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Patient Safety and Services at Kingsboro Psychiatric Center

A Report

by the
New York State Commission on Quality of Care
for the Mentally Disabled

July 1995

Patient Safety and Services at Kingsboro Psychiatric Center

Clarence J. Sundram
CHAIRMAN

Elizabeth W. Stack
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COMMISSIONERS

July 1995

New York State Commission on Quality of Care
for the Mentally Disabled

Executive Summary

On November 20, 1994, George Allman was found mortally wounded, with multiple stab wounds to his chest, in his bed at Kingsboro Psychiatric Center. He died later that day at Kings County Hospital.

A fellow patient, John Bishop—who had escaped from Kingsboro the evening before, returned to the facility early on the morning of November 20, and later alerted staff to a "dead body" in the dormitory—was arrested in connection with Mr. Allman's death and indicted for murder in the second degree.

Pursuant to its responsibility to investigate unusual deaths in mental hygiene facilities, the Commission commenced an investigation into the events of November 19-20. As these events raised broader questions about "the safety, security, and quality of care provided to patients" (MHL §45.07 subd.[e][1]), the Commission expanded its investigation to include a general review of patient care and treatment at Kingsboro Psychiatric Center with particular attention to the investigation and response to reports of untoward incidents, including assaults and unauthorized leaves of patients.

This report presents the Commission's findings, conclusions, and recommendations. It should be noted that during the period of time covered by this investigation, Kingsboro Psychiatric Center was accredited by the Joint Commission on Health Care Organizations and certified by the Health Care Financing Administration.

Findings

1) The Patients

The Alleged Assailant (Report pp. 7–11)

John Bishop, age 49 and first hospitalized for psychiatric treatment at age 7, had more than 20 psychiatric hospitalizations between 1952 and 1994. While not hospitalized, Mr. Bishop lived on the streets, in shelters, with his mother who was an alcoholic, or in jail. A polysubstance abuser, Mr. Bishop was arrested on more than a dozen occasions between 1971 and 1983. His string of convictions included menacing, criminal mischief, petit larceny, possession of drug paraphernalia, attempted assault, assault, robbery, and parole violation.

In December 1984, while living in a homeless shelter, Mr. Bishop stabbed a fellow resident to death. Arrested for murder in the second degree, Mr. Bishop admitted killing the man, stating that the victim had been following him around and bothering him. Mr. Bishop was adjudicated as not responsible for his act due to mental disease or defect and was placed in Mid-Hudson Psychiatric Center, a secure forensic hospital, for continued care and treatment under Section 330.20 of the Criminal Procedure Law.

On two occasions Mr. Bishop was transferred to Kingsboro Psychiatric Center. On both occasions he threatened fellow patients, escaped, and was quickly returned to Mid-Hudson.

On September 29, 1994 Mr. Bishop was admitted for his third trial stay at Kingsboro, pursuant to a court order of transfer. After one week on Kingsboro's Admission Service, he was moved to Ward 22, a locked ward. Within the next two weeks, Mr. Bishop's psychotropic medications were dramatically reduced by half with no written rationale. And for most of October and November 1994, there were no notes by Mr. Bishop's psychiatrist who was expected to meet with him weekly and record his findings. Also not mentioned in the record, but reported by staff and patients, was that Mr. Bishop ran a black market business of selling cigarettes to other patients at inflated prices.

THE VICTIM (Report pp 6–7)

George Allman was admitted to Kingsboro Psychiatric Center from Maimonides Hospital in October 1994 after he decompensated at home where he lived with his elderly mother. On November 10 he was transferred from the Admission Service to Ward 22, where Mr. Bishop resided. The following day, Mr. Allman's social worker noted in the record that he may be vulnerable on the ward and would be more appropriately placed on a different ward. The social worker explained to Commission staff that Mr. Allman, 51, was socially and behaviorally different from Ward 22's other patients; his retiring demeanor and nonverbal nature, she felt, made him easy prey for exploitation by the ward's more active, streetwise patients. The record is silent on how this social worker's concerns were addressed, and no minutes of weekly treatment team meetings were kept to indicate whether or not this issue was discussed.

2) The Escape, Return, and Homicide (Report pp. 11–20)

The circumstances of Mr. Bishop's escape from Kingsboro on November 19, his return the next morning, and Mr. Allman's death on November 20 reflected lapses in security and search practices, communications, and clinical judgement.

- Mr. Bishop's escape from a locked ward in a locked building at dinner-time was facilitated by the fact that a patient was used to supervise other patients in transit from one secured area to another and that staff had failed to lock doors which should have been locked; his escape route took him past one security guard posted at a gate who failed to notice the patient's elopement.
- Following the escape, off-duty senior facility staff, including the Executive Director, were not kept reasonably informed of Mr. Bishop's elopement and subsequent events, nor did the Administrator On Call respond to the facility to offer less senior on-site staff direction and guidance.
- When Mr. Bishop returned to the facility in the early morning hours of November 20, he was not thoroughly searched, due in part to confusing search policies which left staff unsure of what to do; Mr. Bishop reportedly purchased a knife when he escaped from the facility and secreted it on his person upon return.
- Although nursing personnel advocated that Mr. Bishop, who had been drinking while on escape status, be admitted to the Secure Care Ward, a psychiatrist returned him to Ward 22 at 5:30 a.m. without any orders for increased supervision.
- At 10:30 a.m. on November 20, upon being informed for the first time of the events of the past 17 hours, the Executive Director ordered that Mr. Bishop be transferred to the Secure Care Ward. While preparing Mr. Bishop for transfer, staff found a knife in his clothing; he told staff that there was a dead body in the dormitory.

Mr. Allman was found in bed with multiple stab wounds to the chest. He died later at Kings County Hospital due to perforations of the heart and lung. None of the four staff and 34 other patients on Ward 22 reported hearing or seeing anything untoward that morning.

3) Conditions at Kingsboro Psychiatric Center

The lapses which contributed to Mr. Bishop's escape and Mr. Allman's murder in November 1994 were not isolated events.

A) Safety (Report pp. 21–23)

- During a six-week period surrounding the escape and homicide, 209 untoward incidents occurred. Nearly one-third (32%) involved patient-to-patient assaults or fights. In nearly half of these incidents (46%), one or both patients sustained in-

juries ranging from scratches to swollen, seriously bruised eyes to lacerations requiring sutures.

- During the same period, there were 12 reports of dangerous contraband, including knives, razors, matches, and illicit drugs, being found on patients; there were also 9 incidents of attempted suicide or serious self-inflicted patient injury.
- While on site, Commission staff surveyed half of the patients on five of the wards visited: 53% reported being afraid of being injured by other patients; 43% stated they had seen a patient hit or sexually hurt by other patients; and 47% said their possessions were stolen.
- During 1994, there were 445 reported staff injuries at Kingsboro, half (or 225) were patient-related injuries. Of these patient-related staff injuries, 72% resulted in work days lost totaling 2,131 work days. This equates to ten full-time equivalent staff items being lost to patient-related staff injuries over the full 1994 calendar year.

B) Security (Report pp. 23–34)

The second largest single category of reported incidents during the six-week period reviewed was unauthorized patient departures.

- Between November 1 and December 16, 1994, there were 56 patient elopements; most (94%) involved patients residing on locked wards. In 30% of the elopements, the patient was deemed dangerous to self or others.
- The means of elopements varied; but in 25% of the cases, patients simply walked out doors which should have been locked, frequently while being escorted to meals, like Mr. Bishop.
- According to facility records, senior staff were long aware of problems contributing to patient elopements: staff failing to lock doors, staff keys being lost and possibly in patients' possession, and the fact that the key issued to all staff unlocks most buildings and wards on the campus—but no significant action was taken until after Mr. Allman's death.

C) Quality Assurance (Report pp. 45–56)

Kingsboro's Quality Assurance mechanisms failed to meaningfully address many of the long-standing problems, which converged on November 19 and 20, 1994 resulting in tragedy, for several reasons.

First, the OMH's incident classification system obscures the seriousness of many incidents, including assaults and elopements, which are often categorized as the least serious of incidents. Kingsboro's classification *or misclassification* of incidents determined the level of scrutiny the reports received by both the center and outside parties. Incidents classified as minor, in terms of seriousness of harm to the patient, are not subject to any formal investigation or review by senior center staff. Thus serious issues in staff performance related to unauthorized patient departures, privileging decisions associated with these elopements, and clinical treatment issues associated with frequent patient assaults on other patients and staff, often received little attention from center officials. And while facilities are required to report incidents of abuse or neglect to the Commission (MHL §45.19), the center's failure to identify possible staff neglect in most of such incidents resulted in these reports not being sent to the Commission for further scrutiny.

Secondly, where facility investigations were conducted, they were not completed in a timely manner and were sometimes not initiated until months after the event. Many were flawed by poor investigative techniques—failures to interview all patient and staff witnesses, failures to target staff performance issues for inquiry, etc.

Finally, committees designed to identify and oversee the implementation of appropriate corrective actions, namely the Incident Review Committee and Safety and Risk Management Committee, were not timely in their deliberations and overlooked needed corrective actions and/or effective processes for their implementation.

D) Quality of Care (Report pp. 35–44)

Compared with conditions observed in the mid-to-late 1980s, certain conditions at Kingsboro observed during the Commission's recent review were noted to be markedly improved. Wards were cleaner and several were less overcrowded; attention to patients' hygiene and clothing needs had improved; nearly three-fourths of the patients surveyed indicated they participated in their treatment planning; and the Commission noted a cautious use of restraints and medications.

However, problems persisted.

- The center's intermediate care wards, especially those designated for the most dangerous patients, were overcrowded. Large numbers of patients with serious mental health problems confined to relatively small common areas made it difficult to maintain a calm, quiet atmosphere. It also contributed to skirmishes and more serious patient conflicts, and made the conduct of meaningful group activities or therapy sessions nearly impossible.
- Despite officials' reports that approximately half of Kingsboro's newly admitted patients have a concomitant problem with drug and/or alcohol abuse, these specialized treatment needs are not forthrightly addressed. With the exception of Kingsboro's "Fresh Start Program," all other teaching groups or activities targeted to alcohol or substance abuse problems are informal and are not well coordinated. And only 30 of the approximately 270 inpatients with drug and/or alcohol abuse problems were enrolled in the facility's Fresh Start Program in January 1995.
- Finally, documentation provided by the Center illustrated that overall psychiatric practice at the hospital suffers from basic problems in psychiatrist performance, problems which have been identified but are slow to change and were evident in Mr. Bishop's care.

Conclusions and Recommendations

In seeking explanations for the state of affairs at Kingsboro Psychiatric Center which contributed to the death of Mr. Allman, as well as the many other untoward and harmful events which have long compromised patient and staff safety, some explanations are readily apparent. Other explanations are more complex, intricately woven in the fabric of the emerging role of state psychiatric hospitals, especially in New York City.

The most immediate explanation for this tragedy—the evident mistakes, poor judgments and misconduct of staff--first merits discussion. Notwithstanding the difficulties which have besieged Kingsboro Psychiatric Center over the last decade—or the acknowledged improvements noted in many aspects of its operations—the number, nature, and seriousness of the staff performance problems which surrounded Mr. Allman's death are striking. Yet, as the Commission discovered, they were not unfamiliar to staff working at Kingsboro Psychiatric Center.

Virtually all of these performance problems were well-known to senior staff at the hospital; most had surfaced not on one or two, but most of the hospital's adult wards in the past year. Likewise, numerous reports confirmed that most of these issues were discussed frequently by the center's senior cabinet during its daily morning meetings. The center's Safety and Risk Management Committee minutes also frequently referenced most of these problems.

What soon became apparent was that although many senior staff were aware of and concerned about serious lapses in staff performance like those which contributed to Mr. Allman's death, the center's internal quality assurance mechanisms and its management team were not capable of effectively studying these problems, identifying reasonable corrective actions, or putting identified solutions into place on a timely basis.

Additionally, although senior staff of the NYC Office of Mental Health Regional Office and at least some staff of the OMH Central Office were routinely notified of many serious incidents at Kingsboro Psychiatric Center via a computer-networked communications system, this communication also did not trigger sufficient alarm or notable systemic corrective action to address apparent recurring problems. It appeared that staff resources and responsibilities in regional and central offices to address these reports have not been well identified, and clear expectations for the actual responses of these state officials to serious incidents have not been established or ensured.

Notwithstanding the primary importance of the above problems, other more complex underlying issues are also critical to a full understanding of the continuing troubled role and performance of Kingsboro Psychiatric Center.

Acute Admissions Role

Although New York State's Comprehensive Mental Health Plan identified the role of state psychiatric centers as treatment facilities for intermediate and long-term psychiatric care for nonacute patients, Kingsboro Psychiatric Center, like many NYC state psychiatric centers, is actually providing substantial acute psychiatric care—often to individuals with severe psychiatric illness and documented histories of polysubstance abuse and service and treatment resistance. Many of these patients are also dangerous—some as an apparent outcome of their mental illness, others in response to their abuse of illegal substances or alcohol, and still others as a result of volitional, antisocial, and criminal conduct.

Limited Physical Space

Closely related to the above problem is Kingsboro's limited physical capacity. Although Kingsboro Psychiatric Center is less overcrowded than it was during 1988, when a state of emergency was called at the center, the center today is still seriously overcrowded. The rush at Kingsboro's front door and its limited physical space have led routinely to the placement of dangerous and violent patients in wards with many other patients, most of whom are not dangerous, but who quite reasonably fear assaults and other threats on their safety.

Inadequate Special Services for MICA Patients

A serious and well-recognized underlying problem affecting Kingsboro Psychiatric Center's performance is its limited services and specially trained staff to address the special problems of its many patients with concomitant drug and alcohol abuse problems. Although these services are more available today at Kingsboro than they been in the past, they remain woefully inadequate.

A More Realistic Approach to Safety and Security Issues

There is a need to come to a more realistic approach to issues of safety and security in state psychiatric centers generally. The state has both the right and the obligation to securely confine patients who are believed to be seriously mentally ill and dangerous based on their recent past behavior, while they are treated in a psychiatric hospital. It has the right and the duty to ensure that they do not escape and do not harm either themselves or others. At the same time, the state has the obligation to ensure that patients who are *not* dangerous are also kept safe and are not needlessly deprived of their freedoms.

The manner in which state psychiatric centers are constructed, and their limited safety officer staff, make it both difficult and undesirable to attempt to secure entire campuses. But, it is important to examine the feasibility of securing portions of the facility campus, including outdoor

space, assigning patients with the highest security needs to these portions, and assigning adequate program and safety staff to these areas. This approach would permit attention to security needs of part of the patient population without unnecessarily restricting the rights and freedoms of all patients.

Psychiatrists at Kingsboro and other state psychiatric centers would benefit from comprehensive training in assessing the dangerousness of patients with concomitant alcohol and drug abuse problems.

Recommendations

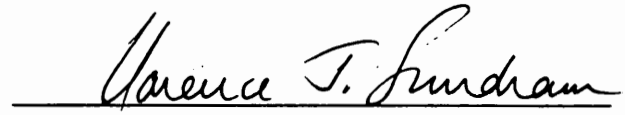
In this report, the Commission offers a number of recommendations to address the identified problems (Report pp. 67–70), including:

1. OMH should consider placing patients with histories of violent behavior on special wards with enhanced staffing ratios and staff especially trained to manage violent behavior.
2. OMH, in cooperation with other providers of psychiatric services, should reduce the significant role that state psychiatric centers in New York City play in providing acute psychiatric services—a role for which they are neither staffed nor adequately reimbursed.
3. OMH should develop and provide a specialized training program for clinical and direct care staff in meeting the needs of patients with concomitant alcohol and substance abuse problems—a group which now comprises approximately 50% of all admissions to state psychiatric centers in New York City.
4. The overcrowding at Kingsboro Psychiatric Center must be reduced by eliminating direct admissions, diverting admissions to other hospitals, and establishing census caps of 25–30 patients per ward.
5. Through increased supervision, a reduction in overcrowding, and better staff compliance with new policies and procedures, incidents which endanger patient and staff safety must be reduced.
6. The serious problems with incident reporting, investigation, and remedial action must be corrected forthwith.
7. OMH should develop an effective system for monitoring the operations and quality of care provided by the five state psychiatric centers in New York City.

