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**Disability Rights New Mexico
Investigation Report of**

**Westside Emergency Housing Center
Incident from February 16th, 2023**

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I. Introduction

Disability Rights New Mexico (DRNM) is the designated Protection and Advocacy System (P&A) for the State of New Mexico. DRNM is authorized to “investigate incidents of abuse or neglect of individuals with disabilities if the incidents are reported to the system...or if there is probable cause to believe that an incident has occurred or may have occurred.”¹ Congress granted the P&As broad access rights to facilities, residents, and records in the PAIMI Act² for individuals with mental illness, in the Developmental Disabilities Assistance Bill of Rights Act (DD Act)³ for persons with developmental disabilities, and in the Protection and Advocacy of Individual Rights (PAIR) Program of the Rehabilitation Act of 1973⁴ for persons with other disabilities. The courts treat these P&A Acts as a set and often refer to the DD Act to explain authorities under another P&A provision and vice versa.

On March 8th, 2023, DRNM attorney Holly Mell received a report from a community member that an individual with disabilities (who will be referred to as ‘Resident’ for the purposes of this report) died suddenly after falling from an upper bunk at the Westside Emergency Housing Center (the WEHC) on or around February 15th, 2023. DRNM contacted a family member of the deceased individual who also reported that they had been told by WEHC staff that the Resident died from falling out of an upper bunk and that the Resident had numerous disabilities including

¹ 42 U.S.C. § 15043(a)(2)(B); 45 CFR § 1326.27(c) 42 U.S.C. § 10805. et seq,

² 42 U.S.C. § 10801 et. seq.

³ 42 U.S.C. § 15001 et. seq.

⁴ 29 U.S.C. § 794(e) et. seq.

mental illness and traumatic brain injury. The reporter expressed concern that the WEHC was unsafe. DRNM contacted the Office of the Medical Investigator and was able to confirm that the Resident died at the WEHC facility on February 16th, 2023. Based on the information provided to DRNM at that time, DRNM asserted access authority to conduct an investigation of the events leading up to the Resident's death at the WEHC facility. The findings of the investigation indicated that negligence from the WEHC was not substantially related to the individual's cause of death. However, the investigation also revealed neglectful conditions at the WEHC pose a danger to current and future residents. Follow up actions need to be taken by the City of Albuquerque and Heading Home to put a stop to preventable deaths occurring within their facility and to ensure that the facility meets a higher standard of safety and care for their residents.

II. Description of Parties

DRNM is New Mexico's designated P&A. P&As are afforded broad authority to access individual clients, their records, and all areas of facilities that are used by residents. Additionally, P&As are authorized to immediate access (within 24 hours) to records without any consent in the case of a death of an individual.⁵ Pursuant to this authority, DRNM attorney, Holly Mell, and non-attorney advocate, Robin Garrison, conducted the investigation into the incident at the WEHC, with some assistance from other DRNM staff

The WEHC is owned and operated by the City of Albuquerque who contracts with a nonprofit agency, Heading Home, to run and provide services within the facility. Originally built as a jail, the WEHC is located 18 miles from downtown Albuquerque. It was originally intended to be a temporary shelter for winter time but has since expanded to operate year-round 24 hours a

⁵ 45 CFR § 1326.27(b); 42 CFR § 51.42(b)

day, 7 days a week. Heading Home provides almost all of the staffing and services involved in the day-to-day operation of the WEHC, however, the City also contracts with other organizations to provide free shuttle transportation and security guards. The City of Albuquerque owns the building itself and any changes to the building and interior equipment are typically approved and paid for by the City. In addition, other service providers come to the WEHC during the day several times a week to provide other services for the unhoused including healthcare and case management. At the time of DRNM's investigation, Heading Home provided case management at the WEHC but they no longer offer these services.

Records from a recent budget request regarding the WEHC indicate that the facility provides shelter beds for an average of 450 individuals overnight and an average of 250 individuals during the day. However, it should be noted that DRNM has received conflicting reports regarding the capacity at the facility. Staff estimated to DRNM that there are approximately 700 residents during the winter months. The facility allows pets and has no limits on length of stay. WEHC staff estimated to DRNM that about 100 of their residents were elderly and that a large number of residents had disabilities. Staff informed DRNM that the official policy of the shelter is that they cannot take people who cannot independently perform activities of daily living because of their disability. However, the reality is that hospitals and emergency services routinely transport individuals to the facility with ongoing medical needs and the WEHC staff do not have a way to identify residents with complex medical needs at intake.

The facility consists of 9 dorms total with an average of 63 residents per dorm separated into men and women's dorms. At the time of DRNM's visit, one of the dorms was set aside sheltering refugees and another operated as a family/ couple dorm which allowed men and women to stay together but had a much smaller capacity.

III. Summary of Findings

A. **Cause of Death**

1. Resident had Chronic Medical Conditions and was in Poor Health Preceding Their Death

Review of medical records in the year prior to Resident's death show that they suffered from a number of chronic medical conditions and disabilities and had been residing at the WEHC on and off for several years. Resident was 53 years old at the time of their death. Between November 2022 and February 2023, the Resident was admitted to the Presbyterian Rust Medical Center 8 times with abdominal pains and complaints of being hungry and cold. Records indicate that the Resident was also frequently admitted into Lovelace Hospital with similar issues. For each visit, the Resident was discharged the same day. The past surgical history indicated that the Resident had required an appendectomy in 1974, a head injury and orthopedic surgery in 1995, and, in 2016, required a procedure to treat erosive esophagitis and a hiatal hernia. In addition, the Resident had been diagnosed with a number of chronic conditions including traumatic brain injury, Hepatitis C, Schizoaffective disorder, seizures, and substance abuse disorder.

