11/18/74

November 18, 1974

SUBJECT: Death of a Resident -
Paul Waymont Jenkins - Birth Date: 5/25/57 -
CTB 8:30 p.m. E.S.T., November 13, 1974

TO: Mr. Charles A. Peters
Commissioner for MR - Western Region

FROM: Robert J. Hiltner
Superintendent
Western State School

Paul Waymont Jenkins (B.D. 5/25/57) was admitted to Western State School August 27, 1964. Our records indicate that Paul had never lived with his family. He was born prematurely, remained in the hospital for sometime after birth, and then was transferred to Roselia Foundling Hospital in Pittsburgh. At age three months he was diagnosed as hydrocephalic. A lumbar-peritonial shunt was installed at age six months. At age two, Paul was made a ward of the Juvenile Court of Allegheny County. He was placed in the Jayne Home and later at Allegheny Valley School, from which he was transferred to Western State.

Paul came to Western State in a wheelchair with his arms restrained reportedly in order to restrain self-abusiveness. Our diagnostic evaluation revealed that Paul was severely mentally retarded as a result of his hydrocephalus, but had a greater potential for development than had been previously believed by his former placements. In the first five years following admission to Western State, our records indicate that Paul showed progress; he became able to walk (awkwardly) unsupported; he gained a greater use of his arms; his self-abusive behavior was almost extinguished; and he was able to progress from baby food to regular diet. Paul remained, however, non-verbal. About 1970, Paul's progress seemed to have slowed and some time later to decline. In March of 1971 Paul was evaluated at Children's Hospital of Pittsburgh because of concern over apparent decreasing capacities. At that time, however, no evidence of a progressive neurological disorder could be found. The decline in Paul's abilities has continued over the last few years and he gradually became confined to his wheelchair for greater periods of time; he has had greater difficulty in controlling arm movements and has been less able to feed himself. He was re-evaluated by Children's Hospital in March of 1972 and at Presbyterian-University Hospital in September of 1974. These examinations failed to identify the neurological reasons for Paul's continuing deterioration. Because of the deterioration, Paul was started on a physical therapy program in January of 1974. The program was terminated in July because of the lack of progress.

I became aware of the death of Paul at approximately 9:40 p.m. when Mrs. Mary Goodman, R.N., Evening (3:00 to 11:00 p.m.) Supervisor, called me at home to report the incident. Mrs. Goodman reported that Paul had aspirated a piece of meat, efforts to revive him had been unsuccessful, and that Frank Hazlett, M.D. had pronounced him dead at 9:30 p.m. I arrived at Pine Lodge at about 10:20 p.m. and spoke to Mrs. Goodman, Mrs. Mary Mack, R.N. (Building Charge Nurse),

Dr. Frank Hazlett (the "on-call" physician for the evening), and Richard Gaydos (caseworker who had come to WSS to assist in reaching Paul's mother). After examining the piece of meat which had been taken from Paul's throat (a slice of roast beef approximately 1/8" thick, 6" long, and 2" to 3" wide - it was described to me as having been removed from the throat "rolled into a tight ball"), the possibility of staff negligence appeared sufficient so that I instructed Dr. Hazlett to request a Coroner's autopsy and investigation.

The autopsy was performed by Dr. Ernest L. Abernathy, Pathologist and Chief Deputy Coroner, the next morning, 11/14/74. Death was found to be caused by asphyxiation resulting from aspiration of food particles found lodged in the larynx. On the afternoon of November 14, I talked with both Assistant Coroner, Louis Sollon, and the Coroner, Mr. Farrell Jackson, about the known limitations of Paul's eating ability and the size of the piece of meat. Mr. Jackson requested that everyone connected with Paul's meal on the previous evening be assembled at 4:00 p.m. so that an informal investigation could be held. All of those directly involved in the incident, the supervisory personnel of departments involved, and representatives of local AFSCME Union (who requested to be present) were assembled as requested excepting Mrs. Mary Goodman, R.N. who was not scheduled on duty and who could not be reached, Dr. Frank Hazlett who was not on duty, and Mrs. Emelda Webb, Director of the Dietary Department, who had gone home ill.

Following is a summary of salient facts brought out in the informal hearing:

1. There were three direct care staff on duty in Paul's Residence Unit, Pine Lodge, Unit I, on the 3:00 to 11:00 p.m. shift on the evening of November 13. There were 36 residents present on Pine I that evening. The lead CCA II, David McConnell, has had about six years experience at Western, the CCA I on duty has had about eighteen months experience and, also, on the unit was one trainee who has had less than a month experience and was in training under Mr. McConnell's supervision.

2. Of the residents on the Pine I unit, only a few are able to feed themselves without supervision. About six must be fed by staff entirely. Most of the residents are given "finger food trays" (eg. meat and other foods cut in "bite size" pieces) from which they can eat themselves but require assistance and supervision.

3. The Food Service Worker II, the lead worker on the evening shift in the Pine Lodge Cafeteria that evening, was aware that Paul required a "finger food tray". She is sure that she had cut up the meat (roast beef) on his tray.