A draft of the Commission's report was sent to the Office of Mental Health and to Kingsboro Psychiatric Center on April 10, 1995. On June 28, 1995, the Acting Commissioner of OMH submitted a response that substantially concurred with the Commission's findings and identified a series of corrective actions being implemented by OMH and Kingsboro Psychiatric Center. This response is appended to the Commission's report.

The Commission will continue to monitor the conditions at Kingsboro Psychiatric Center and the implementation of the corrective actions.

The findings, conclusions, and recommendations expressed in the report reflect the unanimous opinion of the Commission.



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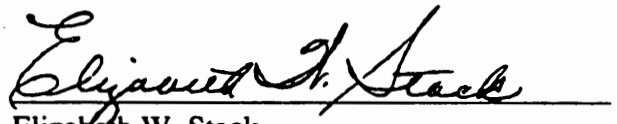

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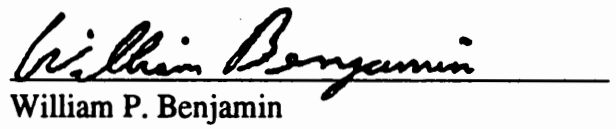

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Chapter I
Introduction

On November 20, 1994 shortly after 11:15 a.m., George Allman,[1] a patient of Kingsboro Psychiatric Center, was found mortally wounded in his bed with multiple knife wounds. Mr. Allman was allegedly stabbed by a fellow patient, John Bishop,[2] in the large dormitory area on his treatment ward sometime earlier that morning. Mr. Bishop had escaped from the ward the night before around dinner time. Law enforcement officials were promptly notified of Mr. Bishop's escape by Kingsboro Psychiatric Center staff, and police in patrol cars and helicopters, as well as with dogs, responded to the center to search for Mr. Bishop. These search efforts were unsuccessful, but Mr. Bishop returned to the center on his own early on the morning of November 20. When he returned, Mr. Bishop was sent to his former ward. Although he was reportedly searched by Kingsboro safety officers, it has been alleged that Mr. Bishop brought a six-inch folding knife with him and used the knife to kill Mr. Allman.[3]

This incident raised concern that patients being treated at Kingsboro Psychiatric Center may not be safe from the untoward acts of fellow patients. It also raised concerns of public safety, as a review of Mr. Bishop's record indicated that in 1984 he killed a fellow resident of a homeless shelter in Brooklyn and that he had a long history of psychiatric hospitalizations, most recently in a state forensic psychiatric hospital, and many documented episodes of violent and criminal behavior.

The apparent ease with which a patient such as Mr. Bishop could escape from the state hospital raised questions about supervision and security at Kingsboro Psychiatric Center. These concerns were heightened by initial reports that his escape was facilitated by inadequate staff supervision, staff failure to keep doors locked as required, and an apparently common practice of relying on fellow patients to hold doors open for patients as they traveled up and down stairs to dining rooms for meals.

Mr. Allman's murder, apparently at the hands of another patient, raised concerns for both patient and public safety.

The Commission's Review

The Commission, in accordance with its statutory responsibility to investigate unusual and unnatural deaths, has completed a comprehensive review of the immediate circumstances surrounding Mr. Allman's death, as well as the related concerns of patient and public safety raised by this homicide. In the course of this review, the Commission also determined that an assessment of patient safety, staff supervision, and medical, mental health, and rehabilitative services at the hospital was relevant. This report provides a summary of these activities and offers recommendations to the administration of

1 A pseudonym.

2 A pseudonym.

3 The suspect in this case was indicted for murder in the second degree and criminal possession of a weapon in the fourth degree.

Kingsboro Psychiatric Center, the Office of Mental Health (OMH), and the Governor and the State Legislature toward the prevention of future similar tragedies.

In conducting this investigation, Commission staff spent a total of 21 staff days at Kingsboro Psychiatric Center. Commission staff visited 12 of the 17 patient wards at Kingsboro's Clarkson Avenue campus, and many of its day programs, interviewed key ward, administrative, safety, and quality assurance staff, observed daily onward activities and group programs, and met and spoke with patients.

The Commission spent 21 staff days at Kingsboro, visiting 12 patient wards and many program areas, and interviewing senior staff, direct care staff, and patients.

Additionally, over the course of this review, the Commission requested and reviewed many documents provided by Kingsboro Psychiatric Center. These documents included:

- facility reports of all untoward incidents or situations at the center for the six-week period, November 1-December 16, 1994, which surrounded the reported homicide;
- Safety and Risk Management Committee meeting minutes for 1994; Untoward Incident Review Committee meeting minutes for the period September-December 1994;
- all special investigations of untoward incidents (and related documents) completed by the center for the period June 1994-January 12, 1995;
- the hospital's Central Nursing Log for the days surrounding the homicide; and
- the hospital's Safety Officer logs for the month of November 1994.

Kingsboro Psychiatric Center: Its Past

Kingsboro Psychiatric Center is located between Utica Avenue and Albany Street in Brooklyn, New York, and it is adjacent to another large public general hospital, Kings County Hospital Center. The campus encompasses approximately 27 acres and has 25 separate buildings.

In the recent past, Kingsboro Psychiatric Center has been recognized as one of New York City's most troubled state psychiatric centers. It lost its accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) in 1985, and it did not regain accreditation until May 24, 1993—and then only with many Type 1 (the most serious) violations.[4] Over this period of time, the federal Health Care Financing Administration (HCFA) also excluded Kingsboro Psychiatric Center from participation in the Medicare and Medicaid programs due to deficient conditions and services, thus depriving the center of valuable sources of federal revenue, especially for its services to children and adults over the age of 65.

Over the years, Commission reviews have also consistently found seriously deficient conditions in basic custodial care services at Kingsboro Psychiatric Center. From 1984–1988, when the Commission was regularly conducting custodial care reviews at state psychiatric centers, conditions and services at Kingsboro were among the worst in the state psychiatric

[4] The Type 1 violations cited by JCAHO included deficiencies in pharmaceutical services, life safety management, safety management, equipment management, medical staff, and nursing.

center system. Commission reports regularly criticized the center for overcrowding, serious maintenance and plumbing problems, fire safety problems, roach and rodent infestations, serious housekeeping concerns, patient idleness, and few scheduled activities.

Kingsboro, recognized as one of New York's most troubled state psychiatric centers, lost its JCAHO accreditation and HCFA certifications from 1985 to 1993.

In June 1988, the Commission Chairman met with Richard J. Surles, then Commissioner of the Office of Mental Health, asking that a state of emergency be called at Kingsboro Psychiatric Center in view of its serious overcrowding, safety concerns for patients, and general deficiencies in custodial care and staff supervision for patients. Although the Office of Mental Health did not call a state of emergency immediately, on August 25, 1988, subsequent to follow-up Commission site visits to Kingsboro Psychiatric Center, a state of emergency was called at the center for 60 days. As a result of this action, a cap was placed on admissions to the center, and more than 190 longer-term patients were transferred to other centers to relieve overcrowding. Additionally, an admission service dedicated to patients with substance abuse and alcoholism problems was to be established, and a restructuring of clinical services at the center was planned.

In the intervening years between 1988 and the present, the Commission, like the Office of Mental Health and the Joint Commission, generally witnessed improving conditions at Kingsboro Psychiatric Center. Although individual complaint reviews and investigations of patient deaths revealed some continuing problems at the center, as documented in numerous pieces of Commission correspondence with center administrators and the Office of Mental Health, basic custodial care for patients, patient census management, housekeeping, and maintenance improved over this period. There was also indication that despite continued high levels of patient idleness and lapses in record documentation of prompt medical care, the center had established more rehabilitative programs for patients and that minimal standards for psychiatric treatment planning were in place more often for patients.

Who Receives Care at Kingsboro Psychiatric Center

During this period of time, Kingsboro Psychiatric Center's role in the New York City psychiatric service system was also changing and becoming a more challenging one. Although the center's census has declined significantly from approximately 950 patients in 1984 to 518 patients in 1994, it has continued to admit nearly 1,800 patients annually—only slightly down from its admission of 2,100 patients in 1984. The 17 patient wards are reserved for primarily male patients (62%), a large percentage (39%) of whom are under 35. Kingsboro senior staff also reported that at least half of the center's nongeriatric adult patients have a history of substance abuse and alcoholism.

By 1993, conditions at Kingsboro had improved, but problems related to medical care and therapeutic programs for patients persisted.

Additionally, although the New York State Mental Health Plan indicates that state psychiatric centers will primarily provide intermediate and long-term psychiatric care and that psychiatric units in general hospitals and private psychiatric hospitals will primarily provide acute psychiatric services, this goal has not been substantially realized for many state psychiatric centers in New York City, and especially Kingsboro Psychiatric Center. According to OMH officials, Kingsboro Psychiatric Center's

admissions include individuals presenting at general hospital emergency rooms who had been discharged from Kingsboro Psychiatric Center within the past 90 days, other individuals residing in Kingsboro's own "direct" admission catchment area who presented at general hospital emergency rooms for evaluation, and still other individuals who had been treated for 30 - 60 days in a psychiatric unit of a general hospital and were unable to recognize their need for inpatient care and treatment.

In 1994, Kingsboro admitted 1,792 patients; center officials estimate that fewer than 15% percent of these patients were admitted after acute stays in psychiatric wards of general hospitals. The remaining patients were directly admitted after presenting acute psychiatric symptoms in hospital emergency rooms. Additionally, Kingsboro officials reported that in 1994, 85% of Kingsboro's admitted patients were admitted on involuntary status, indicating that they were mentally ill, dangerous to themselves or others without treatment, and unable to recognize their need for inpatient care and treatment.

Most patients admitted to Kingsboro in 1994 were directly transferred from hospital emergency rooms, presenting with acute psychiatric symptoms.

Forensic Patients

Another significant characteristic of Kingsboro's patient population is the substantial number of patients who either are admitted on Criminal Procedure Law status, released directly from a state prison to Kingsboro due to their mental health problems and potential dangerousness, or admitted on civil status, but who have in the recent past faced criminal charges for dangerous behavior. It appears that prior to Mr. Allman's death these patients were placed across all wards of the center. Although patients transferred back to Kingsboro Psychiatric Center from Mid-Hudson Psychiatric Center (a state forensic center) were usually placed initially, as was Mr. Bishop, on one of the center's three admission wards, which are all locked wards and have some enhanced clinical staff, they often move on after one to three weeks to one of the hospital's intermediate care wards.

Almost all of Kingsboro's patients are admitted on involuntary status, most have problems with alcohol and drug abuse, and a significant minority are forensic patients.

A memorandum from the center's clinical director, dated November 28, 1994 (subsequent to Mr. Allman's death) indicated, however, that Kingsboro's administration revised this policy and decided to congregate forensic patients, as well as other violent and escape risk patients on Wards 3 and 4. Of note, there were no special security measures on Wards 3 and 4, and according to ward staff and the unit chief, these wards are not provided enriched staffing.

Summary

In short, Kingsboro Psychiatric Center has had a troubled recent history, and by various accounts, its service role in Brooklyn is becoming more difficult. Not only is Kingsboro one of the few state psychiatric centers which still has a "direct" admitting catchment area, but also many of its patients have problems with substance abuse and alcoholism which complicate their successful long-term transition to the community, and thus they are often referred back to the center, after presenting with acute symptomatology in local hospital emergency rooms, within 90 days of their discharge from the center. Kingsboro's ongoing service provision to a significant number of individuals currently on Criminal Procedure Law status and others with recent criminal histories has also complicated the difficulty of its service provision role.

Chapter II
The Homicide

On the afternoon of November 19, 1994, John Bishop, a 49-year-old man with a lengthy history of psychiatric difficulties and criminal behavior, including murder, eloped from Kingsboro Psychiatric Center to which he had been recently transferred from a state forensic psychiatric hospital. In the early morning hours of November 20, 1994, Mr. Bishop returned to the facility voluntarily and was placed on his regular ward after he was reportedly searched by facility safety officers and examined by a psychiatrist.

As the morning progressed, a decision was made to transfer Mr. Bishop to Kingsboro's Secure Services Ward. As he was being readied for transfer, a knife was found in Mr. Bishop's possession. Moments later, Mr. George Allman, a 51-year-old patient on Mr. Bishop's ward, was found in bed bleeding from multiple stab wounds to the chest. Despite resuscitative efforts by Kingsboro staff, EMS personnel, and staff of Kings County Hospital Center to which he was transferred, Mr. Allman died. Mr. Bishop was arrested and subsequently indicted for the murder of Mr. Allman.

The Commission's Investigation

Upon notice of Mr. Allman's death, the Commission on Quality of Care for the Mentally Disabled commenced an investigation into the circumstances surrounding Mr. Bishop's escape and return to the facility and the death of Mr. Allman. The investigation entailed a review of both patients' clinical records and other documents retained by Kingsboro Psychiatric Center, including various ward logs or daily communication journals, incident reports, records of communications and incidents maintained by the facility's Central Nursing Service and the Safety Department, and the facility's policies concerning missing persons, escapes, patient searches, and patient transfers. The report of the facility's internal investigation of Mr. Allman's death was also reviewed, as were the more than 50 written interview statements taken by facility investigators from staff and patients who had, or may have had, knowledge of the circumstances surrounding Mr. Bishop's elopement and return, the interactions between Mr. Bishop and Mr. Allman, and the death of Mr. Allman.

Additionally, Commission staff directly interviewed:

- members of Mr. Allman's family;
- patients familiar with Mr. Bishop and Mr. Allman;
- safety and security officers on duty during Mr. Bishop's escape and return to the facility or who responded to the scene of the homicide;
- clinical staff responsible for the care of Mr. Bishop and Mr. Allman;
- administrative staff responsible for the facility's internal investigation;
- senior facility staff who could clarify facility policies or were on duty or on call at the time of the incidents; and
- a detective with the New York City Police Department and an assistant district attorney.

The Patients

George Allman

George Allman was 51 years old when he was admitted to Kingsboro Psychiatric Center on October 4, 1994. Diagnosed as having chronic undifferentiated schizophrenia, Mr. Allman's psychiatric difficulties began when he was 14 years old, and he was first hospitalized in a state psychiatric center in 1959 when he was 16.

Following this initial hospitalization of six years, Mr. Allman was hospitalized at various other facilities. At one point, he was hospitalized at Kingsboro Psychiatric Center for 14 years. Between hospitalizations, Mr. Allman would reside at home with his mother or in adult care facilities. However, noncompliance with his prescribed medication regimen would lead to an exacerbation of his psychotic symptomatology (i.e., auditory hallucinations and delusions, inattentiveness to personal needs, and periods of aggressive behavior) and result in eventual rehospitalization. Although Mr. Allman would become somewhat hostile or even assaultive during periods of decompensation, he had no history of criminal activity (e.g., arrests or convictions); nor did he have a history of alcohol or substance abuse.

George Alllman had a long history of psychiatric illness, many extended stays in state psychiatric centers, but no known history of criminal behavior or alcohol or substance abuse.

In early 1994, Mr. Allman was residing in a home for adults following a hospital stay at Creedmoor Psychiatric Center. At his family's request, however, he moved out of the home in March to live with his brother and mother, who was in her 80s. Shortly after the move, Mr. Allman's mother became ill and had difficulty caring for him. He apparently stopped taking his medications and, in time, decompensated, becoming assaultive towards his mother. Consequently, he was involuntarily hospitalized at Maimonides Hospital in June 1994. On October 4, 1994, Mr. Allman was transferred to Kingsboro Psychiatric Center for long-term care.

During his seven-week stay at Kingsboro, Mr. Allman showed improvement, but he was a loner, usually speaking to other patients only to ask for cigarettes.

Upon admission to Kingsboro Psychiatric Center, Mr. Allman was noted to be untidy and unkempt. He was not oriented to date or time, and he admitted to hearing voices. He denied suicidal or homicidal ideations and denied having delusions. His speech was slow and monotonous, and at times he would mumble incoherently and stutter.

At 5'4" in height and weighing 140 pounds, Mr. Allman's only medical problems were a slightly elevated cholesterol level and dermatitis of the scalp. Upon admission he was placed on a special chopped diet to control his cholesterol and to compensate for missing lower teeth; he was also prescribed a special shampoo. As Mr. Allman had allergic reactions to Haldol in the past—and evidenced little lasting benefit from medications such as Stelazine, Navane, and Prolixin—the medication regimen of Loxitane, Klonopin, and Cogentin, which had been started at Maimonides, was continued at Kingsboro.