Notably, WEHC staff had called Emergency Services on behalf of the resident on February 14th, 2023, two days prior to their death. A WEHC incident report from this date states that the Resident was throwing up and complaining of stomach pain. The WEHC report indicates that follow up would be required stating, "Client is expected to return. Will monitor health and wellbeing." In addition, several WEHC staff told DRNM that the Resident had appeared ill in the past few months. Presbyterian Rust Medical Center records indicate that the Resident was

admitted and discharged the same day with nausea medication on February 13th, 2023 and then admitted again on February 15th, 2023. The Presbyterian narrative summary states, “Patient had recently been discharged the day before, but came back because they are still ‘not feeling good.’ Patient reports nausea, fatigue, fever, shortness of breath and vomiting.” The Resident was again discharged the same day. The Presbyterian records indicate that the results of a physical exam had been “reassuring” and that the “plan is to [discharge] with strict return precautions and output [follow-up]”.

2. Summary and Timeline of the Resident’s Death

On February 16th, 2023, WEHC staff reported seeing the Resident arrive at the C-dorm sometime between 12:00 am- 3:00 am and walk in the direction of their bunk. DRNM confirmed from the WEHC Bed Report that the Resident was assigned to bunk C-19, an upper bunk.

WEHC staff were not able to confirm whether the Resident was actually in the bunk and were not present in the C dorm when the incident began. DRNM was able to get a statement from a Witness (referred to as Witness for the purposes of this report) to the event who reported that the Resident was not actually sleeping in their bunk and recalls that they were lying on the floor. The Witness stated that WEHC staff attempted to assist the Resident into their bunk, although staff interviews do not mention this occurrence.

The Witness states that at some point the Resident began to walk down the aisle and was stumbling into the surrounding bed frames. The Witness describes seeing the Resident stiffen and fainting face down onto the ground without putting their hands up. At this point, the Witness went out to the hallway and called for WEHC staff to come into the dorm.

WEHC Staff stated that they saw the Witness calling for them in the hallway and went into the dorm to see the Resident lying on the floor with some blood that appeared to be coming from their nose. The Staff attempted to get a response from the Resident and called on the radio for the Supervisor. The Supervisor and Staff accounts both state that they were initially able to get a response from the Resident and that the Resident was breathing at this stage but unable to stand. The Supervisor left the dorm to call EMS and write the incident report.

DRNM obtained audio recordings of the EMS calls which are generally consistent with the statements of both the Staff and the Supervisor. According to the Albuquerque Fire Department (AFD) records, the first call to EMS took place at 3:12 am. The Supervisor told the dispatch that the Resident was initially not responding and they noticed blood. The Supervisor conducted a sternum rub and the Resident responded. Dispatch stated that they would send EMS and to call back if the situation worsened.

According to the Staff and Supervisor statements, the Staff called again on the radio for the Supervisor to come back into C dorm because the Resident had stopped breathing. The Supervisor stated that they attempted to find a pulse and could not find one. The Supervisor initiated CPR but, upon compressing the Resident's chest, the Resident began to vomit large amounts of blood. One of the Staff statements indicated that the Supervisor attempted to set up the AED machine, however, the other statements do not mention the use of the AED machine and EMS records indicate that an AED machine had not been used prior to EMS arrival.

The Supervisor instructed the Staff to call EMS again to update them. DRNM also reviewed audio of the second EMS call to dispatch. Again, the call is largely consistent with the statements given to DRNM in interviews with WEHC Staff. EMS asked Staff whether they were administering CPR, and the Staff responded that they stopped because of all the blood coming

out of the Resident's mouth. EMS asked Staff whether they administered Narcan and they stated no because they did not observe signs of an opioid overdose. Staff also reported that the Resident was gasping and breathing in jerks, and that they had positioned the Resident on their side while blood continued to come out of their mouth.

EMS upgraded the call type and the Witness and Staff left the dorm to direct EMS to the Resident upon their arrival while the Supervisor remained with the Resident. In the APD logs, the arrival time of EMS is listed as 3:45 am. However, the AFD records indicate that EMS did not arrive to the Resident until 3:54 am. EMS records show that no one was conducting CPR upon EMS arrival and that there was a large pool of blood surrounding the Resident who was not breathing and pulseless. EMS attempted to ventilate the Resident but were unable to revive them. EMS discontinued CPR at 4:15 am.

DRNM requested lapel camera footage for APD and was able to observe the scene following the death of the Resident and made several observations. In the video, the Resident's body was lying on the floor surrounded by a large pool of blood. The bunks directly next to the Resident's body were occupied by other individuals who were still sleeping. DRNM observed that other individuals staying at the WEHC were able to observe everything and had not been evacuated from the room. DRNM observed several wheelchairs and walkers throughout the aisles in the C-dorm. The C-19 bunk did not have a mattress in it or any visible bedding. The lower bunk, C-20, had a mattress and bedding although the bed was still made and did not appear disheveled.

