Death Coverup

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How Did Retarded Youth Die? Truth Cloudy 4 Years Later

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Frank C. O'Connors was 19 years old when he died of massive head injuries at Sonoma State Hospital on Mother's Day, 1973.

The death was listed as "accidental," the result of an unfortunate encounter with a metal locker and subsequent suffocation in his own vomit.

"Accidental," was the word from the coroner's office. "Locker fell on victim."

"Frankie," as he was known to his family, was born severely mentally retarded and, as he grew older, tended to be a "tease," though a nonviolent one. In his 10 years at home, he was a frequent disruption, harassing the other three normal kids in the family and generally wreaking havoc. His family finally had to place him in the state hospital.

"We took him there when it just became impossible," his mother told a Santa Rosa newspaper reporter. "I just hated to do it . . . I thought he was going to a safe place."

What really happened to Frankie O'Connors on the evening of May 13, 1973? Could massive head injuries of the sort that killed him be caused by a falling metal locker? Where were the employes responsible for his supervision?

A state attorney general's investigator asked those questions in 1973, and concluded in a confidential report which was apparently filed and forgotten that Frank C. O'Connors "was struck with at least two severe blows by (another patient) . . . during the absence of hospital dormitory personnel."

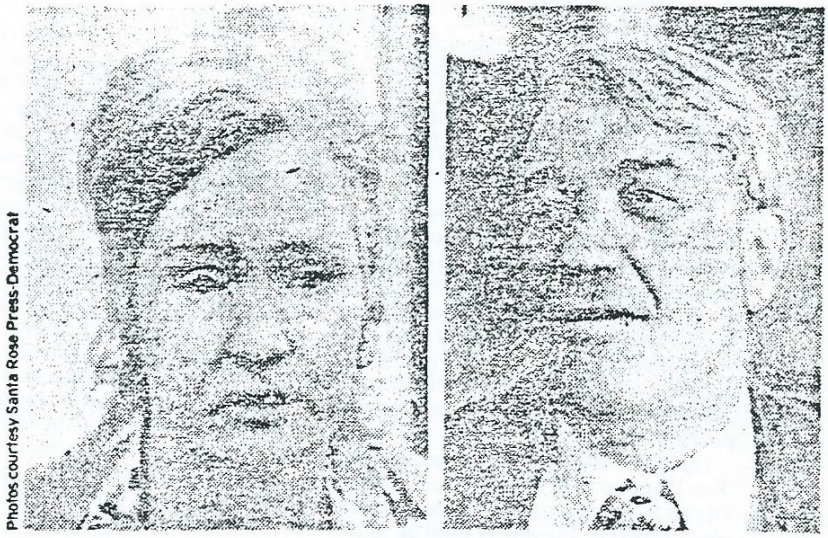
Sonoma County District Attorney Gene Tunney says his office never saw the report. The attorney general's office says the case was discussed with a district attorney's investigator before the report was issued, but the details of that conversation go unrecorded. The investigator assigned to the case in the attorney general's office is dead; the district attorney's investigator is retired.

Although the report apparently was not seen by the State Health Department either, a hospital employe who was fired two months after O'Connors' death wrote a letter to an assemblyman in 1973 which was referred to the department. In it, Pamela Elizondo alleged that the youth was struck by a baseball bat and said she was fired for being too critical of hospital conditions.

The health department got around to a full investigation of the O'Connors case in its 1976-77 probe of death and abuse in state hospitals. "Admittedly," one state health administrator wrote another in a confidential memo last January, "it's years late."

As a result of that investigation, the director of the program where O'Connors was assigned has been fired for falsifying reports on the incident; the psychiatric technician who was fired in 1973 is being reinstated; procedures for reporting and investigating state hospital deaths have been substantially tightened by the health department, and the boy's parents are again contemplating legal action.

Like so many of the more than 100 "highly questionable" patient deaths unearthed in the state investigations, there will be no criminal charges. The district attorney says it's too late, too legally nebulous.



Photos courtesy Santa Rosa Press-Democrat

EVANA T. SMITH FRANK O'CONNORS
. . . parents may reopen their legal fight

Program director Peggy Bair, a former teacher once regarded as a "model" administrator in the state hospital system — apparently because there were so few reports of "incidents" on her program — was fired last month for her role in the O'Connors case, for failing to forward 400 other "special incident" reports to hospital and health department administrators, for conflict of interest in sending a patient to a school run by her husband, and for allowing her brother and son to participate in an interview with a prospective employe.

Locker theory concocted to cover lax supervision?

She has appealed the April 29 dismissal to the State Personnel Board. Her attorney, A. Leonard Bjorklund of Sausalito, says the charges are untrue. "It's hard for me to understand," he says, "why the state took so long to do what it did."

State health investigators suspect ward personnel were either attending or planning a party for a fellow employe when Frank O'Connors was fatally injured. The "locker theory," they surmise, was concocted to cover up lax supervision of the ward.