During the first several weeks at Kingsboro, Mr. Allman showed some signs of improvement. He became more oriented and began going to programs; his mumbling and stuttering speech patterns impeded his full participation in activities, although he stayed for the full duration and attended to what was transpiring. His attentiveness to grooming also improved somewhat. Given these improvements, Mr. Allman's

Loxitane was decreased from 75 mg thrice daily to 75 mg twice a day.

Despite a remission in some of Mr. Allman's psychotic symptomatology, long-term care was still viewed as necessary, and on November 10, 1994 Mr. Allman was transferred from Kingsboro's Admission Service to Ward 22, a locked, intermediate care ward on Kingsboro's Psycho-Social Rehabilitation Service. Progress notes by Ward 22 staff over the next week indicated that Mr. Allman presented no management problems on the ward and was interested in attending activities. His verbal participation in programs was minimal, however, as were his interactions with fellow patients during nonstructured time. He spent these free hours pacing the halls alone, or speaking with other patients only to ask for cigarettes, with which he seemed obsessed.

Soon after his arrival on Ward 22, or less than ten days before his death, Mr. Allman's social worker noted in his record that he may be vulnerable on the ward and would be more appropriately placed on a different ward. In an interview with a Commission investigator, the social worker elaborated that Mr. Allman was socially and behaviorally different from the ward's other patients; his retiring demeanor and nonverbal nature made him easy prey for exploitation by the ward's more active and street-wise patients. The record is silent on how this social worker's concerns were addressed, and no minutes of weekly treatment team meetings were kept to indicate whether or not this issue was discussed.

Clinical records, communication logs and incident reports, also made no reference to Mr. Allman's involvement in any untoward events with fellow patients during his stay on Ward 22, until November 20. Family members, who spoke with Mr. Allman over the phone and who were interviewed by Commission staff, indicated that Mr. Allman voiced no concerns about harsh treatment by staff or fellow patients at Kingsboro Psychiatric Center, although, according to his mother, in one telephone conversation, he stated that he wished he had remained at the adult home.

John Bishop

John Bishop was born in 1945. As a child he was aggressive, frequently fought with peers, and showed little interest in school. At age 7 he was hospitalized for "conduct disorder and primary behavior disorder in children."

John Bishop, first hospitalized for psychiatric treatment at age 7, had more than 20 psychiatric hospitalizations from 1952 through 1994.

This five-year hospitalization was the first of more than 20 psychiatric hospitalizations as he aged through his teenage years and well into adulthood. He was often violent towards other patients and frequently eloped from facilities. His diagnoses over the years included psychosis with psychopathic personality disorder, borderline mental retardation, emotional instability with schizoid features, chronic undifferentiated schizophrenia, and, more recently, chronic paranoid schizophrenia with antisocial personality disorder.

When not in psychiatric hospitals, Mr. Bishop would live on the streets, in shelters, or with his mother who was an alcoholic. An abuser of marijuana, LSD, heroin, and cocaine, Mr. Bishop was arrested on more than a dozen occasions between 1971 and 1983. Among other things, he was convicted for menacing, criminal mischief, petit larceny, possession of drug paraphernalia, attempted assault, assault, robbery, and parole violation. He was usually incarcerated in local jails for periods ranging from 30 days to up to a year. For one conviction, however, he was sentenced to state prison for two and one-half to five

years. During this period of incarceration he received inpatient and outpatient mental health services from Central New York Psychiatric Center, a secure care forensic hospital.

A multidrug abuser, Mr. Bishop was arrested on more than a dozen occasions between 1972 and 1983, with convictions for menacing, assault, robbery, and other crimes.

In December 1984, while living in a homeless shelter, Mr. Bishop stabbed a fellow resident to death. Arrested for murder in the second degree, Mr. Bishop admitted to the act, stating that the victim had been following him around and bothering him. Following his arrest, Mr. Bishop was admitted to Mid-Hudson Psychiatric Center, a secure care forensic facility, for evaluation of his fitness to participate in the criminal proceedings he faced. Found fit, Mr. Bishop was eventually adjudicated as not responsible for his act due to mental disease or defect, and he was returned to Mid-Hudson under Section 330.20 of the Criminal Procedure Law for continued care and treatment in a secure forensic hospital.

Over the years at Mid-Hudson, Mr. Bishop was prescribed a variety of the major neuroleptics, and his mental status waxed and waned. At times he was delusional, threatening and assaultive, requiring mechanical restraints; at other times he was quiet, cooperative, and free of overt psychotic symptomatology.

On two occasions, following months of stable behavior, Mr. Bishop was transferred to Kingsboro Psychiatric Center, once in 1989 and again in 1992. These attempts at care in a nonforensic state psychiatric center were short-lived, and Mr. Bishop was returned to Mid-Hudson after several months. On the first occasion, Mr. Bishop threatened to kill patients if he was not returned to Mid-Hudson; he also escaped from Kingsboro. On the second occasion, Mr. Bishop was returned to Mid-Hudson from Kingsboro when he again began threatening to kill weaker patients and again escaped.

During the summer of 1994, Mid-Hudson staff were of the opinion that Mr. Bishop's condition was sufficiently stable to warrant transfer to a nonforensic state psychiatric center. This was confirmed by an independent psychiatrist who, at the request of the district attorney's office, examined Mr. Bishop.[5] In his letter to the district attorney's office, the independent psychiatrist opined, "with a reasonable degree of

In December 1984, Mr. Bishop was arrested for murdering a fellow resident of a homeless shelter.

medical certainty"...that..."Mr. Bishop's mental condition has improved to the point that he no longer represents a danger and he could be transferred to a less secure facility." The psychiatrist noted that Mr. Bishop's chronic paranoid schizophrenia was well controlled with medications. His medications at the time were Thorazine 400 mg twice daily (bid)—once in

[5] Patients remanded to the custody of the Office of Mental Health pursuant to Section 330.20 of the Criminal Procedure Law (CPL) cannot be transferred from a secure facility to a nonsecure facility without a court order. The involved district attorney's office is notified of the intent to transfer a 330.20 CPL status patient and may request a court hearing on the matter prior to the issuance of the order. Based on the independent physician's report to the district attorney's office, the district attorney's office did not oppose the transfer and thus no hearing was held on the issue.

the morning and once at night—and Benadryl 100 mg at hour of sleep (hs). The psychiatrist recommended, however, that given Mr. Bishop's impulsive nature, the possibility of escape existed and that to prevent further escape attempts, he should be placed initially on a locked ward at the nonforensic facility.

From December 1984 through September 28, 1994, Mr. Bishop remained at Mid-Hudson (Forensic) Psychiatric Center, except for two brief, unsuccessful transfers to Kingsboro in 1989 and 1992.

In late August 1994, the Supreme Court in Orange County issued an order directing Mr. Bishop's transfer from Mid-Hudson to a nonforensic facility. Mr. Bishop was transferred to Kingsboro Psychiatric Center on September 29. Upon arrival at Kingsboro, Mr. Bishop's Criminal Procedure Law status, escape risk, and history of assaultive and homicidal behavior were duly noted as "alerts" to staff. He was placed on a locked ward on the facility's Admission Service.

During his initial mental status examination, Mr. Bishop appeared oriented to person, place, and time. He denied homicidal or suicidal ideation, as well as auditory or visual hallucinations. He admitted to killing another man who he thought was bothering him. He also admitted to using illicit drugs in the past, but not since his arrest for murder in 1984.

During the evaluation, Mr. Bishop expressed some paranoid and persecutory delusions about people following him at Mid-Hudson. His medication regimen of Thorazine 400 mg bid and Benadryl 100 mg hs, which was started at Mid-Hudson, was continued upon arrival at Kingsboro. A large man, standing nearly six and one-half feet tall and weighing nearly 240 pounds, Mr. Bishop's only health concern related to diet. Without teeth and with no gag reflex, Mr. Bishop was at risk for choking. He was thus placed on a chopped diet, which he didn't like, and he spoke nostalgically about the food served at Mid-Hudson.

On October 5, after one week on Kingsboro's Admission Service, Mr. Bishop was transferred to Ward 22, a locked, long-term care ward on the facility's Psycho-Social Rehabilitation Service.

Upon arrival on the new ward, Mr. Bishop complained that he didn't like taking Thorazine in the morning. His psychiatrist, therefore, discontinued the morning dose of Thorazine 400 mg and increased the evening dose of Thorazine from 400 to 600 mg. In making this medication change, the psychiatrist reduced Mr. Bishop's daily Thorazine intake by 200 mg, or 25 percent. It appears that the order for Benadryl 100 mg hs was also discontinued at this time, but no rationale for this was documented by the psychiatrist.

In fact, the last note by Mr. Bishop's psychiatrist, who was to have weekly sessions with the patient, was on October 13, more than one month prior to Mr. Bishop's escape. This note indicated that Mr. Bishop was talking nostalgically about Mid-Hudson's food and that he liked Mid-Hudson better than Kingsboro.

Mr. Bishop was admitted for his third trial stay at Kingsboro on September 29, 1994. After one week on the Admissions Service, he was moved to a regular ward.

One week later, on October 21, Mr. Bishop's medication was further reduced by the psychiatrist from Thorazine 600 mg daily to 400 mg daily. No written rationale for the change was offered by the psychiatrist, and Mr. Bishop's social worker told the Commission investigator that he was unaware of the medication reduction and reason for such. Upon interview, the psy-

chiatrist acknowledged his lapses in documentation with regard to entering progress notes on weekly therapy sessions and any medication changes; he reported that he reduced Mr. Bishop's medication (to less than half of what he had been receiving one month prior at Mid-Hudson) because Mr. Bishop complained of being "groggy" and it was his (the psychiatrist's) intent to facilitate Mr. Bishop's participation in ward activities and programs by reducing medications and their sedative effect.

While the psychiatrist neglected to enter regular progress notes on Mr. Bishop for most of October and November 1994, other clinicians made such entries. Notes by the social worker, nurse, and recreation therapist indicated that Mr. Bishop complied with ward routines and went out of his way to stay out of trouble, walking away from patients who wanted to fight with him. They noted that while he was loud and boisterous, pretending to be a staff member and maintaining he didn't need medications, he was cooperative and compliant with his medication regimen.

Mr. Bishop's psychotropic medications were dramatically reduced during his first three weeks at Kingsboro, reportedly due to his complaints of being groggy.

One of the last notes by the recreation therapist, dated November 17, indicated that Mr. Bishop had not engaged in any activities during the previous week and spent his time in the dayroom looking at every move made by staff or other patients. This behavior, she indicated on interview, was not viewed as significant; she chalked it up to the patient having an "off week."

On the same day, the ward nurse noted that Mr. Bishop's behavior remained unchanged over the past month—he remained friendly, even patronizing at times; he denied he needed medications, but took them; and he required constant reminders of the hospital's rules versus "jailhouse tactics."

A therapist's note dated three days before the homicide reported that Mr. Bishop had stopped participating in activities and appeared to watch every move of patients and staff.

This latter note, it appears, refers to Mr. Bishop engaging in some black market activities. According to patients interviewed after the homicide, Mr. Bishop would sell cigarettes to them for 50 cents or a dollar per cigarette. He would never sell on credit; instead he demanded money up front. According to the patients, Mr. Bishop would conduct the transactions when staff were not around; and although the patients reported that he was intimidating (given his size and history), they did not report that he harmed any individual to collect money.

Upon interview, staff acknowledged that they were made aware of Mr. Bishop's activities through patients' complaints. They further indicated that Mr. Bishop's conduct was discussed in a team meeting and that he was admonished for such. Additionally, they recalled that a search for contraband (excessive amounts of money, cigarettes, matches, etc.) was conducted in the dormitories of Ward 22 in mid-November with negative findings; they were uncertain whether this search was conducted in response to concerns about Mr. Bishop specifically, or contraband issues in general. However, the issue of Mr. Bishop's black market cigarette business was not reflected in his treatment plan, progress notes or minutes of treatment team meetings (which were not recorded for the months of October and November). Nor were the reasons for and results of the dormitory search conducted during the week of November 13 documented.

The available documentation, however, indicated that from the time of Mr. Bishop's arrival on Ward 22 on October 5 and Mr. Allman's arrival on the same ward on November 10, neither was involved in any significant incident until Mr. Bishop's elopement on November 19, 1994.

The Escape

All the wards in Kingsboro's Building 3, where Ward 22 is housed, are locked. However, dining rooms in this four-story structure are located on every other floor. Thus, at meal times some patients must leave their locked wards and be escorted via a stairwell, the doors to which are supposed to be kept locked, to another floor. Patients of Ward 22, located on the building's third floor, for example, were to be escorted to the dining room on the fourth floor.

To prevent patient elopements while patients are being escorted in stairwells, the building's front door was supposed to be locked during mealtimes. Usually this door was kept unlocked at all other daytime hours to allow for the coming and going of visitors and patients who were allowed to leave their locked ward without escort.

Finding: The circumstances of Mr. Bishop's escape suggest several lapses in security.

At approximately 5:00 p.m. on Saturday, November 19, 1994, staff of Ward 22 received notice that it was time to escort patients from their locked ward to the locked dining room on the fourth floor. On duty at the time were four staff: one nurse and three therapy aides. Present on the ward were 34 patients, six of whom were on special restrictions—meaning that they could not leave the locked ward even for meals; their dinner meal would be delivered to them.

A decision was made that two of the therapy aides would transport the 28 patients who could leave the ward, including Mr. Bishop, to the dining room, while one therapy aide would remain behind to supervise the six patients on special restrictions. The nurse would also stay behind to tend to records and other duties.

The two therapy aides assigned to escort duty assembled the 28 patients in a line. One took a position at the front of the line to lead the patients and, in the process, unlock all the doors en route to the dining room, which included the ward's main door, the third-floor stairwell door, the fourth-floor stairwell door leading from the stairs to the fourth floor proper, and the door entering the fourth-floor dining room. The second staff member took a position at the end of the line of patients, to usher them from the ward, up the stairs, and into the dining room. This staff member was to lock the various doors used as the procession passed through them.

As this group of 28 patients and two staff left Ward 22 and began entering the stairwell to ascend to the fourth floor, one patient assumed the job of holding open the stairwell door at the third floor. Upon interview, the patient indicated he usually did this to assist staff and ensure that patients ascended the stairs to where the lead staff person was located. This patient informed Commission staff that he felt bad for ward staff who were overworked, and that he was frequently paid by staff with cigarettes for such services as helping them in the transport of patients or mopping the ward's floor.

According to this patient, as he was holding open the door to the third-floor stairwell, Mr. Bishop pushed by him and went down the stairs, rather than proceed up to the fourth floor. According to the staff member at the front of the line of patients ascending the steps, she observed Mr. Bishop heading down the stairwell and called out to him, but he proceeded downward. This staff member's account was con-

firmed by the patient holding the door. The staff member at the rear of the procession also heard the call; but neither staff could pursue Mr. Bishop, given the congestion in the crowded stairwell.

Both staff escorted the remaining patients to the dining room, secured them there, and then one left to report the elopement to supervisory staff. The Safety Department, according to its logs, received the report of Mr. Bishop's elopement at 5:05 p.m.

It is noteworthy that one safety and security officer reported, on interview with the Commission, that during a routine security check, one or two days prior to Mr. Bishop's elopement, he observed a patient being utilized in Building 3 to secure doors while patients were being transported between floors at mealtime; this officer stated that he filed a report on his observation of this incident—which he viewed as a breach of security—with his supervisor. At the time of the interview, the officer could not produce a copy of the report and the Commission requested that the facility investigate the matter further and interrogate both the officer and his supervisor, who was supposedly given the officer's report.

The Escape Route

As will be discussed subsequently, Mr. Bishop voluntarily returned to the facility several hours later. Upon his return he gave, or staff heard, two different accounts of how he eloped. In both, he admitted to pushing past the patient who was holding open the third-floor stairwell door. He also stated that he gave this patient two cigarettes as he pushed by him. The other patient denied this.

Finding: A patient was used to safeguard against escapes.

Mr. Bishop stated that after he pushed past the patient holding the door, he proceeded down the stairs and entered the first-floor lobby through a stairwell door (which should have been locked). It is at this point the accounts differ. In one version, he reported that he left Building 3 through its main door on the first floor (which should have been locked).

Finding: Doors which should have been locked were not.