Police stayed with the Resident's body for over an hour waiting for staff from the Office of the Medical Investigator (OMI) and crime scene investigators to arrive. At one point, WEHC staff attempted to move one of the bunk units away from the blood pool which continued to

expand. Staff moved the bunk with another resident still asleep in the upper bunk. Staff informed police what had occurred and the narrative was largely consistent with the written statements. DRNM staff noted that only one WEHC employee was visible managing the scene and interacting with police personnel. At one point, another WEHC resident approached the police officer to ask if they would be taking the Resident's belongings. When police replied no, the person mentioned that they would want to take the deceased Resident's shoes. At one point in this exchange, the police officer asks the individual about another death occurring at the WEHC the day before and the person responds that it was several days ago. The officer also asks the individual whether the blood was from the Resident throwing up and asks whether the Resident "fell off of anything" and the individual replies no. DRNM noted that this individual was still present at the scene after APD left and the body was transported out and may have had an opportunity to take the deceased Resident's belongings.

One of the lapel camera videos shows police greeting the OMI investigator in the parking lot. The worker that arrived to transport the Resident's body made a remark to the police saying, "seems like a lot of people keep on dying at the shelter." The Officer mentions that the Resident had several hospital bracelets still on and states, "[the Resident] looked like they had a rough, rough life. When you see the body, you're gonna know. They're very skinny. They're head seems like, I don't know, they've been beat up before."

When OMI arrived at the body, they examined the Resident and informed APD that there were no signs of trauma to the body and that the Resident likely bled out from an internal hemorrhage. The APD officer remarks that this was consistent with the EMS workers assessment.

After the Resident is transported out of the facility, the lapel camera footage stops. Statements from the Staff and Supervisor indicated that they bagged the deceased Resident's belongings and had to continue with the rest of their shift.

DRNM obtained the post examination report and a toxicology report from the Office of the Medical Investigator following the Resident's autopsy. The cause of death is listed as accidental, with no visible trauma to the body from a fall. The exam noted that the Resident had hospital bracelets and some old, dirty medical tape overlying gauze on the right arm. The cause of death is listed as "a gastrointestinal hemorrhage due to duodenal ulceration with acute and chronic methamphetamine use as a significant contributing condition." The toxicology revealed that the Resident had amphetamines in their system but no alcohol or opioids.

DRNM attempted to have a follow up interview with the OMI but were unable to get an appointment with them before the report. Some remaining questions that DRNM had were whether the severity of the Resident's medical condition would have been evident in the hospital visits prior to the death, how chronic use of amphetamine might have related to the ulcer and hemorrhage, and whether a fall could have triggered the hemorrhage. The OMI records are consistent with the statements made by WEHC staff.

B. Investigation Findings

1. The Remote Location of the WEHC Causes Significant Delays in Emergency Response Times

The WEHC is located 18 miles from downtown Albuquerque. DRNM reviewed several incident reports from the WEHC as well as reports from Emergency Medical Services. involving the Resident. On August 22nd, 2022, EMS was called at 7:05 pm and arrived at 7:30 pm. On

February 14th, 2023, EMS was called at 9:39 pm and arrived at 10:05 pm. On February 16th, 2023, the night of the Resident's death, EMS was first called at 3:12 am and arrived at the Resident at 3:54 am.

DRNM also reviewed Albuquerque Police Department lapel camera video for the night of the incident. In one section, the APD officer is greeting the transport team that arrived to take the Resident's body and explains that they are still waiting for staff from the crime scene unit. The officer comments, "The shelter is, unfortunately, kind of far away from the City."

The remote location also makes it difficult for Residents to make calls because of poor cell phone and internet connections. This could create a significant access problem for residents who rely heavily on community supports and services.

2. The Allegation that the Resident Fell from an Upper Bunk is Unsubstantiated

Staff did not observe whether or not the resident had been in Bunk C-19 on the night of their death. While the incident reports and emergency medical reports all mention a "fall", the Witness interviewed stated that the Resident was sleeping on the floor and fell from a standing position. DRNM was not able to discount a fall from the bunk entirely, but it seems unlikely given that the video footage revealed that the upper bunk did not have a mattress or bedding. In addition, the footage also shows police asking another witness whether the Resident was bleeding from a fall and they responded in the negative.

3. The Resident's Cause of Death was Unrelated to a Fall

The Resident's cause of death was found to be "accidental" in the postmortem examination and was related to an internal medical issue. Much of the evidence suggests that the

Resident did sustain a fall from a standing position, however, none of the medical records suggest any signs of significant trauma to the body. The Staff interviews and records from the night of the incident indicate that staff followed the WEHC policies and procedures, appropriately notified EMS, and attempted to perform CPR.

4. Upper Bunks at the WEHC Pose a Significant Risk for Falls

DRNM reviewed WEHC records to determine which bunk was assigned to the Resident. WEHC staff reported that they do not assign upper bunks to people who have mobility impairments; however, a review of the Bed Report from February 13th, 2023 shows that the Resident was assigned to bed C-19, which is an upper bunk.

