The Wayback Machine - https://web.archive.org/web/20030825204613/http://www.csindy.com:80/csindy/2003-…

Pinned Down

Devereux Cleo Wallace cited for violations of restraint policy in the death of 15-year-old Orlena Parker

by Kathryn Eastburn



We don't know a lot about Orlena Parker. We know that she was 15 years old with black hair more than 2 feet long. We know that her middle name was Leatrice. We know that she was a member of the Salt River Pima-Maricopa Indian Community of Arizona.

We know that Orlena Parker suffered from depression and had lived for 18 months in Colorado Springs at Devereux Cleo Wallace residential treatment facility for mentally ill children until her death on March 10, 2003. We know that on that day she became agitated and was pinned face down by at least six, possibly seven, adult staff members.

We know that after struggling for several minutes, Orlena Parker stopped breathing and died. Details of exactly how she died vary from one account to another.

On March 11, Colorado Springs Police Department Lt. Skip Arms said: "She was very aggressive. ... Because of her aggressive actions six men and one woman had to restrain her." According to the initial report in the *Gazette*, police said Parker "resisted for a short time, and when she stopped, staff let go and realized she wasn't breathing."

Yet the El Paso County coroner's official report noted that Parker had been restrained by six staff members, not seven.

"According to their statements," the report said, "she was placed on the floor with four individuals restraining her arms and two individuals restraining her legs. Approximately 10 minutes into the restraint she suddenly vomited and then became unresponsive." Cardiopulmonary resuscitation was administered and Parker was transported to Memorial Hospital where she was pronounced dead at 8:41 p.m. The coroner concluded that the cause of death was undetermined.

In yet another account, reported by El Paso County Department of Human Services (DHS) to the State of Colorado DHS, "staff had stepped away from the restraint and had come back periodically to check on the child."

We don't know which account accurately reflects what happened on March 10. The 300-page police report of the incident has been withheld from the public at the advice of city attorney Pat Kelly, who cited Colorado Juvenile Code, which is designed to protect the confidentiality of juveniles.

Vote for the Best of 2003!

SUBMIT AN EVENT

Independence Community Fund Info

Philanthropy and Giving

Environmental Listings

Job Openings & Internships

Springs Weather

45 F
more...

take note

Stay! No wait, leave!
A toxic mess
The FB-eye may be watching

old news

Roadblock to Peace
No to war

After reviewing the file, 5th Judicial District Attorney Jeanne Smith determined that no criminal charges would be pursued in the case.

In addition, an investigation by the county Department of Human Services found no evidence of child abuse.

However, following its own inquiry, the Colorado Department of Human Services has cited Devereux Cleo Wallace for at least four violations of restraint policy. They are recommending the institution fix its policy and better train its staff, and are recommending negative licensing, a process to be considered by the attorney general's office that, according to Colorado DHS Public Relations Director Liz McDonough, is "in process now and hasn't been concluded."

Negative licensing, said Ken Lane of the attorney general's office, could mean anything from restrictions or corrective actions to the removal of a license altogether.

Whatever the attorney general's office decides, the death of Orlena Parker raises difficult and disturbing questions: Was this death the result of institutional failure or was it an isolated, aggravated incident? Does Devereux Cleo Wallace, a facility that has faced state investigations and charges of overuse of restraints in the past, train its staff adequately and put enough resources into crisis intervention techniques to keep other children safe? Is physically restraining patients a last resort at the facility or is it a commonly used practice? How do institutions with clients who might become aggressive best prepare themselves to de-escalate a situation that could become deadly?

Was Orlena Parker's death a rare and isolated tragedy or was it an accident waiting to happen?

Trouble behind

Devereux Cleo Wallace is housed on the bucolic100-acre site of the historic Myron Stratton home in south Colorado Springs. A second facility is in the Denver suburb of Westminster. The Springs center has 118 beds, treats males and females aged 5 to 21 and has a special program for dually diagnosed mentally ill and developmentally delayed children whose IQs fall between 55 and 70.

