

The Death of David Dahlke:

Winfield State Hospital and Training Center

Amy McCart

B.S. Human Development and Family Life  
University of Kansas, 1988

Submitted to the Department of Special Education and the Faculty of the School of Education of the University of Kansas in partial fulfillment of the requirements for the degree of Masters of Science in Education.

**Redacted Signature**

\_\_\_\_\_  
Professor in Charge

**Redacted Signature**

**Redacted Signature**

\_\_\_\_\_  
MEMBERS

12-17-97

Date project accepted

On January 10, 1989, David Dahlke died at Winfield State Hospital and Training Center located in south central Kansas. His death left many unanswered questions about the kind of care he received during his six-year stay at the hospital. Although Winfield State Hospital and Training Center was under public scrutiny to provide better services for the people who resided there, David's death was not satisfactorily investigated by the hospital. The Dahlke family was very concerned about the numerous serious injuries David had sustained over the years. With the help of their lawyer and the Department of Special Education at the University of Kansas, the family uncovered a pattern of abuse that was demonstrable.

**David and his sister, Raine**  
**Her 23<sup>rd</sup> Birthday**

*“And so David’s legacy of purpose continues to unfold as his story is kept alive through the dedicated efforts of those making a difference on behalf of all the Davids that remain, and for all the Davids yet to come.” Raine Dyani, 1997*



## DEDICATION

This paper is dedicated to my dear friend James, who spent several years in Winfield State Hospital and Training Center. He was also a victim of abuse. It is my hope that someday he will have his dreams fulfilled.

## ACKNOWLEDGMENTS

To the Dahlke family, thank you for letting your son's life help others. Thank you for pursuing the lawsuit on David's behalf. Thanks most of all for loving him.

Secondly, I would like to extend my appreciation to Doug Guess, Barbara Thompson, Rud Turnbull, and Ed Hund for helping to show that David was repeatedly abused, and that Winfield State Hospital was responsible. Additionally, thanks to the graduate students who came before me and gathered and summarized tons of records from Winfield.

Thank you to Community Living Opportunities (CLO), for each and every day of the year being there for people like David, and facilitating a quality of life that is memorable.

Finally, Thank you to my mother, whose compassion knows no bounds, whose friendship is unwavering and whose dedication to the service of others is admirable.

## TABLE OF CONTENTS

	Page
Abstract -----	ii
Picture of David and his sister, Raine -----	iii
Dedication -----	iv
Acknowledgments -----	v
Table of Contents -----	vi
Introduction -----	1
David -----	4
Pictures of David -----	11
Pattern of Abuse and Neglect at WSH -----	12
Graphs /Pictures of David -----	32
Litigation -----	37
Conclusions -----	72
References -----	76
Appendix A -----	89
Pictures of Winfield State Hospital	
Appendix B-----	104
David Mandt Deposition: Randel Goad Memo	
Appendix C -----	106
Newspaper Articles Regarding David's Death	

## INTRODUCTION

Sunday morning, January 10, 1989, Winfield Kansas State Hospital.

David Dahlke, a small, 39-year-old male with severe mental retardation returned to his living area (ward) from breakfast at the institution's cafeteria. He was escorted to the bathroom, and then returned to the day room (a room in the hospital that people spend their waking hours). After being seated, David asked that the television be turned on. One of the aides on duty at the time told David the TV could not be turned on during the day and they gave him a magazine. David became upset, threw the magazine and grabbed the aide's shirt. The aide moved away and David slid from his chair to the floor. Another male aide told David, "We don't lay on the floor here."

While still on the floor, David then grabbed the hair of the male aide. At this point, David was placed in a "personal control" position by the two aides. Although very confusing, the report next indicates that David temporarily released his hold on the aide's hair. David was then asked by the male aide if he wanted to get up. At this point the struggle resumed. David reportedly grabbed and kicked the male aide, and also bit his own hand. A third aide then returned to the ward from her break. While the male aide was straddling David, and one female aide was holding his feet, the second female aide left to get the "rollerboard".

The male aide who was straddling David lifted up off of him. David no longer struggled. The female aide noticed David's lips were turning blue and his face



pale. The male aide yelled to the aide station, "Does David have seizures?" A "Code Blue" was activated, and shortly afterwards David was receiving CPR and oxygen by the institution nurses and physicians. An ambulance took David to a local hospital in the community (Excerpts from Risk Management Committee Findings and Recommendations, Winfield State Hospital and Training School, January 18, 1989).

David was pronounced dead at 10:47 a.m., upon arrival at the emergency room. The diagnosis from hospital records at the time of admission read "Seizure. Respiratory arrest followed by cardiac arrest" (Out Patient and Emergency Record, January 10, 1989, The William Newton Memorial Hospital, Winfield, Kansas). The same diagnosis was recorded on the hospital Record of Death for David. A later autopsy on David indicated the immediate cause of death was "irreversible anoxemia" (Pathology report).

The "Risk Management Committee Findings and Recommendations Report" (1989) from the institution concluded that "...any allegation of physical abuse/neglect is unconfirmed" (pg. 11). In most cases the incident would likely have ended there. After all, David had some challenging behaviors. David's parents, however, were courageous enough to ask questions and pursue legal claims on David's behalf. This action was taken, in part, as a response to a history of incidents involving their son while he was a resident in the institution.

The legal action brought to light an exceedingly sad story. A story that should not go untold nor unnoticed by anyone concerned with the rights and treatment of

people (Contributed by Dr. D. Guess, University of Kansas, Department of Special Education).

The purpose of this project is to outline what David Dahlke's life was like prior to going to Winfield State Hospital and Training Center. Additionally, identified within the paper are patterns of abuse that took place with David and the litigation that his family initiated on his behalf. The primary information contained within this paper is summarized from years of data from Winfield State Hospital, and the detailed legal documents. Also included were interviews with David's family and those closely involved with the case. In closing, this paper will put forth a challenge to improve services for all individuals with disabilities.

## DAVID

David was born on January 26, 1949 in Niagra Falls, New York. He was the first son of Victor and Grace Dahlke. David had four sisters and two brothers: Debbie, Jonathan, Lisa, James, Joanna, and Raine. David's father was a minister, and his mother took care of their seven children. David lived at home until he was eight years old. On May 13, 1957, he moved to Bethesda Lutheran Home in Watertown, Wisconsin. David's family believed he needed more formal education and medical treatment. Bethesda offered both. Additionally, Bethesda was connected with the Lutheran Church in which the Dahlke's were very involved.

After David moved, his family would pick him up on Saturdays and he would come home for the weekend. His mom recalled some of her happiest times with her children were when David came home on the weekends. She would go into David's room on Sunday mornings and all her children would be sitting on David's bed, so excited that their brother was home. David's mother recalled the following: "David was always a part of the family. The kids would play church with all the dolls. They would sing songs and have fun times together. We would always eat at the table together. We had breakfast, supper and dinner as a family. David would sit with us at the table and we would all pray. I can't think of a thing that we did as a family that David wasn't a part of."

No one is exactly sure how or why David had severe mental retardation. When he was two years old, he was sitting in his highchair and started blinking his

eyes and then his head dropped. That is when his mother believed that his seizures started. David had both petite mal and grand mal seizures, although he only had two grand mal seizures in his lifetime.

Some of David's greatest times were when he was at church, which was a big part of the Dahlke family life. David spoke very little, but when he did, he would often talk about Jesus or sang songs about Jesus. His mother stated, "He loved to sing "Jesus loves me." His mom would sit at the piano for long periods of time, playing songs that David would sing. "Music was a big part of David's life."

David also had several hobbies. He tremendously enjoyed looking at trains and railroad tracks. He loved looking at sewing machines and pictures of sewing machines. He also loved his Dad's old truck. His mom would take him for drives in the old truck to look at the railroad tracks in their town.

Some of David's frustrations were that he could not speak as he would have liked. He could say some words like: "truck", "Jesus", "Dad", "pray." David's mom repeatedly commented that David was perceptive, very smart. Although he got frustrated at home occasionally, he never broke things. He wanted to stay home as long as possible. When his family took him back to the facility, his mother could always tell which staff were kind to David and which were not, by the way David responded. He always smiled at the staff who were kind, and ignored the staff who were not.

David's family remained very involved with David as he grew up. The Dahlke family loved to celebrate birthdays. There were always birthday parties for all the children. David loved them. David also enjoyed the family vacations in Wisconsin on the farm. The family had such good times together. David really enjoyed an old sewing machine at the farm. David's sister Joanna, remembered these times fondly. She helped David play with the sewing machine. She also remembered David loving the trains and train tracks.

David lived at Bethesda Lutheran Home for 25 years. At that point, Bethesda began changing its services. Bethesda staff determined David needed more supervision. David liked to leave the home and walk around. Staff believed David should be at a "locked ward" to prevent him from wandering. On November 6, 1982, David moved to Kansas. His family had already moved to Hutchinson, Kansas. He went to stay with his parents for a few days, and then moved to Winfield State Hospital and Training Center (WSH) on November 10, 1982. The Dahlke's visited WSH several times prior to David moving there. Although they were not completely comfortable with David moving to Winfield, they were told WSH was the only option for David in Kansas.

After moving to Kansas, David continued to see his family. Of David's brothers and sisters, there was one David deeply cared for. This was his youngest sister, Raine. David and Raine spent a great deal of time together. When Raine was a baby, she and her mother would ride the train to visit David. There was a closeness

between them that was uncanny. Raine offered the following insight about her brother:

David was so charming because he was so real. His mannerisms were unpretentious and his presence was authentic. From a very young age, nothing gave me more joy than to play with him and to make him laugh. At times we'd get to laughing so hard there would be no more sound--only two shaking bodies and four quivering nostrils. David loved so many things but his primary loves were trains, sewing machines, and church. In fact, those are the three words (among his vocabulary of about 50 or 60), he repeated over and over again with the sincerest of thought and enthusiasm. "Train? Ch-ch train? Chine? Chine? Church?" He would ask eagerly awaiting a confirming acknowledgment and reply. We'd say, "David, are you going to go to church?" And he would immediately glow with excitement. David squealed with delight while at church during his favorite hymns, but especially when he saw his dad go to the pulpit. He'd get so excited that he couldn't contain it and didn't know how to channel it. That's when he would bite his hand and reach out and grab hold of someone's hair or clothing with the other hand. All he needed was a little patience and understanding, and he would gently release his grip. Even as a little girl, I was always able to manage just fine with David, which made me question why 'trained' staff members could not. Anyway, David idolized his father and when he was preaching, David's eyes never moved.

Trains were David's trademark. He loved everything that had anything at all to do with trains, from playing with them on the floor, to looking at them in books and driving over tracks in a car--and the bumpier the tracks the more David loved it. His eyes would get big and round and he'd let out a low, rumbling "oooh!" He knew all about the different cars. 'Little Red Caboose' was one of his theme songs which he dearly loved and which we sang over and over again. Mom used to take David in Dad's old truck and drive him around the train tracks south of town so he could see them all up close. David was so blessed to have my mother. Her loving and unwavering devotion to him was unsurmountable.

One of the things David looked so forward to upon his visits home was the old needleless treddle sewing machine which once belonged

to our grandmother. He spent endless hours at that machine. Because he was so entranced by the sounds and movements of all the parts, he'd always want someone with him to work the peddle so that he could watch what was going on.

David loved to sing and he had many favorite songs from certain Christmas carols to 'Jesus Loves Me', to his other theme song, 'One Little Boy Named David'. He'd clap his hands and stomp his feet and together we'd clasp hands up high in the air and dance.

If David was especially fond of you then you'd know it. In his unprotected and uninhibited desire to show his affection for someone, he would reach over and place his hand around your neck gently pulling you towards him. He would then press his chin into your forehead or into the side of your face, brimming an almost contented smile or adoring hum. He did this so genuinely, it was a true expression from his heart. David had a special connection with children and they with him. There was an instant recognition of truth and honesty within the innocence of children and that is what they gently shared.

David loved haircuts, shaves and putting on nice clothes. He loved to have smoke blown in his face. He loved birthday cakes, and blowing out candles and opening up presents. If he opened something a little less desirable like a shirt, he would graciously pass the package along. But if inside he found thread, or trains or books, he was in spellbound paradise. David was mesmerized by TV, especially when watching news reporters, and would he ever have a ball when the game shows were on! He'd get more excited than the people participating! He loved going shopping and picking out snacks, books and new spools of thread. He loved to be squirted with water and honking the horn under bridges. He loved Sears catalogs and knew just where all of his favorite things were located.

When David visited his parent's home after moving to WSH, his mother became concerned about the number of cuts, bruises, bite marks and scratches David had. She particularly noticed this when she helped bathe him. He kept coming home

with more and more injuries. When she asked about these injuries, she was told by Winfield staff that David was difficult to handle and that this was what happened. David began to lose weight after he moved to WSH. His overall physical condition began to worsen.

Mrs. Dahlke decided to take matters into her own hands. Once she spoke to the governor of the State of Kansas to express her deep concerns that her son was being abused. On February 27, 1987, the Governor assured her that he would check into the situation. Summarized below are Governor Mike Hayden's comments:

**I understand your concern regarding possible mistreatment of your son David who is a resident of Winfield State Hospital. I have asked David Morris of my staff to contact the Department of Social and Rehabilitation Services regarding this matter...**

On March 4, 1987, David Morris responded. Below are excerpts from his letter to Mrs. Dahlke:

**I contacted Gerald Hannah, Commissioner of Mental Health at the Department of Social and Rehabilitation Services, and requested that he personally look into your son's case. He reported to me today that he does not believe that David has been the victim of the reported abuses at the Winfield facility. Since the fracture of David's left upper arm on May 21, 1985, he has not experienced any injuries. This opinion is supported by the fact that the majority of the abuse to patients took place in Unit A. Fortunately, David was assigned to Unit B when he entered the hospital in April 1985...[David actually entered the hospital in 1982, he entered Unit B in 1985]**

On March 18, 1987, Commissioner Gerald Hannah also responded to Mrs. Dahlke:

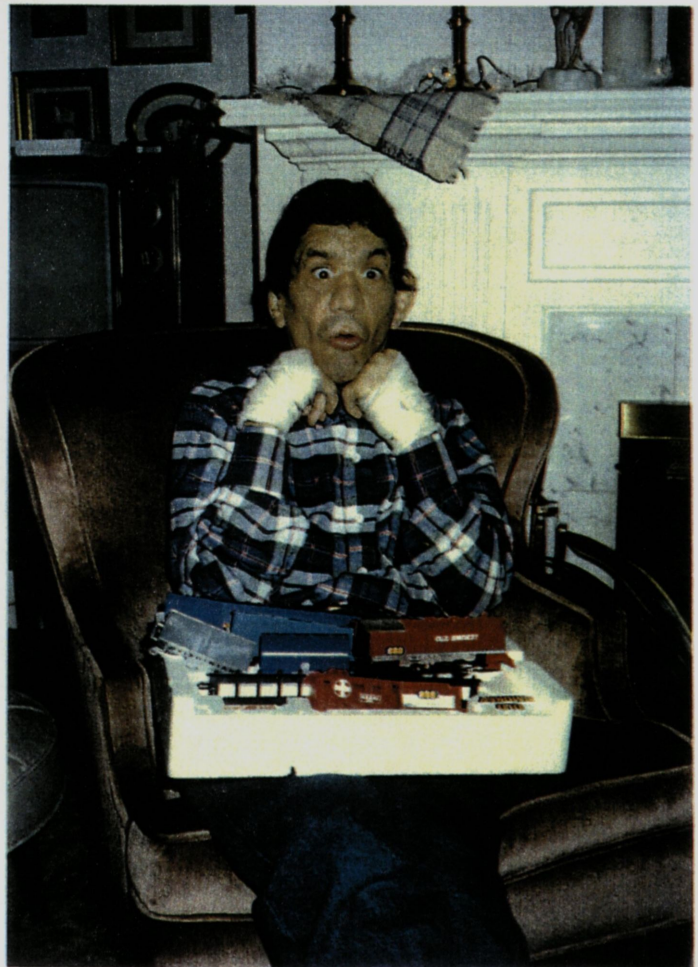
**We have investigated into your concerns regarding David and have found that although David has had problems in the past, there have been no reported major injuries since April, 1985.**

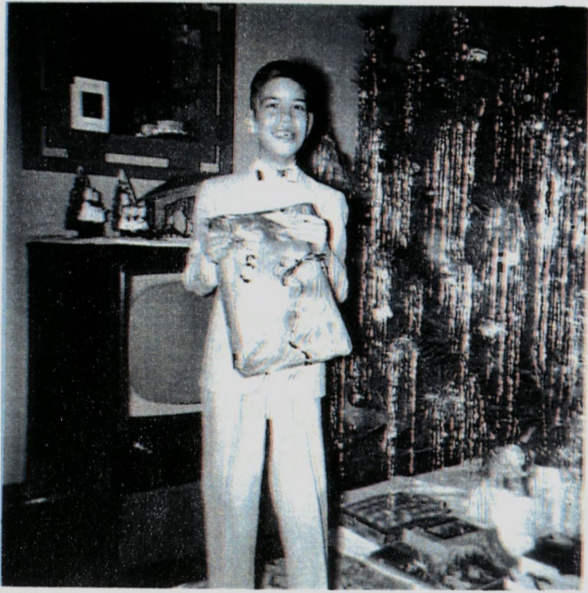


David's leg was broken in May of 1988, and after continuous injuries and restraints, David died at the hands of Winfield staff on January 10, 1989.

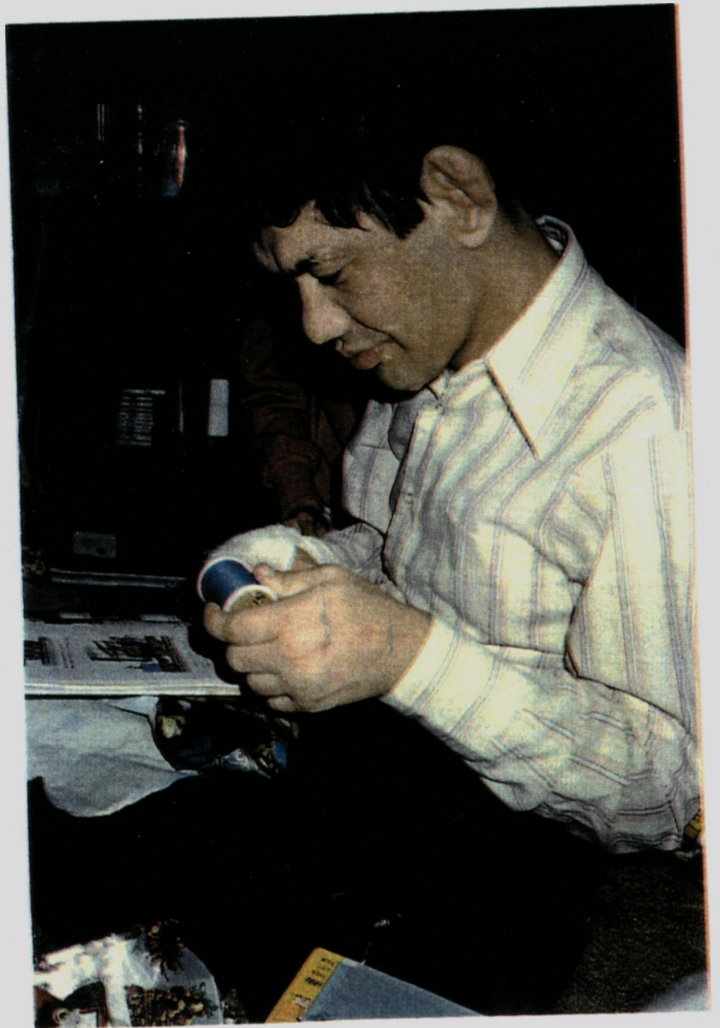
## **David at Home with his Family**







DEC • 61



## PATTERNS OF ABUSE

### **Winfield State Hospital and Training Center**

WSH is the oldest and largest of three state-operated institutions for people with mental retardation in Kansas. The other large institutions are located in Parsons (Parsons State Hospital and Training School) and Topeka (Kansas Neurological Institute). Established in 1887, WSH sits on a hill, surrounded by 422 acres, outside of Winfield (see attached photographs). The old limestone buildings are primarily occupied by people with severe and profound disabilities. It is important to note the State of Kansas also located a prison on the same grounds.

Although research has indicated for quite some time that institutional care is substandard, WSH remained in operation, due to the potential economic impact of losing employment within this community. Services in Winfield were being questioned by state and federal surveyors, as well as family members of those living in the institution, since the early 1980's.

David resided at the institution during an especially tumultuous period for WSH. In the mid and late 1980's, WSH was repeatedly cited for failure to meet minimum government standards of service for people with disabilities. (Palmer, 1989). In order to receive government funds through the Medicaid program, each institution must comply with federal regulations. Each state has a regulatory agency to ensure their standards are being met. In Kansas, the Department of Health and Environment serves as that agency. The surveying agency reports to the federal

Health Care Financing Agency (HCFA) of the U.S. Department of Health and Human Services.

Below is a time line detailing the continuous problems occurring at WSH while David lived there. Following that is a time-line detailing the abuse and injuries David suffered during his institutionalization. The time-lines reveal that David suffered a total of 389 documented injuries during his time at WSH.

## 1984

In April 1984, the Department of Health and Environment surveyed WSH and reported very serious concerns. There were inadequate numbers of direct care staff to meet the needs of the individuals, as staff were insufficiently trained. There were also too few professional staff to provide adequate services to people. Finally, there was a lack of active treatment. Active Treatment was particularly important, because it refers to whether the staff is providing service that meet the needs of the people who reside there. This is evidenced by staff who are teaching and providing daily opportunities to learn, as well as addressing any areas of concern for the individuals they are working with.

In May of 1984, the Health Care and Financing Administration did a full inspection of the hospital. HCFA reported even more serious concerns than H&E raised in the previous month. HCFA determined nursing services were inadequate at controlling infection among the residents. Documentation errors were also prevalent

at the hospital. Most alarming are the final two citations indicating there were gross violations of personal privacy of the individuals who lived at WSH, as well as excessive use of chemical and physical restraints.

In September of 1984, HCFA revisited WSH. The problems noted previously were still evident. None of the citations were corrected.

## 1985

In April of 1985, WSH was surveyed again by HCFA. These surveyors again cited the institution for failing to provide active treatment, as well as staff abuse of the men and women who lived at the hospital. Additionally, the individuals living in the hospital were abusing themselves and others. This pervasive abuse included broken bones, and injuries requiring sutures. Below is an excerpt from the 17-page "Statement of Deficiencies and Plan of Correction" report filed by HCFA following the survey.

**All 499 residents were screened by the survey team for injuries. Over one-third of the residents had injuries that ranged from numerous minor scratches and small cuts to broken bones and sutures.**

**Though the use of leather restraints have been eliminated by order of the Superintendent, other restraints are still used (mittens, velcro). Virtually all of the instances of restraint use observed by the team were a result of a medical order. Many of these orders are continued for months without an appropriate training-behavioral intervention being developed by the interdisciplinary team.**

**The human rights and abuse committees have failed to function effectively to curb the high rate of physical injury to residents and abuse of their rights.**



**Accidents and injuries to clients are so frequent that they are accepted as routine and not reported as required.**

**The survey team observed few training programs for residents, with obvious needs in hygiene, grooming and toilet training. Most "training" was actually custodial care carried out by the staff.**

**The facility does not provide active treatment. All residents observed in the sample received little more than a token exposure to active treatment. Based on documented observation by the survey team, residents receive 15-45 minutes of training (at the most) during program hours. Most time is spent by residents in the following ways: sitting, sleeping, lying on the floor, self-stimulatory behavior, eating grass, aggressiveness, self injurious behavior and eating at meal times.**

These conditions in 1985 were indicative of the institution's way of providing care and treatment (or lack thereof) to the men and women who resided in the facility. These federal findings indicate there were serious life threatening conditions for people with severe disabilities. These conditions noted in 1985 were not effectively responded to, despite large amounts of state funding made available to the hospital. These conditions are the exact conditions that lead to David's death.