DRNM took photos and measurements of bunk C-19 and noted several concerns. The bunk frames do not conform to a standard size. The upper bunk measurements were 27" x 75". The smallest standard size twin mattress is 38" x 75". Because the frames are several inches narrower than the mattresses, the mattress overhangs the edge of the frame by 11 inches. This is compounded by the lack of any lip or railing on the upper bunks that would prevent a Resident from rolling over the edge.

The next concern was the lack of any ladder or steps to climb into the upper bunk. DRNM noted several kindergarten size chairs next to a few bunks that presumably were being used as a step up to get into the upper bunk. The chairs are not secured to the floor and also create a risk for falls. The majority of the bunks did not have chairs and residents would need to pull themselves up into the bunks. The frames have sharp metal corners at the joints and the floor

is concrete. Any resident using an upper bunk is at risk of serious injury due to falls.



Photo of Bunk C-19

- No step or ladder to upper bunk
- No railing around upper bunk frame
- Hanging oversized mattresses
- sharp metal corners

5. The WEHC Does Not Have Sufficient Staff to Supervise the Residents or the Environment

The WEHC averages 450-700 residents at night and 250 during the day. On the night of Resident's death, there was one Staff and one Supervisor rotating between dorms A, B, C, D, and F. The average capacity of the dorms is 63 residents. Neither the Staff or the Supervisor was present in C dorm when the incident began, and were alerted to the situation by another resident.

WEHC's Death Reporting Policy states, "When a death occurs at the WEHC, staff must preserve the dignity of the deceased as well as ensure that the area in which the death has

occurred is safeguarded against possible contamination by others if an investigation by law enforcement is necessary.” It goes on to state that the Shift Supervisor should, “immediately instruct security personnel and other program staff to discretely remove all unnecessary personnel from the area and to safeguard the deceased as well as the area in which the deceased is located by creating a perimeter around the deceased of no less than 10 feet in any direction whenever possible.”

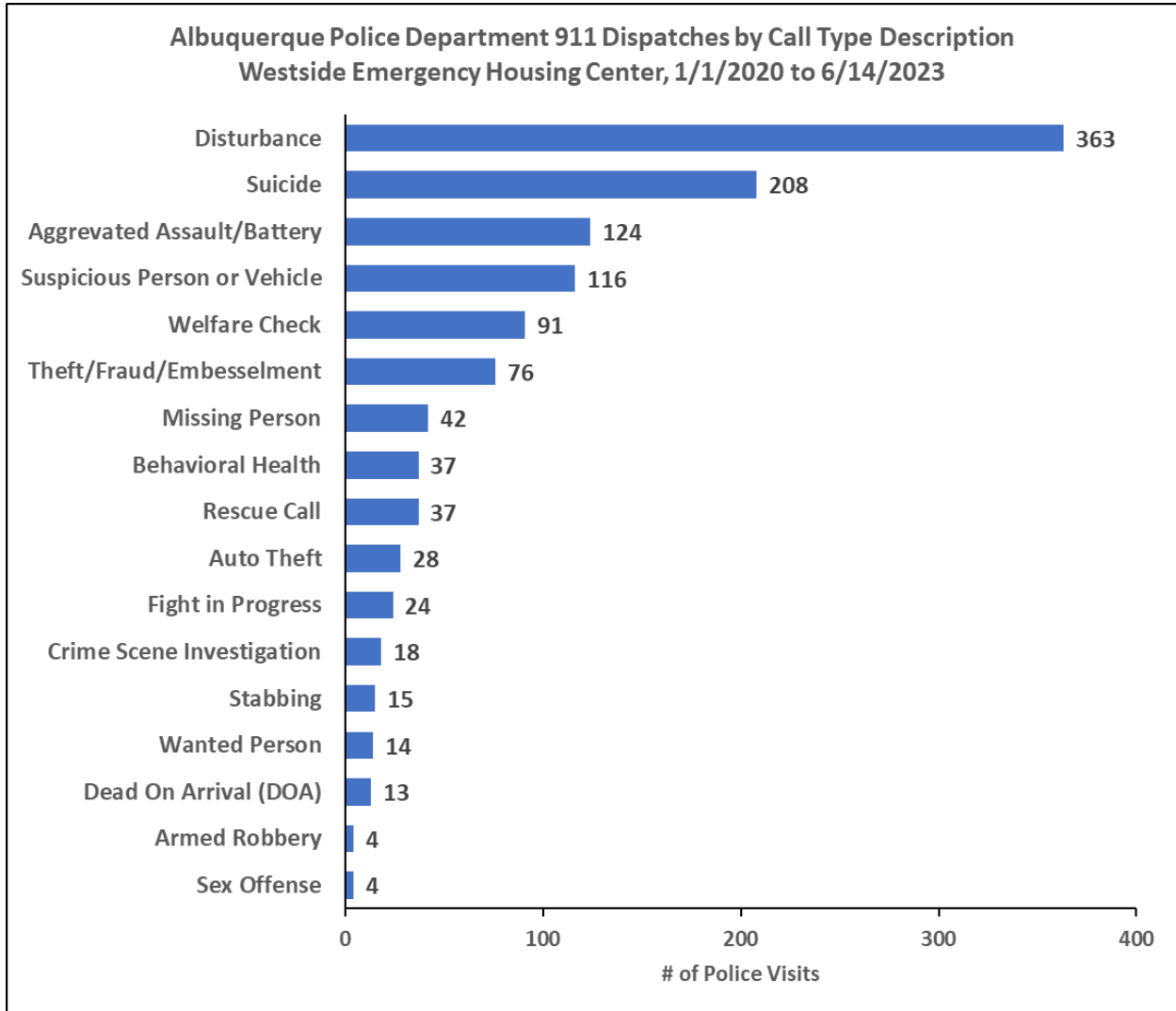
From the APD lapel camera footage, WEHC staff were not able to appropriately manage the scene and ensure that other residents were not unnecessarily observing the death or contaminating the scene. In particular, there was one resident asleep directly next to the deceased for over an hour, and another resident asking to take the belongings of the deceased. Since there was only one staff attempting to assist police and EMS workers, there was not enough staff to attempt to appropriately evacuate the area and preserve the dignity of the deceased.

