Girl, 16, dies during restraint at an already-troubled hospital

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The charge nurse found Alexis Evette Richie alone in a small room at SSM DePaul Health Center, motionless and sprawled facedown on a bean bag chair.

Minutes earlier, the 16-year-old foster child had tried to hit, scratch and bite staff members in the adolescent psychiatric ward. Two aides grabbed her arms and took her down a hall and into a small room called the "quiet room."

They held her facedown in the chair while a nurse injected a sedative into her hip. Alexis continued to struggle and then went limp.

The nurse and the two aides left without checking her pulse or making sure she was breathing.

Charge nurse Iris Blanks checked on her minutes later and didn't think Alexis looked right. An aide helped Blanks roll the girl over. Alexis wasn't breathing. Her pulse was faint.

It was 12 minutes after she stopped moving before anyone tried to revive Alexis. By then it was too late.

"Why did they leave her like that?" Blanks wailed over the phone to her daughter that night, according to a police report.

The "little girl," she said, "didn't have to die."

The medical examiner agreed, concluding that Alexis had suffocated on the bean bag chair. Her death on Oct. 26 was ruled a homicide.

Alexis' death came less than two years after the Bridgeton hospital had been warned by the state and federal regulators that patients weren't safe. In January 2008, a patient with doctor's orders for constant supervision died alone after five days in seclusion. That led to a state inquiry that uncovered instances of improperly secluding and restraining patients and failing to report deaths to authorities.

A health inspector was already investigating an operation in which a urologist removed the wrong kidney from a patient.

Last week, officials with SSM Health Care, the St. Louis-based corporation that operates DePaul and several other hospitals, said they could not speak about specific patient cases because of federal privacy laws. "The desire to defend ourselves and paint an accurate and full picture does not outweigh our patients' right to privacy," they said in a statement.

They said safety is the first and most basic promise that they make to patients and cited the training throughout SSM that empowers all employees to protect patient safety.

In early 2008, DePaul was required to explain to state inspectors how it would improve patient safety.

It satisfied the state by passing a full inspection. Its written improvement plan included suspending certain surgeries until surgeons earned proper credentials. DePaul also promised to continuously monitor patients in seclusion and make sure all its behavioral health employees were trained in first aid and restraining patients.

As is the case in most instances when hospitals are found to be unsafe, nothing was done to alert the public.

Even though DePaul had updated its safety procedures, many things went wrong the night Alexis died. Patients held facedown need extra care to make sure their breathing isn't constricted, according to standards established by a national group that credentials hospitals. Failing to check on a patient after giving a sedative is a breach of basic care because the drugs can slow a patient's breathing.

A state health inspector especially wanted to know what caused the 12-minute delay before CPR was started on Alexis.

"I don't think they knew what to do," one aide said.

The government found — again — that DePaul patients were in immediate jeopardy. A federal agency placed a three-paragraph legal notice in the Post-Dispatch classified section indicating that DePaul was scheduled to be "terminated" from the Medicare program because it was "not in substantial compliance with Medicare Conditions of Participation."

There was no explanation of why.

And, once again, neither the state nor the hospital alerted the public that inspectors had determined DePaul patients might be in danger.

Errors unreported

At least two of these episodes at DePaul were so-called "never events" — a list of 28 serious errors or incidents that the health care industry agrees should never occur at a hospital, from baby abductions to wrong-site surgeries.

How often these occur nationwide is unknown. Only about half the states, including Illinois, mandate reporting of never events to state authorities.

Missouri does not, but hospitals can voluntarily report to the Missouri Center for Patient Safety, a nonprofit group in Jefferson City created to study never events. It plans to release general figures on medical mistakes — without naming hospitals or doctors — sometime next year.

Even among states that require hospitals to report never events, compliance is spotty. A report by the U.S. Inspector General for the Department of Health and Human Services in 2008 acknowledged that many errors go unreported.

Missouri health officials in the past year have found 11 cases of hospitals with such serious problems that patients were considered to be in immediate jeopardy.

While those inspection reports are public records, they are difficult to access.

The state is too strapped for cash to put its inspection reports online, said health department spokesman Kit Wagar.

It's another way that Missouri patients are in the dark. Earlier this year, the Post-Dispatch highlighted failures of hospitals to report when they discipline doctors. Reporting of serious disciplinary actions is mandatory, yet the newspaper found just eight reports a year by Missouri hospitals, a number experts said was low.

Some states provide much more detailed information about problems at hospitals. California and Minnesota — two states that require hospitals to report never events — publish reports online that name the hospital and infraction.

"If you have routine regular public reporting, I do think that builds public trust," said Louise Probst, executive director of the St. Louis Area Business Health Coalition, which represents local employers' interests in the health care debate.