Also in April 1985, the State of Kansas decided to address the terrible circumstances at WSH by bringing in a team of professionals from across the state to assist in providing services to the individuals at the hospital for one week. Their efforts improved the situation for that week, but the effects of this brief visit were not long term.

In May, when HCFA revisited the facility, it found the team of professionals helped to remove some people from immediate danger, but there were still significant issues of protecting people from harm across the hospital units. There

were more staff hired, but still no active treatment occurring. In June of 1985, HCFA again cited WSH for no active treatment at the facility. Winfield was given 30 days to correct the problem or it would decertify the institution, meaning federal funding would end.

By September 1985, WSH did not lose its certification, but there were still many improvements needed.

## **1986**

In May, 1986, WSH was surveyed by the Kansas Department of Health and Environment. Several deficiencies were again cited, including lack of active treatment, insufficient staff training, failure to follow dental orders and inadequate infection control.

## **1987**

During this time, the media began to investigate the reports of resident abuse at the hospital. An article by Bill Hirschman of the Wichita Eagle Beacon, (February 6, 1987) reported that earlier unsuccessful attempts by an employee to convince institution supervisors and state agencies that some hospital workers were mistreating residents was an issue of great concern. The employee persisted by repeated calls to HCFA. Eventually, Gerald Hannah, Commissioner of Mental Health and Retardation for the Department of Social and Rehabilitation Services in Kansas, requested a two-week investigation of WSH. Instances of abuse were substantiated.

Several employees were charged with abuse of residents, and with making terroristic threats against other employees who were willing to talk about these abuses.

The following are excerpts from a memorandum by the Division of Mental Health and Retardation Services (January 27, 1987). The material in the memorandum was taken from interviews with two former employees at WSH.

**He witnessed an aide slap and punch a resident countless times, nearly every day. Another Aide also was observed hitting and slapping a resident many times.**

**On October 11, 1986, when he arrived on the unit to begin work, he was told by an aide that he could hit patients as long as coworker #1 or coworker #2 weren't around, anyone else was cool**

**A patient by the name of \_\_\_\_\_ who wears a chest protector, was abused by an employee. The employee would hit him in the chest knocking him down sometimes striking his head on the floor. The employee made the comment to the witness, "you can really have fun with this guy."**

**A staff would say to patients, "get away from me you filthy m---- f-----". Then she would hit the patient with her fist.**

**After a survey team had visited, an employee got an elderly patient in his mid 60's, and another patient in the bathroom and proceeded to beat them for acting up during the survey visit. The employee said "I have had enough of your s---". He then kned the elderly man in the stomach and chest. Later that night the elderly man vomited a black substance on two occasions.**

**MR.----- said the staff could hit the patients anywhere it wouldn't leave marks. If it did, they could chart it as self-abuse or that another patient did it.**

**Witness #2 also talked about his efforts to fill out complaints against employees who were abusing the residents. He was told by other staff that his protection could not be guaranteed. On October 17, 1986 (witness #2) received an anonymous phone call at his mother's house. A male voice said "You're dead." "That's when I decided not to work there anymore."**

On February 23, 1987, the Wichita Eagle-Beacon (Cross, "Reports of abuse at Winfield detailed") published additional information from the employee whose complaint started the investigation of staff abuse at WSH. The employee related accounts of cruelty and cover-ups by supervisors and administrators. Between October 16 and December 17, 1986, he observed nine residents abused with five staff members participating in these incidents. The abuses included: three female employees wrestling a 65-year-old man to the floor and rolling him over and over until he was bleeding; a staff member punching a resident in the stomach who was confined to a wheelchair; a staff member struck the head of a resident with the hard side of a brush; and a resident was denied an evening meal by a staff who had a grudge against him.

On February 26, 1987, Commissioner Hannah removed Michael Dey as Superintendent of WSH. Dey, who was superintendent for six years maintained he was unaware of abuse at the institution. Tony Lybarger was appointed as Acting Superintendent of WSH.

On February 27, 1987, Robert Harder, Secretary of the Department of Social and Rehabilitation, released to the press a review of steps taken to ameliorate the staff abuse at WSH. Action for dismissal or suspension was initiated against 19 employees. Those employees who threatened other staff for reporting abuse were terminated. The press release also reported that from the period of February 25-26, the new abuse/neglect committee reviewed 57 reported incidents.

On May 22, 1987, a "sunrise" inspection by a HCFA survey team (HCFA) found problems associated with shortages of trained staff on two of the institution's special medical units, and inadequate basic skills training for residents. WSH was again threatened with withdrawal of federal Medicaid funds. The state responded by hiring additional medical personnel, and then passed a follow-up inspection by HCFA. Tony Lybarger was named permanent superintendent in early June, 1987.

Also in 1987, R.J. Hendricks was employed as a Special Investigator III in 1987 by the State of Kansas. He was assigned to Winfield State Hospital. His primary responsibilities were to investigate allegations of abuse. He was in this position for approximately one year. In a memorandum of an interview by Mr. Hendricks with the Dahlke's attorneys on July 19, 1990, it was reported that:

**The first incident of abuse involving David that Hendricks investigated involved an employee named Jim Coon, who broke David's leg. He first reviewed the medical reports and then talked to the doctor in town and learned that the injury was a spiral break, which occurs when the bone is twisted until it breaks. The doctor explained to him that this type of injury is relatively rare and takes a considerable time to heal.**

**Hendricks interviewed Coon in his office with two secretaries present. He had Coon use a mannequin to demonstrate exactly what occurred. Coon demonstrated the hold or restraint he used on David. He showed how he straddled David's chest with his knees on David's shoulders. When David kicked Coon's back. Coon reached up over his shoulder, grabbed David's leg and yanked. He heard a loud pop as David's leg broke. When he demonstrated this during the interview with Hendricks, the mannequin's leg came unbolted and snapped off.**

**Hendricks said that he was very concerned and frustrated while at WSH because, in part, they refused to allow his department to investigate deaths at the hospital. The investigators were not even notified when a death had occurred. He believes that all deaths should have been processed as if a homicide was suspected.**

**Hendricks said that the general attitude of the staff members at WSH is that the residents are objects to be controlled and that they will do whatever is necessary to make sure they don't cause any problems during their 8 hour shift. It's his opinion that many of the abuse problems are a result of this attitude and that this attitude is**

fostered by generations of WSH staff. He believes there is now so much "in-breeding" of staff that the old methods and philosophies survive despite the institution's attempts to provide training.

Hendricks believes that far too much physical force is used at WSH. He noted that the force used in penal institutions in which he has worked does not come close to that used in the hospital. He also commented that it's obvious at the hospital that the residents usually have no clue why they are being physically attacked. He said that he was told that some time ago there was an unwritten policy at WSH known as the "three-second rule." Staff members were essentially given immunity for any force they used against residents in the first three seconds following any threat by the resident. The thought was that the staff were allowed these seconds for normal human reactions. As result, the staff knew they could beat the residents during this time period without fearing disciplined.

Hendricks seems to have a fairly detailed memory of the events that happened at WSH...In his mind, Hendricks said, the abuse cases, including David Dahlke's case, are still open because nothing was ever done to conclude the cases and to right the wrongs.

## 1988

On June 22, 1988, the Department of Health and Environment completed a full state survey of WSH. The survey team found more than 138 violations out of a possible 489 of the state and federal regulations. That is nearly 30% of the total regulations. Some of the deficiencies included continued violations of the rights of the men and women who resided at WSH. Below are excerpts from their findings:

**w240** The facility may not use physical restraint as a substitute for activities or treatment:

**On Units A and B** there was a high use of physical restraint without a corresponding emphasis being placed on "positive programs" of interest to the clients.

**w235** The facility may not allow: A resident to be placed alone in a locked room. Staff interviewed indicated that two residents of Unit B are placed alone in a locked room as a part of a behavior management program.

In January of 1988, Frederick J. Fuoco, Ph.D. was asked to come to the hospital to do a review of the overall conditions at the facility. Below are excerpts of his findings:

**In many cases it appeared that “packaged programs” were prescribed for residents without adequate consideration given to his/her presenting problems, needs, and capabilities.**

**Based upon review of injury reports, resident records, and staff interview there is a large number of [resident] injuries at the facility...**

**Restraint procedures are frequently used...**

**It appears that since March, 1987 allegations of abuse/neglect are promptly and thoroughly investigated, and appropriate action is taken when abuse/neglect is substantiated.**

**In some areas of the facility, there does not appear to be adequate involvement of the psychologists in the development, evaluation. And revision of treatment plans as evidenced by below standard behavioral treatment plans that are not sufficiently individualized and that do not contain modification based upon the resident’s right to treatment.**

**Training of direct care staff in the implementation of behavior management procedures has not been completed.**

**Continued efforts should be made to reduce the number of incidents of resident abuse/neglect at the facility.**

**Continued efforts should be made to promptly and thoroughly investigate allegations of abuse and neglect.**

**Efforts should continue to train staff in the areas of prevention of resident abuse/neglect , resident safety, etc.**

**Facility administration should continue efforts to study the frequency, cause, etc. of resident injuries. Intense efforts should be made to reduce the number of injuries...**

## 1989

Problems continued for WSH during the Health and Environment Survey in July 1989, several serious concerns were still noted. The survey found:

**On fifty one of fifty five days reviewed the facility did not meet the minimum ratios for certified direct care staff.**

**Not all facility staff demonstrated the skills and techniques necessary to administer interventions to manage inappropriate client behaviors and/or to implement programs for each client they were responsible for ...**

During this time, a letter was written by a concerned employee of WSH. The letter went to the hospital, HCFA, Governor Mike Hayden, the Director of Mental Health, the Attorney General's Office, the federal Department of Health and Human Services, several newspapers, television and radio stations. The letter was as follows:

**Dear Sirs**

**I take pen in hand to ask you to help prevent, reduce, or permanently stop the resident abuse at the Winfield State Hospital & Training Center in Winfield, Kansas.**

**Naturally, I have a particular incident that caused me to write this letter. A few days ago, while working in Unit B, I personally observed a LMHT [supervisor], Loretta King, physically and verbally abuse a resident. I later asked someone else who obviously noticed it, and they only replied, "It wouldn't do any good to report it. Others have complained and no one will do anything about it. She has a personal friend on the Risk Committee and they block it for her."**

**I could hardly believe what this person was saying to me. If I hadn't seen and heard what Loretta did, with my own eyes and ears, then I would have probably never believed it myself. I decided to do a little research of my own on the matter and learned that during the past three years, there has been a noticeable increase in resident harm reports, employee injury reports, and resident deaths. An increase in resident deaths alone should be a sure sign that the present administration (including the state director) are not doing their jobs very well. If they allow their supervisors to abuse residents in front of the direct care staff, then what else could be expected but the same thing from them. The direct care staff only know what they are told and trained to do by their supervisors.**



**Someone, somewhere has to do something. It can not continue to happen forever. I regret that I cannot come forward with my name, but let's face it, if I do my life will be just as miserable as the life of the residents at Winfield State Hospital & Training Center.**

Channel 12 television news in Wichita contacted Mrs. Dahlke about this letter and immediately sent her a copy. The media was aware of the fact that David had died, and felt this information might be of benefit to the Dahlke's. This letter continued to substantiate the allegations of abuse and neglect of many of the residents at the hospital.

## **1990**

During the follow up survey by Health and Environment in September 1990, concerns were still being cited:

**On all days, during observations by all surveyors it was found that staff [were] inconsistently intervening appropriately and effectively in maladaptive behaviors such as but not limited to SSB and SIB. It was also noted that some staff had "invented" and were implementing some behavior programs informally.**

**The facility failed to provide sufficient direct care staff to manage and supervise clients...as evidenced by but not limited to the following: 1. Clients were to be left for extended periods of time without the benefit of direction and interaction...**

## **My observations of WSH, 1997**

Winfield continued it's rocky reputation of abuse and neglect at the hospital though the years. I have visited WSH approximately 20 times in the last 10 years. I most recently visited in September 1997. On that trip, I could not believe the number of people laying on the floor.

I was at the hospital for nearly three hours, and during that entire time I did not see one teaching interaction. There was a lack of active treatment. There were no activities for anyone to do, except watch television. There were insufficient staff to adequately supervise and care for the individuals. Staff were not intervening in self injurious behavior or self stimulatory behavior. Several of the staff I observed were reading the newspaper, watching television, or simply standing guard at the door to ensure that the ten to thirteen people they were responsible for stayed in the day room.

The staff also let an individual sit on the toilet for approximately thirty minutes without any clothing, except his shoes and socks, because he had taken off his clothing. They would not get him clothing until I requested they do so. I sat next to a man who had a cut on his head, of unknown origin (although it involved a thrown chair, the staff reported). The cut was poorly cared for, and had minimal stitches. He had dried blood all over the side of his head that needed to be cleaned.

The staff also reported to me the staffing ratios in the evening are usually one staff to thirteen residents. This is an environment that is extremely deprived for the

80 individuals still residing in this facility. It is clear WSH has historically provided substandard care and treatment for people with disabilities. This environment was, and still is, horribly abusive and neglectful.

### **The Injuries of David Dahlke**

Active treatment for David was virtually nonexistent during his entire stay on the Special Treatment Unit (STU). The STU was a unit that was developed to put all the individuals that had the serious behavioral needs. His records indicate less than 45 minutes per day in programs. His annual goals (ie: washing hair and brushing teeth) remained virtually the same throughout the duration of his time at WSH. The use of the Mandt procedure and the various restraint devices constituted the virtual sum of David's activities and programming on the Special Treatment Unit.

Additionally, David sustained a total of 389 documented injuries during 1983 - 1989. This does not include all the injuries that may have occurred that went unnoticed or undocumented by staff during David's stay at WSH. Graphs at the end of this section detail the number of injuries David sustained as well as information on the restraint devices that were used. Also, included are photographs showing the types of restraint devices that were used on David.

## **1983**

David sustained 21 injuries in 1983 and was restrained by staff 35 times. Of the 21 injuries that David received 12 of those are of unknown origin, 2 of the

injuries were caused by himself (scratching, biting, hitting or pinching), and 7 injuries were caused by staff and/or other people living at WSH (see attached graphs). Although it is not indicated in David's medical records, David's mother recalled that David broke his hand on September 23, 1983. She was told by Winfield staff that he injured it by putting it under a rocking chair that someone was rocking in. His mother found that to be very unusual, in that, they have always had rockers at their home and David had never even attempted to put his hand under it.

## 1984

On April 5, 1984, David was admitted to William Newton Memorial Hospital with recurrent swelling of the left elbow. He had the elbow operated on to decrease swelling. It is unclear what caused the injury to his elbow, other than speculation by the physician, that the injury was caused by some type of trauma.

One month later, David was admitted to William Newton Memorial Hospital for recurrent swelling of his left ear. There was a large hematoma on the ear causing it to appear completely ballooned. Again, it is unclear how the injury occurred, although the physician notes stated, it may have been caused by self injury. David's mother expressed concern to the staff at Winfield that she did not want him to return to the ward so soon after surgery, for fear that his ear would be pulled on again. He was injured again when someone (records state another resident) pulled David's ear so hard it tore out the stitches, leaving his ear permanently disfigured.

David spent 17 days during 1984 in the medical hospital. He received a total of 31 injuries, of those, 2 were of unknown origin, 1 was self inflicted, and 28 were done by staff or residents of WSH.

## 1985

On April 30, 1985, David was again seen by Dr. Samuel (David's physician outside of WSH) that William Newton Memorial Hospital, for large swelling of the right elbow. The doctor stated that it appeared to be very painful to David. Once again, there is no explanation of how or where the injury occurred. The elbow required surgery to repair, just as the left elbow did.

Then, less than one month later, David returned to William Newton Memorial Hospital. This time David had a fracture of his left arm. It is stated in the William Newton Memorial Hospital's medical records that David was attacking an attendant and fell while doing so, injuring his arm. It is not clear what transpired during that interaction. The fracture David received was described in the medical records as a "grossly displaced fracture". The fracture required surgery and a six hole plate to be placed in his arm. It would have required some force to sustain that kind of injury, David only weighed about 140 lbs. Therefore, that injury remains a question.

On July 25, 1985, David was re-admitted to the hospital by ambulance for large swelling of his right elbow. Again, it is unclear of the origin of this injury.

The frequency of restraints dramatically increased when David transferred to the Special Treatment Unit on April 17, 1985. This increase occurred even though he spent 144 days of this year in the medical hospital or medical unit after having his arm broken two weeks after transfer to the Special Treatment Unit. David sustained a total of 143 injuries during 1985. Of those injuries 98 were of unknown origin, 13 of the injuries were self inflicted and 32 were caused by staff or residents.

## **1986**

The frequency of restraints increased to 213 times during the course of the year. David spent 831.58 hours in restraints this year. The equivalent of spending nearly five weeks in restraints. He sustained 55 injuries, more than one a week for the entire year. Twenty-eight of those injuries were of unknown origin, 12 were self inflicted and 15 were caused by staff or residents.

There are no hospital records from William Newton Memorial Hospital for 1986. It is unclear whether David went to hospital for any of the 55 injuries he sustained.

## **1987**

The total number of times David was in restraints further increased during this year to 294. David sustained 58 injuries this year. There were no hospital records for this time that could have given some indication as to whether David obtained any

treatment for the 58 injuries. Of the total injuries received, 38 were of unknown origin, 15 were self inflicted and 5 were caused by staff or residents. This again shows the tremendous lack of involvement the staff had with David, when he could go year after year with incredibly high numbers of injuries, but no one knew how they occurred.

## 1988

In 1988, David was the victim of a spiral fracture of the right femur. WSH confirmed this injury as a case of abuse. David sustained this injury during a physical altercation with Jim Coon, an employee of WSH. The Risk Management Committee recommended Mr. Coon be terminated from the hospital, and he was terminated. Mr. Coon appealed to Dr. Lybarger, the superintendent of the hospital, for his job back. He was then rehired to work in another direct care position with the men and women who resided at WSH.

This action showed a total disregard for the people at the hospital from the top down. This sent a message to the employees, that if they sat on person's chest, and pulled up so forcefully on their leg that it makes a loud pop, and subsequently causes a spiral fracture, you could still work at the hospital. This was considered acceptable behavior. David's leg never healed properly. He was restrained for months in a hospital bed, while the leg healed. After the leg fracture, his walking was permanently impaired. His leg was so severely damaged that it was one and half inches shorter than before the break.

On May 20, 1988, Lisa Winters, David's sister, wrote to express her concern over the abuse that appeared to be occurring at the hospital, as well as how the chairman of the Risk Management Committee (Wm. Phillip Brooks) handled her concerns. Below are key components of her letter to Dr. Lybarger:

**The comment that so disturbed me at the meeting on May 18, 1988, (which was attended by Ron Hammock, Roxie Namey, Janie Brooks and Bill Brooks), was made by Mr. Brooks early in the meeting. He said, "What you probably do not realize, Lisa, is that much of what happens to David here he brings on himself as a result of his behavior." Although he did say that David did not, of course, deserve broken bones, he, along with the other staff members, went on to talk at length about David's difficult behavior problems and how there were no guarantees at WSH because, after all, staff are only human.**

**I would like to voice my objection and that of my mother, as legal guardian, for the record, to having Mr. Brooks serve as the head of the Risk Management Committee studying David's injury case. We believe his attitude is uneducated, prejudicial, offensive and distressful to us as family members. Furthermore, we seriously question the advocacy Mr. Brooks generates on behalf of the patients at WSH as the assistant to the Superintendent, and while he may be an asset to the bureaucratic system of this institution, in our opinion, he is not as asset to the patients who live there.**

**In follow up, Dr. Lybarger, we are deeply concerned about staff who become immune to the individuality and human dignity of the mentally retarded, and who over time develop a (perhaps subconscious) belief that these patients are responsible for their acting out behaviors not unlike "prisoners" who are sentenced to institutionalization. We would request that you take responsibility for seeing that sensitivity training toward the MR [people who have mental retardation] is built into your staff orientation...**

**Finally, I would like to request on behalf of my parents as legal guardians, all records, reports and facts concerning David's broken leg in order that we can be assured that everything that could have been done and should have been done as a result of this incident, was done....**

In addition to 97 days in the hospital, due to the leg fracture, David sustained an additional 70 injuries. Fifty-one of those were of unknown origin, 10 were self inflicted and 9 were caused by staff or residents.



## 1989

David was admitted to William Newton Memorial Hospital for a final time on January 10, 1989. He was pronounced dead within minutes of his arrival. The reason for his death was listed as seizure, respiratory arrest, followed by cardiac arrest. The staff (Bill Heddon, and Bea-Jay Lanning) were restraining David because he wanted to watch television and he became upset when they refused. When the WSH staff said he could not watch TV (one of David's favorite things to do), David attempted to pull a staff's shirt. Mr. Heddon began to take David to the ground, eventually straddling his chest. Mr. Heddon finally raised off of David. It was too late.

It is significant to note that David lived for only 10 days in 1989, and on each of those days, he was injured. Six of the injuries were of unknown origin, 2 were self inflicted and 2 were caused by other staff or residents. On the tenth day of January, he died.

Had David lived another sixteen days, he would have gone home to celebrate his 40<sup>th</sup> birthday with his family.