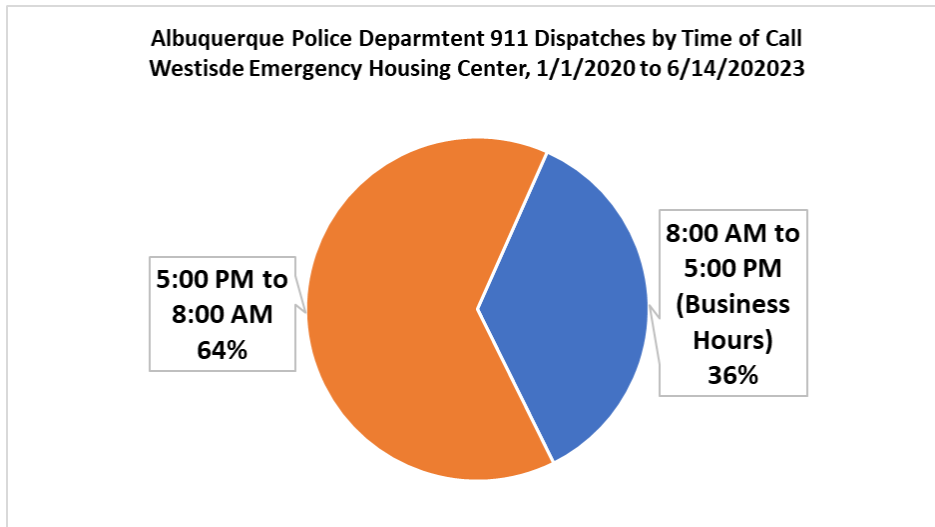
6. The WEHC’s Standard of Care is Inadequate to Meet the Needs of Residents with Chronic Medical Conditions and Disabilities

During the course of its investigation, WEHC staff mentioned that there had been multiple deaths that occurred at the facility. In one of the written statements by WEHC staff they stated, “I’ve been working here for a little over a year and have been around a couple of deaths.”

The WEHC is not a licensed healthcare facility. Its staff are required to be certified in First Aid and CPR and are trained in Mandt which teaches a particular method of safe restraint and de-escalation techniques. The WEHC sometimes has outside providers able to provide medical support but these providers are only available during the daytime.

DRNM reviewed all of the city dispatch call entries to the WEHC between January 1st, 2020 and June 14th, 2023. DRNM organized the information into the following two tables to reflect the type of calls and the general times that the calls were made.





The data showed that there were 13 calls listed as “Dead on Arrival.” This number only reflects the number of residents who died at the WEHC location before police arrived at the scene and does not include individuals who were transported to a hospital and subsequently died.

Alarming, there were 208 calls recorded as “Suicide”, although there is not sufficient information to know how many of these calls might have resulted in death or injury.

The records indicate that there are a high number of incidents at the WEHC where Emergency services are dispatched. The majority of the incidents occur outside of regular business hours when there are no staff who can provide medical care beyond basic First Aid and CPR.

7. The WEHC Facility is Not Accessible Under the ADA and Does Not Meet the Minimum Standards Established by the U.S. Department of Housing and Urban Development

DRNM reviewed the 2023 Point-in-Time count conducted by the Coalition to End Homelessness organization. Their report includes results from a survey which asked unhoused individuals why they were not using the shelter system. The data identified the most common

reasons were that “individuals had had previous negative shelter experiences, that they had safety concerns including the fear of violence, and that shelters were unhygienic (many respondents mentioning bed bugs and the spread of disease).” Common policy reasons included “accessibility issues”; the shelters being too far away, or respondents lacking the transportation to reach them, and shelters not accommodating people with disabilities or chronic illness.”

DRNM did not perform a full inspection to determine whether the WEHC complied with the ADA architectural standards but still identified several accessibility concerns at the WEHC that impose significant barriers for residents with disabilities. Some of these concerns include:

- The bunks are not accessible (see section above).
- There is a step to get into the row of showers that would prevent a wheelchair from entering the area.
- Some of the dorm showers have a push button to operate the water that needs to be repeatedly pressed every few seconds. The button is too high for people using shower chairs or wheelchairs or for individuals with limited upper mobility.
- There are not enough shower chairs available for the number of residents with limited mobility.
- There is no secure storage for medications or refrigerated medications such as insulin. Residents reported medications being stolen was a common problem.
- There are no washing machines on site so there is no way to launder clothes, towels or sheets outside of the weekly schedule. Individuals who are immuno-compromised are at high risk for infections.
- Historically, the WEHC has had ongoing plumbing issues which necessitate the use of portable toilets. An accessible portable toilet should also be provided.

