
- (10) A Training Manual should be developed and given to each new employee while he is attending the Child Care Aide Training Course. Also, a complete manual should be kept on each department at all times for reference for all employees.