# Graphs

# Frequency of David's Injuries

## 1983 - 1989

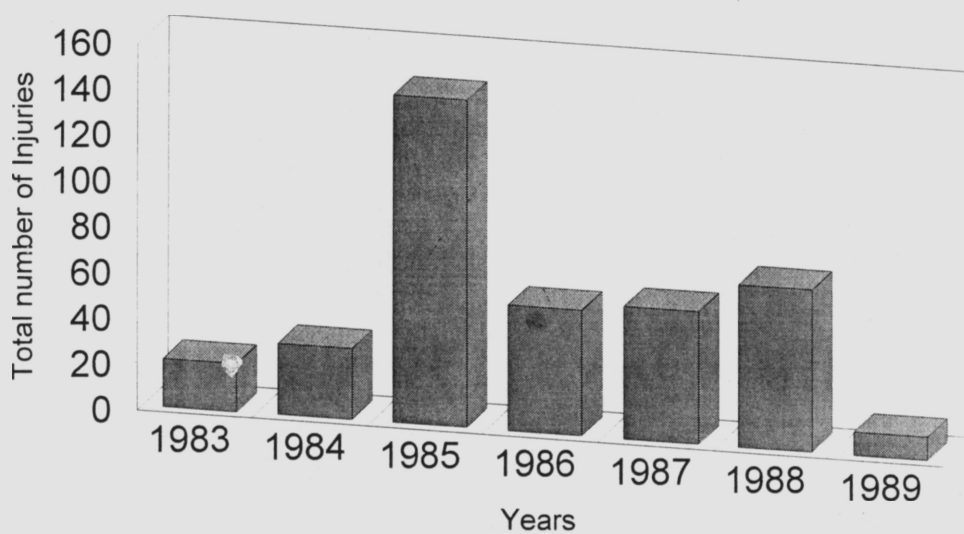
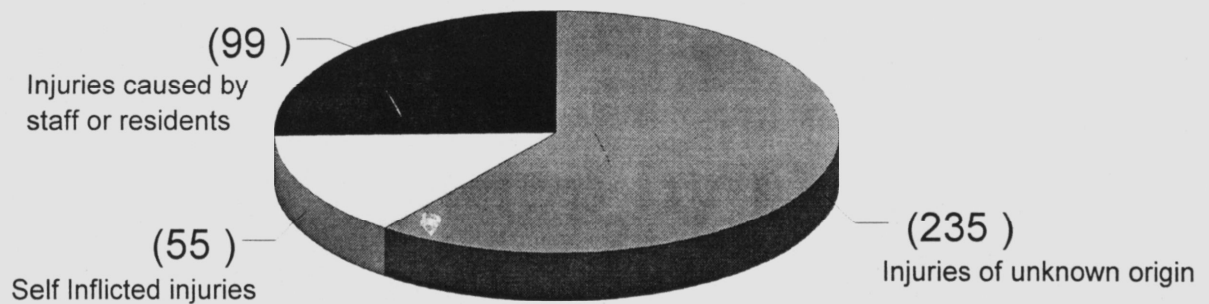


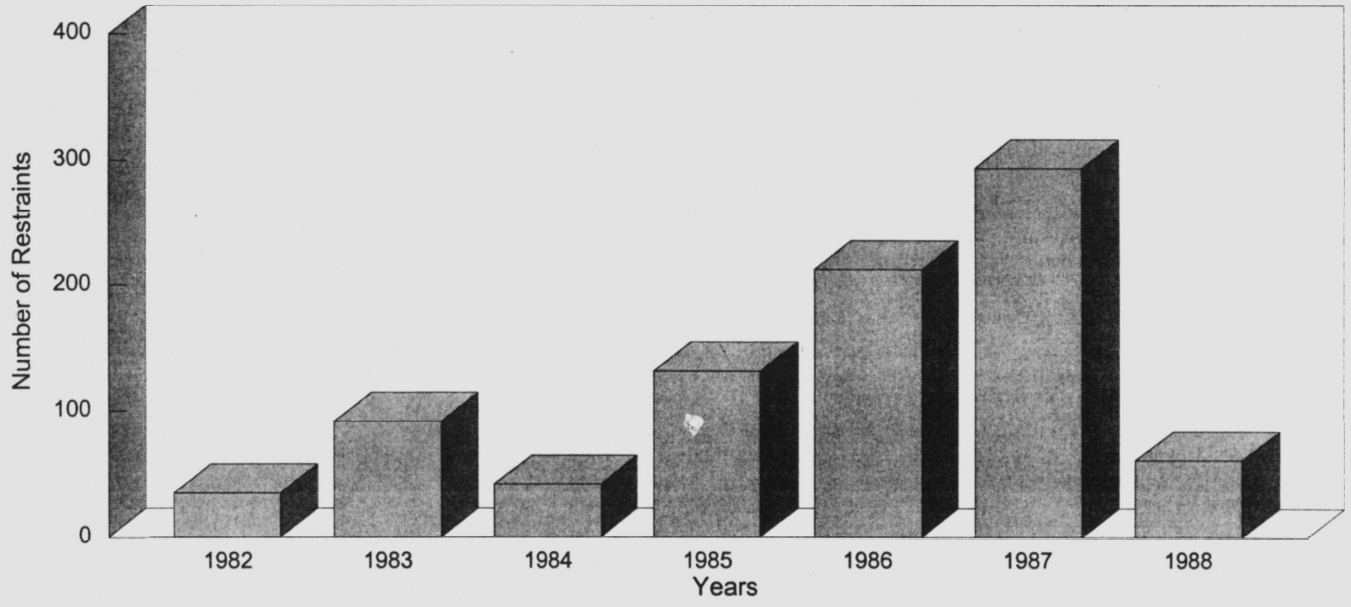
Figure 1: In 1985, David moved to the Special Treatment Unit of WSH.  
In 1989, David died on the 10<sup>th</sup> of January. On each of the 10 days of that year, he was injured.

# David's Injuries by Category

1983 -1989

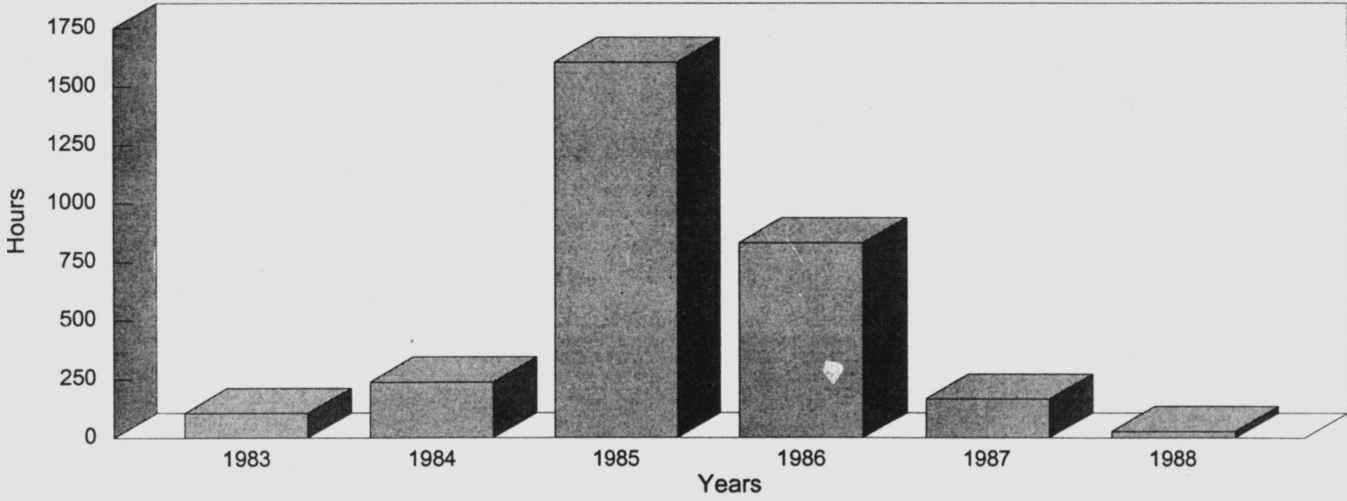


### Total Frequency of Restraint 1982 - 1988



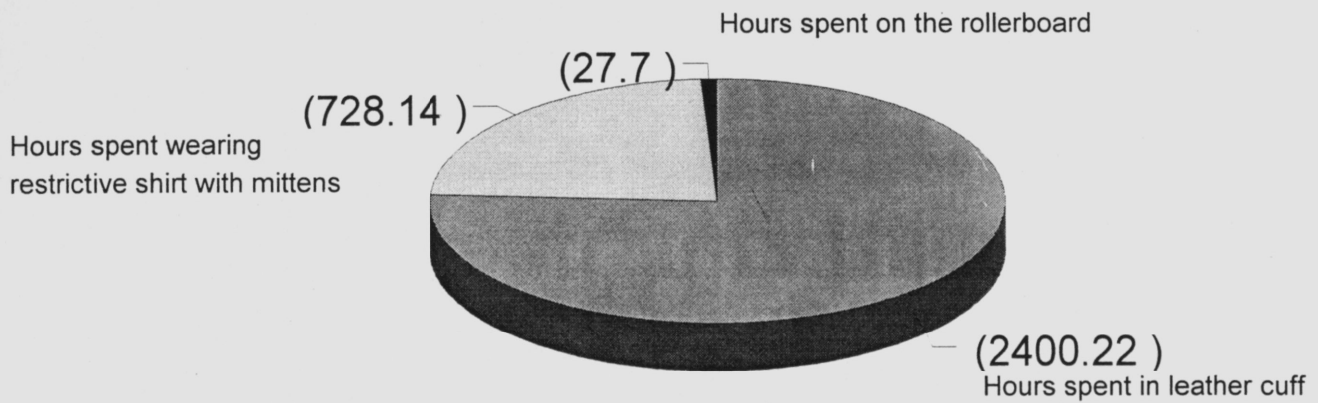
# Number of Hours in Restraints

1983 - 1988



# Types of Restraints Used on David

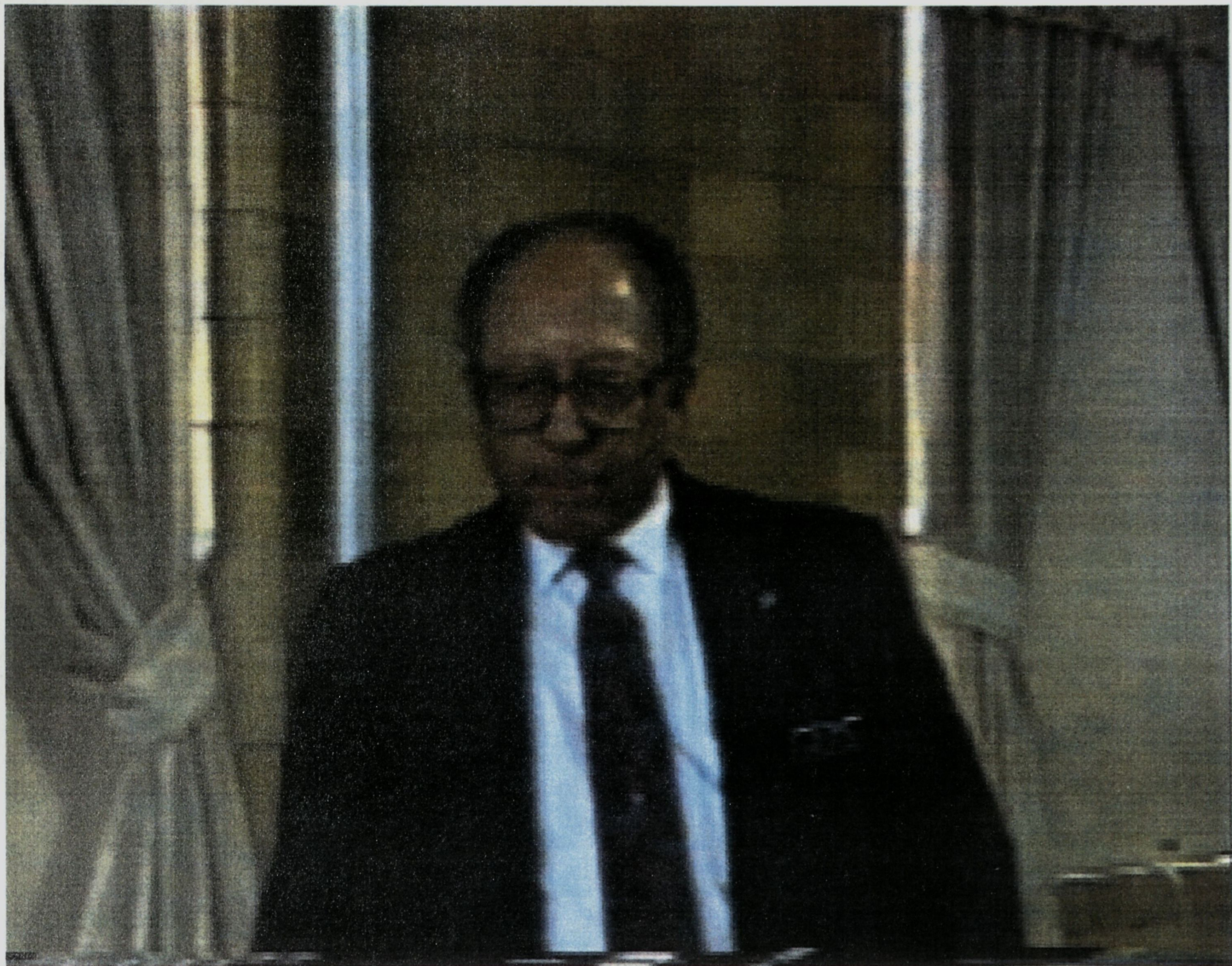
1982 - 1988



**Mr. William Brooks**  
**Current Superintendent of WSH**

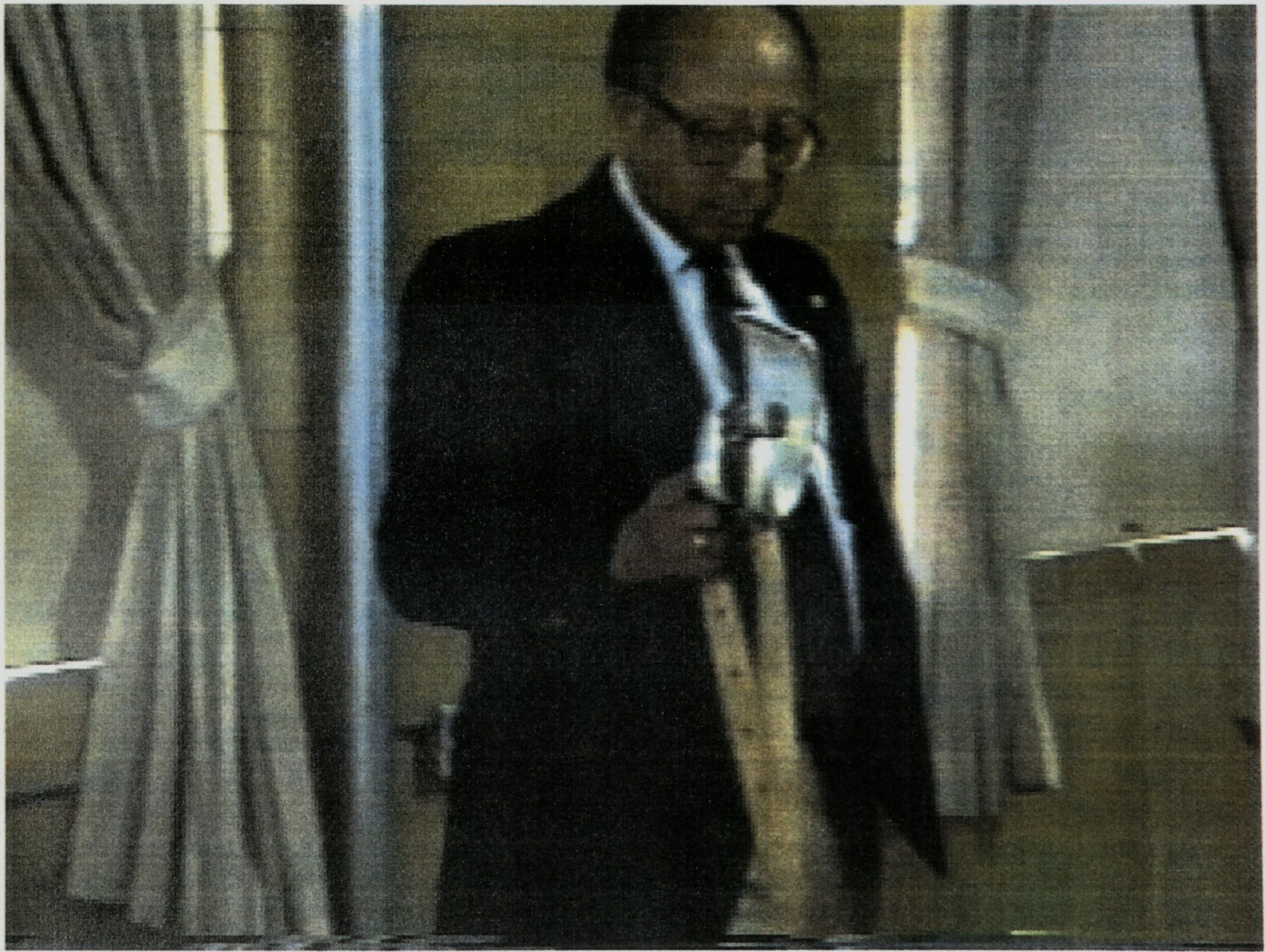
Photographs taken from a video taped deposition. Mr. Brooks is describing the various kinds of restraint devices that were used with David.

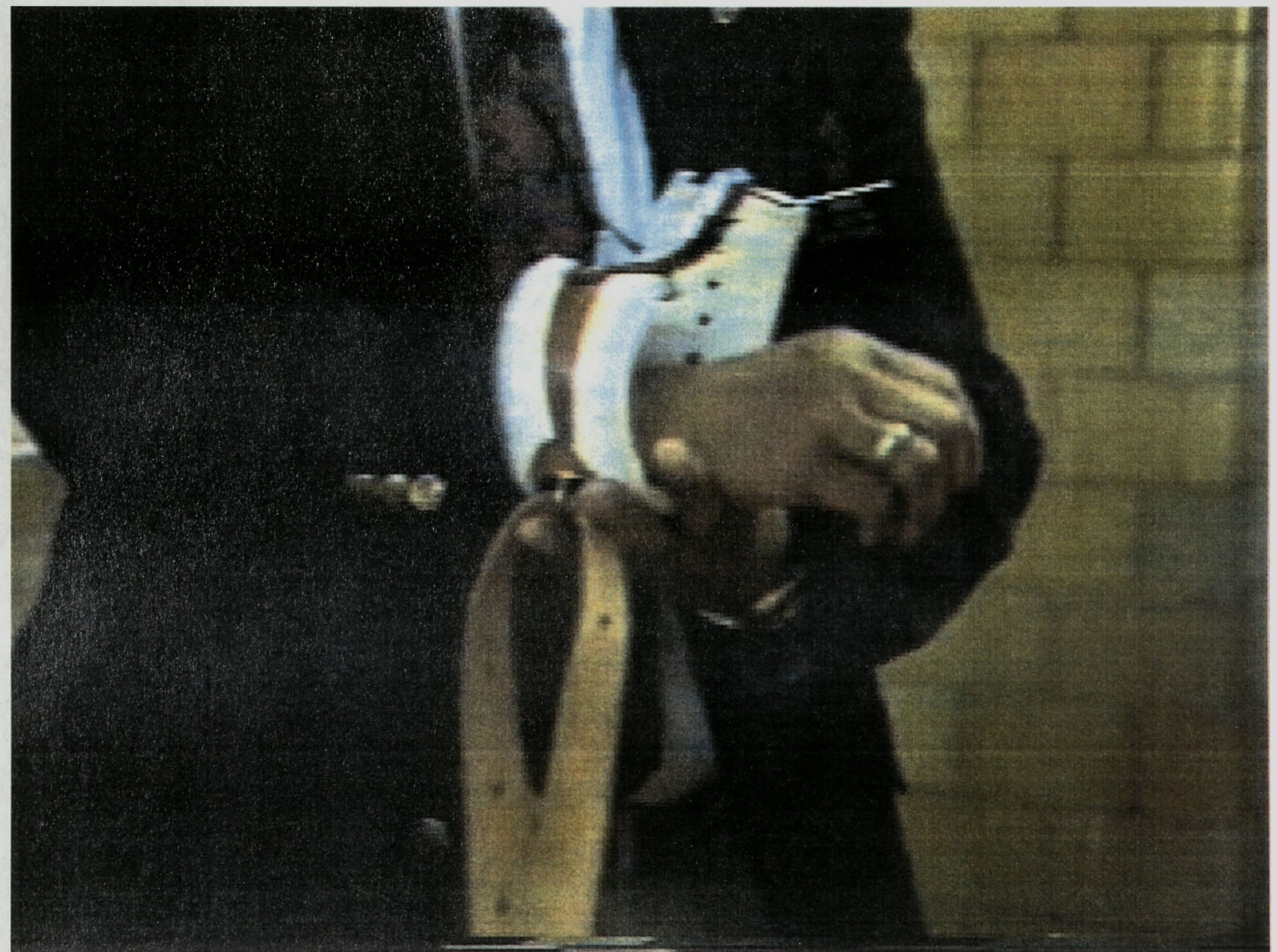




## **Mr. Brooks holding a Leather Cuff**

This cuff locks on to either the ankle or wrist, and is then buckled with the leather strap to a bed or chair. All four extremities are restrained.









## **Shirt with Mittens**

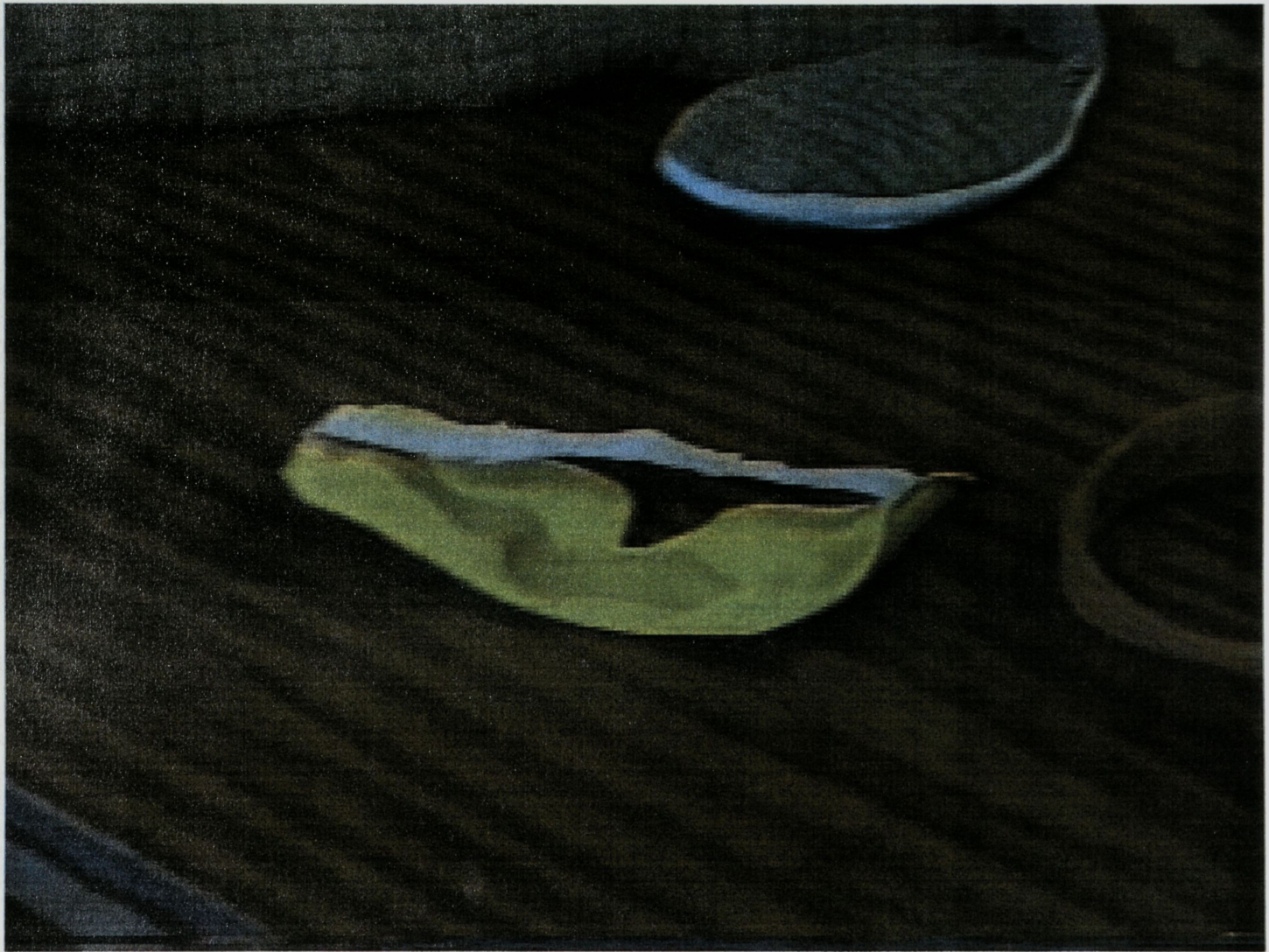
The back view of a shirt with mittens. The shirt made of thick clothe and was worn with the opening in the back. On the back there were many ties to keep it secured on the individual.