- Some dorms do not have access to electrical outlets.
- Limited access to cell phone and internet services.
- Extended travel time to get into the City and back to the shelter.

8. Inadequate Policies and Protocols to Investigate, Respond, and Follow Up on Critical Incidents

While WEHC Staff were cooperative in providing all requested records to DRNM, the records that they had were sparse.

The WEHC has assessments and forms that are filled out for Residents receiving Case Management. The Resident had a Case Manager assigned but none of these assessments or forms existed with the Resident's information. DRNM reviewed a form entitled "WEHC Guest Emergency Information Form" which asked about the Resident's Diagnosed Mental Health Problems, Physical Disabilities, Chronic Health Issues and Current Medications but the responses simply stated "No" for each category. The only records relating to the Resident that the WEHC was able to provide were three incident reports and the "Guest Emergency Information Form". WEHC staff had completed an incident report for the Resident's death, a one-page form with a small summary of what had occurred.

The WEHC does not have cameras and prohibits residents from taking photos or video (although the Residents have to sign a form allowing the WEHC to take photos of them for promotional purposes). This is a safety concern because the facility cannot verify any reports of abuse, neglect, or any other incidents that occur for either residents or staff. Residents do not have a mechanism to safely report allegations involving staff or other residents without being

able to collect evidence. Cameras in at least the hallway areas would help provide more information regarding the timeframe of any incidents and who was present.

Incident reports had been filled out by WEHC staff for February 14th, 2023 and February 16th, -2023, but there was insufficient information in these reports to determine whether or not the Resident had fallen. The incident report from February 14th, 2023 indicated that follow up would be needed to monitor the Resident's well-being, but it is unclear how this monitoring would have been communicated to other staff or what staff were expected to do in response.

Staff who were interviewed regarding the incident stated that they were told the Resident had fallen, but could not confirm whether the Resident had been in an upper bunk or whether the fall had been from a standing position. The reporter that initiated DRNM's investigation stated that WEHC staff had informed them directly that the Resident had fallen from a bunk, but there was no written record confirming whether this had occurred and no Staff had actually witnessed a fall.

The WEHC did not conduct an internal investigation of the death and did not take additional steps beyond the initial incident report to gather additional information about what had occurred. WEHC staff informed DRNM that deaths occurred at the facility multiple times a year, but there was no protocol in place to review these deaths in a systematic way to identify common issues or improvements that might be made to help prevent future incidents.

IV. Recommendations

A. The WEHC Should Have On-Site Emergency Medical Supports

DRNM's review of the dispatch records indicate that the WEHC calls for EMS services occur daily, sometimes multiple times a day. This is not only expensive but indicates a serious

concern because of the longer than average response time for EMS services to reach the WEHC. During the course of the investigation, WEHC staff and APD commented on the frequency of deaths occurring at the facility, and it is apparent that the population served at the WEHC has frequent need for Emergency Medical Care. DRNM would recommend that the City of Albuquerque have a dedicated crisis unit operating during the nighttime on site at the WEHC facility. This measure alone could have a significant impact in reducing the number and severity of preventable deaths and injuries that are occurring at an alarming rate at the facility.

B. WEHC Staff should Administer Narcan when a Resident is Unresponsive and Not Breathing

The WEHC Emergency Policy and Procedures do not mention the use of Narcan and when it should be administered. However, the National Institute of Drug Abuse has a list of common opioid overdose symptoms for when Narcan should be administered including: unconsciousness, very small pupils, slow or shallow breathing, vomiting, an inability to speak, faint heartbeat, limp arms and legs, pale skin, and purple lips and fingernails. Although the Resident did not have opioids in their system, they were exhibiting at least 5 out of the above 9 symptoms. Since Staff are not healthcare professionals, a best practice recommendation would be to administer the Narcan if a Resident is unresponsive and not breathing. Any potential negative side effects from Narcan do not outweigh the risk of death.

C. WEHC Should Have an Intake System That Allows Them to Identify the Medical Needs of Residents and Whether They Can Safely Reside at the Facility

WEHC Staff commented to DRNM that they frequently have residents with complex medical needs that they are not equipped to manage at the facility. DRNM would recommend a system to be able to access the medical records of residents during intake and to have a better communication system with hospitals so that medical care services are not discharging patients unsafely to a facility that cannot monitor or respond to their needs.

In this investigation, it was clear that the Resident who died was chronically ill and had been needing emergency medical assistance in the days before their death. WEHC Staff had noted in an incident report that the resident would need ongoing monitoring, but it is unlikely the WEHC had the capacity to monitor their health appropriately.

D. The WEHC Should Maintain an Adequate Staffing Ratio and Limit Capacity to Comply with Safety Standards

DRNM did not investigate the building code regulations for the WEHC facility, but the fluctuating number of residents within the building, ranging between 450 and 700 raises some red flags. It is evident from this investigation that having two staff monitoring an average of 300 or more residents is not sufficient to ensure the safety of residents or to appropriately respond to emergencies. A report from the Inspector General's office indicated that the WEHC had been inspected in September 2022 and had multiple violations of the fire code. Given the ongoing issues with appropriately staffing the facility, it is likely that the WEHC still has violations of the fire code.