Some of their clients, like Orlena Parker, come from out of state, and many of them have complex mental health problems. Cleo Wallace typically accepts referrals of children with aggressive behaviors, often following interrupted placements elsewhere because of running away or serious behavior problems. It's not an easy place to work and likely not a place where the practice of using physical or mechanical restraints on patients will ever completely be eliminated.

But Devereux Cleo Wallace, formerly Cleo Wallace before it partnered with the Pennsylvania-based Devereux Foundation in 1999, has faced accusations of excessive use of restraints in the past. In 1993, 17-year-old Casey Collier, an autistic boy who was 6 feet 5 inches tall and weighed 220 pounds, died of asphyxiation after being held in a physical restraint hold in a Cleo Wallace facility.

In 1998, the Nevada Department of Social Services pulled three of its children, members of the Moapa band of Paiute Indians, out of Cleo Wallace, saying the children had reported incidents of immediate takedown and frequent use of restraint. In February of 1999, Nebraska Health and Human Services pulled 25 children out of Cleo Wallace noting safety concerns.

In September of 1999, El Paso County Department of Human Services temporarily suspended referrals to Cleo Wallace because of concerns over restraints and the ways that children who were acting out were subdued in

the facility. Shortly after the child welfare administrator, Lloyd Malone, announced his concerns, the Devereux Foundation sent experts to Colorado Springs to train Cleo Wallace employees in safe and effective ways to de-escalate volatile situations and reduce the use of physical and mechanical restraint.

At that time, a state investigative team concluded that Cleo Wallace used restraints too often. But the state didn't apply serious sanctions because the institution pledged to change its practices.

Last week, Devereux Cleo Wallace administrator David Fletcher-Janzen declined to release a copy of the facility's current restraint policy, including any revisions that have been made since 1999,

"Our policy on use of restraints is proprietary," he said.

Also proprietary are statistics on the frequency of use of restraints at the facility. "The only oversight group that information would flow to is the board of the Devereux Foundation," he said. "It is considered privileged and protected information. If it is public information, that often adds undue pressure on a certain strategy or technique. It's better to keep it internal so that we can use it to improve our performance."

Fletcher-Janzen said that Devereux Cleo Wallace offers extensive training to staff.

"There is a program put together based upon research and best practices nationwide called Crisis Prevention and Intervention (CP/I)," he said. "The Devereux Foundation trains trainers who go around the country and train and retrain staff with programs tailored toward the type of client served. [The program] is aimed for prevention, then de-escalation of the situation. The third step is that when you do use restraints, you are using certain approved techniques."

Janzen said that DCW has "a very comprehensive performance improvement program that runs from the ground level all the way up to the corporate level," where treatment procedures are tracked and analyzed to identify trends and a task force then "helps us improve in areas where help is needed."

While the state requires that residential treatment facilities keep internal records on the use of restraints, it generally does not review that information unless an inspection or an investigation is going on.

"We have a very open relationship with the county and the state and encourage them to come out and visit any time," Janzen said.

Rules of restraint

Devereux Cleo Wallace staff might have been trained in de-escalation techniques and proper use of restraints, but according to the state, on March 3 they made several mistakes in handling the restraint of Orlena Parker.

In his inspection for the state of Colorado Department of Human Services, inspector Barry Schultz cited these violations of Colorado statutes and the facility's own internal policies:

1) Staff failed "to communicate and disseminate treatment information per the Behavioral Support Plan (BSP) as well as review it monthly" as required by Residential Training Center rules. Specifically, a clinician is responsible for creating and revising the plan and all staff working with the client are responsible for implementing it during working hours. Although Orlena Parker was admitted to Devereux Cleo Wallace on Aug. 1, 2001, and a Behavioral Support Plan is supposed to be completed within 40 days, the only plan found was dated November 2002, 15 months following

her admission. Parker's plan restricted the use of facedown prone restraint because of her obesity; she weighed 270 pounds. In addition, the Behavioral Support Plan was the only place this restriction was noted, though it also should have been included in daily progress notes under Special Treatment Procedure. Further, the Behavioral Support Plan is part of the patient's treatment plan and should have been reviewed monthly. "Had the BSP been appropriately disseminated and implemented," the report concludes, "the appropriate restraint technique may have been utilized." The training manual used by Devereux Cleo Wallace stated that a facedown prone restraint should not be used on a child 30 percent over recommended body weight. Orlena Parker's weight exceeded that percentage.