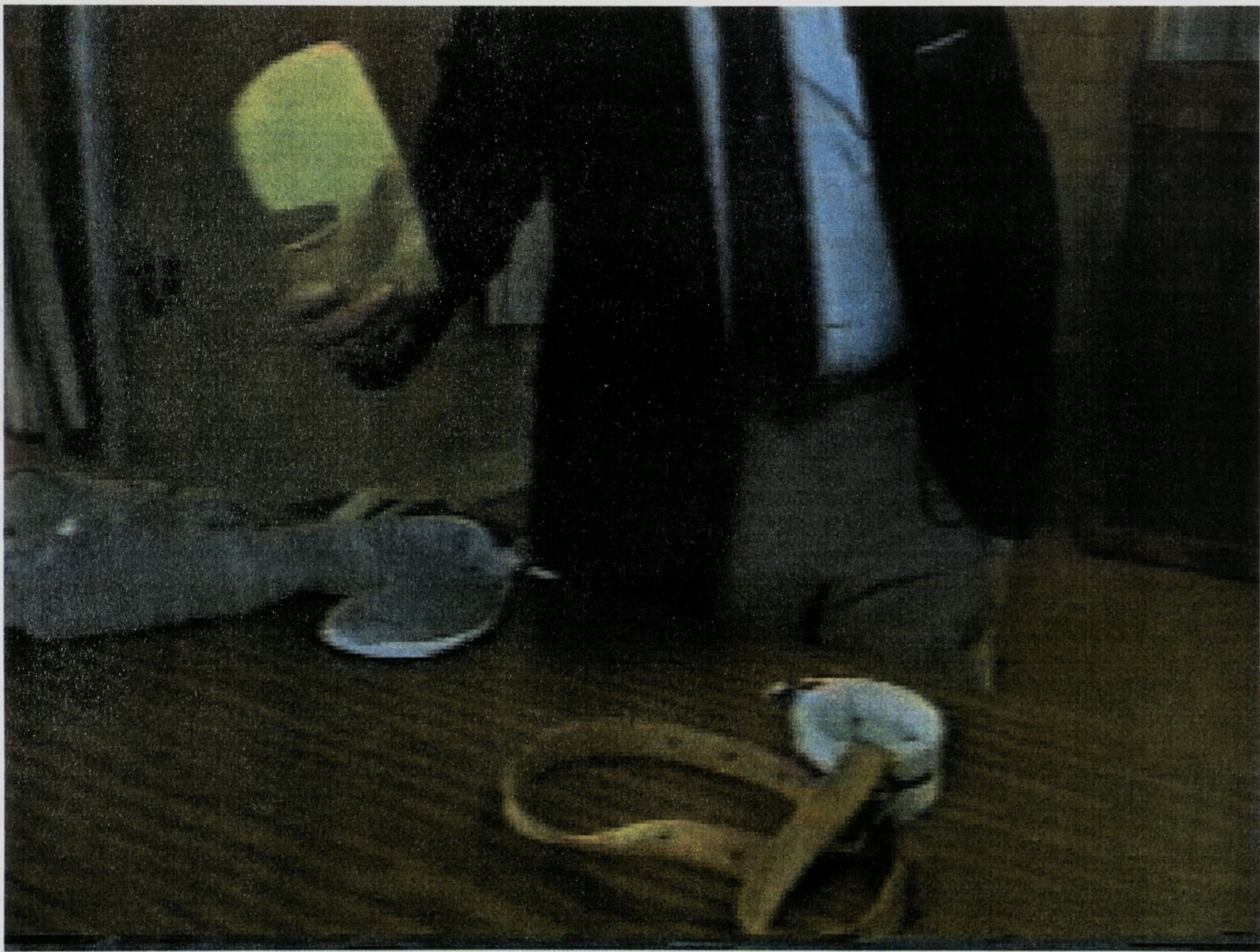




# **Mask**

The mask is used to put over the eyes to restrict all vision. It is often used in conjunction with the leather cuffs.





## **Rollerboard**

The rollerboard has seven straps that go across the body of the individual being restrained. One strap is placed between the legs and secured at the waist, the remaining six straps reach across the body and fasten with metal buckles. The rollerboard is on wheels to move restrained individual. The rollerboards are manufactured in Winfield.

Rollerboards are still in use at WSH today.







## LITIGATION

### **Dahlkes Take Action**

The Dahlke's decided to sue the State of Kansas on behalf of David. The family contacted Edward Hund, a Wichita attorney. He accepted the case. David's parents filed suit in the United States District Court for the District of Kansas.

Detailed in this section are excerpts from legal documents in the case, including comments from the lawyers, plaintiffs, defendants, and witnesses to David's death.

Below are excerpts from the initial complaint:

APRIL 30, 1990

COMPLAINT FILED. Grace and Victor Dahlke filed their lawsuit against:

**Robert Harder:** Secretary of Kansas Department of Social and Rehabilitation Services

**Dr. Tony Lybarger:** Superintendent of Winfield State Hospital

**Michael Dey:** Former superintendent of Winfield State Hospital

**Winfield State Hospital**

**Joe C. Pham, M.D.:** Physician at Winfield State Hospital

**Ed Brooks:** Chairman of Risk Management Committee at WSH

**Jim Coon:** Former employee of WSH

**Bill Heddon:** Employee of WSH

"David was repeatedly and continuously physically injured by the staff at Winfield State Hospital. He suffered serious injuries at the hands of staff members. Further, because of inadequate supervision and protection, David was also repeatedly injured by other residents at Winfield State Hospital.

"...As David was being held down on the floor he became cyanotic, his hands became limp and he became unconscious. David was taken to William Newton Hospital where he was pronounced dead that same day."



Nearly two years after the case, Mr. Hund shared his reflections about this "compelling" case: "David Dahlke was an example of the systemic problems at Winfield. David Dahlke was an example of how wrong everything was at that place."

### **The Department of Special Education University of Kansas**

Mr. Hund contacted the Department of Special Education at the University of Kansas. He spoke to Professor Rud Turnbull J.D., of the Beech Center on Families and Disabilities. Professor Turnbull is an attorney who specializes in the area of people with disabilities, particularly in advocacy of their rights. He has over 25 years of experience in the field, and he is a Professor of Special Education at the University of Kansas.

Professor Turnbull believed the case deserved the attention of the Special Education Department due to the tremendous violation of rights that occurred with David. Professor Turnbull immediately contacted Dr. Doug Guess to assist Mr. Hund in understanding the field. Dr. Guess also had over 25 years of experience in field of people with severe disabilities. Dr. Guess previously worked in an institution for approximately 15 years.

Dr. Guess and Professor Turnbull rallied several key faculty from the department, including: Barbara Thompson, Ph.D., and Marilyn Mulligan Ault, Ph.D., and many doctoral students, including Mary Morningstar, Susan Bashinski, Lori

Noto, and Karen Patterson. These individuals began compiling the data gathered from WSH. Dr. Guess and his team provided Mr. Hund with data to confirm that WSH denied David of any quality of life at the hospital.

Additionally, the Department compiled the information to show the staff at the hospital were neglectful and abusive. The Department of Special Education put forth a tremendous effort to help the family, Dr. Guess, alone, put in over 60 hours of preparation. It is significant to note that no one in the department was paid for any of their services.

MAY 4,1990

Roxanne Namey was added as a defendant to the lawsuit. Her job as a Qualified Mental Retardation Professional was to oversee David's treatment and programming while at WSH.

FIRST AMENDED COMPLAINT FILED. Grace and Victor Dahlke amend their original complaint to add:

**Roxanna Namey:** Qualified Mental Retardation Professional at WSH

"The treatment plan devised, approved and supervised by the defendants herein lack professional insight and was a substantial departure from qualified professional judgment for David Dahlke in that it promoted physical abuse and retaliation by the staff and patients alike and did not provide adequate care and treatment.

"...David was denied the opportunity to participate in alternate treatment programs and was continually institutionalized at Winfield State Hospital in an environment where he was less secure, more likely to be injured and more likely to suffer a premature death."

## Defendants Respond

As the State of Kansas and the employees of WSH obtained legal counsel, the District Court received a barrage of responses from them. Each, of course, denied any liability.

MAY 23,1990

RESPONSE FILED. Joe C. Pham, M.D., submits his defense to the court:

"...[ Dr. Pham] **denies** that he was responsible for the decedent's treatment and programs... This defendant is without knowledge as to the allegations...it is admitted that David Dahlke died on January 10,1989, but the defendant is without knowledge as to the incident leading up to such death."

JUNE 1,1990

RESPONSE FILED. Bill Heddon submits his defense to the court.

"Defendant Heddon... **denies** the allegations contained in paragraph 19 that David Dahlke would be considered as a generally pleasant person. Defendant Heddon admits that David Dahlke enjoyed inappropriate social interaction[s] with residents and staff... Defendant Heddon... specifically **denies** that the staff at Winfield State Hospital was, in all instances, aware of David Dahlke's propensities for seizures, in that his seizure activity was very infrequent and when it did occur, was difficult to recognize."

JUNE 1,1990

RESPONSE FILED. Winfield State Hospital, Dr. Tony Lybarger and Bill Brooks submit their defense to the court.

"...they **deny** the truth of each and every other allegation made in plaintiff's complaint, or are without sufficient information to know the truth or falseness of such allegations and therefore deny such."

JUNE 1,1990

RESPONSE FILED. The State of Kansas and Robert C. Harder submit their defense to the court.

"...they **deny** the truth of each and every other allegation made in plaintiff's Complaint, or are without sufficient information to know the truth or falseness of such allegations and therefore deny such."

JUNE 4, 1990

RESPONSE FILED. Roxanna Namey submits her defense to the court.

"Defendant Namey admits the allegations contained in paragraph 12 that she is a Qualified Mental Retardation Professional, but denies the remaining allegations contained therein and further alleges that she is merely one member of the overall treatment team responsible for David Dahlke's care and treatment while at Winfield State Hospital... Defendant Namey **denies** the allegations...contained in paragraph 19 that David Dahlke would be considered as a generally pleasant person. Defendant Namey admits that David Dahlke enjoyed inappropriate social interaction[s] with residents and staff... Defendant Namey... specifically **denies** that the staff at Winfield State Hospital was, in all instances, aware of David Dahlke's propensities for seizures, in that his seizure activity was very infrequent and when it did occur, was difficult to recognize."

As the defendants were sending documents to the court denying any involvement, the Dahlkes added two additional defendants to the case. The Dahlke's believed the problems at WSH were due not only to the employees based there, but that the State of Kansas was neglectful all the way to the top of the Department of Social and Rehabilitation Services (SRS).

AUGUST 6, 1990

AMENDED COMPLAINT. Grace and Victor Dahlke add defendants to their original Complaint:

**Winston Barton**: former Secretary of Kansas Department of Social and Rehabilitation Services

**Dennis Taylor**: current Secretary of Kansas Department of Social and Rehabilitation Services

The defendants continue to submit to the court their responses, again, all denying any accusations of wrongdoing at the hospital. Specifically denying their individual involvement in David's death.

SEPTEMBER 17,1990

RESPONSE FILED. Michael Dey submits a defense to the court.

"Defendant **denies** that the rights secured to Dahlke by the Constitution and the laws of the United States and the State of Kansas were violated while Dahlke was a resident of the Winfield State Hospital..

"Defendant is without knowledge or information sufficient to form a belief as to the truth of the allegations as to the time that Dahlke died while a resident of Winfield State Hospital."

OCTOBER 31,1990

ANSWER FILED. Dennis Taylor and Winston Barton file their defense to the court.

"...[Defendants Taylor and Barton] **deny** the truth of each and every other allegation made in the plaintiff's complaint, or are without sufficient information to know the truth or falseness of such allegations and therefore deny such... Defendants do admit that the patient David Dahlke did expire during the time period when he was a patient at Winfield State Hospital and Training Center... These defendants are not involved in the medical treatment, diagnosis, and care of the decedent."

### **Comments from Mr. Hund**

Mr. Hund talked with a witness to the incident that ended David's life. Mr. Hund obtained the following information: "This witness stated that Bill Heddon, contrary to his sworn statement, repeatedly took David to the ground, "over and over again."

Further follow up from medical personal outside the City of Winfield (and WSH) found the following, as reported to Mr. Hund: "This continued force caused David's heart to go into fibulation. The Plaintiff's pathologists found David died from heart failure due to significant force, that cause of death was significantly different

than what is stated on the medical report generated in Winfield. The doctor at William Newton Memorial Hospital, located in the City of Winfield, found the cause of death was seizure related which led to respiratory arrest followed by cardiac arrest."

### **Depositions Begin**

On NOVEMBER 1, 1990, the attorneys begin to take recorded information, or depositions, from all those involved in the case.

"YOU ARE HEREBY REQUIRED to bring with you all diaries, correspondence, notes, or any other document or record pertaining to this case of which you have received, created, or which are otherwise in your possession."

Below are excerpts from each of the depositions, outlining the points of view in this case. The excerpts include testimony from both the plaintiffs, defendants, other WSH employees, and professionals considered to be experts in the field of supporting people with disabilities:

#### **Plaintiffs:**

*Grace Dahlke:*

David's mother and father believed they had to speak on behalf of their son. The reasons they chose to speak out included: abuse to David from early on in his stay at Winfield, David being heavily medicated, excessive use of restraint devices, and continual and long-term, severe abuse and neglect.

Finally, they thought someone had to speak out about the atrocities at WSH, so that others would not have to suffer as their son did. Below, as revealed in her deposition, some of these reasons are detailed.

### Early Abuse of David

[8] Q. Is there any event that happened the first year of David's admission that --- that sticks out in your mind that you do recall that relates to Winfield State Hospital?

[11] A. **I really don't recall an event, other than the times when I drove up to take him back, that he didn't always want to get out of the car.**

[14] Q. ...What point in time, if any did you become concerned about the care that David was receiving at Winfield State Hospital?

[17] A. **When I would see injuries on his body when I gave him a bath.**

[19] Q. What kind of injuries are we talking about?

[20] A. **His back would often be very marred, I would carefully put alcohol on it, try and dry up the sores...**

### Heavily Medicated

[13] Q. At any point in time during David's hospitalization, did you have any concern with the type of medication that he was given?

[16] A. **Only to the point that if he was so heavily medicated that he would not be able to function as I would like him to function.**

[19] Q. Did you ever observe him when you thought he was too heavily medicated?

[21] A. **If he was home, that he would not have very much energy, would sleep a lot, but toward the end, I think medication was --- was to the point that he was pretty well regulated with his seizures...**

[9] Q. On an average, how many pills — different pills would he have to take while he's at home?

[11] A. **Oh, a day, I would say he probably had twelve to fifteen.**

### Restraints

[23] Q. What kind of restraints did they tell you that they were using?

[25] A. **They would restrain him in bed if he misbehaved during the day.**

[2] Q. What do you mean by that?

[3] A. **Tie him down in some fashion in bed for a while, they had the chair in the ward that they would sit David and others in and fasten their legs and their arms to the chair so they couldn't get out, they had the mittens that they put on him, they had a shirt that they used, and at the end, they had the roller**

board.

[8] Q. Did you have --- did you express any concern at any of these evaluations concerning the use of restraints on David?

[11] A. Yes, I did. I told 'em that I didn't really like that... they just told me they could not be responsible for David unless that was done.

[20] Q. Did you have any discussions regarding the restraints that were being used on David...?

[22] A. She [Roxie Namey] would tell me how often they were being used. I expressed my opinion that when I saw that chair in the ward where they had their legs and arms fastened, that I thought it was a very medieval way of disciplining those young men.

### Continual Abuse

[4] Q. Do you know a Ron Westfall?

[5] A. Yes. I don't know him personally. I know who he is.

[6] Q. Have you ever talked with him?

[7] A. Yes. He called me.

[8] Q. And when would he have called you?

[9] A. He called me -- I don't know the time frame, shortly after David died, and he was very upset and said he did not want to get me upset, but he wanted -- had something to tell me about David.

[13] Q. What did he tell you?

[14] A. He told me that the word at Winfield during all the coffee breaks began and ended with, "When David Dahlke was killed."

[17] Q. Did he say anything more about David Dahlke being killed?

[18] A. Yes. He -- nothing more about that, but he said that he had seen David abused many times.

[20] Q. Do you recall what he told you over the phone?

[21] A. He told me that he saw David body slammed in the dining room, he said, David was pushed in the corner with a table, table legs on his feet, he said he saw them pin these boys in cold showers, so they would want to stay in bed at night...

### Final Comments

[11] Q. What did you talk with him [Jim Rice, former surveyor for HCFA, who surveyed WSH] about last night?

[16] A. --the fact that we had a lawyer and that we were going to pursue this, so that we could help other adults that will be born some day in David's position, so that they would not ever, ever have to be hurt as he was hurt.



**Defendants:**

*Roxanna Namey*

Ms. Namey was the Qualified Mental Retardation Specialist (QMRP) responsible for the ward where David lived. She was directly responsible for providing David with an environment that included quality programming, active treatment, and freedom from harm.

[9] Q. Are you familiar with a survey team's finding that, "The residents at the facility are not free from physical abuse. The resulting number of injuries to residents and staff is so high that it poses an immediate jeopardy to the people living in the facility. All 499 residents were screened by the survey team for injuries. Over one-third of the residents had injuries ranging from numerous minor scrapes and small cuts to broken bones and sutures. The survey documented three causes of this high rate of injuries to residents. One was aggressive residents physically attacking other residents; two, self-injurious behavior; and three, staff." Are you familiar with that document?

[24] A. Yes.

[7] Q. If the number of restraints imposed on David following these memos [written by Ms. Namey] increased dramatically as compared to the year before, wouldn't that be some indication that the behavior program was going down the wrong trail?

[12] A. Not necessarily....

[2] Q. Would you be alarmed if a changing program that authorized more restrictive use of restraints went from a total hours in one year of 237 hours to 1603 hours the next year?

[7] A. From '84 to '85?

[8] Q. Yes, ma'am.

[9] A. No....

*William A. Lybarger, Ph.D.*

Dr. Lybarger was the superintendent of Winfield State Hospital for most of David's stay at the hospital. As superintendent he was responsible for the

administration the hospital as well as providing quality active programming and protection from harm for the people living at the hospital.

[7] Q. In general terms, what rights do the developmentally retarded clients have here at Winfield State Hospital ?

[10] A. **For all practical purposes, the same rights that we have.**

[17] Q. Was there a finding by that federal survey that the faculty and professionals at this institution failed to protect the staff and the residents from harm at that time?

[21] A. **I don't remember the exact citation, but that's -- that was cited, in general.**

[23] Q. Was there also specifically reference to the overuse of restraints, as well as physical abuse by staff to clients at that time?

[1] A. **Yes.**

[1] Q. The roller boards that this institution has, have they been bought commercially?

[3] A. **I'm inclined to think we make them.**

[11] Q. It was your philosophy that you put and grouped together people who had behavior programming and maladaptive behaviors, is that correct?

[15] A. **Yes.**

[24] Q. Did you hire him [Jim Coon] back after he had been terminated following the May 1988 incident involving David's fractured leg?

[2] A. **Yes.**

[21] Q. Was he also prosecuted criminally because of abuse at the institution?

[23] A. **That's true.**

[8] Q. Well, since it wasn't clear, did you issue any internal policies before the standards changed that would keep the personnel office from hiring some one who had previously been involved in abuse?

[13] A. **I would -- I don't have any obligation to promulgate any policy here that exceeds state statute or the standards.**

[3] Q. Okay. For instance, guideline W128 provides [regulates to]... "ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints." And under Guidelines it says, "The chronic use of restraints may include one or more of the following: The individual's developmental and/or behavioral needs are not being met and the appropriateness of placement should be questioned." That is the kind of information that you as an administrator, in interpreting of No. 128, might find useful in reviewing the performance of one of your employees or professionals; is that correct?

[19] A. I would find that beneficial in the overall operation of the facility related to that W number.

*Wm. Phillip Brooks:*

Mr. Brooks was hired at WSH in 1957 as a laundry worker. Through the years he held many positions while at WSH. He was the unit director of Unit B, David's unit, until October 1987. After that position he was the Social Service Administrator II, which primarily meant he was responsible for monitoring all allegations of abuse and neglect within WSH. Additionally, he was to help prevent abuse at the facility by recommending to the superintendent standards that provided protection from harm for the people living at the hospital. He stated through the course of his deposition that although he supervised QMRP's, psychologists and social workers, he had no formal training for doing that.

[1] Q. Were you aware of the fact that David was injured in 1985 and that he was injured in the process of being put in a hold by an employee, the result of which was a fractured arm?

[5] A. Yes.

[21] Q. Did you direct that a report be made of the circumstances of that incident?

[23] A. No.

[24] Q. Was anybody disciplined as a result of that incident?

[1] A. No.

[2] Q. Did the injury to David Dahlke, this fractured arm in 1985 cause you to monitor David's behavioral management program and the restraints that were being used at that time?

[6] A. No.

[25] ...Did the superintendent or anyone else inform you that Mrs. Dahlke, in particular, was concerned about the safety of David in this institution and that her concern was such that she chose to talk to the governor of the state of Kansas about the potential injury to her son in this citation?

[7] A. No.

[15] Q. Did you make recommendations to the superintendent as to whether or not Mr. Coon should or should not be retained as an employee?

[18] A. **Risk management committee made the recommendation Mr. Coon be terminated.**

[24] Q. After your investigation in May of 1988, did you have an opportunity to speak with the Dahlke family about their concerns of David's injuries and potential future injuries?

[3] A. Yes.

[4] Q. So you recall who you had conversations with?

[6] A. Lisa.

[7] Q. Lisa is David's sister?

[8] A. Yes.

[1] Q. Do you recall being shown a letter that Lisa Winters wrote to Superintendent Lybarger on or about May 20<sup>th</sup>, 1988, which I believe was after this meeting that concerned you?

[8] A. Yes.

[12] Q. She attributes you in the second paragraph of that letter a statement about David in which she says you said, "What you probably do not realize, Lisa, is much of what happens here he brings on himself as a result of his behavior." Is that a statement you made to Lisa in those conversations?

[19] A. **Not the way that she stated it.**

[16] Q. Well, I'm trying to find out whether her questions about her brother's injuries and how he was treated and concerns were ever converted into action to avoid an incident such as the one in May of '88.

[21] A. **I -- I heard -- I gave no assurance and I heard no assurance given.**

A video deposition with Mr. Brooks was taken to visually show some of the restraints used at the time David lived at WSH. Below are statements from that deposition. For the most part, Mr. Brooks acted as if he was terribly uninformed about what the restraints are and how they are used. This ignorance seems ludicrous given the fact that Mr. Brooks was a 34-year employee of WSH.

[24] Q. Okay. So if cuffs were used on David in '82, '83 and '84, is that likely the type of cuff that was used to restrain his--restrain him?

[2] A. I don't know. It-- it could be. If they said it was a lock leather cuff, that more likely could be the kind that was used.

[3] Q. And if a four-point restraint was used in 1985 in a bed, would the leather portion of the cuff likely have been used to anchor the cuff?

[6] A. I've not -- I couldn't answer that because I don't -- I've not used this. And I don't know -- as I said previously, I've seen residents in them but I've not been there when residents were being placed in them.

[11] Q. As a unit director of Unit B, at no occasion in your 34 years of employment at Winfield State Hospital have you seen a cuff being placed on a resident; is that correct?

[15] A. No. That wasn't what I said. I said that I have not seen them in a four-point -- I've seen them in cuffs but I've not placed them in cuffs.

[22] Q. Okay. Now, in 1988 records indicate that David was restrained with cuffs and a roller board. Has a roller board been brought here to this room?

[1] A. Yes. This a roller board.

[13] Q. Do you know where this roller board was purchased?

[15] A. No.

[17] Q. Are those roller boards in use at Winfield today?

[18] A. I -- I think so.

### *James Edward Coon*

Mr. Coon was an employee of WSH . He was terminated due to confirmed abuse by the risk management committee of WSH. He was hired back to the institution by Dr. Lybarger, Superintendent. Mr. Coon's position was Mental Retardation Technician I (level one). He was hired to work directly with the men and women living at WSH.

[5] Q. Where did you attend college?

[6] A. Cowley County Community College.

[7] Q. What subjects did you study there?

[8] A. Geez. Geez, how does this have any relevance to anything? What subjects did I study there? Basically girls and weight-lifting, with a strong major in girls.

[18] Q. Have you ever been arrested for any offense other than a minor traffic offense?

[20] A. Yes.