In a second version, recorded by a security officer who was with Mr. Bishop as he was being interviewed by a psychiatrist almost immediately upon his return, Mr. Bishop indicated that when he reached the first-floor lobby, the main door to the building was locked, so he went out a different door on the first floor (which should have been locked) leading to a tunnel connecting buildings and then exited from the tunnel to the grounds.

If either of these accounts are true, it would appear that once Mr. Bishop pushed past a patient holding open a door on the third-floor stairwell, he exited the building via one of two other doors which should have been locked.

Once on the grounds, Mr. Bishop stated, he left the facility proper by walking through a gate. In one account, the gate is described as "the big gate." In the second account recorded by the security officer, it is referred to as Gate 1, the facility's main entrance located by the Administration Building. The facility also has a second gate, or entrance, located near Building 3. While neither gate is locked, and each accommodates vehicles and pedestrians, a safety officer is stationed at each gate at all times to check the identity of unknown persons entering or leaving the facility. And at the time of Mr. Bishop's elopement, according to Security logs, officers were stationed at the gates.

Although it cannot be determined with certainty which gate Mr. Bishop walked through —the Administration Building or Building 3 gate—it appears that he walked past one of the

two safety officers assigned to gate duty that evening without detection.

Immediate Actions and Notifications

When the Safety Department was notified of Mr. Bishop's elopement at 5:05 p.m., all officers were notified via radio, and a search of the facility's grounds and perimeter was initiated. Simultaneously, the on-call physician, Dr. Lowe, was notified and responded to the ward to assess Mr. Bishop's history.

Noting Mr. Bishop's Criminal Procedure Law status and his long history of violent, unpredictable behavior since childhood, Dr. Lowe placed Mr. Bishop on escape status.[6] He further recorded in his note to the chart that it was his opinion "with a reasonable degree of medical certainty, that Mr. Bishop did not rehabilitate to the point that he could remain in a closed ward, but needs to be transferred to a secure facility."

Kingsboro Psychiatric Center's policies concerning missing patients requires that during the daytime (i.e., business hours) the Executive Director, Director of Treatment Services, Director of Quality Management and Director of Nursing be notified of patients placed on escape status. The policies do not specify a chain of upper management notification during nonbusiness hours.

However, the facility has a separate policy creating an Administrator on Call (AOC). According to this policy, during nonbusiness hours, a senior facility staff member will serve as AOC and act on behalf of the Executive Director on all major issues, including major patient incidents, contacts with outside agencies, allegations of abuse, or other unusual or potentially sensitive events.

Finding: Senior staff were not kept reasonably informed of the escape and subsequent events.

The AOC is to be constantly available by phone or beeper and, as the need arises, is to be contacted by the overall nurse administrator on duty (i.e., the person on-site responsible for the facility during nonbusiness hours). The AOC is responsible for coming to the facility to provide senior managerial intervention when major emergencies arise. He or she is also responsible for informing the Executive Director of such emergencies or any other major event not necessarily requiring direct intervention but which may be "community sensitive."

In addition to these internal notification policies on escapes and other incidents, the facility

[6] Patient elopements are classified as either Leaves Without Consent (LWOC) or Escapes based on an examination of the patient's history and retention status. Patients not considered dangerous to themselves or others are placed on LWOC status. Patients considered dangerous to self or others or who were being retained under a court order pursuant to Criminal Procedure Law, Corrections Law or Family Court Act or who were transferred from the Division For Youth are placed on escape status. Placing a missing patient on either LWOC or escape status triggers different notifications and search procedures and, ultimately, discharge decisions, should the patient not be found. For example, in addition to internal facility notifications, the police, district attorney, the court ordering retention and any party identified by the court must be notified of any patient elopement which is classified as an escape due to the patient's Criminal Procedure Law status. Such notifications need not be made for patients placed on LWOC status. And whereas voluntary patients on LWOC status must be discharged after 72 hours if not found, CPL-escape status patients who were initially considered dangerously mentally ill, even if there was a subsequent change in status, cannot be discharged.

has policies on notifications to external parties (namely law enforcement agencies) concerning escape incidents.

Generally, it appeared that after Mr. Bishop was placed on escape status, external parties (including the 71st Precinct and the district attorney's office) were appropriately notified. However, there were lapses in keeping senior facility staff informed of events.

The evening-shift overall nurse administrator on duty was notified immediately of Mr. Bishop's elopement, deployed Dr. Lowe to assess his history, and facilitated the notification of appropriate law enforcement authorities of Mr. Bishop's escape status. With the assistance of the Safety Department and maintenance staff, she also accommodated the needs and requests of city police officers who responded to the scene and wanted to set up a command post on the campus, search areas of the facility which were locked, and interview patients and staff.

The evening-shift overall nurse administrator on duty, however, did not notify the AOC of Mr. Bishop's escape until sometime around 11:00 p.m., nearly six hours after his elopement, although she did have contact with the AOC several times after the escape and prior to 11:00 p.m. to report issues relating to staffing coverage.

The evening-shift nurse administrator's call to the AOC to report the escape was prompted by the Chief of Service for Mr. Bishop's unit. Although off duty, he had been called shortly after Mr. Bishop's escape, but was not at home at the time, so a message was left on his answering machine. Upon arrival home at around 10:30 –11:00 p.m., the Chief of Service received his message, called the facility, and was updated on the status of Mr. Bishop's escape, the notifications which had been made, and the police search activities on the campus. He instructed that the AOC be informed of the events and also suggested that the Executive Director "could be" contacted. On this instruction, the evening-shift overall nurse administrator on duty called the AOC, with whom she spoke previously about staffing matters, and informed her of Mr. Bishop's escape. The AOC, evidently, did not notify the Executive Director.

Finding: The Executive Director was not promptly notified of Mr. Bishop's escape because center staff had the wrong telephone number.

As the night progressed into the early morning hours of November 20, 1994, city police searched the campus, with the assistance of Kingsboro security staff, dogs and reportedly a helicopter. As the morning progressed, representatives of the media began congregating around the facility.

After the change of shifts, the night-shift nurse administrator on duty—who had been told of Mr. Bishop's escape and that all notifications had been made by the evening-shift administrator—tried several times to contact the AOC to report the media's presence at the facility. However, the AOC could not be reached, so messages were left on her answering machine. The night-shift nurse administrator also attempted to call the Executive Director, but couldn't as the telephone numbers she had were wrong, it was later found out.[7]

[7] According to the Director for Treatment Services, the former Executive Director had moved a couple of years before Mr. Bishop's escape, and the telephone numbers for her house and beeper had been changed. Shortly before the November escape incident, the roster of senior facility staff maintained by the Central Nursing office for use by the nurse administrator on duty was transcribed from an old, well-worn book to a new one. In the transcription process, the former Executive Director's old telephone numbers were erroneously listed as her current ones.

The night-shift nurse administrator on duty then called the Director of Treatment Services, reported Mr. Bishop's escape and the presence of reporters outside the facility, and consulted with her on the handling of the media. (It was agreed that Security would keep the media off grounds, and all press inquiries would be referred to the Public Relations Office in Albany.) The nurse administrator places the time of this call at around 3:00 a.m.; the Director of Treatment Services places it at 4:30 a.m.

Return and Search Issues

Shortly after 4:00 a.m., on the morning of November 20, the New York City Police Department started winding down its search efforts at Kingsboro and broke up its command post. At 4:30 a.m., as city police were leaving the facility, Mr. Bishop was spotted by a Kingsboro security officer walking through the gate near Building 3. Two Kingsboro officers were dispatched to escort Mr. Bishop, who was ushered away from the gate-side media by the security officer stationed there, back to his building. The two officers, who had assisted city police in their search, were reportedly told by the departing police officers to search Mr. Bishop.

At the time of Mr. Bishop's escape, Kingsboro had at least two sets of policies in place which touched upon the topic of patient searches. The directives embodied in these policies are confusing to an objective reader. And, as Kingsboro found in its investigation, most of the direct care staff who encountered Mr. Bishop upon his return were not trained in the search procedures, or there was no documentation of their training.

Policy OM-525 describes search procedures for drugs and other contraband. Among its requirements is that any patient returning from an unescorted leave from the facility receive a "routine search" by the staff of his ward who allow the patient entry to the ward. "Routine search" includes a pat-down of the patient's body (by a member of the same sex) from top to bottom, to feel for concealed objects, removal of any jacket or coat, and the turning inside-out of any pockets.

More specifically, the policy calls for a more thorough search of any patient admitted to the facility. During the admission process, the patient must be placed in a hospital gown for examination by a physician. In this process, Admission Service staff must thoroughly examine the new patient's clothing/belongings, and the physician is instructed to be vigilant for contraband during the physical examination. Further, in discussing procedures for the Admission Service, the policy directs that patients returning from escape or LWOC will undergo the same search process as upon admission before being readmitted to their unit. While it appears that this provision refers to patients on the Admission Service and not patients of other services, its language is ambiguous. The confusion is compounded by the fact that the policy's directives for other adult service units (i.e., those not part of the Admission Service) are silent on the issue of searches of patients returning from escape or LWOC or their disrobing and physical examination (which amounts to a strip search).

Finding: Facility policies do not give clear guidance on the performance and extent of searches of dangerous patients who return from escapes.

Yet, the facility's policy (PM-648) on Escapes and LWOCs seems to indicate that patients returning from an elopement will be physically examined or strip searched. According to this policy, a nurse is to examine the patient and record his/her findings concerning any bruises or injuries or call a physician who will document his/her findings.

Depending on whom one asked at the facility, one received different opinions as to whether

Mr. Bishop should have been disrobed and searched upon his return to the facility—which he wasn't—or whether the search he underwent was thorough.

Rather than being escorted back to Ward 22, Mr. Bishop was taken by the two security officers to the nursing supervisor's office in Building 3. There he was searched by one of the two officers. This officer reported having Mr. Bishop remove his jacket and empty his pockets. The officer also reported "patting-down" Mr. Bishop. The second officer corroborated the first officer's account. The supervising nurse, who was present, indicated he observed part of the search—the emptying of pockets, an officer bending down "checking the lower part of Mr. Bishop's legs," etc. However, the nurse did not observe the entire search due to the officers' positions and the fact that the nurse turned his attention to calling and speaking with the nurse administrator on duty.

Found on Mr. Bishop were cigarettes, matches, a lighter, a Walkman radio, batteries and a large sum of money. Neither officer counted the money. One estimated it to be at least $50, the other over $100. Both reported that there were large denomination bills—tens and twenties. (The money was handed over to ward staff and placed in Mr. Bishop's account. A receipt for $77 was written for Mr. Bishop.)[8]

While Mr. Bishop was being searched, the nurse supervisor and the nurse administrator on duty agreed during their telephone conversation that Mr. Bishop should be transferred to the facility's Secure Services Ward in the Admission Building. The psychiatrist on duty, and stationed in the Admission Building, Dr. Pong, was briefed on Mr. Bishop's history and alerted that the patient would be escorted there for evaluation and placement on the Secure Services Ward. Between 4:30 a.m. and 5:00 a.m., Mr. Bishop was escorted by Security to the Admission Building for Dr. Pong's evaluation. His chart and medications were also sent to the Admission Building.

At around this time, the AOC woke up and noticed messages left on her answering machine. She called the nurse administrator on duty, who had tried reaching her earlier in the morning, and was informed of the morning's events and Mr. Bishop's recent return to the facility. The AOC was also informed that Mr. Bishop was being evaluated for admission to the Secure Services Ward, a plan with which the AOC agreed.

Upon arrival at the Admission Building, Mr. Bishop was not searched as Dr. Pong was informed by the security officer who accompanied the patient that he had already been searched.

Finding: Depending on whom one asked, one received different opinions as to whether Mr. Bishop should have been disrobed and searched, which he was not.

Dr. Pong reported that during his evaluation, Mr. Bishop was calm and cooperative—which was the opinion of other staff who had encountered Mr. Bishop upon his return to the facility. When questioned, Mr. Bishop described how he eloped from the facility and what he did while out—he went to Manhattan, drank some beers and liquor, and then returned to the facility.

Dr. Pong noted in the record that Mr. Bishop did not appear psychotic, was oriented and,

[8] How Mr. Bishop obtained this money is a mystery. He arrived at Kingsboro with less than five dollars and received seven dollars a week in personal need allowance monies. After seven weeks at Kingsboro (9/29–11/19/94), he would have had no more than about $55. Although it was determined that he sold cigarettes to other patients, the large denomination bills suggest this money was not the proceeds from his cigarette sales.

although smelling of alcohol, did not appear intoxicated. He also noted that the patient denied suicidal or homicidal thoughts, intent or plan. He concluded that the patient did not warrant admission to the Secure Services Ward and that he should be returned to his regular ward, Ward 22, and not be allowed to leave the ward (e.g., for meals) until reevaluated by his regular psychiatrist. The nurse administrator on duty was informed of Dr. Pong's decision, and she informed the AOC.

Finding: Despite requests by nurses that Mr. Bishop be placed on a secure ward, Mr. Bishop was placed back on Ward 22.

Mr. Bishop was returned by Security to Ward 22 between 5:30 a.m. and 6:00 a.m. Handing over the items found on Mr. Bishop and stating something to the effect of, "That's all we found on him," the officer escorting Mr. Bishop left receiving ward staff with the impression that Mr. Bishop had been thoroughly searched. Thus ward staff did not conduct any search of Mr. Bishop, who returned to his bed in one of the ward's two dormitories.

Shortly after Mr. Bishop's return to Ward 22, another of the ward's patients returned to the ward from LWOC status. (He had failed to return from a pass granted the day before, November 19.) Upon this patient's return around dawn on November 20, Ward 22 staff conducted a full search, including having the patient disrobe—which no one had done in Mr. Bishop's case.

The Homicide

During the day shift of Sunday, November 20, 1994, there were four staff assigned to Ward 22. They included the ward's regular nurse, two therapy aides, and a nurse from another ward who was floated to Ward 22 to provide additional coverage for the ward's 34 patients. As it was a Sunday with no formal programs scheduled, the ward's two dormitories—a small four-bed dormitory in which Mr. Bishop slept, and a larger dormitory accommodating 30+ beds in cubicles—were left unlocked to allow patients the opportunity to rest after having breakfast and medications.

The 30+ bed dormitory, in which Mr. Allman slept, is located just opposite the ward's dayroom. A desk from which staff can monitor dayroom activities is situated just outside the entrance to this large dormitory off the ward's central hallway. Mr. Bishop's smaller dormitory is also located off the main hallway, but approximately 25 paces from the entrance to the larger dormitory, and the desk stationed near that entrance. A staff member is usually stationed at the desk to observe dayroom activities. (From this position, though, one cannot observe what is transpiring in the large dormitory and its smaller divided cubicles in which beds are clustered.) On the morning of November 20, the nurse who was floated from another ward to Ward 22 spent most of her time stationed at this desk; rounds, or patients' whereabouts checks were conducted hourly.

According to the hourly check sheets, between 8:00 a.m. and 11:00 a.m., Mr. Bishop was noted to be in the dayroom or his small dormitory. Mr. Allman was observed to be in his larger dormitory at 8:00 a.m. and 9:00 a.m., in the dayroom at 10:00 a.m., and in his dormitory at 11:00 a.m. The 11:00 a.m. entry on Mr. Allman's whereabouts appeared to have been altered. According to the staff member making this entry, he conducted the check at 10:55 a.m. and observed Mr. Allman sleeping in his bed. However, he claimed that he erroneously coded Mr. Allman's whereabouts as "DR," meaning in the dayroom, then realized his error and changed the entry to "DB," meaning dormitory or bedroom.

On interview, staff reported seeing Mr. Bishop up and about on the morning of November 20 listening to his walkman; but none indicated seeing him go into the large dormitory. At

least two patients, however, indicated that they saw or heard Mr. Bishop in the large dormitory, although no patients reported any confrontation between Mr. Bishop or Mr. Allman that morning or on any other day.

At approximately 10:30 a.m. on November 20, the Director of Treatment Services (DTS), who was home, called the nurse administrator on duty who had called her earlier in the morning when the AOC was unreachable. The administrator on duty informed the DTS that since they had last spoken, Mr. Bishop returned, was searched, examined for placement on the Secure Services Ward, but was returned to his home ward, Ward 22. The DTS questioned why she was not informed of these events and was told that the AOC had been informed.