SSM executive Robert G. Porter said in an interview Thursday that the company would support an effort such as Minnesota's in which there is open sharing of information by all hospitals, so long as it didn't create a culture where people were afraid to report mistakes.

"If health care workers were fearful that any mistake they made would be automatically publicly scrutinized, what incentive would they have to openly and honestly report errors — or even near errors — so that we can learn from them and improve?" SSM said in its statement.

Becky Miller, who directs the Missouri patient-safety nonprofit group, said the issue is also about lawsuits. "A lot of these safety issues can be very litigious events, so there is a reluctance to openly talk about them and to report them," she said.

The federal agency U.S. Centers for Medicare and Medicaid Services, or CMS, investigates most cases of an unexpected patient injury or death reported to it.

The agency's website, Hospital Compare, has some information for patients but none about never events.

CMS has the authority to cut off federal funding to any hospital that fails to fix a serious problem, essentially shutting it down.

It rarely wields that power. Each year, CMS cuts off two to four hospitals out of more than 6,000 nationwide. No St. Louis-area hospital has ever been terminated, according to CMS; DePaul came close after Alexis' death.

Five days in seclusion

When a patient dies during or soon after being secluded or restrained at a hospital, it's a red flag that could signal negligence. That's because those patients need constant supervision for their protection.

Hospitals must report the deaths to CMS as a condition of participating in Medicare and Medicaid. But DePaul didn't report two such deaths in January 2008.

Few details are available about one of them: the death of an 87-year-old cardiac patient who had been in wrist restraints, according to an inspection report.

The second death involved a patient who was supposed to get continuous, one-on-one supervision in a room apart from other patients.

On the fifth day of seclusion, an aide reported seeing the patient, who had a history of seizures, "slithering around on the floor like a snake" and falling when he tried to stand up, according to the health inspector's report. When the shift ended, the aide reported that the patient was asleep.

No one checked for at least 12 minutes after the aide left. A staff member on rounds found the patient dead on the floor.

The aide who had been monitoring the patient later told an investigator that it wasn't the first time that a patient needing "one-to-one" monitoring had gone unsupervised. A nurse said the staff was short because of budget cuts.

Investigators warned that DePaul psychiatric patients were in "immediate jeopardy." In addition to the failures involving the two deaths, the hospital did not always document reasons for restraining patients and did not always check the vital signs of restrained patients as required.

The hospital promised to review all restraint episodes every week and retrain its staff on restraints.

In their statement last week, SSM officials said they "regularly monitor and review our staffing levels to ensure we are providing safe patient care."

A troubled life

Alexis was abused and abandoned in her short life.

Her medical and foster-care records indicate that after Missouri child-welfare officials removed her from her home at age 7, she bounced around foster homes and institutions.

Around age 11, she tried to kill herself by running into traffic. She was admitted to DePaul on Oct. 16, 2009, after stabbing a teacher at Evangelical Children's Home with a pencil.

In therapy at DePaul, Alexis said she knew she needed to behave. She wanted to go home to her foster family in time for her 17th birthday on Nov. 4.

She could be cheerful and attentive — but was often angry or tearful, according to the records. Being around younger girls would trigger flashbacks of when she was 7 and a family friend sexually abused her.

She was constantly seeking attention, primarily from boys, and was often defiant to staff.

Staffers sometimes encouraged other patients to ignore her — a therapeutic tactic.

Nurses and aides sedated and restrained her several times during her 10-day stay.

The day before she died, Alexis removed a screw from a window panel in the nursing station, taunting workers with it. She wouldn't calm down. An aide named Leon Harriel held her down. She got shots of two drugs, Ativan and Geodon, according to her medical records.

After she quieted, Alexis was asked whether she felt safe while she was restrained.

"Safe," she answered.

The next night, when Harriel told Alexis to go back to the girls hall for bedtime, she cursed him and said, "I'll kick your ass."

He told her he was going to get a shot to calm her down. That made her angrier.

"You can't give me a booty dart!" she yelled.

He went to tell a nurse to get her one. As he walked past Alexis, she punched him in the jaw. Several witnesses said she tried to bite, punch and kick him and others. She scratched Harriel's hand, drawing blood.

At 9:10 p.m., Harriel and another aide, Mike Manetta, grabbed Alexis' arms.

They took her to a small room and held her facedown in a large bean bag chair.

Alexis "continued kicking her legs as we held her," Manetta told a Bridgeton police detective.

Nurse Pam Wooten told investigators that she drew shots of Geodon and Ativan and followed them into the room. She saw Alexis lying facedown with her face and upper chest in the bean bag chair. The aides were kneeling on either side of Alexis, holding her arms as she struggled.

Alexis yelled, "Let me go! I am going to kill you!"

Wooten pulled back Alexis' waistband and injected the drugs.