- [21] Q. What was that?
- [22] A. **Where do you want to start?**
- [23] Q. Anywhere you want to start.
- [24] A. **I was arrested in 1984 for possession of marijuana, I was arrested in 1988 for possession of marijuana with the intent to sell, I was arrested for failure to affix tax stamp, I was arrested for one count of illegal use of a weapon, I was arrested for possession of drug paraphernalia one count, possession of drug paraphernalia the second count, making a threatening and a harassing phone call. Geez, what else? Battery and I think I was arrested for battery again.**
- [13] Q. What training did you receive when you were initially hired?
- [15] A. **None.**
- [16] Q. Pardon me?
- [17] A. **None.**
- [18] Q. Okay you were in direct contact with the residents in the hospital without training, is that your testimony?
- [21] A. **Yeah.**
- [12] Q. So do you know what happened on May 5, 1988 at approximately six p.m.?
- [14] A. **(Witness nods head.)**
- [15] Q. Is that correct?
- [16] A. **Yes.**
- [17] Q. What happened?
- [18] A. **I broke David Dahlke's leg.**
- [19] Q. Tell me how it happened?
- [20] A. **All right, I got up, I went to work, and I broke David Dahlke's leg.**

**Employees of WSH:**

*Bea-Jay Lanning*

Ms. Lanning was an employee of WSH. Her job title was Mental Retardation Technician I (level one). Her primary responsibilities were to work directly with the men and women that lived at WSH. She was one of the employees who was restraining David when he died.

[21] Q. Okay. Go ahead.

[22] A. At one point, my III [her supervisor], Bill Heddon [Ms. Lanning's direct supervisor], came into the ward, or into the family room where David and I were sitting. And everyone knows that David can be absolutely perfect, he can be an angel; but when someone walks into the room, it's like his immediate reaction was to grab my hair and my blouse.

[3] Q. Had he been an angel up to that point?

[4] A. Yes, he had. Yes, he had been wonderful. And when Bill walked into the room, he grabbed my hair and my blouse. Bill came over and got his hands out of my hair and his hands off of my blouse, and then as soon as he got his hands out of my hair, he put his hands in Bill's hair.

[10] Q. Had you had a chance yet to use your method of just relaxing and letting David release your hair by himself by the time Bill got over there?

[13] A. No, there was no chance of that.

[14] Q. All right.

[15] A. And, so, after Bill got -- Bill says, get a mat, Bea-Jay. So I got a mat, and then we took David down on the mat in personal control. I laid across David's legs and Bill straddled David, because that was his -- that was his program, because one person was not allowed to take David down in personal control, it had to be two or more because of -- because he was aggressive, very aggressive. So, as I was laying across David's feet, Bill had him straddled, and he had his hair, his hands in Bill's hair, and Bill had his hands on David's wrists so he wouldn't yank his hair out by the roots.

[4] Q. Okay. And was there a response, or what happened?

[5] A. The more that David was taken down in personal control, the more agitated he became. This went on four to maybe five times.

[8] Q. What do you mean by "this"?

[9] A. Taken down in personal control four to five times at 2 minutes at each interval.

[13] Q. How much time would he have been out of personal control in between each episode?

[15] A. Seconds. Just seconds.

[14] Q. Okay. And then you said you knew something was wrong. How did you know something was wrong?

[16] A. I knew something was wrong because David wasn't kicking like he could kick. He was jerking. He jerked instead.

[19] Q. Through his legs?

[20] A. Through his legs. So I immediately got off of David's legs and I said, Bill something is wrong, something's wrong with David. And he got off of David, and he goes, I think he's having a seizure. And I told Bill then, I said, Bill it's not a seizure, it's not a seizure, it looks like a heart attack... All I know - is David hadn't never had a seizure the whole year I'd been there with him.

[14] Did you have a chance at that point to see David's face or to observe his physical behavior?

[16] A: Oh, yes.

[17] Q. And can you describe what you saw?

[18] A. **David's face was purple and his eyes was back, rolled back in his head to where you could see the white of his eyes. That's what made Bill think he was having a seizure. But he was going ka-ka-ka. He was trying to choke, but he was too weak to choke, so I would assume that would be what they would call the death rattle. They did revive David once after it happened, but he did not -- they couldn't keep him alive.**

[22] Q. Okay. And, again, the behavior that caused David to be taken down that day was just the pulling of your hair and shirt?

[25] A. **Yes. Yes, it was.**

### *William Heddon*

Bill Heddon was an employee of WSH since 1968. His position was Mental Retardation Specialist. He was the group/family leader of six of the men and women who resided in the Special Treatment Unit, including David. He was responsible for supervising approximately five employees one of which was Bea-Jay Lanning. Mr. Heddon was the employee that was restraining David as he died.

[23] Q. While you were head of a family or a group leader in STU, could you describe for me approximately how many time a week it was necessary for you to put residents in personal control?

[3] A. **Numerous times.**

[4] Q. Was it as many as a dozen time a day?

[5] A. **Possibly so, yes.**

[8] Q. Was a rollingboard used institution-wide for other patients before it was used on David?

[10] A. **No.**

[21] Q. Okay. What I'm trying to find out is if David was one of the first persons that a rollingboard was used on in the institution.

[24] A. **With us starting the use of it on STU, any of the residents that were on that area would be the first ones it would be used in.**

[2] Q. Which would include David?

[3] A. **Yes.**

[4] Q. And STU is the first unit that a rollerboard was used in, correct?

[6] A. **Yes.**

[7] Q. So we can conclude that David was one of the first patients that a rollerboard was used on, for that reason?



[10] A. Yes, yes.

[5] Q. On how many occasions do you believe that you found it necessary to strap David to a rollerboard between the time it was first introduced until he died?

[9] A. I would just have to estimate that it was probably at least once a day, as an average.

[11] Q. And before the rollerboards were instituted, was David restrained in any other manner?

[14] A. Yes.

[15] Q. How?

[16] A. Four-point restraint with lock leather belts and leather cuffs to a bed.

[18] Q. He was tied down in his bed?

[19] A. He was restrained in his bed, yes. Or let me clarify that. He was not restrained in his bed. He was restrained in a bed specifically that was only used for that.

[14] Q. And then what happened?

[15] A. And then I felt him stiffen and jerk, and I turned my head to his face and seen that he was turning cyanotic.

[16] Q. It's your testimony, under oath, that you put him in personal control on the floor only one time prior to the time that you noticed that he was cyanotic; is that right?

[20] A. Yes.

[22] Q. Have there been any other deaths in that unit since David died?

[23] A. Yes.

### *Ronald M. Westfall*

Ron Westfall was an employee of WSH for approximately one and a half years at the time of David's death. Ron was also hired to work directly with the men and women who lived at WSH. Eventually, Ron was suspended and terminated from the hospital due to allegations of abuse and neglect. During the time of his suspension from WSH, he wrote a letter to the Dahlkes expressing his concern for the treatment of David. Below are excerpts from his deposition.

[3] Q. And what was your purpose in sending the letter?

[5] A. I guess to, in my own mind, clear my own conscience. From what I saw there and what I have to go on, living with afterwards, I would have nightmares about this unit. As a matter of fact, about any of the units...

[1] Q. And do you know or have any information or knowledge concerning the manner in which his leg was broken?

[4] A. Well, the fellow who broke his leg went to my music appreciation class and he approached me one morning. He said, "You work at the hospital, don't you," cause we had seen each other on the grounds, and I said, "Yes." He said, "Where at?" He looked at me and he said, "What family [group of residents]?" And I told him and he said, "you took my family." and I said, "No, I just applied for a position there." And he said, "Well, I'm the one who broke David Dahlke's leg." And at that time I wasn't all-'cause I wasn't on that unit at the time his leg was broken and so I wasn't that familiar with what all he was saying. But he did make the remark that David was very tough to fight with. He said that he would at— there was times when he would have to hold him down for 20 minutes or more.

[13] Q. Do you recall anything else about your conversation with Mr. Coon?

[23] A. ...He said, "I've spoken with Dr. Lybarger and Dr. Lybarger assured me that after a period of time that I can go back to work there." ...And I did see him again and he said, "I'm back to work and they put me on Unit D, but I don't want it. I want to be back in Unit B."

[12] Q. You describe David's behavior as being primarily attention getting rather than aggressive.

[15] A. That is true.

[11] Q. What is it that you observed the other staff members doing with David Dahlke?

[13] A. David was intentionally provoked into... aggressive behavior, where he would become... upset... David's favorite pastimes, was reading a magazine. And Mr. Nally, Jeff and Doug would like to give his magazine to him and then take it away...

[19] Q. Did you ever observe Rodney Trout do anything to David that you felt was inappropriate?

[21] A. One time that I felt that he was unjustified, and I don't think he did it intentionally, I believe it's simply because he was there before me and had seen the practice done, when he was giving a resident a shower and he was using ice cold water. I mean this was pretty common practice to straighten out resident if they felt -- or if they wanted to see them go off.... I said "you don't do that"...

[9] Q. You also observed Jeff and Doug force David on a routine basis, into a cold shower?

[11] A. That is true.

[23] Q. You also recall seeing staff members make David stay in one place for long periods of time while other ones were allowed to wander around?

[2] A. Yes, he was.

[3] Q. And you felt that was inappropriate?

[4] A. Well, if David wanted to get up and just simply change chairs, he would be called down, you know, "Stay put, don't change chairs." Well, maybe he was tired of sitting in that one spot...

[17] Q. Did you observe any staff members physically keep him in a seat so he'd stay put?

[19] A. I've seen him shoved back into his chair, yeah.

[24] Q. You also indicate that you recall a specific incident when David pushed a table into a corner before dinner and that Jeff told him to take it or put it back, which David did, but then Jeff pulled him across the top of the table and body slammed him into the floor.

[6] A. This was an instance where it wasn't the resident going off, it was a staff member... have you ever watched Saturday Night Wrestling when they take and throw them over the body and throw them to the floor? That's basically what he did.

[23] Q. You also indicate that you saw either Jeff or Doug intentionally shove a table into David's stomach?

[1] A. That is correct.

[2] Q. Where did that occur?

[3] A. In the dining room. David ate alone at his table.

[5] Q. And what happened?

[6] A. David was— he'd stood up and -- kind of stood up— leaning, and he was taking the table and pushing it forward, and I'm trying to recall if it was Jeff or Doug on this particular instance, told him to "leave it alone, don't do that," and David still was shoving it, and he just took hold of the table and just literally gave it a shove right into his stomach.

[23] Q. And then in August, approximately, seven months later, you remember specifically that Bea-Jay Lanning told you that David got up to turn off the TV, and this is at the top of Page 3--

[2] A. Some things you don't forget.

[3] Q. -- "and that Bill told him to sit down and then took him down, He's not sure why this disciplinary measure was taken at all. Bill took him down and Bea-Jay held down his legs. While Bill was still on top of David, he began to turn blue and when he got even bluer Bill decided to administer CPR. By this time, David had already started to relax, which Ron interprets as indicating he already started to become unconscious. She told Ron that Bill did not get off David until he started CPR."

[14] A. This is what she told me, yes.

*Donna Rochelle Morgan:*

Donna Morgan was an employee of WSH for nearly six years at the time her deposition was taken. Her position at the hospital was called Mental Health Technician (MRT). Her primary responsibilities were to work directly with the men and women who lived at WSH. She helped with their daily care, as well as their activities for the day. Her position is often referred to as the "direct care staff." She worked with David a great deal until his death. Donna had developed a good relationship with David and she knew him well. Her deposition primarily revealed much about what she and David did together.

[8] Q. Let me have you expound a little bit on David's capabilities a second. Did David like and appreciate music?

[11] A. **He was fond of church music. I don't know what other kinds he might of liked, but he was particularly fond of Christmas carols and such.**

[15] Q. What are the things he liked to do?

[16] A. **He liked to go on bus rides and car rides. He liked to watch television.**

[5] Q. What other things did he like to do?

[6] A. **He loved to sing.**

[7] Q. Any particular songs that he liked?

[8] A. **Yeah, Jesus Loves Me, Gloria, The Saints Come Marching In. There's quite a few.**

[17] Q. And you went to the train station and you went around to some churches?

[19] A. **And sometimes we'd go and get french fries, or his mother said that he liked shakes, I believe, so I'd get him one of those once in awhile, but mainly he liked french fries or pop.**

[1] Q. And he'd sit in the car and eat french fries with you?

[3] A. **Usually we'd go to the park and watch the ducks and stuff.**

[3] Q. Can you tell us why you took David on these little trips in your car, or in the car?

[5] A. **Because David was my friend and I enjoyed having some time with him.**

*Ronald G. Hammock*

Mr. Hammock began working at WSH in February 1988. He was the program director for Units A and B. As the program director, Mr. Hammock was responsible for supervising the staff, providing input and direction for the overall programming, including ensuring active treatment to the people who resided on those units.

[3] Q. You were aware then that particularly Units A and B have been criticized by the federal surveyors in the area of active treatment and programming just prior to you assuming your duties?

[7] A. **That's correct.**

[8] Q. Can you tell me specifically what policies, if any, you instituted in order to correct the deficiencies that you either observed or became aware of from the surveys?

[12] A. **Well, when I - - when I came after reviewing the extensive citations on the previous reports in my observations, we basically began with some environmental improvements. About the time I came, the federal government switched regulations from the current standards to some - - very similar but a little bit different, so we started implementing the procedures as written. But we also did some basic common sense things and some - - you know, considered basic areas, making sure that the place was - - the environment was improving and making sure that we consistently kept things clean and that it was - - that it was done on an accountability basis, that individual staff members - - it was clarified exactly what - - what it was that they were supposed to do.**

[2] Q. Was his [David's] case or his particular file brought to your attention at all?

[4] A. **His file - - his case was in terms that I was concerned about David. David was restrained frequently. David was injured during the time I was here. David was engaged in a high rate of maldeficit [mal adaptive] behavior. I was aware of David. I knew David. Not very well, but I - - I knew him.**

**Expert Witnesses:**

*Phillip Douglas Guess, EdD*

Dr. Guess is a Professor at the University of Kansas in Special Education. He has over thirty years experience in the field working with individuals who have severe disabilities. Dr. Guess was a critical player for the plaintiff in this case. He along with the Department of Special Education gathered unbelievable amounts of data and compiled and analyzed it. He spent over 60 hours reading depositions, literature, policies, and procedures and regulations to provide Mr. Hund with current philosophies and practices in the field. Additionally, he helped Mr. Hund prepare for the many depositions that were taken in this case.

Typically when expert witness are used in a case they are compensated for their time, as the defendants expert witness were. Neither Dr. Guess, nor any one in his department, were compensated for their work for this case. This was volunteer work was done because the faculty, staff and students could not believe such atrocities could occur in the state of Kansas. Dr. Guess believed David's story had to be told. People had to know that life for people with severe disabilities should not end at the hands of institution staff. Dr. Guess summarized his concerns through a detailed report. His conclusions were as follows:

**The administrative decision to establish the Special Treatment Unit (STU) at the institution represents out-dated logic at both the programmatic and administrative level. To continue David's residency on that unit from 1985 through his death in 1989 depicts a lack of concern for his humanity, and a disregard for his personal safety and well being. It represents, moreover,**

**inadequate administrative surveillance, coupled with questionable professional competence and knowledge regarding the treatment of persons with mental retardation who injure themselves and others.**

**1) The administration at WSH&TC consistently failed to provide appropriate measures for the safety and emotional well being of David during his residency at this institution. The STU, especially violated his basic rights to live in an environment that was free from physical harm, psychological impoverishment, and emotional stress.**

**2) The treatment programs provided by the professional staff at WSH&TC demonstrated a significant lack of awareness of factors and conditions that contribute to self injury and aggressiveness among individuals with mental retardation. The living environment in which David was placed could only exacerbate these types of behaviors. Additionally, the types of procedures used to control David's behavior encourage inappropriate application and staff abuse.**

**3) There was a failure among both administrators and professional staff at WSH&TC to adequately monitor and supervise the procedures used with David, and the negative effects that these procedures were having on his physical health and emotional well-being. This is reflected in an excessive number of injuries to him during his stay at the institution (including two broken bones), and a finding of staff abuse resulting in one of the broken bones in 1988. Additionally, David was kept in an extremely impoverished and unstimulating environment devoid of learning opportunities or pleasurable activities. It is difficult to understand how the administrators and professional staff of this institution allowed this to continue.**

**As a final personal note, I have worked in the field of mental retardation for about 25 years, including 13 years in a state institution. Over these years I have visited across the country many types of residential facilities and community programs for persons with mental retardation, and I have read extensively about abuse and neglect in this population of citizens. I have never, however, encountered a situation that was any more devastating than the treatment that David Dahlke received at WSH&TC. What is even more disturbing is the fact that this all happened within the past decade in a facility in the state of Kansas.**

Dr. Guess continued to express his concern for David during his deposition.

He points out the importance of **not** using aversive procedures with any one.

Q. Now if you could tell me about that article and its impact on your opinion in this case?

A. ...we -- review the literature and looking through many, many journals in terms of published articles that concerned how the use of aversive procedures came about with the population of persons who had mental retardation and why, and then we did a critique of what this was done. There are several major things in there that really had an impact on me when I looked at the literature. Number one is the fact that most aversive procedures are used with persons in institutions, and we give reasons why this might occur. Secondly, we tried to point out in some of the discussion that the use of aversive procedures with this particular population was in large part due to the fact that they could not talk back to you, they could not complain about what was being done to them. Aversive procedures have been tried with prisoners, very similar, and they said, no, hey, stop doing this to us. And they did. The psychiatric community decided, well, we shouldn't be doing this with prisoners. But persons who have mental retardation, especially the type I am talking about who have no way of communication, like David Dahlke and other patients, they can't say, hey, stop doing this to me. Because they have no way of communicating this... We also found, and I think very significant to this case, that when you are using aversive procedures with this population, there are some major problems... the procedures themselves were an abridgement of the rights of these people to be free from harm.

*James L. Rice*

Jim Rice was a surveyor with HCFA when WSH was in the process of being decertified. Mr. Rice felt very strongly have observed WSH over 700 times that the facility need to be decertified. His supervisors would not let the hospital be decertified. Mr. Rice left HCFA and is the President and CEO of his own consulting firm. He does consulting and training in the field of developmental disabilities. Mr. Rice was not compensated for any work that he did with this case.

[12] Q. All right... Why don't you give me a little, brief synopsis of what you mean by "you turned them in?"

[17] A. Well, with regard to this Winfield situation, we decertified the facility on immediate and serious threat, under what's called a "Fast - Track Action" --we call it a "Fast - -Track Determination Procedure," under Section 1910(c) of Medicaid. And there are some pretty stringent requirements for a facility to come back into the program, once that has occurred. And our Regional



Director, Mr. Gene Hyde, told us to -- well, first, he announced that he was giving the certificate back, to our survey team. This was after it had already been decertified. And in our teams opinion -- including team, I mean, the aforementioned Dee Paul and Eloise Beechiner -- the facility was not safe; nor did it even begin to meet minimal requirements to be recertified. And you know, we had real concerns about the health and safety of the clients.

[13] Q. Okay.

[14] A. And so the fellow came to us and said, " Well, I'm going to give the certificate back anyway. I've met with the people from the State of Kansas. And I'm satisfied that they're going to do it. They're going to get the thing done." Which was fine. Okay; maybe that was the case; but that wasn't the law. And he gave -- he recertified the facility without another survey being done; which there is no provision in Medicaid to do that. And he ordered me to remove all evidence of immediate and serious threat from our survey report. And I refused to do it. He then said that he would do it. He then didn't do it. He then held a press conference and told the world, that based on the findings of our survey team and our recommendations, he was recertifying the facility -- which we felt was something other than the truth. And at that point, you know, it was kind of like: What do we do now?

[7] Q. How many times did you meet David, personally?

[11] A. ...I would say that I came in contact with him and saw him and observed him probably over -- between 1985 and 1987, probably, I was in his living area and saw him at least twenty time -- at least.

[6] Q. Was there anything, at that time, particularly distinguishing him from any of the other residents at Winfield?

[9] A. Other than that, he was like all of the other clients who were in the area: they were poorly dressed. It looked like they had poor nutrition. I can't say David, specifically -- I'd have to look at our -- at our specific surveyor records, which are in Kansas City -- but I'm sure he was among the injured, I'm almost sure. Because I know virtually everybody in his living area were injured -- was injured in some way. And you know, they were poorly groomed. Poorly dressed. Not much for them to do, you know. It was pretty much the same for everybody in those units; especially in Unit A and Unit B.

[24] Q. Okay. Is it your real recollection that he [David] was treated any differently?

[1] A. He was -- well, the way I would put it, is that he was treated "just as badly" as the other people in the area. It's pretty dehumanizing, quit frankly. It's pretty dehumanizing.

[8] Q. What was wrong with the environment ?

[9] A. It was filthy. It was unsanitary. There were mice and bugs in their living environments; in their clothes; and their food -- in their eating situations. It was sterile. It was sterile --

[14] Q. When -- when, specifically, did you observe --

[16] A. Every time that I was there, it was like that. Every time.

[18] Q. The place was constantly covered with bugs?

[19] A. It was filthy. And, yeah, there were roaches all over the place. There

were roaches. There were mice. There was mice feces in the clothes. You would pull out the doors, and there would be mice droppings in the clothes, constantly -- every time we were there.

[7] Okay. All right. Anything else that constitutes "sterile environment" other than lack of --

[10] A. The bedroom. The sleeping areas were wide open. There was no provision for privacy or dignity, in terms of one individual being in a room . This was just a big -- it was a huge ward; very depersonalizing, dehumanizing environment. You could not dress in your own bedroom without others seeing you being dressed or undressed or cared for. The bathrooms were usually just filthy; just filthy. Missing toilet paper, much of the time. Full of urine and feces, unflushed. It smelled terrible. A very dehumanizing, depersonalizing environment.

*Dr. Richard Saunders*

Dr. Saunders is a Senior Scientist, University of Kansas. He was subpoenaed to testify in the Dahlke case. Dr. Saunders was one of the professionals asked by the State of Kansas to help WSH when it's certification was at risk. He stayed on the hospital grounds and made many changes to help keep the hospital open. His efforts resulted in the hospital retaining its federal funding, but the overall abuse at the hospital continued.

Q.. And what is your summary of the special training unit during that time period?

A. It's one paragraph. You wish me to read it?

Q. Yes, if you would.

A. "The 34 residents of the Special Training Unit were exhibiting severe maladaptive behaviors on May 1 of 1985 at the rate of 16 per week per client. During the week of the current survey, this rate was a fraction above 1 per client per week, a reduction of 94%. The program which effected this change included the use of time-in/time-out bracelets, exclusionary timeout and emergency physical restraint, if the client was still not under control. The frequency of 4-point use has declined from 5 per week per client to less than 1 per week per client, concurrent with the reduction of drug dosages directed at the same problem for the same time period. A few other clients have been on programs using these procedures and success has been elusive. However,

numerous program changes have been attempted and these changes have been appropriately documented, demonstrating an active treatment approach. If we can identify any client under these procedures for whom the above charges are not occurring--" I'm sorry, correction, "for whom the above changes are not occurring and whose programs have been--have not been monitored in a timely fashion, they will be removed from such programs or a more aggressive monitoring system will be in place by July 15th, 1986."

Q. ... What do you recall about Mr. Dahlke?

A. Very little, except what I inferred from observing him on one or two occasions, he became violent, and that was that he was extremely difficult to manage.

Q. When you say he became violent, what specifically do you recall was indicative of this violence?

A. That there were only one or perhaps two episodes in which I was in the vicinity of his group and something happened. I didn't see the precipitating event. And he became assaultive in some form and the nature of the interaction that ensued between himself and the direct care staff was intense and physical and frightening.

Q. Do you recall what type of restraint was being used, if any on Mr. Dahlke during the incident that you observed?

A...in the case of the one incident I saw, he actually was taken down to the ground and restrained there.

*Dr. Frederick J. Fuoco*

Dr. Frederick J. Fuoco was hired by the State of Kansas as an expert witness for this case. His Doctorate is in clinical psychology with specialization in behavior therapy. He was hired in 1988 to do an investigation of the services provided by WSH. This was after the hospital was threatened with losing its funding due to allegations of abuse and many deficiencies noted by the Department of Health and Environment, as well as the Health Care and Financing Administration. Dr. Fuoco did a follow up visit to the hospital after David's death to report his findings to the State. Dr. Fuoco was paid \$1000 a day for his testimony in this case.