During this conversation, the DTS received a call from the Executive Director and put the nurse administrator on duty on hold. The Executive Director reported that she had just heard of a patient's escape from her superiors and questioned why she hadn't been informed. The DTS explained the events of the previous 17 hours as best she could, being off duty herself, as well as Mr. Bishop's history. The Executive Director issued a verbal order for Mr. Bishop's transfer from Ward 22 to the facility's Secure Services Ward.

Finding: The Executive Director issued an administrative order for Mr. Bishop's transfer to the secure unit; however, there was confusion as to how to effect the order.

At 10:45 a.m., the nurse administrator on duty, who was "on hold" during this conversation between the Executive Director and the DTS, was brought back on the line and informed by the DTS that the Executive Director ordered an administrative transfer of Mr. Bishop to the Secure Services Ward.

There appeared to have been some confusion over what an "administrative transfer" meant. Upon interview, the DTS indicated that all the nurse administrator had to do to effect this executive order was call Security to transport the patient to his new location. The nurse administrator indicated in her statements her belief that a physician needed to be informed of the directive and write an order for transfer. The facility's policies offer no guidance on the issue of "administrative transfers" and the roles of physicians.

Finding: While being readied for transfer, Mr. Bishop told staff there was a dead body in the dormitory.

The day shift, on-duty physician was contacted by the nurse administrator on duty prior to 11:00 a.m. and informed of the Executive Director's administrative order. He responded to the ward, saw Mr. Bishop resting in his dormitory area; and then reviewed the chart in the nursing station.

The physician then asked that the patient be brought to the nursing station so that he could be told that he was being transferred to the Secure Services Ward. Mr. Bishop was located in the dayroom area, brought to the nurse's station and informed of the decision. According to the physician's notes, Mr. Bishop was calm and cooperative when the physician spoke with him, and then left the nursing station.

A decision was made to enlist Security's assistance in the transfer from Ward 22 to Secure Services; the call for such assistance was placed at 11:15 a.m., according to Security logs.

While staff assisted Mr. Bishop to get ready for his transfer, a knife was found protruding from his clothing. The knife was confiscated by ward staff to whom Mr. Bishop made reference about a "dead" body in the large dormitory.

Ward staff and security officers, who were now on the scene, responded to the large dormitory, as did the ward's nurse and the physician

who had been called to effect the transfer. Mr. Allman was found in bed bleeding from several stab wounds in his chest. He had been stabbed six times in the chest and suffered perforations of the lung and heart. None of the patients who had been in or around the dormitory where Mr. Allman's cubicle was, reported hearing or seeing anything untoward when interviewed by investigators.

According to the Commission's Mental Hygiene Medical Review Board, the location of the stab wounds to Mr. Allman's chest, as well as a defense wound to his hand, suggest that he was not stabbed while he slept peacefully, but rather a struggle ensued.

Finding: Mr. Bishop reportedly confessed to fatally stabbing Mr. Allman with a knife he bought while on escape status.

While medical staff initiated CPR, a code was called (at 11:35 a.m.) summoning additional medical and security staff and New York City EMS and police. While emergency medical personnel worked on Mr. Allman, Mr. Bishop was placed in handcuffs and guarded by security officers.

Mr. Allman was transferred to Kings County Hospital where he died that afternoon from the injuries he sustained. Mr. Bishop was transferred to the Secure Services Ward where he was placed in four-point restraint and monitored by two Kingsboro staff and two New York City policemen. He was released from Kingsboro to police custody on November 21.

While under surveillance, Mr. Bishop reportedly made incriminating remarks. He admitted to stabbing Mr. Allman upon the orders of the FBI, CIA, and other parties whom he heard through his walkman. He also reported that he had purchased the knife the day before while he was in Manhattan. He stated that he wrapped the knife in a cloth and stuck it in the groin area of his pants in order to avoid detection when he returned to the facility and was frisked.

According to the district attorney's office, Mr. Bishop confessed to the murder of Mr. Allman.

Discussion

If, as he reportedly confessed, Mr. Bishop stabbed Mr. Allman, it is not clear when he did. Mr. Allman was seen alive in the dayroom at 10:00 a.m. He was also seen in bed at 10:55 a.m. and, according to the staff member who conducted this check, he seemed alive; the staff member recalled seeing him move at that time, although he cannot recall the exact position of the body. It may also be that Mr. Allman was already mortally wounded by the 10:55 a.m. check and the staff member didn't notice. This same staff person responded to Mr. Allman's cubicle after Mr. Bishop made his statement about a "dead body" after 11:15 a.m. Upon approaching Mr. Allman lying still on his side, the staff member did not notice Mr. Allman had been stabbed until he rolled him over and saw a bloodied and ripped shirt. Mr. Allman was pulseless at this time and, according to some responding medical staff, appeared cold, pale and, according to one, a little cyanotic. The blood at the scene, according to responding physicians, was not fresh; it was dark and clotted.

It is also not clear why Mr. Bishop stabbed Mr. Allman. Although Mr. Bishop reportedly indicated that he acted on command hallucinations, neither of the two physicians who examined him, nor any of the staff who interacted with him that morning, described him as delusional or overtly psychotic. And none of the patients reported seeing Messrs. Allman and Bishop involved in an altercation of any sort.

If, in fact, Mr. Bishop did kill Mr. Allman, however, it is clear that this was a preventable incident and that a number of mistakes and errors in judgement set the stage for its occurrence. Some constituted departures from clearly

articulated facility policies; others, departures from the dictates of common sense; and still others arose from conflicting or confusing policies concerning staff performance. All converged to create tragedy.

- Contrary to facility policy, a physician significantly reduced Mr. Bishop's medications without written rationale and also failed to document the content of his weekly sessions with the patient or the patient's mental status, progress, or lack thereof, for more than a month prior to the homicide.

- Contrary to the dictates of common sense, a patient was utilized by staff to hold a door open for patients being escorted from one locked area to another, and at some point staff failed to lock other doors in the locked building after they had used them. This created the opportunity and means for Mr. Bishop's escape. As one investigator put it: When you operate a locked patient care unit, you don't let patients hold open doors and you certainly relock the one you just used.

- If Mr. Bishop's escape route was as he reported upon return, he passed at least one security officer stationed at a gate without detection.

- Upon return to the facility at about 4:30 a.m. (carrying a knife secreted in his groin area, he reportedly disclosed), Mr. Bishop was not asked to disrobe for a search. Facility policies were confusing on this issue and by the time he returned to Ward 22, staff there—who strip searched another patient who had eloped and returned around the time Mr. Bishop did—assumed that Mr. Bishop had already been searched and did not ask him to disrobe.

- Despite the written note by Dr. Lowe, who placed Mr. Bishop on escape status at about 5:30 p.m. on November 19 (a note which indicated that the patient had not demonstrated his ability to function even on a locked ward and should be placed in a secure facility), and despite the recommendation of nursing supervisors who wanted Mr. Bishop placed on the Secure Services Ward when he returned to the facility at 4:30 a.m. on November 20, the physician who examined him at that time determined that Mr. Bishop could be returned to Ward 22, his home ward. Had Mr. Bishop been placed on a Secure Services Ward at that time he would have had to disrobe and the knife may have been discovered; for security reasons, all patients placed on Secure Services surrender their personal clothing and are given special hospital garb (sweat suits).

- Even though there was concern that Mr. Bishop warranted placement on a secure ward, when he was returned to Ward 22, no one ordered any increased level of supervision. He received merely hourly checks, as all patients on the ward do.

- Due to lapses in communication, the facility's Executive Director was not notified of Mr. Bishop's elopement for more than 17 hours. Although on-site management staff attempted to call the Executive Director and were unsuccessful due to erroneous telephone numbers being posted, more senior off-site administrators who were aware of the situation did not attempt to call the Executive Director; nor did she report to the scene to offer guidance to less senior management staff. When notified of his elopement, return and current placement on his home ward, the Executive Director immediately ordered his transfer to Secure Services at 10:45 a.m. on November 20. Apparently, there was some confusion as to what this administrative/executive order of transfer entailed: Did a physician need to be consulted? Or was this an unnecessary, and time-consuming step? A physician was called to examine the record and effect the transfer. During this nearly 30-minute period, Mr. Allman was found fatally injured.

Chapter III
Safety and Services at Kingsboro Psychiatric Center

The Commission's investigation of the death of Mr. Allman at Kingsboro Psychiatric Center on November 20, 1994 identified many different specific acts and circumstances which contributed to the center's inability to protect Mr. Allman. Thus, the second phase of the Commission's review of Mr. Allman's death examined overall services and conditions at the center, with a central focus on the protection from harm of its patients and staff.

Commission staff had the opportunity to interview with most senior staff at the center, including the Safety Chief and safety officers and to discuss ward conditions and services with many unit chiefs, team leaders, nurses, and direct care staff who work on the front lines of the center's wards. Discussions were also held with many patients, and patients on five of the adult wards visited were offered the opportunity to complete a consumer satisfaction survey. Documents provided by the center related to untoward incidents, interventions by the center's Safety Office, and the activities of the center's Safety and Risk Management Committee, Incident Review Committee, and senior cabinet in response to events which posed threats to patient and staff safety were also reviewed.

Patient Safety at the Center

For the 46-day period, November 1–December 16, 1994, which surrounded the death of Mr. Allman, staff at Kingsboro Psychiatric Center completed 254 incident reports, relating to 209 unique "untoward" incidents. Of these 209 reports, almost one-third (32%), or 67 reports, cited an incident of a patient assault or fight with another patient. Almost half (46%) of these reports resulted in at least some minor injury to one or both patients, including lacerations requiring sutures, scratches, and swollen, seriously bruised eyes.

The second largest single category of reported incidents was unauthorized patient departures. During the 46-day period, there were a total of 56 unauthorized patient departures. In 17 of these cases (30%), the treating psychiatrist determined that the patient was dangerous to himself/herself or others, and the departure was classified as an escape.

Finding: From November to December 16, 1994, there were 67 reports of patient assaults on other patients and 56 reports of patient elopements at Kingsboro.

Another 12% of the reports cited accidental injuries, including patients falling, or suffering minor cuts or bruises from other accidental events. Other reports filed during the period included 5 reports alleging staff physical, sexual, or verbal abuse of patients, 12 reports where dangerous contraband, including knives, razors, matches, and illegal substances, were found in the possession of patients, and 9 reports of suicide attempts or serious self-injury by patients.

During this same period, 45 other reports (not included in the total of 209 unique "unto-

ward" reports) documented patients returning from unauthorized departures. In total, 25 of these reports referenced patients who had eloped during the 46-day period studied, including 11 of the 17 patients who had been placed on escape status during this period. Although none of the 45 returning patients were identified as being significantly harmed or to have harmed others seriously during their time away from the center, many had allegedly abused alcohol and illegal drugs, some had been difficult with family members, and *all* had not taken their prescribed medications.

As suggested by the above statistics, untoward events which present protection from harm issues for patients are relatively common at Kingsboro Psychiatric Center. These observations were echoed in the responses of 62 patients on the five visited adult wards who agreed to respond to the consumer survey distributed by Commission staff.[9] More than one-fourth of these patients (29%) reported that they did not feel safe; 47% said that their things were stolen; 53% said that they were afraid of being hurt by other patients; and 43% stated that they had seen a patient hit or sexually hurt by other patients.

Finding: In 1994, Kingsboro filed 225 reports of patient-related staff injuries which resulted in 2,131 lost workdays.

Staff Safety at Kingsboro Psychiatric Center

Many staff working on the patient wards at Kingsboro Psychiatric Center also reported that in recent years the patient population had become more difficult and dangerous. Staff specifically cited an increase in the number of patients being admitted who had long-term drug and alcohol abuse histories, resistance to treatment, histories of being violent with family and friends, and histories of criminal charges being filed against them for assaultive or other dangerous behavior.

These staff perceptions were reinforced by "untoward" incident reports documenting patient assaults on staff. During the 46-day period studied, 17 incidents of patient physical assaults on staff were reported. Many of these reports resulted in minor staff injuries or apparently very threatening situations for the staff involved. Several examples of the reports filed are illustrative.

- On 12/6/94, a patient reportedly attacked a female staff person when her back was turned, hitting her in the back of her head and kicking her in the back of her legs.
- On 11/30/94, a patient reportedly threw a floor cone (designating caution for a wet floor) at the head of a treatment team leader. Reportedly, as the treatment team leader counseled the patient, she kicked the treatment team leader in the groin. After being placed in restraints, the patient reportedly threatened to stab the treatment team leader with a knife.
- On 11/25/94, a patient reportedly tried to hit another patient with a garbage can. When a staff person intervened, the patient hit the staff person in the face, pulled her hair, and twisted her hands. The patient was initially given a STAT dose of medication, but when he did not calm down and reportedly attempted to hit another staff person, he was placed in restraints.
- On 11/9/94, a patient reportedly attacked a female staff person by throwing chairs and tables at her. The staff person reportedly tried to calm the patient down, but ultimately

[9] Total census of these five wards was approximately 125 patients.

staff from another ward were called to assist and the patient was restrained after he reportedly continued to act aggressively and threatened to kill everyone.

In addition to these reports, Kingsboro Psychiatric Center (like all state psychiatric centers) also maintains separate records of all reported staff injuries. Although it was not possible with available recordkeeping documentation to compare the data from the center's incident reports and staff injury reports and specifically to discern the degree to which reports in the two systems include duplicate reports, data from the staff injury system are helpful in fully understanding the impact of patient-related staff injuries.

During 1994, Kingsboro reported a total of 445 staff injuries, 225 of which were patient-related. Of the 225 patient-related staff injuries, 72% had resulted in workdays lost. In total, Kingsboro Psychiatric Center reported that as of December 31, 1994, 2,131 workdays (or approximately ten full-time equivalent staff items) were lost to patient-related staff injuries reported over the full 1994 calendar year.

This is an undercount of actual days lost for 1994 patient-related staff injuries, however, as some staff injured during the year were still out on disability at the close of the year. Despite this limitation, these data indicate that on average, Kingsboro reported losing about two staff workdays due to patient-related staff injuries per every one of its 1,100 employees in 1994. Even without consideration of workers' compensation costs or the overtime costs associated with replacement staff, estimated staff costs for these lost workdays were more than $250,000 in calendar year 1994.

Security Lapses and Patient Elopements

The Commission's investigation of Mr. Bishop's escape identified several apparent lapses in security which had facilitated Mr. Bishop's escape. Staff had left a patient in charge of watching the open hallway door in the stairwell, and another staff person had apparently also left a first-floor door unlocked, which allowed Mr. Bishop to exit the building once he was able to elude staff in the stairwell.

The review also indicated that for the period November 1–December 16, 1994, proximate with Mr. Bishop's escape, patient elopements were relatively common events at the center and that many patients were able to elope due to lapses in security precautions similar to those noted in Mr. Bishop's case. During this relatively brief period, a total of 56 patients had made unauthorized departures from Kingsboro Psychiatric Center; 53 of these 56 patients resided on "locked" wards.

The means of these patients' unauthorized departures varied, but 25% (n = 14) had simply walked out unlocked doors or doors that had been apparently left ajar. Five (5) of these 14 patients had escaped, like Mr. Bishop, during transport to dining rooms, assisted by unlocked building doors.

Finding: Lapses in security, including unlocked ward and building doors and inadequate patient supervision, contributed to many patient elopements at Kingsboro.

The largest group, however, had eloped by abusing off-ward escorted or unescorted privileges. Thirty percent (30%) had absconded while attending an off-ward program activity they were authorized to attend; another 30% did not return from a home pass, and 13% had eloped when being escorted by a staff person to a medical appointment, an off-ward program, or the store. Only in the rare instance had patients undertaken extreme measures to elope from locked wards, such as escaping through windows or actually assaulting or threatening staff in an attempt to leave (Figure 1).

Figure 1

Running Away From Kingsboro Psychiatric Center: Several Case Examples

- On 11/1/94, a patient was put on escape status after failing to return to the facility from a home pass.

- On 11/8/94, a patient apparently eloped through an unlocked exit door. He was discovered missing when staff conducted a face check of all the patients, *after the exit door was reported unlocked.*

- On 11/14/94, a patient eloped from the dental clinic. The staff person, who had escorted three patients to the dental clinic, had been busy assisting one of the patients in the office, when the patient ran away.

- On 11/20/94, a patient eloped through an unlocked basement door when returning from the off-ward dining area.

- On 11/29/94, a patient ran away from staff while being escorted with several other patients to the gymnasium for an activity.