2) Devereux Cleo Wallace failed "to include pertinent physical monitoring information for the restraint process" in their Seclusion and Restraint Policy as required by state quality standards. The policy "did not address how the facility monitors the physical well-being of the child during and after the restraint, including but not limited to breathing, pulse, color and signs of choking or respiratory distress." El Paso County DHS' initial report indicated that staff said they had moved away from the child and came back to check on her, even though a CP/I trainer said they were trained "not to leave the side of a patient who is lying still after a restraint."

3) Staff failed "to exhaust all positive and constructive methods of dealing with the child prior to utilization of physical restraint," per restraint policy and rules. Orlena Parker was agitated and acting out in her bedroom, according to the report, and not a present danger to other children or to staff. Staff said they didn't know if she was a danger to herself, although she had been in the facility for 18 months. Rather than attempting to enact an accepted de-escalation scenario, they tried to get Parker out of her room by walking away with a softball she had thrown at the door, supposedly to lead her to "the quiet room." She became angry and attacked the staff member holding the ball and was then restrained facedown on the floor. The CP/I trainer did not recognize this as a de-escalation technique. According to Schultz, this intervention also violated "the child's right to have reasonable and appropriate adult guidance, support and supervision."

4) The restraint used violated Devereux Cleo Wallace's own training manual on how to apply restraint. Although the inspector acknowledged that the restraint was justified based on Parker's attack on the staff member, the method was faulty. The manual states that up to four, even five staff can be used, "but presents no conditions for more than five staff." If five staff members are used, three should be on the lower body and one on each arm. In Parker's case, according to the report at least six staff members -- possibly seven, depending on conflicting reports --held her down with two adults on each arm.

The state report concludes with recommendations that the process of communicating Behavioral Support Plan information to staff be improved, that the facility modify its Seclusion and Restraint Policy to address issues of monitoring the child carefully, and that it ensure that de-escalation and physical management techniques be conducted in accordance with the CP/I training manual.

Devereux Cleo Wallace has until Aug. 1 to respond.

Mark Ivandick, an attorney with the Legal Center of Colorado, designated by the governor to provide protection and advocacy for people with mental illness, says the Center is also investigating Orlena Parker's death and restraint practices at Devereux Cleo Wallace.

"Any report of a restraint-related death has to come to us; we follow up with an investigation," said Ivandick. "Also, we follow up on complaints, usually by clients who have been restrained, to look and see whether

there's any system or policy that needs to be changed to protect other residents.

"We have special access to any internal investigations at the facility, to patient records, et cetera," he said. "We make recommendations to the facility on how they do business; if they refuse to change their policy and we believe it's important enough to protect others, then we can file an injunction."

As the state agency in charge of protection and advocacy, Legal Center attorneys report any licensing violations to licensing entities such as the Board of Nursing, the Board of Medical Examiners, or in this case, the state of Colorado Department of Human Services Mental Health Division.

"It's more or less a licensing issue," said Ivandick. "If they're violating the law or regulations for Residential Training Centers, for 24-hour facilities for children, they can be subject to having their license pulled."

The Legal Center report on Orlena Parker's death and restraint practices at Devereux Cleo Wallace is currently pending.

Good faith

Nancy Lanning, manager of Residential Services for El Paso County Department of Human Services, says that Cleo Wallace responded well to complaints made in 1999.

"There was a time [a few years back] when we were very concerned," said Lanning. "It kind of seemed as if restraint was sometimes their first resort rather than the last resort.