Wooten said she left to get arm restraints, stopping briefly to wrangle other patients into their rooms.

Harriel told DePaul officials that he and Manetta told Alexis that they would let her go if she calmed down.

Manetta said Alexis "went limp." He told investigators that he and Harriel didn't check on or speak to her because they thought she was playing. Alexis remained facedown. Harriel left to get his hand bandaged. Manetta stayed outside the door. He told investigators later that he could see Alexis' back rising and falling.

Both aides should have recognized that Alexis was in distress because she did not reposition herself after they released her, investigators said later.

The time was 9:16 p.m. When Wooten came back minutes later, Manetta told her that Alexis had calmed down. Wooten told investigators that she didn't check on her.

Blanks, the charge nurse on her rounds, described finding Manetta at the door. She said Manetta told her that Alexis had passed out after getting shots from Wooten.

Blanks went in and got no response when she called Alexis' name and tapped her on the arm. She asked Manetta to help roll Alexis over.

The girl's pulse was weak. Her pupils were fixed, her reflexes gone. She was soaked in her own urine.

Blanks described the girl's face as "lifeless."

"I'm not sure why I didn't start CPR," Blanks told investigators later.

Instead, she left the room to get a light to look at the girl's pupils and sent Manetta to get a blood-pressure machine.

Blanks left again to get a stethoscope. She left a third time to find Wooten and tell her "something is not right."

Panic and questions

Wooten came back and tried to wake Alexis up, shaking her and calling her name. Then she went to the nurses station to call a "code blue," summoning an emergency team.

An aide who heard the alert, Christine Foster, asked if she should start CPR. Foster said nurses told her no because there was no breathing mask. Foster started chest compressions and mouth-to-mouth anyway. It was 9:28. She said she stepped in because "panic took over."

It took nine more minutes for a doctor to put a breathing tube down Alexis' throat. The team tried to restart her heart.

Alexis was pronounced dead at 10:06.

Hospital administrators arrived, followed by the St. Louis County Medical Examiner, who called the police.

Early speculation from the failed attempt to revive Alexis was that she had choked on chewing gum. The doctor who put the tube down her throat said the gum wasn't blocking her airway.

The death affected patients in the unit, and two children were blaming themselves the next day.

"It's my fault," one of them said during an interview with police and hospital officials. "I gave her a piece of gum at lunch — Hubba Bubba — and she was still chewing it."

Lamented another: "It was my fault. I gave her the piece of gum. A piece of Juicy Fruit."

The autopsy later confirmed that she died from being sedated and suffocated in the bean bag chair.

Because Alexis was a ward of the state, an agent from the Children's Division started a child neglect investigation.

Hospital officials insisted no crime had occurred. In the days that followed, DePaul refused to turn over the bean bag without a subpoena or give the Children's Division access to its personnel.

While the state health inspector said the most egregious error was leaving Alexis for 12 minutes after she stopped moving, the children's division investigator found a host of problems.

She blamed Harriel for inciting Alexis by threatening her with a tranquilizer. She said there was no evidence that anyone tried to calm Alexis by other means before restraining her.

She said Harriel, Manetta and Wooten neglected Alexis by leaving her sedated and alone facedown in a beanbag chair.

Bridgeton police, after a months-long investigation, presented the case for involuntary manslaughter to St. Louis County prosecutors, who declined to file criminal charges.

Prosecuting Attorney Robert McCulloch said no charges were filed because there were too many people involved in the case to determine who was responsible.

"We couldn't just narrow it down to the actions of one," he said.

The aftermath

The Children's Division sustained neglect allegations against Harriel, Manetta and Wooten.

Blanks was immediately fired, and the state Board of Nursing charged her with misconduct for failing to perform CPR. The disciplinary case is set for a hearing in November. She declined to comment.

Wooten was reported to the nursing board but charges have not been filed. She also declined to comment; Harriel and Manetta, whose jobs are not regulated by the state, did not return messages left at their homes. The men, in interviews with authorities, said they were distraught over Alexis' death.

Alexis' biological family wouldn't meet with reporters or share a picture. They've hired an attorney who said he was investigating the case.

Her foster mother said Alexis was "special to me" but said she didn't have permission from the foster agency to say anything more.

DePaul officials also aren't talking publicly about Alexis or any of the other cases.

Porter, the SSM executive, said errors are inevitable in an environment as complex as a health care setting. "Our concern is that this telling of disparate incidents will result in portraying a hospital as an unsafe environment, which we know is grossly inaccurate," he said.

Mistakes are made in every hospital. For now, many are hidden from view.

Alexis Richie is buried under a shade tree alongside a road in Laurel Hill Cemetery. Her grave is unmarked, and cemetery workers were not sure exactly where she rests.