[5] Q. ...In your evaluation of David Dahlke's records in this case, [do they] exceed or does it fall below the regulations as promulgated by the HCFA active treatment

and training program?

**[10] A. Overall. And by "overall" I mean across the various areas and across time, it meets those standards.**

[21] Q. Okay. In your- I want to find out in the opinions that you have here today, are you standing for the proposition that under no circumstances, in your opinion, was David Dahlke abused while he was a resident of Winfield State Hospital?

**[2] A. No, obviously not. There's a few— sometime ago you asked if I agreed with the committee's findings regarding the--which incident, was it '85, and I told you I agreed.**

[6] Q. Are there other instances where you agree there is at least some evidence of abuse of David Dahlke?

**[9] A. Actually the two fractures.**

[10] Q. Okay. Talking about the arm fracture and the leg fracture?

**[12] A. Yes. Certainly with one of the fractures I think there's substantial and significant evidence indicating that there was abuse. With the other fracture, at a minimum there was improper use or implementation of the procedure.**

[18] Q. Is it your understanding that both of the fractures that we're referring to occurred during an attempt by a direct care staff to restrain David Dahlke?

**[22] A. Yes.**

[22] Q. Is the hiring of a person who has been found to have been guilty of abuse in the direct care of patients in this kind of a facility, is the rehiring of that person following abuse contrary to established hiring practices?

**[2] A. By HCFA standards, yes, it is.**

[1] Q. Was there an effort by the Justice Department and HCFA to, nationwide, to improve the conditions in facilities like Winfield over a period of time beginning about 1984 and ending about 1988, because of a finding that institutions across the country were not delivering adequate care within the standard of practice according to some standards that were done and some Senate hearings that were conducted?

**[10] A. Uh-huh. That was certainly the case that during that period there was more sensitivity, based on a result of various investigations, publications and findings, that raised some red flags for HCFA and for the Justice Department, that increased their efforts in that area.**

[11] Q. Do you think that anyone who was practicing state of the art would have approved this method of restraining David Dahlke in 1988, 1989?...

**[18] A. I can't say whether any one would or not, but probably the majority would not. And it may not necessarily be because of the method of restraining an individual, but more because practicing state of the art methods would result in the development of alternative interventions.**

Below are excerpts from Dr. Fuoco's Consultant Report, dated October 22, 1992. In this report he draws a substantial amount of information from a report he

completed in 1988.

The initial and comprehensive habilitation plans developed by Mr. Dahlke's interdisciplinary team met minimally adequate standards. Problems noted in the initial comprehensive plan were: (a) with some interventions there was insufficient detail regarding implementation; (b) incentives/rewards/positive reinforcers were not specified in some of the earlier plans and in some reviews procedures for their use were not specified in sufficient detail... Staff members should have received additional training in habilitation planning and development in the early 1980's.

Based upon the resources available, staff level of expertise, and Mr. Dahlke's history and presenting problems, it appears that staff attempted to provide appropriate and effective behavioral programming services to Mr. Dahlke, did so with a sincere and conscientious approach, and in fact did provide minimally adequate training treatment and care, including behavioral programming.

*Robert Miller Snell, Ph.D.*

Dr. Snell was an expert witness for the defense. He was paid \$500 a day for his involvement in the case. Dr. Snell was previously employed at WSH. He was both a program director and the acting director of psychology.

[8] Q. What about the program itself; did it conform to the best practices, in your opinion, for the treatment of aberrant behavior?

[11] A. It included the minimal amount of information to try to address his treatment needs. Treatment practices don't always include information in regards to protection from harm, which I think was the major emphasis of David's behavior program at that time.

[17] Q. Did the program relating to protection from harm address his aberrant behavior with the best practices available at the time?

[20] A. If best practices include other possible questions in hindsight, I don't know if that meets best practice, but at the time they developed the program, I think they tried to ask all the questions that were appropriate at the time.

[22] Q. What I'm suggesting, however, is that the opposite happened, is that the restraints went up and the recorded incidents as reported by you went down. But does that suggest that they were restraining him for reasons other than the exhibition of these behaviors?

[1] A. It would be hard for me to tell without knowing the incident surrounding each restraint.

[8] Q. So what you're suggesting is that perhaps maybe the program wasn't the cause of the injury, but the employee's misapplication of the program?

[12] A. Very much so.

[25] Q. Did David have, under that definition, a therapeutic environment during his stay at Winfield?

[3] A. **I think he had aspects of it. The very fact that he sustained injuries may mean that we did not meet that entirely as a principle, but you can do that and people still exhibit behavior problems.**

*Dr. Charles L. Spellman*

Dr. Spellman earned his doctorate from the University of Kansas in Special Education and Human Development with emphasis on mental retardation. In 1985, Commissioner Gerald Hannah asked him to spend one week at WSH, along with a team of other professionals around the state of Kansas. The purpose of their visit was to try to save the hospital from permanent closure. Dr. Spellman and his team were assigned to Unit B. This was the unit where David lived. His recollections of his first few hours at the hospital were horrific. He was asked to give his testimony on behalf of the defendants.

[21] Q. Was it your understanding that the federal agency that had found these problems had only found these problems relative to this special behavior unit?

[25] A. **No. They had other problems, I think. Sanitary problems. I remember a lot of cockroaches and filth. Urine soaked carpet. Injuries across more than one unit. But this was the— I think the one that they suspected there were more opportunities for harm.**

[15] Q. What do you recall that you first saw when you set foot on the behavioral unit?

[17] A. **Oh, yes. When we walked in, there's a urine soaked carpet that reeked. I could not believe it. There were people in a room, like caged animals, hitting each other or themselves, pacing, self-stimulation, and the staff were all sitting behind this window and there was just chaos... I'm not even sure they had chairs to sit on. There was not enough chairs to go around. It was horrible. It was just really bad.**

[24] Q. I think you told me that you recall someone from HCFA indicating that they were surprised at the progress that had been made on that particular unit, correct?

[3] A. **Yes, because I think they ended up certifying them or temporarily**

certifying them. They didn't lose funds, and they were at risk in losing funds. We had real mixed emotions about that. On the one hand, we like to be helpful and keep funds coming to our state. On the other hand, we feel very guilty fixing a bad thing that we knew probably wouldn't stay fixed. So we had a real moral dilemma about even helping, frankly. That was something that was real hard for us to decide where to help. We decided to do that, but it wasn't an easy decision, nor am I sure we made the right one. If we had to do it over again, I would never help them.

[18] Q. What makes you think it wouldn't remain fixed?

[19] A. There's a whole body of literature about institutions and a lot of people have tried to fix them and no one ever has.

[22] Q. So it's basically institutions are not fixable?

[23] A. Yeah. Close them down.

[23] Q. Does that sound like what you told him [Doug Guess]?

[24] A. ...I thought I told him, seemed like everyone had a cut or a bruise. And if I remember right, they had Merthiolate, which makes things look worse, but there was cuts and bruises, and stitches. I've never seen --they really looked like a football team that lost. They were really beat up...

*David Mandt:*

David Mandt testified on behalf of Winfield State Hospital. He is the CEO of Client Management Techniques Incorporated, also known as David Mandt and Associates. Mr. Mandt was responsible for developing the Mandt program and philosophy of managing individuals who are aggressive, as well as those who are not aggressive. He is best known for his physical techniques that were developed to help staff intervene when people are being aggressive. His techniques are often referred to as the "Mandt technique or hold." Below are excerpts from his deposition:

[13] Q. Would you identify 65, please?

[14] A. 65 is a memo that was written by my vice president, Randel Goad, G-O-A-D. He was doing a workshop in December 14<sup>th</sup> through the 18<sup>th</sup> at Winfield State Hospital. And this was a memo that he wrote to me explaining that Mr. [Bill] Hedden had come over and demonstrated a particular restraint

**technique on the floor. And his comment was that, or at least Randel's comment was that that is not a technique that we teach, and if they do teach that particular technique that they need to do that outside of our course, that it has nothing to do with our course. (See attached Memo)**

[3] Q. Mr. Hedden is also listed as a trainer in this exhibit, is he not?

[5] A. **That's correct.**

[6] Q. This represented that he was first certified in 1983 and recertified in 1985 and 1987; is that correct?

[9] A. **That's correct. August '88 certificate expired and he was no longer certified to teach the program.**

[12] Q. Do you know why he and other persons listed on this document allowed their certifications to lapse at that time?

[13] A. **No, I don't...**

[3] Q. So in other words, you have developed the Mandt system that has, so to speak, stood the test of time and you provide no services that would allow for deviation for most techniques?

[7] A. **That is correct. Depending upon the definition of "deviation". As far as teaching a technique where you straddle someone, you're correct, we would not use that as part of our program...**

[13] Q. Would you, for me, define what you believe to be the proper philosophy?

[15] A. **Okay... People need to be treated as individuals with dignity and respect, with the least amount of intervention possible...**

[3] Q. So what you are suggesting is that developmentally disabled persons who might be the subject of the behavior management in an explosive situation would pick up on the attitude of the person who is intervening or interaction. And if that person's attitude is improper, it might contribute negatively to the situation rather than de-escalate it or escalate the situation. Instead of making worse, it may make- instead of making it better, it may make it worse, correct?

[13] A. **Yes...**

[13] Q. And it's in print in the section concerning that subject about never sitting on top or straddle a person when holding or restraining?

[16] A. **That's what we teach, correct....**

[20] Q. Why are you offended that it was referred to as a modified Mandt technique?

[22] A. **Because that is not what we teach. It has nothing---**

[24] Q. It is not the Mandt system?

[25] A. **Exactly.**



### Final Defendant Responds

After approximately eight months, the final defendant answers the complaint, also denying implications that he was ever abusive to David.

JANUARY 4, 1991

ANSWER FILED. Jim Coon files his defense with the court.

"...the answering Defendant [Coon] admits that he is a former employee of Winfield State Hospital and that David Dahlke's leg was broken during a restraint procedure. The answering Defendant **denies** the implication that injury to David Dahlke was the results of abusive and/or improper action on the part of the answering defendant... [Coon] admits that a Risk Management Review Committee made a final determination of confirmed abuse. The answering Defendant specifically **denies that said final determination was correct and denies that he was ever abusive to David Dahlke.**"

### Two Defendants Dismissed

APRIL 15, 1995

DISMISSAL OF DEFENDANT. Michael Dey, the former superintendent of Winfield State Hospital, is dismissed from the case.

"THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED that the plaintiffs' Complaint against the defendant, Michael Dey, be and is hereby dismissed without prejudice."

AUGUST 6, 1991

DISMISSAL OF DEFENDANT. Joe C. Pham, M.D., a Physician at William Newton Hospital, is dismissed from the case.

"THEREFORE, IT IS ORDERED, ADJUDGED AND DECREED that the plaintiffs' Complaint against the defendant, Joe C. Pham M.D., be and is hereby dismissed without prejudice."

### Comments of Mr. Hund

Michael Dey, former superintendent of WSH, had moved out of the state of Kansas while this case was being compiled. Mr. Hund decided to dismiss Michael Dey because Mr. Hund believed it would be more costly to include him as a defendant. Additionally, all other interim directors would be accountable for the activities of the hospital and would need to have been involved with the case. This would have added a tremendous amount of cost to the case for the Dahlkes.

Mr. Dey was fired from Winfield State Hospital on February 26, 1987 after serious allegations of abuse at the hospital during the time he was superintendent.

There was no factual basis to pursue allegations of malpractice with Dr. Pham. Dr. Pham seem to lack an understanding of behavioral intervention, therefore he approved the use of the modified Mandt technique which eventually lead to David's death. Dr. Lybarger confirmed in his deposition that Dr. Pham had no training in the area of behavioral intervention. He approved behavioral intervention when he was not knowledgeable about the techniques. His medical records did provide a baseline of David's physical state during his stay at Winfield State Hospital. For example, Dr. Pham's records indicate that:

**September 27, 1983: David's arm was broken.**

**May 5, 1988: David's leg was broken.**

**January 10, 1989: David is dead.**

## Judge Transfers

APRIL 2, 1992

MINUTE ORDER. The judge in charge of the case, Sam A. Crow, transfers the case to The Honorable Monti L. Belot.

## Comments of Mr. Hund

The case is transferred because Sam Crow moved to Topeka.

## Problems for Mr. Coon

JULY 2, 1992

MOTION FOR FEES AND EXPENSES. Defendant Coon did not appear for his originally scheduled deposition that he was required to attend.

"As a result of defendant Coon's failure to appear at his scheduled deposition, plaintiff incurred the expense of traveling from Hutchinson, Kansas, to Wichita, Kansas, the site of the scheduled deposition. Further, the plaintiff was forced to retain a private investigator to travel to Winfield, Kansas, defendant Coon's home, to locate him and serve him personally with a subpoena commanding him to appear on Friday June 19, 1992. Lastly, as a result of defendant Coon's failure to appear at his scheduled deposition, plaintiff incurred certain reasonable attorney fees in regard to filing and prosecuting the motion for sanctions now before this court.

SEPTEMBER 14, 1992

ORDER FROM THE COURT. Defendant Coon was order to pay fees and expenses to the plaintiffs.

"...Defendant Coon be ordered to pay the mileage of plaintiff Grace Dahlke from Hutchinson to Wichita in the amount of \$10.00 (40 miles at \$0.25 per mile): Investigative Services for locating and serving Mr. Coon in the amount of \$247.10, and one hour of waiting time for plaintiff's counsel and three hours for preparation time at the rate of \$150 per hour for a total of \$600.00.

IT IS THEREFORE BY THE COURT ORDERED, ADJUDGED, AND DECREED that the plaintiffs...are hereby granted judgment against the defendant Jim Coon, in the total amount of \$857.10."

### Date Set for Trial

Over two years after the first complaint was filed, the judge sets a date for trial.

SEPTEMBER 23, 1992

NOTICE OF JURY TRIAL.

"TAKE NOTICE that the above-entitled case has been set for jury trial, at **9:30 a.m. February 16, 1993**, at the U.S. Courthouse... before the Honorable Monti L. Belot, Judge."

### Parties Ordered To Negotiate

The judge ordered the lawyers and those they represent to meet to try and settle the case.

OCTOBER 6, 1993

ORDER FOR MEDIATION. The parties involved in this case come together to decide whether or not this case can be settled prior to going to court.

"The purpose of mediation is to permit an informal discussion between the attorneys, parties, and the mediator of every aspect of litigation bearing on its settlement value, thus, permitting the mediator to privately express his views concerning the actual dollar settlement value or other reasonable disposition of the case."

The parties did not reach an agreement.

### Defendants Respond Again

The defendants wanted the judge to dismiss them from the case. Mr. Hund believed they would not be dismissed from the case. The case was ready to go to trial.

DECEMBER 15, 1992

MOTION FOR SUMMARY JUDGEMENT. The following defendants felt that they should not be included in this case:

**The State of Kansas**  
**Winfield State Hospital**

**Robert C. Harder**  
**Winston Barton**  
**Dr. Tony Lybarger**  
**Bill Brooks**

"These defendants assert that no proper claim can be made against them under federal law, nor do any of the plaintiff's state law claims reach them, and that therefore they should be granted Summary Judgment and dismissed from this Action.

"David Dahlke was voluntarily placed at Winfield State Hospital and Training Center by his parents...Grace and Victor Dahlke, have never met any of the defendants Robert Harder, Winston Barton, or Dennis Taylor....Plaintiffs Grace and Victor Dahlke never had any conversations about their son's treatment with Robert Harder, Winston Barton or Dennis Taylor during the time he was a resident at Winfield State Hospital...Robert Harder, Winston Barton, or Dennis Taylor were never involved in any decision to place their son in any type of restraint while at WSH"

"Dr. Lybarger, as Superintendent of the Hospital, makes only a general review of the overall levels of restraint that might be used without involving himself in individual decisions with regard to the restraint levels appropriate to any particular resident."

"Mr. Brooks was not involved in David Dahlke's care and treatment. His role as unit director was administrative rather than clinical....Mr. Brooks did not review behavioral management treatment plans for individual residents."

DECEMBER 15,1992

MOTION FOR SUMMARY JUDGEMENT. The following defendants also contended they should not be included in the case:

**Roxanna Namey**  
**Bill Heddon**  
**Jim Coon**

"Her [Namey] responsibilities were to make certain the residents' programs were being carried out, tracking the progress of a resident's program, bringing the team's attention to any problem that were occurring in the resident's program for their review, making certain the residents' daily schedules were being carried out, and that basic needs were being met. Defendant Namey was also involved in formulating the programs for the residents."

"The majority of Defendant Coon's weight was applied to Dahlke's shoulders. While in this position, Defendant Coon indicated that Dahlke started kicking him in the back and that he reached back and took hold of the heel of Dahlke's right foot. When he turned to place his weight back on Dahlke's shoulder, he described hearing a loud pop....Dahlke's behavior program was modified due to concern for his leg fracture."

" Heddson did not place any weight on Dahlke's chest...Dahlke then stiffened and jerked, and Heddson observed he was turning cyanotic. Heddson could not get a pulse and observed that he was not breathing."

### The Settlement

JULY 30, 1993

THE CASE IS SETTLED.

The State of Kansas agrees to pay the Dahlke's to avoid going to trial. The Dahlke's agree to settle because the lawsuit could go on for years, and David's father's health could not withstand a lengthy battle. The Dahlke's received an undisclosed amount of money for the death of their son, some of which they donated to the Department of Special Education at the University of Kansas. The Department established the annual "David Dahlke Community Inclusion Award". This honor is presented to doctoral students that have made an impact on promoting quality community life for people with disabilities.

## CONCLUSIONS

Recently significant strides have been made in Winfield, Kansas to close the hospital. It has been in operation nearly 110 years. Soon, the doors of Winfield State Hospital and Training Center will close. People with disabilities will no longer endure deprivation, pain, abuse and neglect at this facility.

It is evident through the interviews, depositions and surveys that Winfield State Hospital has had a long history of poorly trained staff, no active treatment, excessive use of chemical and physical restraint, and ongoing long-term abuse to the people who reside there. Given these conditions, abusive circumstances resulting in the death of the very individuals this institution was built to protect are inevitable. David is only one of the many who suffered from the systemic problems generated by institutionalization.

There may be people reading this paper who believe there is no other viable alternative for people with severe and profound disabilities except a large, segregated institution. The circumstances of David's death, contrasted against those with similarly severe disabilities who are being served everyday in good community programs in Kansas, proves otherwise. These programs promote community integration, quality teaching, and the upholding and respecting of individual rights.

I would dedicate this impending, and much anticipated, day of closure to David and to the many others who died within the walls of Winfield State Hospital. I challenge the State of Kansas to look ahead to the next institution to further closure

efforts.

David's sister, Raine Dyani, had this insight about her brother's life and

death:

Of the many ways in which my life has been enriched through my experiences, I consider the experience of having known David to be one of the richest of them all. Having been given the honor of being his sister, and the opportunity to have been a part of his life, was a privilege beyond measure. One for which I will always feel grateful.

David had always been the light of my life and I thought there was no one more wonderful. From my earliest of memories there had always been a very precious and immutable bond between us. It was a connection which encircled my soul and permeated the very governing core of my heart. To me, David was an icon, and I had him on a pedestal. It always gave me great pride to talk about him, or to be seen with him. I wanted everyone to know he was my brother. I looked upon him not from a place of pity, but from a place of awe. I saw him not as someone lower, less than, or without. Rather, I saw him as someone filled with something far greater than what perhaps some were able to see -- something beyond the trivial concerns of most, and something transcendent of what society had arrogantly evaluated as a 'normal' and acceptable way of being and interacting with life. I revered him as special, not in a diminished sense, but in a very high and enlightened sense: as someone possessing a secret kind of illuminating power and light that gently surpassed the ignorance of labels and the barriers of fear, isn't it amazing that some see 'disabled' where others see sage?

David was the epitome of purity and the embodiment of love. He lived in a world of simplicity, innocence, and joy and found absorbing pleasure in the magic of small wonders. He celebrated life and savored all that he could possibly fit into each and every moment. He freely expressed the exaltation of his spirit and the aliveness of his soul, and he lived his life from the inside out rather than the other way around. It is from these very intrinsic, child-like qualities that sadly so many have become estranged, and yet it is these very qualities themselves that reflect our highest truth and innermost nature. I believe David came only under the guise of 'developmentally disabled' in order to be a teacher of true wisdom. And perhaps the true disability belongs to those who were incapable of receiving the gifts he came to bare, and the lessons he came to teach.



David was bright, strong willed and quite masterful. He knew exactly what he wanted, and what he didn't. He had far more abilities than disabilities. He was able to do many things by himself and for himself, given loving encouragement. He knew far more than what many gave him credit for, and at the same time he needed far more than what was ever given. Some children, his nieces in particular, seemed to feel an instantaneous and natural connection with him; an inherent knowing of his specialness and a quiet recognition of their shared innocence. He responded quite softly to them and it was beautiful to watch.

He touched all who knew him because he radiated such love. His face was ever pure and the world's harshness melted a little more every time he smiled. His innocence was his power and his offering was his joy.

The essence of who David was and what he represented was undeniably a gift to all, even to those who betrayed him, who violated him, who taunted him and beat him, who used him as a means of lashing out against their own darkness and misunderstandings of life. What we do to others we do to ourselves, and our actions are merely extensions of our peace or reflections of our pain. For this reason, I feel no contempt for David's tormentors, but rather compassion. How wounded they themselves must have been to have done such horrific things to him. I can't help but know that in some grand mysterious way, David must have played an essential role in their own journey of healing and becoming whole.

"...A hero is any one who makes it through his life," is a quote from one of my favorite movies. David was most certainly a hero in my book. The degree of strength and courage in which he lived and died many of us may never have to know. He never surrendered. One sympathetic witness affirmed that he fought to the very end. His was a daily fight to survive the abusive remains of the archaic, debasing system which not only devalued every aspect of his being, but also stripped him of his every spark. His was a daily struggle against the imprisoning chains of oppression, created by the same system which sought to keep him controlled and dimmed instead of inviting his light to shine. Though he lived under constant tyranny, he continued to resonate with love, joy, hope, dignity, and trust.

I no longer see David's death in it's darkness but in it's light, for beneath the veil of all tragedy there lies a pervading wisdom and ubiquitous peace. The orchestrating forces of Divine Order keep life moving forward and reveal to us the beauty and perfection in all things, both in the tragedy of

injustice and in our impassioned fight to end it. I believe we all come with special papers, each with a unique and divine purpose to fulfill. The question as to why some must endure such prolonged suffering, in order to fulfill their purpose is indeed a perplexing one, but perhaps the answer lies within its very words. There was great purpose in David's life just as there continues to be great purpose in David's death. Social change and transformation cannot take place without the catalyst of atrocity to call it forth into action.

And so David's legacy of purpose continues to unfold as his story is kept alive through the dedicated efforts of those making a difference on behalf of all the Davids that remain, and for all the Davids yet to come. Along this ever evolving path towards a higher level of consciousness and a more just and compassionate world, we each become a cobblestone in our own way, paving the road for others and changing the course of life forever. By offering up all that we are, we leave behind glorious remnants of our life, which beautifully become interwoven into the universal fabric of human experience.

David's life had a profound impact on me, as did his death. It propelled me to becoming an even more conscious participant in our collective movement toward peace and reverence for life. It opened my eyes to the work that needs to be done. I now see everyone as the same innocent hero, trying to make through this life the best we know how. I am grateful for all those who so generously give of themselves, living lives of service, helping to create a world where all may be free from harm and the hidden blight of indifference.

The Dahlke family still suffers from the loss of their son and brother. We must continue to provide better services for people with disabilities. If not, we risk exposing those we should protect to inevitable harm. As David's mother recently responded when asked, "What would you say to David today if you could?"

**"David, I'm so sorry I left you in Winfield."**

## REFERENCES

Albin, R. (1991). Report on the Behavioral Treatment Program of David Dahlke at Winfield State Hospital and Training Center. Unpublished Report. Department of Special Education and Rehabilitation, University of Oregon.