4. Mr. McConnell, the CCA II, was aware that Paul was to get a "finger food tray" and of his responsibility for inspecting each tray to see to it that each resident got the correct tray for his needs. He could say, however, only that he believed that he had given Paul a "finger food tray".

5. No one could recall Paul having any trouble eating, or swallowing, his food while he was in the dining room, or while he was being returned to his unit in his wheelchair.

6. Since the period after supper is a very busy time for Child Care Aides with baths, showers, and preparation for bed a major activity, none of the Aides could be sure at what time Paul was last seen to be moving around. The concensus was that they were sure that he was alright up to 7:15 p.m.

7. At 8:30 p.m. the building LPN approached Paul to give him medication. She found him slumped over. When she lifted his head she found that he was cyanotic and had no pulse. She immediately called for assistance from the CCA's on the unit; then she ran to get the aspirator and alert Mrs. Mack, R.N., the Building Charge Nurse. Mrs. Mack, in turn, notified Mrs. Mary Goodman, Evening Supervisor.

8. During the efforts to remove Paul, the large piece of meat, described earlier, was pulled from Paul's throat.

At the conclusion of the informal hearing, Coroner Jackson summarized his findings. At that time he felt that there was sufficient evidence to warrant a full Coroner's Inquest which he tentatively scheduled for November 29, 1974. He indicated at that time lead Child Care Aide, David McConnell, had neglected to carry out his duties in checking Paul's tray and in supervising his eating. He was also critical of the lack of staff and questioned whether it was possible for Aides to properly carry out their duties under such conditions.

At approximately 9:00 a.m. the next morning, November 15, Mr. Jackson called me to say that he had reconsidered his conclusions of the evening before. He did not believe that it was appropriate to single out Mr. McConnell. He noted particularly that Paul had appeared to have no difficulty in the dining room nor when he was returned to his Residence Unit. He also noted the comments of staff that Paul had been known to grab meat from other resident's trays. He indicated that he planned to withdraw the plans for the Inquest and planned to come to Western State at 10:00 a.m. to make a statement concerning his findings.

Staff were assembled for the statement as requested. Mr. Gregory Coleman, Executive Deputy Secretary for Operations, and Mr. Larry Jenkins, Deputy Commissioner for Mental Retardation, Western Region, were present representing the Department of Welfare; Mrs. Virginia

Thornburgh, President of the Allegheny County Chapter/PARC, Mr. Robert Nelkin, Assistant Director of ACC/PARC, and Mr. Norman Mulgrave, Regional Vice President of the PARC organization were present representing the Pennsylvania Association for Retarded Citizens; Mrs. Alyce Goldberg, wife of Dr. Harry Goldberg, President of the Western State School Parent's Group was present representing the Parent's Group. In addition, representatives of the press and television media were present. The media had been informed of the meeting by the Allegheny County Chapter/PARC. A copy of Mr. Jackson's statement is attached.

In conclusion, while I am in agreement, based on the evidence present at the informal hearing, that there is reasonable doubt regarding a specific act of negligence, I remain quite concerned about possibilities that failure to carry out orders with regard to providing residents with food suited to their needs and limitations may have contributed, if not caused, this death. The failure to provide proper food to residents has been the subject of many complaints for staff and by advocate groups. These complaints have been communicated to Mr. Jacob Levinson, Assistant Superintendent for Administrative Services, who supervises Mrs. Emelda Webb, the Director of the Dietary Department, and to Mrs. Webb, herself, with orders to find the source of the problem and correct it. It is ironic that on the evening of Paul's death an unannounced visit of the Joint Visitation Committee was held in another building, Spruce Lodge. The Joint Visitation Committee is composed of representatives of the Western State School Board of Trustees, Parent's Group, and the Allegheny County Chapter of PARC. With the backing of the administration of WSS, they have made periodic unannounced visits to inspect various facets of our care and services. The food service at WSS has been the subject of past criticism and was the subject of their visit of November 13. The written report of the November 13 Joint Visitation Team has not yet been received, however, I have learned from persons who participated in the visit that questions were raised regarding the quality of the roast beef served (eg. its toughness) and the fact that the meat did not appear to be sufficiently cut for many residents. I can find no excuse for this, particularly as these observations may relate to Paul Jenkins' death, and I have told Mr. Levinson and Mrs. Webb so. A reprimand for his failure to act in correcting problems in the Dietary Department is to be sent to Mr. Levinson with instructions to review with Mrs. Webb procedures regarding preparation and serving of food, particularly for handicapped residents, and to report on corrective action in not less than one week. Instructions are also being sent to the Nursing Department and to the Assistant Superintendent for Medical and Health Services to review their procedures for informing the Dietary Department of special diet needs and, in the case of the Nursing Department, their role in inspecting the quality of the food

served to residents in their charge.

RJH:mc

cc: Mr. Gregory Coleman
Mr. Charles A. Peters
Mr. Jacob Levinson
Dr. Ruth L. Scott
Dr. Betty Bradley

bcc: Mr. Robert Nelkin