- On 12/1/94, a patient on CPL status eloped while on unescorted grounds privileges. Reportedly, he called the ward to tell staff that he was going to see his lawyer, rather than go to the Work Activity Center. The incident report stated that staff believed that the patient might be going off-grounds to buy drugs.

- On 12/3/94, a patient eloped while being escorted with other patients to the store.

- On 12/6/94, a patient eloped through an exit door on the ward, which had allegedly been left unlocked by a staff person from another ward. Staff were in the staff lounge when the patient's elopement was reported by a fellow patient.

Kingsboro special investigation reports on patient escapes for the six-month period, June–December 1994, further revealed that there was a pattern of staff members' leaving ward and building doors unlocked, which had persisted for some time prior to November 1994. Many incidents of patient elopements over this longer period were also attributed to patients eloping from off-ward programs or from staff escorts while being taken to programs, clinics, etc.

Delayed Steps in Addressing Security Problems

Documentation indicated that senior staff of the center were both aware of and concerned about the frequency of patient elopements. According to the Director of Risk Management, the former facility director, alarmed about the number of patient escapes, changed the facility's policy as of June 1994 and ordered that all escapes should be subject to special independent investigations rather than investigations by unit staff themselves. There are also numerous references in unit and special investigations over this period, as well as in the Safety and Risk Management Committee meeting minutes that staff needed to be more diligent in keeping doors locked, keeping track of their keys, and in providing sufficient escorts to patients being transported to clinics and off-ward programs. Additionally, at some point in the summer months, signs were reportedly placed on doors reminding staff to keep them locked.

Finding: Although administrators were aware of security problems for many months, significant actions to address these problems were taken only after Mr. Allman's death.

More effective remedies to improve ward security, however, were not put in place until after Mr. Allman's death. At this time, the center began regular monitoring of ward and building doors to ensure that they were locked; plans were drawn up to install double sally-port doors on wards previously secured with only a single door to preclude patients from exiting the ward by pushing past staff (all were reportedly in place as of February 3, 1995); and staff were issued strong directives about not using rear fire exit doors inappropriately or ever leaving these doors unlocked. Slam-lock doors were also installed on a number of ward exit doors. Center staff have also been told that they must wear their center identification badges, and they have been explicitly alerted that failing to wear their badges or leaving doors unlocked will result in referrals for disciplinary action.

A number of other steps were also taken to provide better building security, especially in the two main adult patient buildings. Elevators were adjusted so that they would descend to the basement only with a special key, available to limited staff; and a safety officer was to be stationed in the main foyer of Building 3, from which Mr. Bishop had escaped. Additionally, center staff indicated that they had stationed a phone in the foyer of Building 1, the other main adult patient building, and that they were attempting to staff this area with a volunteer during visiting hours.

Spot-checks of these added safety precautions, and especially the locked status of doors, during the Commission's visits to Kingsboro in January and February 1995 generally revealed that they were being consistently implemented. The one exception was the presence of a safety officer in the foyer of Building 3 and a volunteer (during visiting hours) in the foyer of Building 1. On February 10, 1995, there was no safety officer present in the foyer of Building 3 when the Commission visited, and on January 6, 1995, no volunteer was present in the foyer of Building 1 during visiting hours. Commission staff also noted that staff were sometimes jeopardizing the value of the double sally-port doors by holding both doors open simultaneously.

Finally, the Commission questioned the adequacy of relying on a volunteer to staff the foyer of Building 1. Kingsboro senior staff acknowledged the limitations, but indicated that all wards in Building 1 had a same-floor dining room which removed one serious escape risk and that they did not have sufficient safety staff to place a safety officer in the foyer of both Building 1 and Building 3. They added that it requires approximately five full-time equivalent safety officers to man one fixed station 24 hours a day. Notably, however, Wards 3 and 4, where the center had decided to congregate all of its patients admitted on Criminal Procedure Law status, all of the center's Admissions Service Wards, and the center's Secure Services Ward are all located in Building 1. Thus, by many apparent indicators, the patients served in Building 1 actually presented the greatest safety risks.

The Single Master Key

Early in the review, Commission staff became aware that a single key opened almost all patient buildings and wards on Kingsboro's Clarkson Avenue campus. Additionally, it seemed, and later was confirmed by senior staff, that virtually all of Kingsboro's approximately 1,100 employees were given this key. Thus, Kingsboro employees had access not only to wards and buildings where they were assigned, but to almost all secure patient areas on the entire campus.[10]

Subsequently, the Commission learned from a review of the minutes of Kingsboro's Safety and Risk Management Committee (meeting minutes dated 3/4/94, 4/8/94, 9/15/94) that staff loss of their keys was perceived as a significant problem. Although Commission staff were told that all staff were required to turn in their keys when they left their positions at Kingsboro and that a $5.00 fine was assessed to any staff person who lost his/her key and needed a replacement, these meeting minutes indicated that staff reports of lost keys were an increasing problem. There was also at least one patient elopement report which alleged that the patient had escaped by the use of a staff key.

Finding: A single master key, given to all employees, opens almost all ward and building doors at Kingsboro and most state psychiatric centers across the state.

Further study of the "master key" problem at Kingsboro Psychiatric Center revealed that this same key also opens almost all the buildings and wards on almost all state psychiatric campuses. The exceptions include the few newer campuses, including Capital District, Hutchings, South Beach, and Elmira Psychiatric Centers, as well as the few fully reconditioned buildings on several campuses. Particularly relevant to this review, the Commission learned that this single master key opened most buildings and patient wards at Manhattan, Bronx, and Creedmoor Psychiatric Centers in New York City, as well as Kings Park and Pilgrim Psychiatric Centers on Long Island. In addition, it was learned that this same locking system had been in place for decades, using the same key.

In discussing these problems with senior Office of Mental Health officials, they acknowledged the obvious safety and security problems created by this single master key distributed to literally tens of thousands of employees annually, but they explained that rectifying the problem would be extremely costly. Instead, the Office of Mental Health reportedly plans to introduce a staff identification card entry system for "high volume" and "high risk" buildings on

[10] Commission staff did learn that Kingsboro Psychiatric Center was installing a new locking system for patient wards in Building 2, which is being completely renovated and is scheduled to open in October 1995.

selective center campuses, whereby staff would be required to use both the master key and their personal cards to unlock ward and building doors. Time frames and precise plans for instituting this system, however, were not available.

Contraband on Patient Wards

All Kingsboro staff interviewed during the Commission's review acknowledged that one problem with patients leaving and reentering the campus, as well as the many visitors to the campus, was ensuring that dangerous contraband was not brought onto the wards. Staff reported that the most frequent contraband found was matches and lighters, which was of special concern because of the several fires that had occurred on the wards in the past few years (Figure 2). Reportedly, most fires were unintentionally set by patients seeking to smoke cigarettes secretively and who then sometimes hastily and carelessly disposed of them. Safety officers and ward staff also reported that small amounts of marijuana were also relatively frequently confiscated from patients. Less frequently, staff found more dangerous items in patients' possession, including knives and razors.

Finding: Dangerous contraband was frequently found at Kingsboro, and 36% of the patients surveyed said it was not hard to bring weapons and contraband onto the wards.

As noted above, ward staff filed nine incident reports citing dangerous contraband on the patient wards for the period November 1–December 16, 1994. Meeting minutes of the Safety and Risk Management Committee further indicated that safety officers searching patients returning from unauthorized departures also regularly discovered dangerous contraband. In February 1994, safety officers reported confiscating a toothbrush made into a "shank," a 12-inch butcher knife, and a kitchen knife. In July 1995, scissors and a butter knife were confiscated from a patient; on September 15, 1994, a patient was found with a three-inch blade; and on November 29, 1994, a patient was found with a razor hidden in his sneaker.

According to all staff and most patients, it was routine practice to search patients upon their return to wards after unescorted grounds passes or home visits. Eighty percent (80%) of the patients responding to the consumer survey stated that patients were searched when returning to the ward. Somewhat inconsistently, however, 36% of the patients responding to the survey stated that it was not hard to bring weapons and contraband onto the wards.

Confusion About Patient Search Policies

These paradoxical reports became more understandable as Commission staff interviewed senior staff, usually unit chiefs, team leaders, and/or nurse administrators on five Kingsboro adult wards about their actual procedures for searching patients returning from unescorted grounds passes or home visits. Across these wards, Commission staff heard different reports on which patients were to be searched, as well as how they were to be searched. Staff reports of search requirements for patients returning from authorized and unauthorized departures were especially conflicting.

When asked about the actual nature of the searches conducted, staff reports were vague and inconsistent. When pressed on this point, most staff stated that patients were asked to empty their pockets and "pat-down" searches were usually conducted, but that more intensive searches, which required patients to change their clothes, were conducted "when warranted." No senior staff could articulate clear criteria which would trigger a more intensive search. Although some staff indicated that all patients returning from escape status would be asked to change their clothes and put on a hospital gown

Figure 2

Contraband: Matches, Lighters, and Ward Fires at Kingsboro Psychiatric Center

2/15/94 Building 1. Fire in the bathroom.

2/17/94 Ward 6. Fire on the porch.

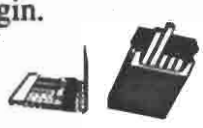
2/20/94 Ward 6. Fire in the bathroom.

5/?/94 Building 1. Fire (no description).

5/?/94 Building 3. Fire (no description).

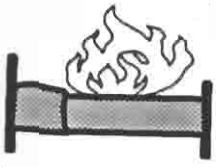
6/1/94 Building 1. Suspicious t-shirt on fire on air conditioning unit (Ward 1) outside the building.

6/16/94 MEBCC. Suspicious fire reported. Building evacuated and patients transported to PC, Assembly Hall. No injuries; damage confined to area of origin.



6/17/94 Building 1. Unauthorized smoking triggered fire alarm on Ward 15, Room 71. Matches and cigarettes were confiscated.

7/5/94 Ward 5. Patient tried to set fire to sheets.



7/23/94 Building 1. Two patients ran up the hall screaming fire. Staff found a mattress on fire in the back dorm of Ward 2. Patients evacuated. One of the patients had a lighter although she denied setting the fire.

8/14/94 Ward 18. Fire. Lighter and matchbook found.

9/16/94 Building B. Patient found smoking and burning paper in the bathroom on Ward 57.

9/16/94 Building 1. Paper burning on window sill outside unit (Ward 6). Matches and cigarettes confiscated.

9/29/94 Building 8. Female patient found burning her nightgown in the bathroom on Ward 57.

9/30/94 Building 3. Patient suspected of setting garbage can on fire on Ward 17's porch. He allegedly received cigarettes through the gate on the porch. Matches found on the patient.

11/13/94 Ward 19. Fire started in a trash can in the bathroom. Two patients found with lighter, matches, and bamboo paper.

11/24/94 Ward 17. Book of matches found on patient.

for a physical exam (at which point the physician would also discreetly search the patient), this clearly was not the case in Mr. Bishop's return to Kingsboro on November 20, 1994, despite the presence of police, helicopters, and dogs on the campus to locate him.

Additionally, while Kingsboro's formal written policy required ward searches three times weekly on all admission wards and at least four times a month on all other adult wards, ward staff were not uniformly knowledgeable of these searches. While on site at Kingsboro, Commission staff did note references to ward searches in the staff logs on several wards, but they were not consistently documented, and it did not appear that there was uniform compliance with the ward search requirements.

Sometime in the fall of 1994, Kingsboro Psychiatric Center had also purchased some metal scanners to assist ward staff in searches of patients. Commission staff were told during a February 1995 visit to Kingsboro that these scanners were now available between the sallyport doors on all adult wards of the center and that staff had been instructed to "scan" all patients reentering the ward from authorized passes, as well as unauthorized departures.

Finding: In January 1995, Kingsboro staff gave variable and often vague accounts of patient search requirements.

This report, however, was contrary to the most current "draft" version of Kingsboro's patient search policy which continued to allow wide discretion in the use of metal scanners:

> *The use of a metal detector may be employed for patients and visitors when there is reasonable cause to believe that a metal object which could cause harm to self or others is being brought into a patient area. ("Search Procedure for Drugs and Other Contraband"; January 1995)*

Center's Patient Search Policy in Flux

Much of the staff's confusion about Kingsboro's patient search and ward search policy could be traced to the fact that the center had apparently been in the process of revising this policy for some time. Many staff had apparently confused the mandates in these revised drafts, as they sought to provide the "right" answer to search questions during Commission interviews.

Finding: Inconsistent accountability for staff performance, as well as the circulation of multiple "draft" policies, contributed to confusion regarding patient and ward search requirements.

Documents provided by Kingsboro administrators indicated that a policy instituted in February 1990 was actually the center's "official" search policy at the time of Mr. Allman's death in November 1994. But in the course of 1994, it appears that at least two other drafts of a hospital patient search policy had been issued in April and October for staff comments. And, in January 1995, still another revised draft policy was issued. While the various draft versions of the policy had many areas of consistent staff direction, there also were apparent differences. All versions were also somewhat difficult to decipher, and Commission staff could appreciate how they had been read to mean different things by different staff.

For example, the February 1990 policy, which was in effect at the time of Mr. Allman's death, implied that all patients returning from unauthorized leave on either LWOC or escape status would be checked on the Admissions Service where they would be asked to change to a hospital gown while being searched. If such a patient was then to be readmitted to another

ward, he/she would then have another body check done on the ward where he/she was returning. This section is confusing, however, as it is contained in the subsection of the policy under "Admission Services," and staff reports indicated that many thought the special search requirement for patients returning from escape status (like Mr. Bishop), only applied to patients residing on this Admissions Service.

It appeared that over a long period of time prior to Mr. Bishop's return from his escape, there was considerable staff confusion about the requirements for searching patients who had returned from unauthorized leaves. Part of this confusion can be traced back to the center's ongoing, but never finalized, process of revising its 1990 patient search policy, which was acknowledged to be inadequate. The confused staff reports, however, also seemed to derive from the center's administrators' long-standing tolerance of varying staff practices in searching patients. These varying practices, which in some cases were also not compliant with the official 1990 policy, had the inevitable effect of further confusing staff as to what was actually expected.

Campus Perimeter and Grounds Security

The Kingsboro Psychiatric Center's 27-acre campus is completely surrounded by an approximately 8-foot fence, which has two automobile gates, with two adjoining pedestrian entrances, which are kept open at all times. In addition, there is a major construction effort underway, the complete renovation of former Building 2, and the construction company has its own gate, for which it maintains security.

To maintain the security of its campus and 25 separate buildings, Kingsboro Psychiatric Center has 34 authorized safety staff items, 31 of which were filled at the time of the Commission's early January 1995 review. Three of the safety officers in these filled items were, however, out on occupational leave, leaving Kingsboro with a total of 28 safety officers to provide 24 hours-a-day, seven days-a-week security for the campus. These staff are allocated across three shifts daily, with each shift staffed with approximately seven safety officers, five of whom man fixed safety stations and two of whom encircle the campus in a van and on foot, respectively.[11] Simple arithmetic indicates that to maintain these assignments—*even assuming no annual leave, sick leave, or personal leave for staff*—one would need 29.4 full-time safety officers.

Finding: Understaffing of the Kingsboro Safety Department led to the reliance on excessive overtime by the Office for the period surrounding Mr. Allman's death.

Operating with a complement of only 28 full-time staff, *who do, in fact, use authorized annual, sick, and personal leave*, Kingsboro regularly must assign safety officers to work mandatory and voluntary overtime. Indeed, for the 70-day period October 27, 1994–January 4, 1995, Kingsboro's records show that safety officers worked a total 2,245 overtime hours, for a total overtime cost of $51,400. Eight safety officers worked at least 20 hours overtime during at least one workweek of this period, and four worked at least 20 hours overtime during at least three workweeks of this period. One officer worked at least 40 hours of overtime for six workweeks of the period.

Aside from their readily recognizable "safety" functions, safety officers at Kingsboro

[11] The five manned stations include both automobile entrance gates (2), the Mary Brook Campus (1), the main Safety Department on the Clarkson Avenue Campus (1), and the entrance of Building 3 (1).

also serve in a number of other capacities. They respond to crises on the inpatient wards; they escort "dangerous" patients to clinic appointments and court appearances; they are sometimes called to escort staff to their cars in the evening; and they provide all patient transportation to clinics and emergency rooms after 3:30 p.m. when the center's transportation unit shuts down for the day. Safety officers are also responsible for conducting routine fire inspections of the patient wards, including the inspection of all fire extinguishers. Although it was not clear how safety staff are actually assigned to staff these additional functions—it was stressed that the five fixed safety stations were manned at all times.