Bergmeier, D. (1989, January, 11). SRS probing death at state hospital. Winfield Daily Courier.

Bergmeier, D. (1989, January, 12). WSH&TC death still under investigation. Winfield Daily Courier.

Bergmeier, D. (1989, January 20). Abuse not a factor in resident's death. Winfield Courier,  
p. 1.

Brooks, B. (1989). Risk Management Committee Findings & Recommendations (Case No. 89-006). Winfield, Kansas: Winfield State Hospital and Training Center.

*Dahlke v. State of Kansas, et. al.*, No. 90-1225-B (D. Kan. filed April 30, 1990)

**Pleadings:**

Complaint, filed 4-30-90

First Amended Complaint, filed 5-4-90

Summons in a Civil Action, filed 5-4-90

Answer of Defendant Joe C. Pham M.D., filed 5-23-90

Extension of time for Harder, filed 5-23-90

Answer of Defendant Bill Heddon, filed 6-1-90

Answer of Defendants Winfield State Hospital, Lybarger and Brooks, filed 6-1-90

Answer of Defendant State of Kansas, filed 6-1-90

Notice of Service of Response to Discovery, filed 6-1-90

Answer of Defendant Namey, filed 6-4-90

Notice of Service of Defendants' Interrogatories to Plaintiffs, filed 7-31-90

Notice of Service of Request for Production of Documents, filed 7-31-90

Notice of Service of Plaintiffs' Requests for Production to Defendant Robert Harder, Secretary of Kansas Department of Social and Rehabilitation Services, filed 8-3-90

Notice of Service of Plaintiffs' Requests for Production to Defendant Winfield State Hospital, filed 8-6-90

Motion to Amend Complaint, filed 8-6-90

Memorandum in Support of Motion to Amend Complaint, filed 8-6-90

Notice of Service of Response to Discovery, filed 9-10-90

Notice of Service of Response to Discovery, filed 9-8-90

Answer of Defendant Michael Dey, filed 9-17-90

Notice of Service of Defendant Michael Dey's First Set of Interrogatories to Plaintiffs, filed 9-18-90

Minute Order Allowing Addition of Parties Defendant, filed 9-24-90

Notice of Services of Plaintiffs' Responses to Defendants Winfield State Hospital and Training Center, Dr. William Lybarger, and William A. Brooks Interrogatories, filed 10-1-90

Second Amended Complaint, filed 10-11-90

Answer of Defendant Michael Dey, filed 10-16-90

Answer to Second Amended Complaint, filed 10-22-90

Answer of Defendant Bill Heddon to Second Amended Complaint, filed 10-25-90

Answer of Joe C. Pham M.D. to Second Amended Complaint, filed 10-26-90

Answer of Defendants Winfield State Hospital and Training Center, Dr. William A. (Tony) Lybarger, and William A. (Bill) Brooks, filed 10-28-90

Answer of Defendants Dennis Taylor, Acting Secretary and Winston Barton, former Secretary of Department of Social and Rehabilitation Services, filed 10-31-90

Notice to Take Depositions Duces Tecum, filed 11-1-90

Notice of Services of Responses to Interrogatories filed, 11-13-90

Motion for Extension of Time to Answer, filed 12-14-90

Order Extending the Time to Answer, filed 1-2-91

Answer of Defendant Jim Coon, filed 1-4-91

Notice of Service of Plaintiffs' Request for Production of Documents to Defendants State of Kansas; Robert C. Harder, former Secretary of Kansas Department of Social and Rehabilitation Services, filed 1-16-91

Notice of Service of Plaintiffs' Second Request for Production of Documents to Defendant Winfield State Hospital, filed 1-16-91

Notice of Service of Response to Discovery, filed 1-22-91

Scheduling Conference Notice, filed 1-29-91

Scheduling Order, filed 3-1-91

Dismissal of Defendant Michael Dey Without Prejudice, filed 4-15-91

Plaintiffs' Initial List of Witnesses, filed 4-30-91

Plaintiffs' Initial List of Exhibits, filed 4-30-91

Notice of Deposition Duces Tecum, filed 5-24-91

Motion to Dismiss Joe C. Pham, M.D. Without Prejudice, filed 6-7-91

Notice of Service of Defendants' Interrogatories to Plaintiffs, filed 6-3-91

Defendant Namey's Initial Witness List, filed 6-10-91

Initial List of Witnesses of Defendant Bill Heddon, filed 7-9-91

Initial List of Witnesses of Defendants of State of Kansas, Robert C. Harder, Dennis Taylor, and Winston Barton, filed 7-10-91

Initial List of Witnesses of Defendants Winfield State Hospital, Dr. William A. Lybarger and William Brooks, filed 7-10-91

Initial List of Witnesses of Defendant Jim Coon, filed 7-10-91

Journal Entry of Dismissal of Joe C. Pham, filed 8-6-91

Notice of Service of Discovery, filed 8-12-91

Motion for Extension of Scheduling Order Date (by all Defendants), filed 8-29-91

Memorandum in Support of Defendants' Motion for Extension, filed 8-29-91

Notice of Service of Plaintiffs' Interrogatory to Defendants Winfield State Hospital, Dr. William A. Lybarger, William A. Brooks, filed 9-3-91

Order Extending Time, filed 9-3-91

Notice of Service of Response to Discovery, filed 10-1-91

Motion for Extension of Scheduling Order Dates (by all Defendants, with the concurrence of Plaintiffs), filed 12-11-91

Memorandum in Support of Motion for Extending Time Limits in Scheduling Order, filed 12-11-91

Notice to Take Depositions, filed 12-11-91

Notice of Service of Discovery, filed 12-11-91

Notice to Take Depositions, filed 12-19-91

Motion for Additional Time, filed 1-15-92

First Revised Scheduling Order, filed 2-4-92

Notice of Service of Response to Discovery, filed 2-16-92

Notice of Service of Discovery, filed 2-20-92

Notice of Service of Discovery, filed 2-27-92

Notice to Take Depositions, filed 2-26-92

Minute Order, filed 4-2-92

Notice to Take Depositions, filed 4-13-92

Notice to Take Depositions, filed 4-17-92

Notice to Take Deposition Duces Tecum, filed 4-17-92

Notice to Take Deposition, filed 4-17-92

Subpoena in a Civil Case, filed 4-22-92

Notice of Service of Discovery, filed 5-5-92

Notice to Take Deposition, filed 5-5-92

Notice to Take Deposition, filed 5-5-92

Amended Notice to Take Deposition, filed 5-15-92

Notice of Service of Defendants' Interrogatories to Plaintiffs, filed 6-3-92

Notice to Take Deposition, filed 6-8-92

Subpoena in a Civil Case, filed 6-9-92

Motion to Quash, filed 6-16-92

Order, filed 6-24-92

Motion for Fees and Expenses Pursuant to FED. R. CIV. P. 37, filed 7-2-92

Memorandum in Support of Plaintiffs' Motion for Fees and Expenses Pursuant to FED. R. CIV. P. 37, filed 7-2-92

Motion for Extension of Scheduling Order Dates, filed 7-6-92

Memorandum in Support of Defendants' Motion for Extension, filed 7-6-92

Defendants' Qualified Final Witness List, filed 7-7-92



Notice of Taking Depositions, filed 7-13-92

Notice of Taking Deposition, filed 7-13-92

Amended Notice of Taking Depositions, filed 7-13-92

Hearing on Motion for Extension of Scheduling Order Dates, filed 7-14-92

Notice of Taking Deposition, filed 7-15-92

Notice of Taking Deposition, filed 7-15-92

Defendant Coon's Response to Plaintiff's Motion for Fees and Expenses,  
filed 7-16-92

Plaintiff's Final List of Witnesses, filed 8-6-92

Clerk's Court Room Minute Sheet-Motions, filed 8-7-92

Order, filed 9-14-92

Second Revised Scheduling Order, filed 9-15-92

Notice of Taking Deposition Duces Tecum, filed 9-21-92

Notice of Taking Deposition Duces Tecum, filed 9-21-92

Amended Notice of Taking Deposition Duces Tecum, filed 9-21-92

Notice of Service of Plaintiffs' Third Request for Production of Documents  
to Defendant Winfield State Hospital, filed 10-5-92

Notice of Jury Trial, filed 9-23-92

Subpoena in a Civil Case, filed 9-25-92

Subpoena in a Civil Case, filed 9-25-92

Order for Mediation, filed 10-6-92

Notice of Service of Plaintiffs' Fourth Request for Production of Documents to Defendant Winfield State Hospital, filed 10-7-92

Notice of Deposition, filed 10-13-92

Motion for Status Conference, filed 10-19-92

Notice of Withdrawal of Motion for Status Conference, filed 10-29-92

Statement Pursuant to K.S.A. 60-226B, filed 10-30-92

Notice of Service of Response to Discovery, filed 10-30-92

Notice of Service upon the Plaintiffs of Interrogatories, filed 10-30-92

Notice to Take Deposition Duces Tecum, filed 11-13-92

Notice to Take Deposition Duces Tecum, filed 11-17-92

Amended Notice to Take Deposition Duces Tecum, filed 11-23-92

Notice to Take Deposition Duces Tecum, filed 12-1-92

Subpoena in a Civil Case, filed 12-2-92

Motion for Summary Judgement, filed 12-15-92

Motion for Summary Judgement, filed 12-15-92

Transcript of Final Pre-Trial, filed 12-18-92

Journal Entry of Dismissal with Prejudice, filed 7-30-93

**Depositions:**

Deposition of Grace Dahlke, recorded 12-4-90

Deposition of Bea-Jay Lanning, recorded 7-30-91

Deposition of Anita L. Esquivel, recorded 8-1-91

Deposition of Doris Joan Conrod, recorded 8-1-91

Deposition of Dr. Cuong C. Pham., recorded 1-3-92

Deposition of Dr. William A. Lybarger, recorded 2-28-92

Deposition of Donna Rochelle Morgan, recorded 2-29-92

Deposition of Roxanna Lynn Namey, recorded 3-2-92

Deposition of Ronald Hammock, recorded 4-20-92

Deposition of William Brooks, recorded 4-21-92

Video Deposition of William Brooks, recorded 4-21-92

Deposition of Dr. David C. DeJong, recorded 5-3-92

Deposition of James L. Rice, recorded 6-22-91

Deposition of James Edward Coon, recorded 7-14-92

Deposition of William Edward Heddon, recorded 7-31-92

Deposition of Ronald M. Westfall, recorded 9-23-92

Deposition of Dr. Phillip Douglas Guess, recorded 9-28-92

Deposition of Dr. Charles Spellman, recorded 11-6-92

Deposition of Dr. Richard Saunders, recorded 11-6-92

Deposition of Dr. Frederick J. Fuoco, recorded 11-18-92

Deposition of Dr. Robert Miller Schell, recorded 11-20-92

Deposition of David Harry Mandt, recorded 12-2-92

Darrow, D. (1989, January 13). Couple seek the truth in son's death. Hutchinson News

DeJong, D. (1989). The Report of Postmortem Examination. (Case No. A-8908). Wichita, Kansas: Laboratory Medicine & Pathology.

Department of Health, Education and Welfare: Health Care Financing Administration: Medicare Bureau. (1984). Statement of Deficiencies and Plan of Correction (17-G007). Topeka, Kansas.

Department of Health and Human Services: Health Care Financing Administration. (1985). Statement of Deficiencies and Plan of Correction (17- G007). Topeka, Kansas.

Department of Health and Human Services: Health Care Financing Administration. (1986). Statement of Deficiencies and Plan of Correction (17-G007). Topeka, Kansas.

Department of Health and Human Services: Health Care Financing Administration. (1987). Statement of Deficiencies and Plan of Correction (17-G007). Topeka, Kansas.

Department of Health and Human Services: Health Care Financing Administration.  
(1988). Statement of Deficiencies and Plan of Correction (17-8000). Topeka,  
Kansas.

Department of Health and Human Services: Health Care Financing Administration.  
(1989). Statement of Deficiencies and Plan of Correction (17-6034). Topeka,  
Kansas.

Department of Health and Human Services: Health Care Financing Administration.  
(1990). Statement of Deficiencies and Plan of Correction (17-6034). Topeka,  
Kansas.

Fuoco, F. (1992, October). Consultant Report: Dahlke et al v. State of Kansas et al.  
Paper presented to the State of Kansas, Winfield.

Guess, D. (1992). Administrative Policies, Professional Program Decisions, and Staff  
Supervision Affecting the Health and Well-Being of David Dahlke at Winfield State  
Hospital and Training Center. Unpublished Report. Department of Special  
Education, University of Kansas, Lawrence.

Guess, D. (1992). Dahlke Case: Review of Parental Visits, Home Visits, and Letters

from Mother to WSHTC. Unpublished Report. Department of Special Education, University of Kansas, Lawrence.

Guess, D. (1992). Points of Emphasis in the Treatment of David Dahlke. Unpublished Report. Department of Special Education, University of Kansas, Lawrence.

Hendricks, R.J. (1990, July). Interview regarding Winfield State Hospital. Interview given to L.B.S., Ellsworth, Kansas.

Lundstrom Thomas, J. (1989, January, 12). Winfield death probed. Wichita Eagle Beacon.

Lundstrom Thomas, J. (1989, January, 26). Winfield workers cleared: Death puzzling, investigators say. Wichita Eagle Beacon.

Palmerin, P. (1989). Winfield State Hospital and Training Center: Unfortunate Incidents. Unpublished Masters Thesis, University of Kansas, Lawrence.

Samuel, C. (1984-1989). History - Physical Examination - Progress Notes. (Case No. 4027710). Winfield, Kansas: The William Newton Memorial Hospital.

Seaton, D. (1989, @ January, 28). Improper hold to led to Dahlke's broken leg.  
Winfield Courier, p. 1.

Thompson, B. (1991). Summary of Active Treatment. Unpublished Report.  
Department of Special Education, University of Kansas, Lawrence.

Thompson, B. (1991). Summary of Behavior Program. Unpublished Report.  
Department of Special Education, University of Kansas, Lawrence.

**Winfield State Hospital and Training Center**  
**October 1994**

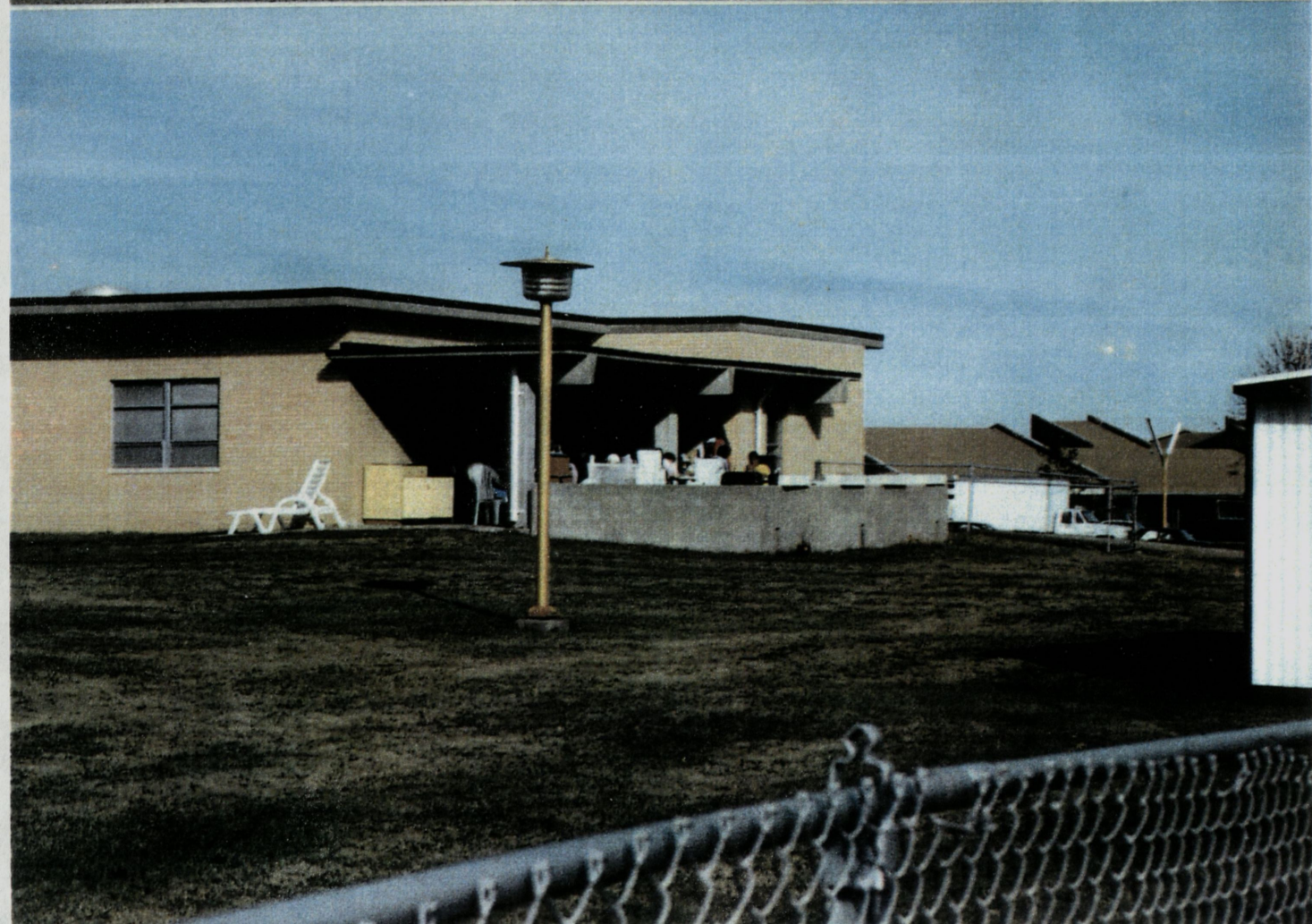
Five years after David's death





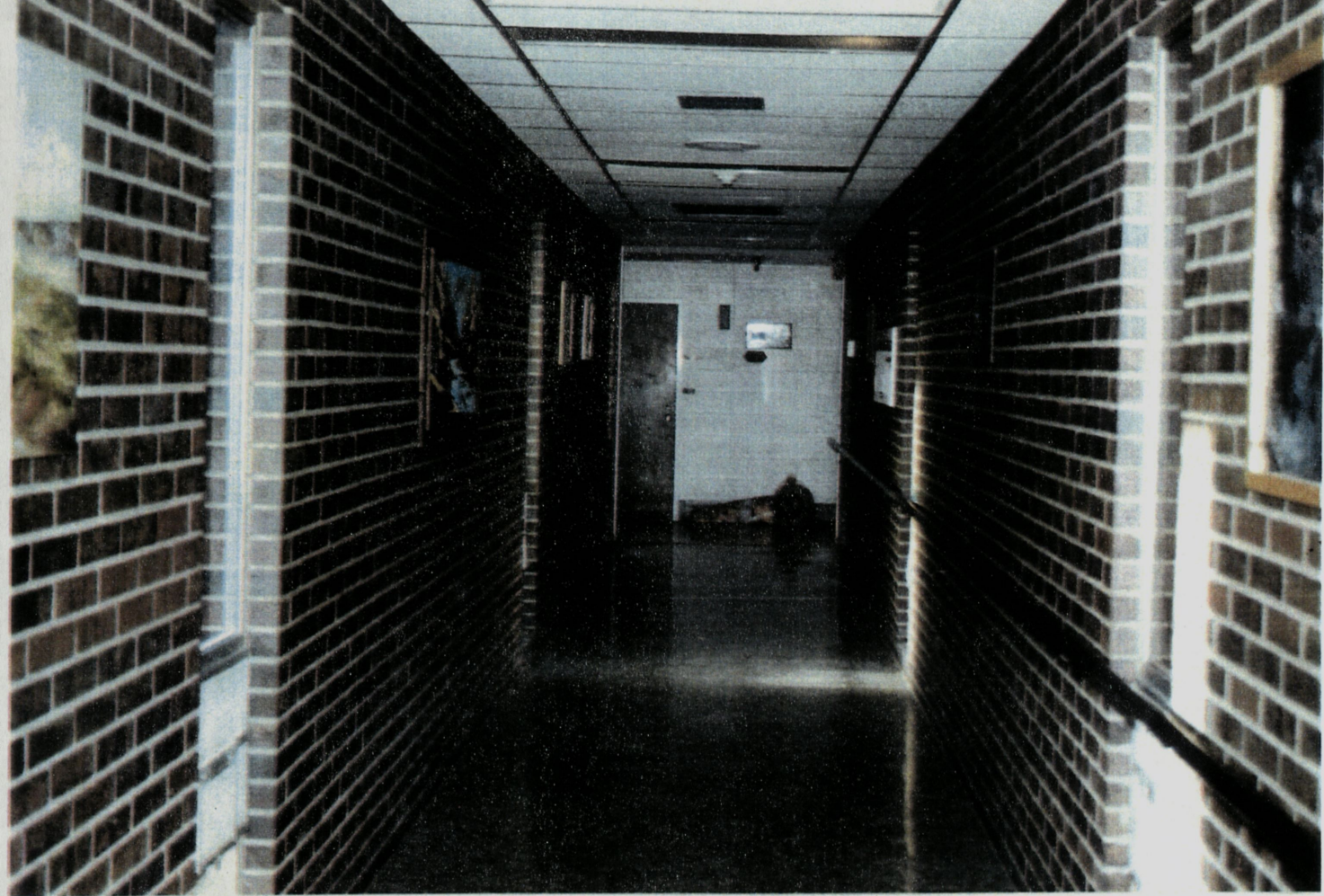
**Special Treatment Unit  
Winfield State Hospital**

David moved to this unit on April 1985  
David ended his life on this unit January 1989



## **Inside the Special Treatment Unit**

Corridor leading to David's locked ward  
Hallway leading to locked bedrooms



**Winfield State Hospital  
Living Room and Bathroom**

Notice:  
Darkness in the Living Room  
No doors on the bathrooms



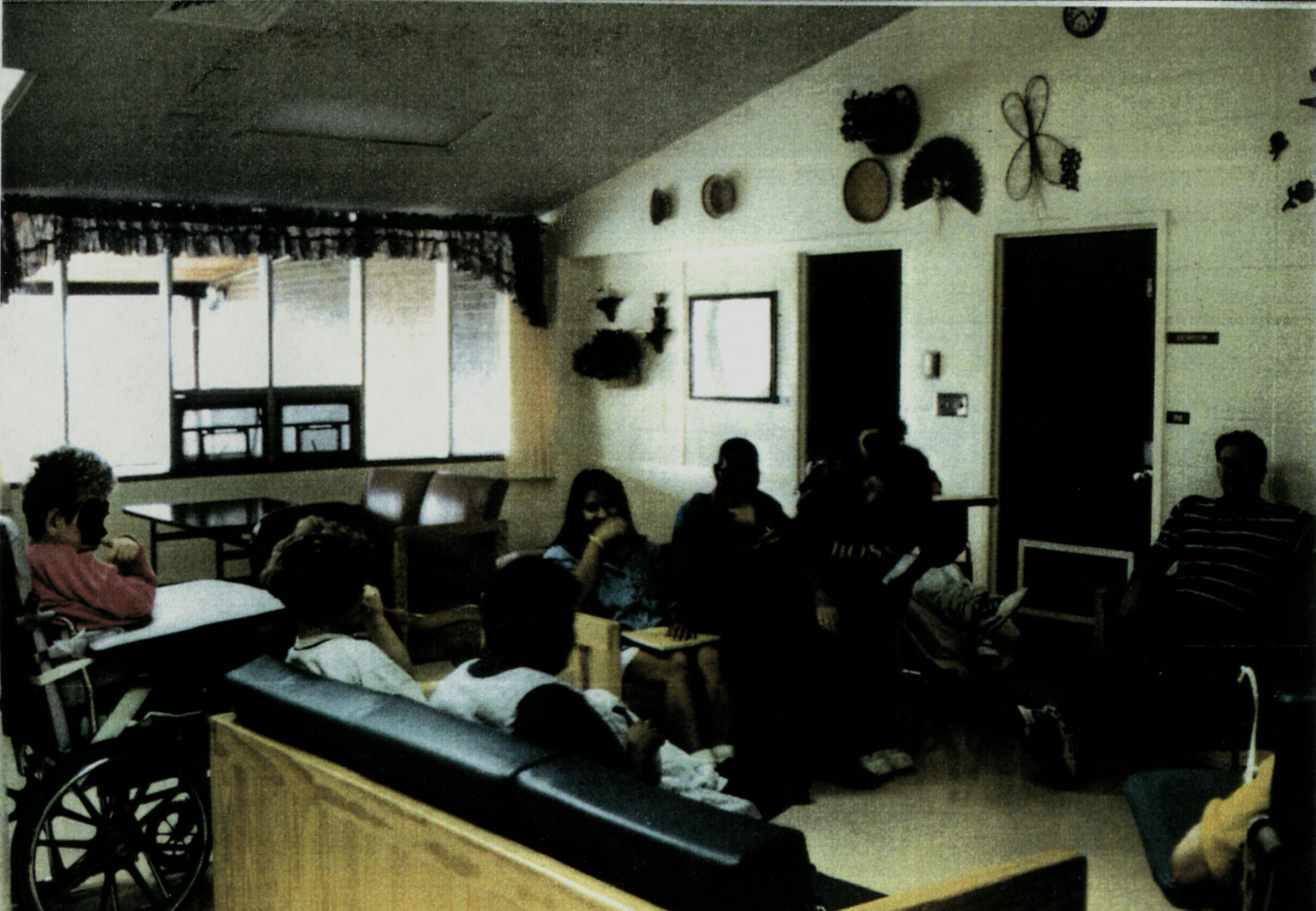
## **Bedroom and Day Room**

Notice:

