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Why They Died

Hospitals Probe Shows Carelessness

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Sonoma State Hospital, 1973. A mentally retarded teen-age boy dies. Official cause: He pulled a locker over on himself and was crushed to death.

Probable cause, based on investigation three years later: He was killed by another patient, also mentally retarded, who hit him with a baseball bat.

Violence of that sort is not unheard of in mental facilities. Such incidents don't usually result in death, but they do happen.

So why cover it up? Why change the details of the incident for "official records"?

Because the staff was having a party at the time the incident occurred, leaving the ward unsupervised.

This account, and others like it, come from confidential sources close to the investigations of patient deaths in California mental hospitals.

The Sonoma incident is currently in the hands of the local district attorney. It is one of the more than 100 "highly questionable" patient deaths unearthed by state investigators during the most extensive probe of state mental hospitals ever conducted.

The Sonoma case is currently the most likely candidate for charges, officials say. The program director has been suspended, and will probably be fired.

"This is technically a felony," said one highly placed confidential source. "If you suppress evidence of a crime, that itself is a crime.

"In investigating this program, we found there had been few incident reports filed (by the Sonoma program director). We learned that 450 special incident reports had been made out over a three-plus-year period, but the program director threw them away."

"Special incident" reports are documents which chronicle every case of unusual injury, violence or dispute in a state hospital. They can be everything from an employe showing up drunk for work to a patient attacking another patient.

"I have a supposition," the source continued, "about why the death and the incident reports were covered up. People tell their bosses what they want to hear — that this is a nice, quiet, orderly program."

Patton State Hospital, 1975. A mentally ill patient is transferred because of serious physical illness to a community hospital, where he later dies of "natural causes."

Back at Patton, a technician is doling out the regular doses of medication taken from bulk containers of pills and liquid. The technician uses a rolling cart, with cards on it for each patient and little vials of medicine on top of each card.

Although the patient who was transferred obviously isn't there, the technician continues to carry his medication on the cart with the others.

When she finds he isn't there, according to officials, she "throws the medication in the john." Then she takes the card with all the others into the "chart room" to be logged on patient medical records.

The medication is thus "charted" for several days after the patient was transferred.

Why?

"She didn't know what else to do," said a state official close to the investigation. "Nobody had told her what else to do."

The technician has since received a "letter of reprimand."

These are two incidents, widely different in circumstances and results. In the first, the obvious inference is that the patient might not have died if the ward had been properly supervised.

In the second, nobody was hurt and the patient apparently did not die as a result of hospital negligence. But you really have to wonder about a system which employs people who record medicine that isn't used for patients who aren't there.

Talking to people who have investigated deaths and

But Few Crimes

mismanagement in the hospitals, you realize how long it has been since anybody took a really close look at this system, which includes 11 hospitals with nearly 16,000 retarded, disabled or mentally ill patients.

You learn that some of the "highly questionable" deaths which have or may result in criminal charges have been investigated — and cleared — by local authorities at the time they occurred.

In Ventura County, where the district attorney recently conducted a highly unusual public grand jury inquiry into patient deaths at Camarillo State Hospital, the district attorney's office admitted that one death which resulted in indictments last year originally had been investigated — and employes cleared of wrongdoing — more than two years before.

"The people who testified were finally willing to talk about it," explained Ventura Assistant District Attorney Mike Bradbury, who did not recall the 1974 memo he wrote clearing psychiatric technician Dean Aguirre of any criminal action in the death of patient Clarence Cormier.

"Everyone has been sensitized," says the health department's patient rights advocate, Michael Albov. "A lot of things are happening, at all levels. When the coroner looks at a death (in a state hospital) today, he *looks* at it.

"There is a change in attitude," says state consumer affairs investigator Don Hauptman, who headed the investigative team hired by the health department to look into patient deaths. "The hospital ad-

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'Before, it appeared to me this was an impregnable outfit'

Bee Photo by Owen Brewer

Raymond Procunier, troubleshooter:

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ministration is now *pressing* for facts. In the past, they'd be happy to just see it simmer for a while and die down. They were afraid of getting sued."

"We expect a lot of lawsuits," says chief state health administrator Ray Procunier, who hired the Hauptman team shortly after his appointment to the health department last fall. "Deaths in public facilities have to be taken seriously. There ought to be an investigation with a bow on it for the FBI and the newspapers and the relatives."

"Procedure now is to sit down with relatives and explain what happened. Every parent deserves that. Before, it appeared to me that this was an impregnable outfit . . .

"I've never seen anything like it. Before, everyone referred everything to someone, and it went into this big maw."

Conferences would follow, he said, and exchanges of paper. Sometimes a lot of time would pass.

In one case later investigated by Hauptman, a probe of two forged state hospital prescriptions presented at a Southern California pharmacy stalled in paperwork for four months.

"Finally, the health department went to the pharmacy," Hauptman recalls, "but by then the owner couldn't remember anything about who presented the prescriptions. In that four months, he had had thousands of people come through the pharmacy, and he just couldn't remember."

The investigation into approximately 1,200 patient deaths in the past three years revealed, according to officials, approximately 140 "highly questionable" deaths in 10 of the 11 hospitals. The Ventura district attorney's investigation into deaths at the 11th, Camarillo, yielded eight indictments against employes. Charges against four have since been dismissed.