Finding: The cost of maintaining absolute security of Kingsboro's 27-acre campus would be prohibitive, underscoring the need for enhanced security of patient wards and buildings.

It is also important to emphasize that in the absence of many more on-campus stationed safety officers, the Kingsboro Psychiatric Center Clarkson Avenue campus is simply not readily secured. The campus is large, located adjacent to a commercial area, dimly lit, and occupied by 25 separate buildings, with many alcoves and corners where individuals may seek cover to escape detection. The fence, which surrounds the perimeter of the campus, is easily scalable by able and agile individuals, and the two vehicle/passenger entranceways, while each manned by a safety officer, easily allow for a patient on foot to elude detection in exiting the pedestrian walkway if the patient's leave is planned simultaneous with a vehicle's entry or exit. Compounding these security challenges, each day approximately 1,100 employees, and many visitors and campus suppliers, as well as a large construction crew, enter and leave the Kingsboro campus.

Psychiatrist Decision-Making in Granting Patient Privileges

Although the death of Mr. Allman was not associated with an authorized patient leave, many Kingsboro staff recognized that the problems related to psychiatrists' practices in awarding patient privileges had contributed to patients' unauthorized departures over time at the center. In particular, the acting administrator expressed her concern that some patients granted unescorted leave privileges were placed on escape status as being a danger to themselves or others when they did not return on time. Given that the determination of dangerousness could be made so soon after a patient's awarding of privileges, the acting administrator questioned the appropriateness of the initial privileging decision.

In addition, long before Mr. Allman's death on November 20, 1994, the center's Safety and Risk Management Committee had noted specific concerns with the escorted leave practices of the center, noting that in a number of incidents, patient elopements were facilitated because staff were being asked to escort too many patients to program areas. Additionally, as early as June 1994, a special investigation report of a patient elopement from an escorted pass indicated that the patient's known escape risk should have precluded his escort to a routine clinic appointment with another patient and only one staff person.

New Privileging Procedures and Forms

Despite these apparent concerns, however, little concrete action had been taken by center staff through 1994 to provide greater accountability for patient privileging decisions. In January 1995, Commission staff were told that the facility had tightened its review and approval procedures for granting patient privileges—which now required the completion of a standard checklist and approvals by the treating psychiatrist, the

supervising psychiatrist, and the unit chief. Despite the added layers of review, however, questions remained regarding the substantive quality of the risk assessments being done.

For example, Kingsboro's new "Privilege Assessment and Evaluation Form" requires the treating psychiatrist, the supervising psychiatrist, and the unit chief all to cosign privilege status awards for all patients. Notably, however, the form does not clarify that supervising psychiatrists or unit chiefs are expected to actually review the case themselves or even to speak with the treating psychiatrist regarding his/her assessment.

Finding: New procedures for awarding patient privileges, instituted after Mr. Allman's death, added layers of psychiatrist review, but left some problems in the quality of these assessments unaddressed.

This form also specifies several specific process steps which must be included in a privileging review. The treating psychiatrist is directed to review the patient's current psychiatric assessment, his/her current "Checklist for Escape Risk, Suicide Risk, and Dangerousness to Others," and his/her current treatment plan, including medications and compliance. The form further requires a review of the patient's history of substance abuse and alcoholism, criminal history and incarcerations, the patient's past month's progress notes and incident reports, and doctors' order sheets (no time frame) for close observation and restraint orders for the patient. The treating psychiatrist must also provide a narrative clinical rationale for the assigned level of privileges, a listing of any medical issues or precautions, and an indication of whether the patient should be placed on escape or LWOC status if he/she fails to return from unescorted privileges.

A separate form entitled "Home Leave Assessment and Evaluation Form" also requires three levels of psychiatrist staff approval and is used specifically when a patient is awarded a home leave. While this form includes many of the specific items on the "Privilege Assessment and Evaluation Form," it ironically omits key items related to the review of patients' substance abuse, alcoholism, and criminal history. By contrast, the "Home Leave Assessment and Evaluation Form" does include several additional items, not on the privilege award form, requiring the psychiatrist to ensure that the patient *and/or* his/her family are informed of the date and time the patient is expected to return, the patient's medications, "suggested activities," and what to do in the event of an emergency. The form does not, however, explicitly require that the psychiatrist (or social worker) contact the responsible family member personally to ascertain that the family would welcome the visit and appeared capable to provide adequate supervision to the patient. The form also does not indicate that family members are informed as to what they should do if the patient makes an unauthorized departure from his/her home, refuses to take his/her prescribed medications, begins using alcohol or drugs which are contraindicated, or behaves in a threatening or dangerous manner to family members or others.

The reliance of both privilege assessment forms on the "Checklist for Escape Risk, Suicide Risk, and Dangerousness to Others," which is to be completed monthly on all high-risk Kingsboro inpatients, also raised concerns.[12] In many records reviewed by Commission staff,

[12] Of note, although Commission staff were told by several Kingsboro staff persons, including at least one unit chief, that these checklists were to be completed monthly, a memorandum from the center's clinical director (December 12, 1994) indicated that checklists should be completed on admission and monthly thereafter *if the patient was previously assessed as being at high risk.*

these forms were not regularly completed on patients, nor were they consistently filed in one section of a patient's record which would allow an historical review of the patient's condition, as reflected in consecutive checklists. In some cases, the most recent checklist form was several months old; in other cases, review of the current form did not inform the reader of critical information about the patient's past behavior and dangerousness assessments during his/her current hospitalization.

Summary

As reflected in this chapter, ongoing safety and security problems were well-known to Kingsboro Psychiatric Center staff for many months prior to Mr. Allman's death in November 1994. First and foremost, these safety issues were directly reflected in the incidence of patient and staff injuries, and especially the significant number of patient-to-patient and patient-to-staff assaults at the hospital. Patient elopements have also been commonplace, and not infrequently, they have been facilitated by clear-cut security lapses, often in staff's failing to maintain the security of ward and building doors.

Other safety and security problems centered on the long-term use of a single master key for all patient wards and buildings at Kingsboro Psychiatric Center, as well as at most other state psychiatric centers. Finally, for the many reasons enumerated in this chapter, maintaining the security of the Kingsboro Psychiatric Center campus is difficult, and as confirmed by several safety officers, for these reasons, basic patient safety and security at the center is severely compromised when there are breaches in patient ward and building security.

Although to some extent virtually all of these problems were known to Kingsboro senior staff prior to Mr. Allman's death, attempts to address them through revised policies and procedures for staff had typically been stalled and, in some cases, as with the patient search policy, multiple revised—but never finalized—drafts only further confused staff's understanding of their performance expectations. In the meantime, based on filed incident reports and completed investigations, it appeared that staff performance, inconsistent with the hospital policy which was *officially in effect*, was often tolerated. Likewise while OMH and Kingsboro officials, in the wake of Mr. Allman's death, moved swiftly to reform patient privileging procedures at the center, revised procedures, despite added layers of psychiatrist review, left notable problems in the quality of these assessments unaddressed.

Chapter IV
Patient Life at Kingsboro Psychiatric Center

Over the eight days that Commission staff were onsite at Kingsboro Psychiatric Center from late November 1994 through early February 1995, most of the staff's time was spent on patient wards observing daily living conditions and basic treatment of patients. Other observations about basic daily living and clinical care and treatment were made based on the review of records and documentation submitted by senior clinical staff.

Finding: Compared with conditions which prevailed at Kingsboro in 1988, basic environmental conditions, overcrowding, and patient custodial care had improved markedly.

In the course of these observations, the Commission staff noted that, overall, environmental conditions at the center had improved markedly from the late 80s. As a general rule, the wards were reasonably clean, there were no apparent serious safety problems, the plumbing worked, and most patients were adequately dressed and had basic hygiene supplies. Sheets, towels, blankets, and patient underwear, which were frequently in short supply at Kingsboro seven years ago, were now uniformly available. Most patients also now had the opportunity to participate in at least one group activity on the ward each day, which was a sharp contrast to pervasive on-ward patient idleness which the Commission had witnessed in 1988 on most of the center's adult wards.

Yet, despite these improvements, continuing problems in living conditions and treatment were also evident in early 1995. Old problems, including overcrowding, too little physical space, too few staff to escort and supervise patients in off-ward programs persisted, and specific concerns regarding the level of performance of psychiatrist staff at the center were identified.

Overcrowding

Historically, Kingsboro Psychiatric Center has suffered from severe overcrowding. Over the period 1984–1988, there were sometimes not enough beds for all patients; patient beds were kept in hallways, and some patient beds in dormitories were fewer than 12 inches apart, providing virtually no patient privacy. Relative to these historical benchmarks, the Commission found that Kingsboro's wards were markedly less overcrowded in January 1995.

However, in January 1995, many of Kingsboro's intermediate wards were significantly over their intended patient census of 25 patients. Most of these wards were serving more than 30 patients—some were serving and regularly served well over 35 patients. For example, as of December 8, 1994, Kingsboro officials reported that all but 2 of its 11 intermediate care wards had a census of over 30 patients. Four (4) of these 11 wards had a census of 35 or more patients, including one ward with a census of 51. Of note, this latter ward (Ward 3) was one of the two wards on which Kingsboro officials had determined as of November 28, 1994 to congregate all patients on Criminal Procedure Law status.

As shown in Figure 3, ward census on most of Kingsboro's adult wards has fluctuated from approximately 20 patients to 40 patients for the period November 1994–March 1995. The admission wards (Wards 2, 5, 6), as well as the Secure Services Ward (Ward 1, capacity limited to 15 patients), have typically served smaller numbers of patients. By contrast, Wards 3 and 4, designated for the placement of the vast majority of the hospital's Criminal Procedure Law status patients and other dangerous patients, not referred to the hospital's Secure Services Ward, have often had among the highest number of patients. Of note, all of these wards are located in Building 3, and all are approximately the same size.

Finding: Most of Kingsboro's intermediate care wards, especially those designated for the center's most dangerous patients, were overcrowded.

Patients on the wards serving more than 30 patients typically sleep in four-bed partitioned areas in large dormitories. During the daytime, however, dormitories are usually kept locked to facilitate staff supervision, and all patients are confined in a single dayroom area, its adjacent hallway, and sometimes a smaller activity room. Most dayrooms have space to seat only about 20 patients. During Commission site visits, other patients paced around hallways, entered and left the dayroom, and in some cases, periodically exited to screened-in, open-air porch areas adjoining many wards.

Maintaining such large numbers of patients on intermediate wards posed apparent problems for patients and staff. Most critically, the crowding of patients and staff into relatively small common areas made it difficult to maintain a calm, quiet atmosphere on the wards and deprived patients of virtually any peaceful, private space. The number of patients also contributed to the skirmishes and more serious patient conflicts, which can occur when large numbers of patients with serious mental health conditions are confined in small quarters. During Commission staff observations on the wards, many such skirmishes were observed and although prompt staff intervention prevented actual violence during these episodes, they confirmed the high violence potential on these wards and helped explain the high incidence of patient-to-patient and patient-to-staff assaults observed in the review of reported untoward incidents at the center.

Overcrowding also limited staff options in providing meaningful activities for patients. As described below (see Report pp. 36 and 38), staff were observed attempting to hold group sessions with as many as 20-25 patients seated in a crowded dayroom, often with little success.

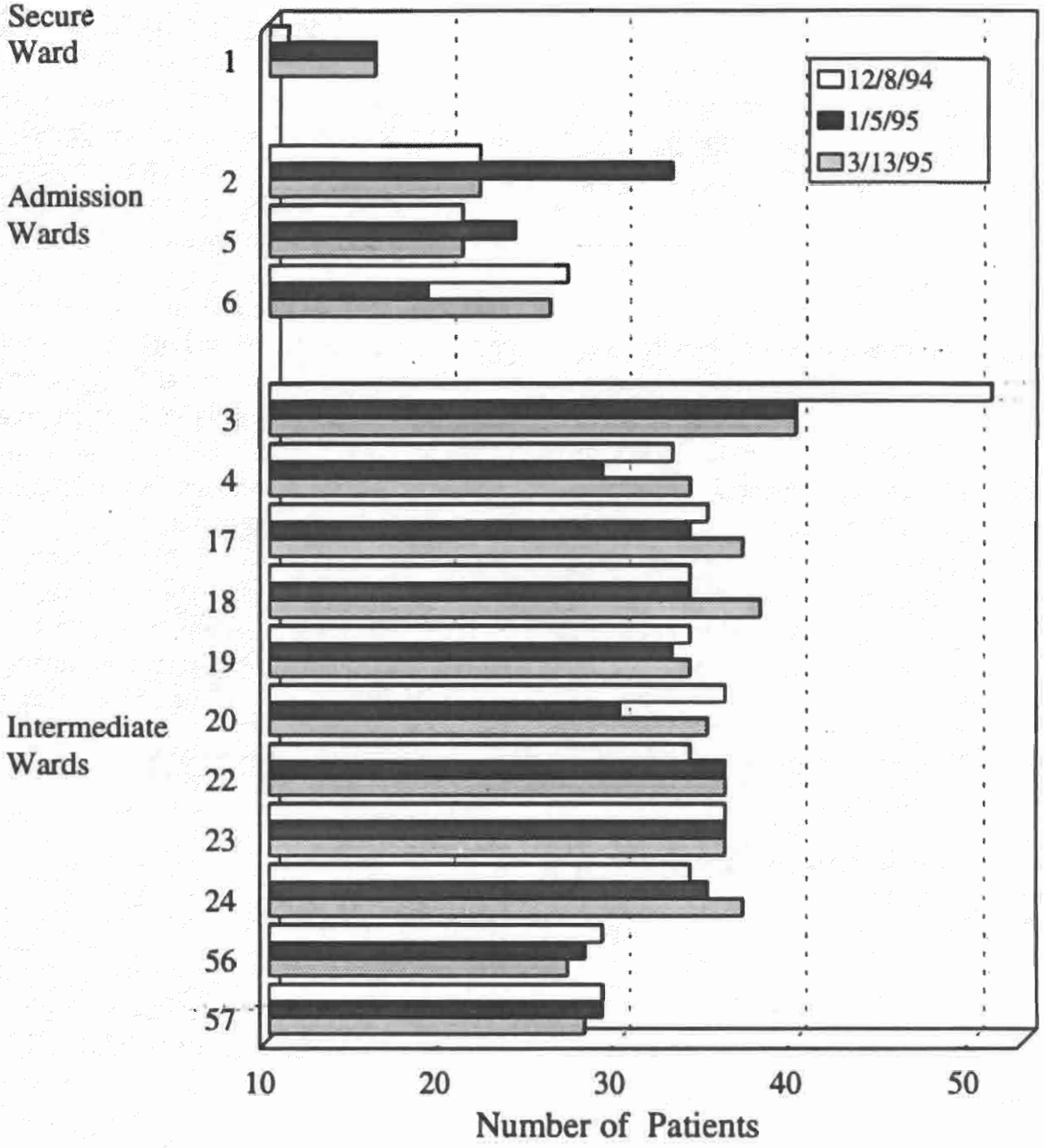
Daily Life on the Wards

At the time of the Commission's January 1995 review of Kingsboro Psychiatric Center, fewer than 20% of the center's approximately 540 patients had any form of off-ward privileges. Thus, for most Kingsboro patients, their days and nights were spent confined to their treatment ward, with the exception of brief excursions to in-building dining areas. For some patients, however, even trips to the dining areas were identified as too risky, and they ate their meals on the wards.

Several times during the day and early evening, patients were also allowed to exit the main ward area to the screened-in porch area where they were allowed to smoke. This was clearly an important and cherished activity for most patients.

In compliance with Office of Mental Health policy, posted ward schedules also usually listed at least 20 hours of on-ward activities weekly.

Figure 3
Wards' Census at Kingsboro Psychiatric Center
(December 1994 - March 1995)



These activities included a variety of events ranging from purely recreational activities, like arts and crafts, music, or table games, to nursing instructional groups on communicable diseases, safe sex, and substance abuse, to psychosocial groups entitled "family" or "men's" or "women's" group, to community meetings which were held daily (Monday–Friday) on most wards.

Finding: More on-ward group activities were available than during previous Commission reviews. Yet, due to overcrowding, many were too large; some were unruly and ineffectual.