Lack of windows, bedding and personal belongings

No activities present for anyone



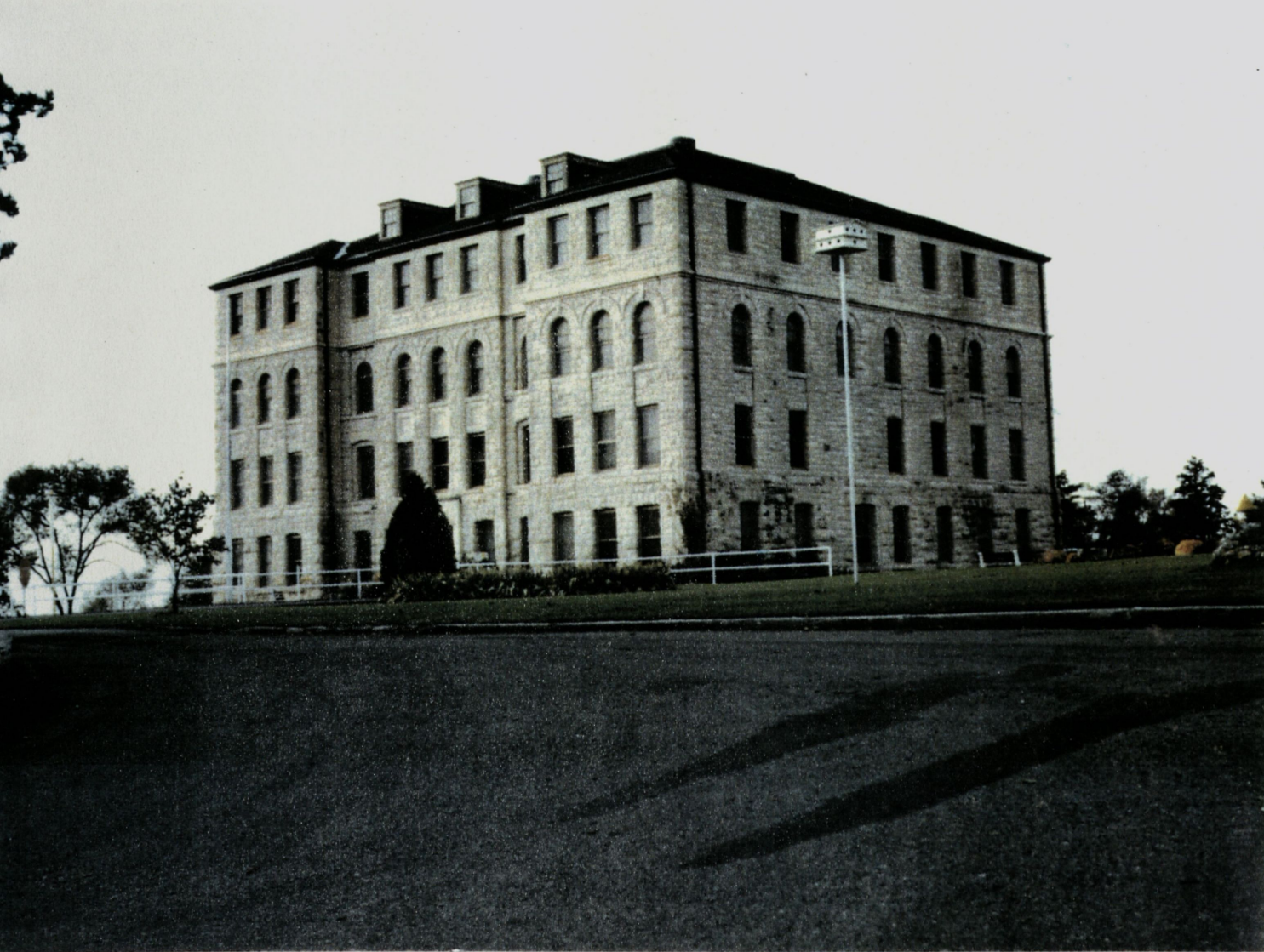


**The Buildings of Winfield State Hospital  
October 1994**

Notice:

Kansas Department of Corrections established a prison at WSH





## **Winfield State Hospital Cemetery**

### **Notice:**

**The location of hundreds of people that have died at the Institution  
The lumps of soil that indicate recent burial  
Lack of headstones and grave markers**

**At the request of his family, David was not buried here.**



**David Mandt Deposition  
Randel Goad Memo**

# David Mandt & Associates

P.O. Box 831921  
Richardson, Texas 75083-1921  
Phone: (214) 495-0755

COPY

memo:

December 22, 1988<sup>7</sup>

Dear David:

On December 14 - 18, 1988<sup>7</sup>, while I was conducting an Intermediate Level Trainer Course at Winfield State Hospital, I was asked by Lupe Alexander, and some other trainers, to look at some of the techniques that were being used by Winfield to restrain someone on the floor. She stated that a Mandt trainer by the name of Bill Hedden was using a technique that she was never shown and would like it clarified. I asked that Mr. Hedden come to a meeting of some of the trainers and demonstrate the technique so that I could make an assessment of the technique. Mr. Hedden arrived and showed me (using another staff person) how, with this particular individual, they would have him lying on the floor on his stomach and Mr. Hedden would sit on his back. His buttocks were about at the small of the person's back, his chest was lying on the person's back, and he stated that this allowed him to talk to the person, trying to calm him down, and that his weight was on his knees, not on the person. Mr. Hedden stated that this had worked well for him.

I informed Mr. Hedden that what he demonstrated was in no form a technique that The Mandt System would support. When the person would try to get up, you would have to place weight on him to maintain him on the floor. That form of restraining a person has never been taught in the Mandt System and never will. I also told him that if he wanted to use that form of restraining, he would have to teach it at some time other than with The Mandt Course. We do not want that type of restraining to be associated with The Mandt System in any way, and he may not teach it as any variation of the Mandt techniques.

After he left, Ms. Alexander told me that what Mr. Hedden demonstrated was not the way he had been doing it on the unit. I told her that what he showed me was not part of our course and was not to be taught as part of our course, and that any other variation that has a person sitting on or straddling another person would not be supported by our organization.

Randel C. Goad  
Vice President

Mandt
EXHIBIT NO. 65
12-2-88
KELLEY, YORK & ASSOCIATES



**Newspaper Articles**  
**David's Death**

Friday, January 13, 1989 Hutchinson News

# Couple seeks the truth in son's death

By Dennis Darrow  
The Hutchinson News

Grace Dahlke will get her answers.

The Hutchinson woman on Thursday said state officials had agreed to release a report within a week detailing the cause of her retarded son's death at Winfield State Hospital.

The report should answer concerns that worker abuse may have played a part in her son's death, a question raised by area media in what Mrs. Dahlke called misleading terms.

State officials are investigating the Tuesday morning death of David Dahlke, 39, the son of Mrs. Dahlke and the Rev. Victor Dahlke.

The officials told the family for the first time Thursday that Dahlke died of a heart attack, Mrs. Dahlke said.

The state had no answers for the family Wednesday.

Because of the ongoing investigation, officials have reported little on the cause of his death or the events surrounding his death.

Winfield State Hospital superintendent Tony Lybarger ordered an autopsy, asked a physician outside the hospital to review the patient's medical records, and assigned a law enforcement officer and registered nurse to conduct an investigation.

Family members knew almost nothing of how he died as a result.

With the little knowledge she had, Mrs. Dahlke told area news media that family members were wondering whether abuse played a role in his death.

Dahlke, who suffered from "behavior problems," including a tendency to make aggressive acts against others, had been the victim of two cases of abuse last summer, she said.

One of the incidents happened when workers broke one of Dahlke's legs during a struggle to restrain him, his mother said. She would not disclose the nature of the

second incident.

Area newspapers, television stations and radio stations misled the public when they reported her comments Wednesday as indicating that the family thought physical abuse could have killed her son, she said.

She clarified her remarks during a telephone interview Thursday.

"I would not say that because I do not know," she said. "The children are wondering because it happened before. But I'm not suggesting it. We are not suggesting it. We're just wondering what did happen."

George Vega, special assistant to

the commissioner of Mental Health and Retardation Services in Topeka, said Thursday that the investigation was a routine procedure of state mental hospitals.

Vega said Winfield superintendent Tony Lybarger ordered an autopsy, asked a physician outside the hospital to review the patient's medical records, and assigned a law enforcement officer and registered nurse to conduct an investigation.

"I will ... tell you," Vega said, "That he (Lybarger) did not do that related to abuse at all. Based on the information that we have, and that we had at the time, there was no allegation or report of abuse, or no reason to suspect abuse was involved. We just wanted to know what the facts were."

Lybarger told the Associated Press Thursday that, "There are no preliminary indications of abuse or neglect; however, the investigation is not complete."

The state will not release any specific information about the case, citing patient confidentiality laws, Vega said.

12-89

# Winfield death probed

White Eagle Beacon

By Judy Lundstrom Thomas  
Staff Writer

Physical abuse could have killed a Winfield State Hospital patient, parents of the patient said Wednesday.

State officials are investigating the Tuesday morning death of 39-year-old David W. Dahlke.

Officials provided little information Wednesday on the investigation at the state's largest hospital for the mentally retarded. A hospital spokeswoman read a prepared statement, saying the death was being investigated and referring all inquiries to George Vega, special assistant to the commissioner of Mental Health and Retardation Services in Topeka.

Vega said it was "standard operating procedure to investigate all patient deaths at state hospitals." But, he said later, the investigation at the hospital actually began before Dahlke's death. He would not say why.

But Dahlke's parents, the Rev. Victor and Grace Dahlke of Hutchinson, said that hospital officials told them that their son was taken to William Newton Memorial Hospital in Winfield on Tuesday morning after a "behavioral problem" occurred.

"They told us he had breakfast in the ward, came back, and there was a little behavioral problem," Grace Dahlke said. "They took him to the hospital and worked on him to no avail. That's all we know."

The Dahlkes said their son had been a victim of physical abuse at the hospital.

"David has been a victim of abuse out there," Grace Dahlke said. "Just this year alone, there were three reports, and two were confirmed. He was sent to the hospital in one case. In the 5 1/2 years he's been there, he has had four to five severe injuries."

She gave no further details about the alleged abuse or the injuries.

"I feel I don't want to mention any more about it right now," she said.

Vega refused to comment on the abuse allegations. But Richard Morrissey, manager of the Bureau of Adult and Child Care at the state Department of Health and Environment, said the investigation could be based on abuse allegations.

"That's the assumption on my part," he said. "But I don't have any first-hand knowledge at this point."

Such allegations would not be the first against the hospital. In 1987, federal reports said that patients were being physically abused by staff members. The reports also cited unsanitary conditions and staff training problems.

# WSH&TC death still under investigation

By DAVE BERGMEIER  
Staff Writer

The state Social and Rehabilitation Services' investigation into Tuesday's death of a 39-year-old resident of the Winfield State Hospital and Training Center has not been completed, a state official said this morning.

David W. Dahlke had been a resident at the state hospital for a little more than five years, according to his mother, Grace Dahlke of Hutchinson. She said her son would have turned 40 later this month.

George Vega, special assistant to the commissioner of Mental Health and Retardation Services said Wednesday that an autopsy had been performed on the man. The results have not been released.

(Continued from page 1)

final step is to send parents a full set of investigative documents and a copy of the autopsy.

A report is also sent to Ed Aldrin, chief of fraud and recovery at the state SRS office, Lybarger said.

Lybarger said information from the uncompleted investigation did not suggest abuse was involved in Dahlke's death.

"We certainly are concerned any time there is a death at this facility," Lybarger said. "I want to make the point that when someone dies at the state hospital, it does not mean there was inappropriate behavior."

Dahlke's mother said she did not know whether physical abuse was a factor in her son's death, but she added that her son was involved in two of three cases of alleged physical abuse that occurred at the hospital in 1988.

She had no comment on how the investigation is being handled and

The investigation is expected to be completed this week or early next week, he said.

Vega said witnesses and people involved in an incident are interviewed by investigators when a report is being prepared. Physical evidence is collected whenever possible, he said.

Investigators may continue to work on a case after an investigation report has been issued, Vega said.

"They may have to go back and look at policies and procedures... and make sure that the reports confirm what witnesses and investigators have said," he said.

"Sometimes in the case of a death, if a person has been ill, nurses and doctors will be called in and interviewed for the report,"

what action she might take after it is completed.

"My daughter went down there (to Winfield) this morning with someone from the legal department in Wichita and she is down there talking to people today," she said.

She said she hopes to receive a copy of the final report. Lybarger has said that a detailed report will be sent.

Mrs. Dahlke said, "It is important to me, as it is for them, to know all the details."

She said there are at least 15 workers from her area who are scheduled to attend her son's funeral.

She said her son had emotional and behavioral problems.

"He was there because he needed help, and anything that happened...to himself or others cannot be blamed on David because that was his condition. He was here (in Winfield) to be watched and helped," she said.

"I don't want to in any way tear

Vega said. "Physicians from within the facility and a physician outside is called in to review procedures."

He said the investigators also review the resident's record at the state hospital.

"We try to look at the big picture," he said. Vega declined to give specifics of Dahlke's background for reasons of confidentiality.

State hospital Superintendent Tony Lybarger said today that in Dahlke's case no allegations of abuse have been made.

He said when a resident dies unexpectedly, a three-step investigation is conducted.

Lybarger requests an autopsy and an internal review. An external review is made by a physician unattached with the state hospital. The (SEE: Death, page 12)

down those wards," she said.

"There are some very special people working out there. I've learned to know them and love them. Anyone can make a mistake. Yet he was there to be protected from himself."

"As David's mother, I feel the direct care staff needs to be complimented and encouraged as they take care of these children," she said. "They also need to exercise much love and compassion."

Lybarger said that if the report states that physical abuse was a factor in the resident's death, he will take appropriate action.

# Winfield workers cleared

## Death puzzling, investigators say

By Judy Lundstrom Thomas  
Staff Writer

No wrongdoing was involved in the recent death of a Winfield State Hospital patient, state officials said Wednesday, although officials still don't know the cause of death.

"The investigation has been completed, and no confirmation of neglect or abuse in the death was found," said George Vega, special assistant to the commissioner of Mental Health and Retardation Services in Topeka. "The staff acted appropriately in this incident."

Two SRS officials began an investigation after the Jan. 10 death of David Dahlke, a patient in the hospital's behavioral ward. State officials routinely investigate deaths at the hospital.

After his death, Dahlke's parents raised questions about his treatment at the hospital. Dahlke, 39, had been abused twice at the hospital in 1988, hospital officials said. In one case, his leg was broken by a staff member, and in the other, his chest was bruised after an infirmary aide struck him.

But Vega said the two confirmed cases of abuse were not a factor in the current investigation.

"The reason we asked for investigation was we wanted to know what happened," he said. "It was not because of a suspicion of abuse."

Hospital superintendent Tony Lybarger said it could be weeks before Dahlke's autopsy results are in.

Dahlke's sister, Lisa Winters, of Norman, Okla., said she was not satisfied.

"How in the world can they determine if it was neglect or abuse if they don't know the cause of death?" she asked. "With David's history of abuse at Winfield State Hospital, it's outrageous that an investigation could be limited to an internal investigation with SRS investigating itself."

Winters said the day after her brother's death, Lybarger told her parents he had ~~had~~ of an apparent heart attack while being physically restrained.

"Then, a couple of days later, he told me the preliminary results were that he did not die of a heart attack, but that it could have been asphyxiation," she said.

Federal officials said they did not know if another investigation would be conducted. Larry Swetman, with the Health Care Financing Administration, which controls funds for the hospital and conducts inspections, said the agency was not involved in the investigation.

"We're going to get a copy of the report," he said. "I don't know what we'll do until after we see that."

Winters said her family would not drop the issue simply because state officials say it is finished.

"We're going to make every effort to find another investigative body to conduct an investigation," she said.

Wichita Eagle  
Beacon  
January 26, 1989

# Abuse not a factor in resident's death

By DAVE BERGMEIER  
Staff Writer

Abuse and negligence was not ruled as a factor in the death of a 39-year-old resident of the Winfield State Hospital and Training Center, state hospital superintendent Tony Lybarger said this morning.

Officials from the state hospital and the state Social and Rehabilitation Services had been investigating the death of David Dahlke, who died at the William Newton Memorial Hospital Jan. 10. Dahlke had been a resident at the hospital for five years.

Lybarger said the investigation's findings were to be sent to the state Social and Rehabilitation Services' central office in Topeka later today.

He said the central office will be responsible for disseminating the information. Lybarger said the parents of the resident, Victor and Grace Dahlke of Hutchinson, will receive copies of the state hospital's report.

20-89

← a  
Dahlke's

Winfield Courier

# Improper hold led to Dahlke's broken leg

By DAVE SEATON  
Courier Editor

David Dahlke suffered a broken leg when Winfield State Hospital and Training Center staff physically restrained him, superintendent Tony Lybarger said Friday. Dahlke was the 39-year-old state hospital resident who died here Jan. 10.

An investigation by the state Social and Rehabilitation Services found no abuse leading to Dahlke's death. However, Dahlke's leg was broken in an earlier incident when staff applied the Mandt procedure to try to restrain him, Lybarger said Friday.

"When we reviewed (that) situation, we felt that the hold was not applied properly. That was the basis of our finding that abuse occurred," he said.

The Mandt procedure is a hold

applied to restrain someone after other attempts to manage his behavior have failed, according to Lybarger. The procedure is accepted in the field of mental retardation and taught to all direct care staff at the hospital for use when a resident is believed to be in danger of hurting himself or others, the superintendent added.

Dahlke suffered a bruised chest in another previous incident. Abuse was also found to have occurred in that incident.

Lybarger said he had been advised by SRS lawyers not to comment on Dahlke's handicap or on actions taken against staff alleged to have abused Dahlke.

Abuse was not found by an SRS investigation to be a factor in Dahlke's death. Lybarger said Fri-

(SEE: Improper, page 10)

Winfield Courier

# Abuse not a factor in resident's death

(Continued from page 1)

Mrs. Dahlke said this morning she had not received a copy of the report.

"My stomach is just in knots. I have been sitting here waiting," she said.

Mrs. Dahlke said she would not comment on the investigation until she had seen copies of its report.

Lybarger said the state probably would not make any statements about the case until Monday. Attempts to reach George Vega, special assistant to the commissioner of Mental Health Retardation Services, were not successful this morning.

George Vega  
date on this  
around 1-26-89

# Improper hold led to Dahlke's broken leg

(Continued from page 1)

day the investigation of Dahlke's death was complete at the hospital.

"We're awaiting the results of the autopsy," he said. "It will be up to the folks in Topeka to do anything else."

Dahlke's sister, Lisa Winters of Norman, Okla., has said she was satisfied with the investigation.

How can this be taken?

DEPOSITION EXHIBIT

6 Dahlke #3  
12-5-90

# SRS probing death at state hospital

By DAVE BERGMEIER  
Staff Writer

The death of a resident Tuesday morning at the Winfield State Hospital and Training Center is still under investigation.

An autopsy has been performed on the 40-year-old man, but results have not been released, said George Vega, special assistant to the commissioner for state mental health and retardation services.

Officials in Topeka and at the state hospital declined to release the man's name or where the death occurred for reasons of confidentiality.

Both Vega and state hospital superintendent Tony Lybarger said the early results of the report did not indicate that abuse was a factor in the resident's death.

"There are no preliminary indications of abuse or neglect; however, the investigation is not complete," Lybarger said.

Vega said the state has not issued a preliminary report because it wants to wait to see the

(SEE: SRS, page 14)

# SRS probing death

(Continued from page 1)

results of the autopsy and investigation.

"We don't know what caused his death so we are going to wait," he said.

The investigation is expected to be finished late this week or early next week.

Vega said, "My understanding is that it takes a few days, sometimes even a couple of weeks. I was told that they sent some materials like blood to a lab and it takes a while to return them. They have to write up the reports first."

Lybarger said every investigation into the death of a resident is handled the same way.

"We are handling this situation no differently than any other situ-

ation and the fact a death occurs at this facility does not in itself infer that something wrong or inappropriate has occurred," Lybarger said.

Vega said investigations are time-consuming because of the type of residents at the state hospital.

"We have some of the most medically fragile people in the state in Winfield," he said.

Lybarger said the staff at the state hospital are always disappointed and hurt when a resident dies.

"The staff at this facility is saddened by this occurrence. . . but continues to make every effort we can to provide best possible care and treatment to every resident at this facility," he said.

# Winfield Hospital death investigated

Topeka Capital Journal

Social and Rehabilitation Services officials confirmed they are investigating the death of a patient Tuesday at the Winfield State Hospital.

George Vega, special assistant to the commissioner for mental health and retardation services, confirmed that a patient in his 40s died at the hospital shortly after 10 a.m. Tuesday.

1-11-89

## David W. Dahlke

David W. Dahlke, 39, died Jan. 10, 1989, at Winfield State Hospital. He was born Jan. 26, 1949, at North Tonawanda, N.Y.

He was a member of Our Redeemer Lutheran Church, Hutchinson.

Survivors: parents, the Rev. Victor and Grace Dahlke, 706 West 21st; brothers, Jonathan, Holyrood, James, Fargo, N.D.; and sisters, Deborah Matan, Columbus, Ohio, Dorcas Winter, Norman, Okla., Joanna Penn, Topeka, and Dinah Holsten, Manchester, Mo.

Services are pending with Elliott Mortuary, Hutchinson.

## Funeral

### David W. Dahlke

Funeral for David W. Dahlke, 39, who died Jan. 10, 1989, at Winfield, will be 2 p.m. Friday at Our Redeemer Lutheran Church, Hutchinson, the Revs. Thomas Mendenhall, Paul Krause and John Reibhoff. Burial will be in Fairlawn Cemetery. Friends may call from 9 a.m. to 9 p.m. today and from 9 a.m. to noon Friday at Elliott Mortuary, Hutchinson. Memorials may go to Chaplaincy Services of Winfield State Hospital, to the church, or to the donor's choice, in care of the mortuary.

Jan. 11  
Hutchinson News  
Jan. 12