All of the state-investigated "highly questionable" deaths have been turned over to local district attorneys, and most have been cleared of criminal consequences. Hauptman and his team are now examining evidence from the Ventura investigation, looking for suspicious deaths which might warrant administrative action, if not criminal prosecution.

All state hospital deaths since the investigation began have been placed in the "highly questionable" category by state investigators, which accounts for the higher number (167) cited in recent health department press conferences. Most of those are natural, fully explainable, authorities say, but are included in the category just to make sure they are thoroughly investigated.

In addition, the 1973 death of the mentally retarded boy at Sonoma and several other deaths — all occurring prior to the three-year period officially covered by the investigation — have been examined as a result of tips or suspicions that all was not right.

The three-year period was chosen, according to state health administrator Dr. William Keating, because of statutes of limitations on most crimes which may have been committed.

Although a "highly questionable" death may not fall within the required

'In all of this, we're talking about hindsight'

criminal definition of "gross negligence," officials say, they may well be at least partly the result of medical sloppiness, administrative errors or bad judgment by hospital personnel.

Each "highly questionable" death was analyzed by investigators aided by a registered nurse and a physician consultant. The Bee examined the reports of eight such deaths of one hospital for the mentally retarded and disabled.

All of the patients were in the acute care medical-surgical ward of the hospital, and all were brain-damaged or physically disabled, or both. One doctor was charged with the supervision of their care. He will probably not be prosecuted, but his name (and those of other physicians included in the state probe) have been turned over to state medical board examiners charged with monitoring the professional conduct of physicians.

A reading of those reports, shows how difficult it is to place blame, much less file criminal charges. The reports show a pattern of neglect, indifference and questionable medical judgments. Civil lawsuits can be filed based on those kinds of human errors, but prosecutors say proving a criminal case is a different matter.

They are replete with incidents of inadequate medical testing, improper or inadequate medication, insufficient effort to make a sound diagnosis.

There is a blind, deaf and retarded patient who died after exhibiting a marked behavioral change from hyperactivity to lethargy. The physician consultant to the state investigators wrote the patient probably had an "overwhelming" infection, had been oversedated and "should have been watched a little closer than he was by the attending physician," whose last "progress note" was entered four days before the patient died.

In another case, a patient treated in a community hospital after he apparently inhaled bits of food was readmitted to the state hospital and died of pneumonia. The physician consultant wrote that "discrepancies" in the X rays taken at the community and state hospitals showed "a diminished expansion of the left lung" and should have "alerted the attending physician that the lung had collapsed again."

In another, a physically and mentally disabled patient with a history of respiratory and urinary tract infections died of pneumonia and kidney problems. Again, the consultant wrote, there had been inadequate testing after a fever was noted nearly two weeks before the patient died.

"In this case," he wrote, "as I feel in every case, there should be a basic number of tests to try to find the origin of the fever . . . There is no excuse for not routinely doing a urinalysis . . . Once a year is poor medical procedure."

In the case of a patient who died of a bowel obstruction, the consultant wrote that treatment was "grossly mishandled," again with inadequate testing and poor medical procedures.

The list goes on, a litany of sorrows for human beings powerless to help themselves.

So, out of it all, what has been learned?

"Considering the period of time we looked at, and the number of people, there wasn't that much that was wrong," said Keating. "There were a lot of culpable actions in which, yes, people could have used better judgment . . . But there weren't that many malicious incidents. There were errors of neglect, omission, unintentional commission . . .

"In all of his, what are we talking about? We're talking about hindsight."

As a result of the investigation, Keating and Procunier say policies and procedures have been tightened throughout the system, to — they hope — prevent incidents such as those unearthed by the investigators.

A girl ran into the ocean and drowned during an outing

KATHY MADER
. . Procunier assistant

DR. WILLIAM KEATING
. . . health administrator

DON HAUPTMAN
. . chief investigator

MICHAEL ALBOV
. . . patients' advocate

On a recent visit to Metropolitan State Hospital, Michael Albov and Kathy Mader, Procunier's chief assistant, noted a "perceptible change" in the medication of patients. "Everyone isn't spaced out staring at a set," Albov said. "People are more active."

That is probably the result of one of the major procedural changes made since the investigation — a system-wide policy on dispensing drugs, devised by Keating and Health Director Dr. Jerome Lackner.

Under Keating's supervision, disciplinary action has been taken against employes, some have been fired or demoted, some have left on their own. Officials say Gov. Brown's decision to increase hospital staffing has had an effect in some places, although Albov and Ms. Mader said none is apparent at Metropolitan.

"I have this nightmare," Keating says about staffing, "that I will go down to a program with 100 per cent staffing and I'll find eight people in the chart room instead of three, and still only one on the ward. We can't have just more employes doing the same thing."

Out of it all, health officials say there are four deaths — three at Metropolitan and one at Sonoma — seriously being considered for criminal charges by local prosecutors. There is one case of "employe intimidation" by another employe at Metropolitan being considered by the Los Aneles prosecutor for charges.

There are the four people awaiting trial on charges arising out of the Ventura investigation, as well as one physician accused of violating the state health and safety code. And there are countless letters of reprimand, staff and procedural changes.

And, officials say, all future hospital deaths will be thoroughly investigated. No more "one-line reports" like the ones Michael Albov remembers seeing from earlier days — reports that sometimes said simply, "Patient died."