E. Staff Should Be Able to Safely Evacuate Residents in the Event of an Emergency

While the WEHC Policy requires a 10-foot perimeter around an incident (when possible), DRNM recommends that WEHC staff need to be able to fully evacuate a dorm when a death has occurred, not only to preserve the scene for law enforcement, but also to maintain dignity and respect for the deceased. This practice would also reduce potential trauma or negative health outcomes for the other residents. If the WEHC does not have adequate space to evacuate a single dorm, this would suggest that the WEHC is unprepared to evacuate the facility during other potential emergencies such as a fire or gas leak.

F. Higher Level Staff Need to be Called to the Facility to Assist in an Emergency

WEHC Policies and Procedures state that in the event of a death: “The Shift Supervisor will notify WEHC Executive Director and Program Directors by phone. It is permissible to leave a voice mail message for the ED and PD Directors if necessary. If the Shift Supervisor is unable to speak directly with either Executive Director or Program Director, the Shift Supervisor will notify the COO by phone.” It is unclear if this ever occurred in this instance, and there were no higher-level staff present in the police lapel video. A death in the facility should be treated very seriously, and the highest-level staff need to be present to assist staff to ensure that they are taking the necessary steps to document the incident, learn what occurred, to assist with emergency personnel, and to manage the belongings of the deceased.

G. The WEHC Needs to Implement a System to Investigate and Respond to Deaths and Serious Incidents

A facility that is supporting hundreds of individuals who are particularly vulnerable must have a system to investigate and review serious incidents to determine what occurred, and to

prevent future harms. Further, the WEHC needs to have a protocol in place to investigate any allegations of abuse or neglect made by residents or staff. This system should ensure that residents have a way to report incidents confidentially. Investigations should also be conducted by appropriate third-party entities, like the state's department of health.

1. The WEHC Should Have Cameras in the Facility

It is important for both residents and staff that the facility has a way to monitor what is happening within the building, so reports of serious incidents can be investigated appropriately. Staff and residents at the WEHC are also at risk of victimization where cameras and other safety procedures are needed. For instance, a review of recent 911 police dispatch calls indicated over 100 calls related to assault and battery and 76 calls related to theft. This is also necessary to have accountability with the staff and ensure that abuse and neglect is not occurring. During this investigation, DRNM determined that the Resident is unlikely to have fallen from an upper bunk, but could only make that determination after reviewing the video taken by APD. At the very least, having cameras in the entrances would have helped DRNM determine who was present during the relevant time frames.

2. The WEHC Should Conduct Mortality Reviews

DRNM would recommend the WEHC conduct mortality reviews for all residents who die at the WEHC or who die in a hospital after being transported from the WEHC. This would allow them to look at patterns between incidents and identify ways to prevent future deaths.

3. The WEHC Should Offer Paid Leave and Therapeutic Supports to Staff and Residents After a Death

Witnessing serious incidents can lead to secondary trauma for residents and staff. The WEHC should be prepared to offer grief counseling or paid leave to both residents or staff who need it following a death. This would help prevent employee burn out and help maintain a safe environment for other residents.

H. The WEHC Facility Needs Critical Improvements to the Building to Comply with the ADA and HUD regulations.

1. The WEHC Should Not Allow the Use of the Upper Bunks Until They are Redesigned to Reduce the Risk of Falls

The WEHC upper bunks are a serious fall risk, and should not be used by residents. HUD regulations minimally require that: “The shelter building must be structurally sound to protect residents from the elements and not pose any threat to health and safety of the residents.”⁶ The upper bunks need to be redesigned to have a ladder or steps to access the upper bunks, to have correctly fitted mattresses, and to have a railing to prevent residents from rolling out.

2. The WEHC Should Have Secure Storage for Residents

HUD regulations minimally require: “Except where the shelter is intended for day use only, the shelter must provide each program participant in the shelter with an acceptable place to sleep and adequate space and security for themselves and their belongings.”⁷ The WEHC does not have secure storage available for residents. Residents at the WEHC report frequent issues

⁶ 24 CFR § 576.403(b)(1)

⁷ 24 CFR § 576.403(b)(3)

with medications being stolen. This can become an ADA issue if residents are unable to safely access shelter services because life sustaining items like medications or assistive devices cannot be secured.

3. The WEHC Should Have Adequate Sanitation and Privacy for Residents

HUD regulations minimally require: “Each program participant in the shelter must have access to sanitary facilities that are in proper operating condition, are private, and are adequate for personal cleanliness and the disposal of human waste.”⁸ The WEHC needs to provide accessible showers and toilets with doors or stalls that allow for appropriate privacy. The facility should meet the fire and building codes. The WEHC should eliminate mold and pests in the facility and provide access to washing machines to regularly sanitize towels, sheets and clothing.