"Cleo was very responsive to hearing our concerns. I know they underwent some very serious policy making, training and retraining of the staff. The number of incidents of use of restraints really did go down."

Lanning emphasizes equally the difficulty of managing children with serious mental illness and behavior problems, and the mandate of the county to monitor use of restraints and potential abuse.

"The kids they take have serious, serious problems," she said. "I don't know how it must feel when one of those kids gets out of control."

A child welfare intake team, ISAT (Institution Safety Assessment Team), investigates any allegations of child abuse from use of restraints. "We investigate them all," said Lanning, "but we don't actually keep a record of the number of times restraints are used in all our facilities."

Most of the investigations, she said, are "fairly routine" and most are handled by the workers. If an accusation of abuse or neglect is confirmed, the team meets with managers and supervisors from DHS, representatives from the facility in question and representatives of the licensing agency.

"We come to a conclusion -- what are the actions that need to be taken?" said Lanning. "Do we (DHS) want to say that we don't want to use this facility any more? We could suspend using them for three months and in that time we expect this, this and this to happen.

"We don't just shirk it off and say, 'Oh, that's a difficult kid' or 'Would you want to take care of that kid?' Our people are very well trained. And the state has improved its training and expectations."

Still, says Lanning, despite safeguards, things happen. At particular risk are kids placed out of state.

"We don't have the wherewithal to monitor our kids placed out of state face to face," she said, adding that DHS tries not to place kids out of state. "As

a system, we don't have a way to see them. The caseworker is in contact by telephone with the kid as well as with the facility; the CASA [Court Appointed Special Advocate] worker is in contact, but none of us are seeing him. The worker accompanies the child when they're placed; you have a sense of where you're leaving them. But it's not the same as, 'Oh, I'm in the neighborhood I think I'll pop in.'"

Each institution decides for itself how and when to use restraints, says Lanning, and there's no way to predict when or how often restraint might be used.

"You never know when this particular child is going to push somebody's buttons despite all the safeguards in place," she said.

Caseworkers with clients in residential treatment facilities, says Lanning, have to be notified after a physical restraint is used.

El Paso County DHS Child Welfare Administrator Lloyd Malone said the county's role in the Stage I report following Orlena Parker's restraint and death was to determine "whether the action or inaction on the part of the staff was directly responsible for the outcome." They concluded it was not.

"We look for abuse and neglect, not policy infractions," said Malone. "It's an interesting and difficult dilemma in our society how you handle these very difficult kids. These facilities become the flash point for public interest after an incident like this, but ultimately it's a public policy issue."

Malone believes that Devereux Cleo Wallace has made significant improvements in their use of restraint since 1999.

"A kid this big that gets out of control so quickly, things happen so fast. That's why it becomes an interesting public policy issue," he said. "Sometimes these little events happen and it appears that something could have been done. I think the facility was doing everything they could for this kid."

A big damn deal

Proper use of restraints on children in mental health facilities is literally a matter of life and death, says Judith Schubert, president of Crisis Prevention Institute, an organization whose Nonviolent Crisis Intervention Training Program has been taught to more than 4.5 million people worldwide.

Though she could not speak specifically about Orlena Parker's death or Devereux Cleo Wallace's restraint policies, Schubert spoke openly about the mortal danger physical restraint can pose.

"When you restrict movement of the diaphragm, you restrict a person's ability to breathe," said Schubert. "An open airway is just one part of breathing. It's interesting that you'll still see in [an institution's] policy -- no covering of the airway, meaning the mouth or nose. That's where the policy stops."

The physical risk of restraint cannot be ignored if there's a chance it's going to be used in a treatment setting, says Schubert. And it's important that staff understand -- someone could die.

"It's risky to say it'll never happen here. We give a little book to all our instructors, all our staff. I guess in that way we put it out there -- if you restrict someone's breathing, you're going to kill her.