The Sonoma County coroner's office apparently accepted the hospital's version of the death. Chief Deputy Coroner Don Noriel said an autopsy was performed, and he disputed investigators' claims that the injury caused by a blow from a baseball bat would be quite different from that inflicted by a falling locker.

"We got all the reports from the people there working and all stated the boy fell under a locker," Noriel said. "Everything was checked over. If people over there (at the hospital) sat down and conspired to lie, there's nothing we can do . . . You can't question the patients. You have to rely on the statements of people working with them."

The 1973 attorney general's investigation was in response to a $100,000 wrongful death claim filed by the boy's parents. It was essentially a civil investigation — to determine the state's liability in the death of the boy — although findings of possible criminal action in such investigations are normally referred to local prosecutors.

Health department investigator Ted Maurino said the Sonoma County District Attorney's office was not made aware of the report until he told DA Tunney about it during the 1976-77 investigations. Tunney said there was no record of the report in the district attorney's files. Nor, he said, was there a record of anyone from the attorney general's office notifying the district attorney of possible criminal behavior in O'Connors' death.

"I was amazed when I saw it," Tunney said of the report. "I couldn't understand why it wasn't filed with us."

A high state health official who asked not to be identified said he believes the report was suppressed in the attorney general's office because "they saw the report as very damaging to a civil case."

Ray Lauritzen, assistant director of enforcement and investigation in the State Justice Department's law enforcement division, said records left by investigator Richard F. Walley, now deceased, indicate he met with district attorney's investigator Ed Cameron on Oct. 15, 1973, more than a month before the report was issued. No details of their conversation are available. Cameron has since retired and could not be reached.

"Our investigation did not go into the criminal aspect," Lauritzen said. "We would assume that was already done . . . If we called it to the attention of the district attorney, it would be their responsibility to follow up on it."

Maurino said he was not allowed to see the report when he first learned of its existence during the hospital investigations. "I'm a peace officer by law and am normally entitled to those reports, but I had to make several trips to Sacramento and San Francisco before I got it."

Lauritzen said Maurino's predicament was the result of a "misunderstanding" and he should have had access to the report when he requested it.

"We certainly have no intent to conceal anything," he said.

In a letter informing Mrs. Bair of her dismissal, health department deputy director Don Z. Miller said she had falsified the report on O'Connors' death and failed to report allegations that the death was not accidental.

Miller's letter and the attorney general's report dispute the coroner's and Mrs. Bair's contention that patients could not be relied upon in investigating the death. Both reports indicate other patients advised employes that O'Connors was struck by another mentally retarded patient who was known to be violent.

Tunney says criminal prosecution in the O'Connors case is impractical because of the law and the time that has elapsed.

Although the attorney general's 1973 report on the O'Connors case may never have made it past a State Justice Department file cabinet, Ms. Elizondo, the hospital employe familiar with the case, did attempt to bring the details to light in October 1973, in a letter to Assemblyman Barry Keene, who in turn referred the letter to then-state health director J.M. Stubblebine.

In her letter, psychiatric technician Pamela Elizondo protested her July 1973 dismissal and contended it was the result of her efforts to expose hospital conditions. She also discussed O'Connors' death.

"The murder was covered up by doctors, program directors and technicians," she wrote Keene. "It was called an 'accident' . . . Nothing was mentioned about the bloody baseball bat that was found at the scene of the 'accident' — it was hidden by staff members who were having a party for a departing technician at the time the 'accident' occurred.

"Inadequate equipment and inadequate staff-patient management was the cause of death. All these facts were covered up and a story was manufactured to account for the death. These individuals responsible for this situation are still employed by the State of California. Why?"

In a response to Keene's inquiry, Dr. William Mayer, then chief deputy

PAMELA ELIZONDO
. . . wants job back

director of the state health department, said he could not discuss the O'Connors case because the boy's parents had initiated legal action.

Efforts to reinstate Ms. Elizondo have since been initiated by state health officials. Ray Procunier, chief state health administrator who ordered the death and abuse investigations after he was named to the health department post last fall, says her allegations should have been investigated more thoroughly when her letter was referred to the department by Keene in 1973.

While Peggy Bair fights her dismissal from a long career in the state hospital system, Frankie O'Connors' father, Frank A. O'Connors of Santa Rosa, says he is considering reinstating the legal action he began in 1973.

For years, he had heard rumors that Frankie's death was something other than "accidental." Because the boy's mother, from whom O'Connors is divorced, did not want the emotional strain of a lawsuit, he did not pursue it.

"The child's mother went to the hospital right after it happened and they looked her right in the eye and told her about the locker," he said. "She asked me to drop it, that the burden was too much. She now feels she was lied to and misled . . .

"Frankie was a tease, but he was nonviolent. If we'd known that he was in a ward with a violent patient, we would have removed him . . . It's a little easier to talk about it today. But there have been a lot of tears."