V. Relevant Legal Authorities and Access

A. **Relevant Legal Authorities:**

For purposes of P&A investigation access authority, the term “abuse” is defined as, “...any act or failure to act...which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual.”⁹ The term “neglect” is defined as, “...a negligent act or omission by an individual responsible for providing services... which caused or may have caused injury or death to an individual... or which placed an individual...at risk of injury or death, and includes an act or omission such as the failure to: establish or carry out an appropriate individual program or treatment plan; provide adequate nutrition, clothing, or health care; or provide a safe environment,

⁸ 24 CFR § 576.403(b)(6)

⁹ 42 U.S.C. § 10801; 45 CFR § 1326.19

including failure to maintain adequate numbers of appropriately trained staff.”¹⁰ P&As such as DRNM may assert their federal access authority to investigate reports or instances of abuse or neglect in a facility when the agency makes a determination of probable cause. The term “probable cause” is defined as, “a reasonable ground for belief that an individual with disabilities has been, or may be, subject to abuse or neglect or that the health or safety of the individual is in serious and immediate jeopardy.”¹¹

New Mexico does not have legislation that specifically sets standards for shelters or facilities serving the unhoused population, however there are federal regulations that are relevant. The WEHC is owned and operated by the City of Albuquerque, making it a “public entity” subject to Title II of the Americans with Disabilities Act of 1990. Where a public entity offers programs, services or activities in a physically inaccessible location, the public entity still must provide equal access to these activities. In addition, the U.S. Department of Housing and Urban Development sets minimum standards for emergency shelters where Emergency Solutions Grant funds have been used to assist in the creation or maintenance of the program.¹² These standards are helpful in establishing the *minimum* expectations for the operation of an emergency shelter.

B. Access:

It is important to note that the WEHC management and staff were cooperative with DRNM investigators, and provided all requested records in a reasonably prompt manner. The facility also provided DRNM access to available staff who were present at the time of the death and access to the dorm where the death took place. DRNM initiated its investigation on March 3rd, 2023. Prior

¹⁰ 42 U.S.C. § 10802(5); 45 CFR § 1326.19

¹¹ 45 CFR § 1326.19

¹² 24 CFR § 576.403

to the initiation of the investigation, DRNM staff had conducted tours at the WEHC and were familiar with their program and facility.

VI. Evidence Reviewed

A. Interviews:

On March 9th, 2023, DRNM staff spoke with the WEHC Director and Supervising staff to request documentation and to determine who was on shift at the time of the incident.

On March 15th and 22nd, DRNM interviewed 2 staff members (referred to as Staff and Supervisor for the purposes of this report) who were on shift before, during, and after the incident. DRNM obtained and reviewed written witness statements from these staff members. DRNM also interviewed and collected a statement from another resident (referred to as Witness for the purposes of this report) who was present before, during, and after the incident. DRNM attempted to interview and collect a statement from a Security Guard employed by Duke City Security who was allegedly present during the incident, however this employee failed to respond to DRNM's requests. There were other staff on shift in the womens' dorms when the incident occurred, but they were not involved or present in the relevant dorm before, during or after the incident.

B. Review of Documentary Evidence:

DRNM requested and reviewed records from the WEHC including incident reports and intake forms from the Resident and standard operating policies and procedures. In addition, DRNM requested and reviewed medical records, videos, and audio logs provided by Emergency Services responding to the Resident before and after their death at the WEHC. DRNM also

requested and reviewed public records relevant to incidents occurring at the WEHC facility between January 2020 and June 2023. A list of the documents reviewed is provided below:

- Presbyterian Rust Medical Center: Admission and discharge summaries for Resident between November 2022- February 2023
- UNM Office of the Medical Investigator: Postmortem Examination and Toxicology Report
- CABQ Albuquerque Police Department: Computer Aided Dispatch Entries to the WEHC between January 1st, 2020 and June 14th, 2023
- NM Coalition to End Homelessness: 2023 Point- in-Time Count
- Albuquerque Ambulance Services: dispatch logs and reports for Resident on February 14th, 2023 and February 16th, 2023 to the WEHC
- Albuquerque Fire and Rescue: Patient Care Reports for Resident in February 2023 and dispatch audio logs from February 16th, 2023
- Albuquerque Police Department: lapel camera footage from February 16th, 2023 at the WEHC
- WEHC: Bed Report from February 13th, 2023, Incident Reports involving Resident, WEHC Emergency Procedures Guide, WEHC Guest Emergency Information Form, WEHC Standard Operating Policies and Procedures, and WEHC Guest Expectations and Agreement for Resident

VII. Conclusions

DRNM conducted an investigation into the death of a resident at the WEHC on February 16th, 2023. The findings of the investigation indicate that negligence from the WEHC was not substantially related to the individual's cause of death. The investigation also revealed a number

of findings that indicate the WEHC does have neglectful conditions that put residents in danger of serious injury or death. Follow up actions need to be taken by the City of Albuquerque and Heading Home to put a stop to preventable deaths occurring within their facility and to ensure that the facility meets a higher standard of safety and care for their residents.



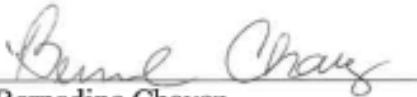
Gary Housepian
Executive Director

1-16-2024
Date




Tim Gardner
Legal Director

1-16-2024
Date



Bernadine Chavez
Director of Program Services

1/16/24
Date



Holly Mell
DRNM Staff Attorney

1-16-2024
Date



Robin Garrison
DRNM Advocate

1-16-2024
Date