"My guess would be that most people who work in a place where a death occurs don't know that it can actually happen," she said. "Adrenaline kicks in, we revert to a primal nature. You have to retrain that -- your body may want to get down on all fours and fight back. That's survival.

"You're really talking about human behavior in extreme, chaotic moments and how to prepare people for scenarios they're most afraid of."

Martha Holden of Cornell University agrees. Her mission is to prevent institutional child abuse, trying to determine the root cause by conducting research on incidents of abuse and death by restraints.

Holden cites several root causes coming together at the same time when a fatal incident occurs, not just an incorrect hold. For example, she said, staff might abandon the agency's accepted crisis intervention process and make their own decisions about how to restrain an aggressive patient.

"Another thing that generally happens is that signs of distress are ignored, like throwing up, because that's what kids do," Holden said.

In addition, she says, out-of-state placements put certain kids at additional risk, because of less direct oversight by caseworkers and family members. And in institutions where physical restraint is routinely used, the danger is often underestimated.

"The more people rely on physical intervention, the less aghast they are," Holden said. "They're not thinking this is a high risk, dangerous intervention. It loses the edge it should have.

"It's a big damn deal," she said. "Everyone in the system should be figuring out how we can manage this kid without doing this."

Mental-health workers must be trained in proper, safe restraint techniques that are appropriate to the setting, says Schubert, but more importantly, if restraints are to be used, they must be seen in context of the entire treatment picture.

"We speak more to assessing all situations," she said. "That should all happen on intake -- medical conditions, history of acting out behaviors, signs of anxiety, all of those things should be known in an assessment process. Obesity is one of those things -- the treatment plan should include early warning signs. [Staff should say], 'Let's consider the size of this person. What are we going to do when she's out of control?' Talk to her about it, you know, 'We don't see a history here of you becoming physically aggressive, but if a situation arises, what can we do?' Sometimes the kid will say, 'Here's what helps me.'"

Holden's training program, Therapeutic Crisis Intervention, recommends that every child with aggressive behavior have a crisis management plan that identifies the triggers, the best way to de-escalate and the safe way to restrain if restraint is required.

Holden and Schubert agree that regulations and laws governing use of restraint, while useful, are not the only motivating factors for positive change. Real change, says Schubert, requires a cultural shift, an internal commitment by the institution to decide and follow through with how it intends to treat its patients.

"I understand that the organizations we work with sometimes have state regulations that motivate them to improve policy. But other times it's from within; it's [them saying that] we don't want to do it this way any more. We've been in what I would call best practice institutions that have very lax state requirements," said Schubert.

"[Those organizations] put a philosophy in place. They say this is how we treat our kids, even in dangerous moments. They tell their staff, 'We're going to give you training, we're going to review incidents; it's all going to be out in the open. It's going



The Devereux Cleo Wallace facility, on the grounds of the Myron Stratton home in south Colorado Springs.

Photo By Creighton Smith

to be something we're going to test you on and we're going to provide you with the tools.'"

Orlena Parker's death by restraint at Devereux Cleo Wallace has triggered a state investigation, but the question remains: Will her death motivate DCW and other facilities to rethink their use of physical restraint and their philosophy of patient management?

"It's a matter of putting resources, training and staff into the problem," said Holden. "There are some places where good things are happening. There are some facilities that work really, really hard at improving their practice."

RECENTLY:

- **Roadblock to Peace** Anxious for Armageddon, Colorado's Christian Zionists oppose the *by Terje Langeland* *(07-17-03)*
- **Want health insurance?** President Bush has a plan to provide medical insurance for every citizen — of Iraq. Part of the $74.7 billion initial allocation for the war in Iraq contains a provision for “rapid, universal health service delivery to the Iraqi population,” according to the Washington Post. For Americans, Bush has mainly offered market-based Band-Aids. *by Kevin Griffis* *(07-10-03)*
- **Get well soon** Improving Colorado health care an uphill fight *by Terje Langeland* *(07-10-03)*

more...

Write a letter to the editor