As a general rule, Commission staff noted that scheduled groups of six to eight patients in enclosed rooms, where some quiet could be ensured, were generally effective rehabilitation activities for patients. By contrast, larger program groups of 20 or more patients held in crowded open dayrooms, where the majority of the patients were often either sleeping, walking in or out of the area, or otherwise not attending to the group, were of dubious value.

These larger groups, which were primarily observed in the crowded dayrooms of the wards in Building 1, were often dominated by two or three patients, and not infrequently, one or more of these patients, either volitionally or due to his/her illness, repeatedly made remarks which were disruptive to the group or simply irrelevant to the discussion.

For example, skill teaching groups on communicable diseases and safe sex were observed where one or more patients' flagrantly disruptive remarks concerning the use of condoms essentially sidetracked the intended personal health care message. Similarly, some community meetings were well-organized efforts in sharing community concerns, resolving patient complaints, and communicating information about ward activities, rules, and general information, while others were largely ineffectual and disorganized.

September 1994 data reported to the Office of Mental Health, by Kingsboro officials stated that 76% of its patients do, in fact, participate in at least 20 hours of scheduled programming weekly.[13] In questioning staff and in observing these activities, Commission staff learned that all patients sitting in an area when a scheduled group was going on would be asked to sign an attendance sheet and would ultimately be counted as "participating" in the activity. As many patients in larger groups held in the only common dayroom were actually just sitting or sleeping in their chairs, reading a newspaper, or doing a crossword puzzle with no apparent attention to the group activity, this reported rate of participation in 20 hours of weekly programming appears overstated, especially for patients confined to their treatment wards. Additionally, both staff reports and Commission observations indicated that while efforts were made to hold ward activities as scheduled, activities were frequently cancelled, due to staff absences, staff assigned to 1:1 patient supervision, or some other disruption on the ward.

Patients With Some Off-Ward Privileges

For patients with some form of unescorted or escorted privileges, daily life offered more opportunities. These patients, who represented less

[13] Almost all the remaining patients (19%) were identified as being exempted from participating in programming, presumably due to a medical condition or their acute psychiatric symptoms.

than 20% of the patient census at the time of the Commission's January visit, may have one of several privilege levels. They may have "escorted" (accompanied by staff) privileges to an off-ward program or activity; they may have "unescorted" privileges only to a designated site, usually a program activity, but occasionally to the patient canteen or another campus area; or they may have "unescorted" privileges to walk around the campus and/or to go to a local store, to visit their apartment, or to attend an off-campus program. In practice, very few patients (usually less than 20) at the center have this latter highest level of privilege at any one time, and most of these patients are being readied for discharge in the near future.

Finding: Kingsboro operates several quality off-ward programs. Yet, very few patients attend these programs daily, and fewer than 20% attend for even a few hours weekly.

Patients attending off-ward programs have several different options. Commission staff observed several very high-quality programs for patients with substance abuse problems (Fresh Start Program) which included self-help groups, a patient-run canteen program, traditional AA/NA meetings, an innovative computer graphics program, and a basic academic education program. On the day of the Commission's visit, however, only approximately ten patients were participating in these programs. In addition, the hospital operates a skills training program and a traditional sheltered workshop which provides patients work for pay. On the day of the Commission's visit, approximately 35 patients were attending the workshop.

According to Kingsboro officials, as of January 12, 1995, 111 of its 540 patients were actually enrolled in one or more of these programs, attending anywhere from 3 to 20 hours weekly. Several of the patients also told Commission staff that they very much enjoyed their "special" privilege to attend these off-ward programs. Kingsboro staff further reported that more patients could benefit from these formal off-ward programs, but concerns about unauthorized patient elopements, along with limited staff to escort patients to programs and to supervise them while participating in the programs, restricted both the number of patients attending these programs and the duration of their weekly attendance.

Both of Kingsboro's main adult patient buildings also have an off-ward activity room which can be used by patients when recreational or other staff are available for supervision. Participation in programs scheduled for these off-ward areas is limited to patients who have unescorted grounds privileges and, when staff escorts are available, to patients with escorted privileges.

These relatively spacious areas are stocked with some game supplies, stereos, and some reading materials, and they are reportedly used for multiple purposes, including general recreation, art activities, and in-building Alcoholics Anonymous and Narcotics Anonymous meetings. According to ward staff, however, these rooms were only irregularly in use for most of November and December 1994, due to staff absences. Sometimes they were reportedly not opened because recreational therapists, scheduled to staff the rooms, were out on occupational, sick, or annual leave. Other times, staff assigned to the recreation areas were reportedly reassigned to wards that were short-staffed due to unexpected absences of scheduled staff.

Clinical Practices

The Commission's review at Kingsboro also included preliminary assessments of the hospital's provision of timely medical care for emerging health problems, the use of restraints

and seclusion in compliance with state law and regulation, and psychotropic medication prescribing practices.

Commission staff checked five to eight patient records on six wards (Wards 1, 3, 5, 6, 23, and 28) to assess the follow-up on doctors' orders and attention to patients' medical complaints as referenced in the staff communication logs. Across all these wards, the sample records documented timely implementation of doctors' orders and attention to patients' medical complaints referenced in recent staff communication logs.

Finding: Cautious use of restraints, attention to patients' documented health complaints, and psychotropic medication regimes compliant with the OMH Drug Manual were significant findings.

The Commission also found that Kingsboro Psychiatric Center, which does not use seclusion rooms with its adult patients, had a relatively low usage rate for mechanical restraints (September 1994) of only 7.1 orders per 100 adult patients in its average daily census. Restraint order sheets for recent restraints on the wards visited by Commission staff also documented that these interventions were not used until less restrictive interventions had failed and unless the situation clearly presented a danger to the patient or others.

Across all wards reviewed, Commission staff also noted generally cautious and conservative standing psychotropic medication orders for patients. Few patients were on multiple psychotropic medications regimes, and no patients' standing medication orders included drug dosages exceeding limits set in the OMH Drug Manual. In addition, none of the patients had drug regimes which evidenced polypharmacy.

Additionally, relatively few patients on any of the wards reviewed had received any PRN or STAT medication administrations of psychotropic medications in the 30 days prior to the Commission's review. In those instances when unscheduled psychotropic medication administrations (either PRN or STAT orders) were given, notations in staff communication logs and staff notes in patients' records usually provided a clear description of the circumstances leading up to the administration and the less restrictive interventions attempted prior to the administration of the medications.

Commission staff did note that on most adult wards, a significant minority of patients were periodically refusing their standing medication orders. In several specific cases, these individuals were acutely ill patients, who were also periodically assaultive and threatening to other patients and staff. Although Commission staff did see some instances where clinical staff had sought court orders to override the refusals of patients to take their medications, hospital staff did not use consistent decision-making standards or timely process in deciding whether to override the refusals, especially for patients who displayed hostile, threatening, or disruptive behavior on the ward.

This issue was also apparently a matter of concern to the hospital's Clinical Director. On March 30, 1994, she issued a memorandum on "Applications for Treatment Over Objections," to the Director of Psychiatry, with copies to many senior hospital staff, including the facility director and all unit chiefs, which stated,

> *It has come to my attention that some applications for treatment over objections are not being processed as timely as they should be by Forensic Services. As I have indicated many times in the past, this matter should be given top priority. I have stressed the importance of having a system to follow up on these applications. I am aware that you have a system, but apparently, it should be reviewed since there seem to be gaps in it.*

Psychiatric Services

At Kingsboro Psychiatric Center, like most state psychiatric institutions, psychiatrists play a key role in treatment services. They prescribe psychotropic medications, the dominant form of treatment; they must approve final individualized treatment plans; only psychiatrists and other medical doctors may authorize restraints and seclusion; and psychiatrists, as explained in the previous chapter, award patients various privileges, including privileges to leave the ward with or without a staff escort.

Finding: More than three-fourths of the patients surveyed stated they participated in their treatment planning, and two-thirds stated staff answered their questions about treatment issues.

On every ward visited, Commission staff sought to better understand the role and activities of psychiatrists in the above areas. On all wards, staff reported that patients usually met with their psychiatrists two or three times weekly, but they also uniformly added that these appointments are not scheduled. Reportedly, psychiatrists do not schedule appointments, because other duties, including admission assessments for new patients, may preclude their ability to keep appointments, which disappoints and angers patients.

Patients' responses to the Commission's consumer survey tended, however, to confirm their regular contact with psychiatrists or other clinical staff about their treatment. More than three-fourths of the responding patients (79%) indicated that they did participate in developing their treatment plans, and two-thirds (67%) reported that if they had a question about their care or treatment, staff would talk with them. In responding to another question, two out of every three respondents indicated that they had "a lot" (38%) or "some" (30%) choice in their overall treatment.

Other documentation submitted by Kingsboro Psychiatric Center indicated, however, that over the course of 1994, the Director of Clinical Services had identified problems in many basic areas of psychiatric practice—some related to key problems also noted by the Commission in its investigation of Mr. Allman's death.

- A March 23, 1994 memo, in response to a request from the chairperson of the Safety and Risk Management Committee, was sent to all emergency beeper holders (including psychiatrists) clarifying their responsibility to respond immediately to Code Blues.
- A March 25, 1994 memo sent to the Director of Medicine and the Director of Psychiatry specified areas of clinical competence which *must* be reflected in psychiatrists' and medical specialists' annual performance evaluation standards. This memo, which referenced the need to revise current performance standards, specifically identified the following standards for inclusion:

  > *medical records documentation showing accurate psychiatric and medical diagnoses, good assessments, inventory of patient assets, appropriate goals and objectives and "active treatment"... progress notes and discharge summary ... census management by aggressive treatment and discharge planning... mandatory daily rounds....*

- An April 14, 1994 memo to all supervising psychiatrists referenced "the contingency plan for psychiatric supervision to improve clinical practice and ensure accountability" in response to a HCFA review. The memo states, "I understand that some of you are already doing group supervision using case

conferencing and conducting 'supervisory rounds'; others who have not done so, should start the process as soon as possible."

Finding: Memoranda from the Clinical Director identified and urged correction of many problems in psychiatrist performance at Kingsboro.

- A June 1, 1994 memo to all inpatient physicians stated that they must write orders for all patients in residence and newly admitted patients for PPD (tuberculosis) testing. The memo clarified that in the past, orders for PPD testing were not always written by physicians, but tests were conducted routinely with or without orders. It also clarified that this new policy (requiring written orders) was actually recommended a year ago, but is only now being implemented.
- A July 27, 1994 memo to the Director of Medicine and the Director of Psychiatry on needed integration of medical and psychiatric services by the Director of Clinical Services stated, "... the treating Psychiatrist and Medical Specialist must meet and communicate regularly with each other. The natural forum for this is the weekly treatment planning meetings, I believe this integration and interface between medicine and psychiatry does not occur consistently in some wards...."
- A November 17, 1994 memo from the Clinical Director to all inpatient psychiatrists stressed that they are to comply with the revised policy on the hospital's level (patient privileging) system and write start and stop dates on all orders for patient levels.
- A November 23, 1994 memo stated that any patient committed pursuant to Section 330.20 of the Criminal Procedure Law (found by plea or verdict to be "not guilty by reason of mental disease or defect") returning from an escape will be automatically admitted to the Secure Services Ward, but that prior to the patient's transfer, he/she should be seen by a psychiatrist in Admission Service where drug screening (when indicated) and a strip search should be performed.
- A November 28, 1994 memo to the Chairperson of the Forensic Committee and the Forensic Coordinator stated that monthly reviews must now be conducted on all patients committed pursuant to Section 330.20 of the Criminal Procedure Law.
- A November 29, 1994 memo to all inpatient psychiatrists, unit chiefs, and treatment team leaders summarized clinical and administrative issues discussed at an emergency meeting (11/28/94, subsequent to Mr. Allman's death) to increase security and minimize patient Escapes/LWOCs. Among many other security matters outlined in the memo, the Clinical Director indicated that psychiatrists, unit chiefs, and team leaders should be reviewing patient privileging levels during their morning rounds and that a reorganization of the Department of Psychiatry has been put in place to ensure that each treatment service *has a supervising psychiatrist.*
- A strongly stated December 12, 1994 memo to all inpatient psychiatrists regarding the completion of the hospital's "Checklist for Escape Risk, Suicide Risk, and Dangerousness to Others" said in part, "It has come to my attention that some of you are not completing the 'Checklist for Escape Risk, Suicide Risk, and Dangerousness to Others' form.... Please be advised that we will monitor your compliance to this important policy and identify those psychiatrists who repeatedly have failed to do so for appropriate administrative action."

Services to Patients With Drug and Alcohol Abuse Problems

As noted above, Kingsboro officials report that approximately half of their admitted patients have a concomitant problem with drug and/or alcohol abuse, yet they are equally candid in acknowledging that these specialized treatment needs of most patients are not significantly addressed during their inpatient stay. While the center has arranged a number of informal teaching group programs and activities on and off patient wards, targeted to patients' problems with alcohol and substance abuse, with the exception of the Fresh Start Program, these are not coordinated efforts, nor do they reach most patients with these needs. At the time of the Commission's January 1995 review, only 30 of the approximately 270 patients with drug and/or alcohol abuse problems were participating in the various components of the Fresh Start Program.

Finding: Only 30 of the approximately 270 patients with drug and alcohol abuse problems were participating in the center's one formal program for patients with these needs.

With the exception of several staff of the Fresh Start Program, Kingsboro Psychiatric Center does not have any dedicated clinical staff with specialized training in program development and service delivery in drug and/or alcohol abuse. Kingsboro has reportedly offered some alcohol and drug abuse inservice training to its clinicians and direct care staff in recent years, but senior staff acknowledge the inadequacy of this training given the number of patients with these problems and the significant amount of "misinformation" about these subjects among center staff. Presently, Kingsboro staff do report that four staff members, two therapy aides and two social workers, are completing the requirements to be certified alcoholism counselors.

Kingsboro does attempt to refer patients with alcohol and/or substance abuse problems upon discharge to relevant outpatient services and, where possible, appropriate residential rehabilitation programs. Kingsboro staff identified ten residential programs which will accept their patients with substance and/or alcohol abuse problems, but they conceded that most programs want assurances that the patient will attend other outpatient services and/or a day program and, in some cases, that he/she has already been attending such programs on or off the Kingsboro campus for several weeks prior to discharge. Kingsboro staff also reported that the Kings County Hospital Center, located adjacent to the center's campus, has recently established a Mentally Ill Chemical Abusers (MICA) Intensive Case Management program which will admit some Kingsboro patients upon discharge. Notwithstanding these available services, however, Kingsboro senior staff confirm that patients with substance and/or alcohol abuse problems often present serious treatment and discharge problems and that they tend to have higher readmission rates than other patients.

Summary

In summary, although basic environmental and custodial care practices have improved at Kingsboro Psychiatric Center since the late 80s, many wards remain too crowded and on-ward and off-ward programming, while more available than it once was, is still not adequate, and most patients remain unengaged in any structured treatment of rehabilitation activity most of their waking hours. The center's data indicate that it uses restraint cautiously and infrequently with patients; similarly chemical restraints in the form of unscheduled PRN and STAT medication administrations are also infrequently used.

Simultaneously, however, there is indication that when patients displaying violent and threatening behavior refuse their standing psychotropic medication orders, the hospital is not always timely in evaluating the need for court orders to provide medications over the patients' objections. Other documentation provided by the center further indicated that overall psychiatric practice at the center suffers from identified basic problems in psychiatrist performance, which have been slow to change.

Finally, and perhaps most important, although persons with serious mental illness with concomitant drug and alcohol abuse problems are a dominant service population of Kingsboro Psychiatric Center, the hospital offers few programs and, in fact, has few qualified clinical staff to address these patients' needs. As a result, most are discharged with little or no attention to their drug and alcohol abuse problems or their confounding effects on their underlying mental health problems.

Chapter V
Quality Assurance and Risk Management Services

In accordance with sound management practices, as well as the specific regulatory and policy requirements of the NYS Office of Mental Health and the published standards of JCAHO and HCFA, all state psychiatric centers are required to establish quality assurance and risk management systems. At Kingsboro Psychiatric Center, the incident reporting and investigation system and its Safety and Risk Management Committee, are critical components of these systems, and the Commission's review included an assessment of the effectiveness of both of these quality assurance processes.

Reporting Untoward Incidents

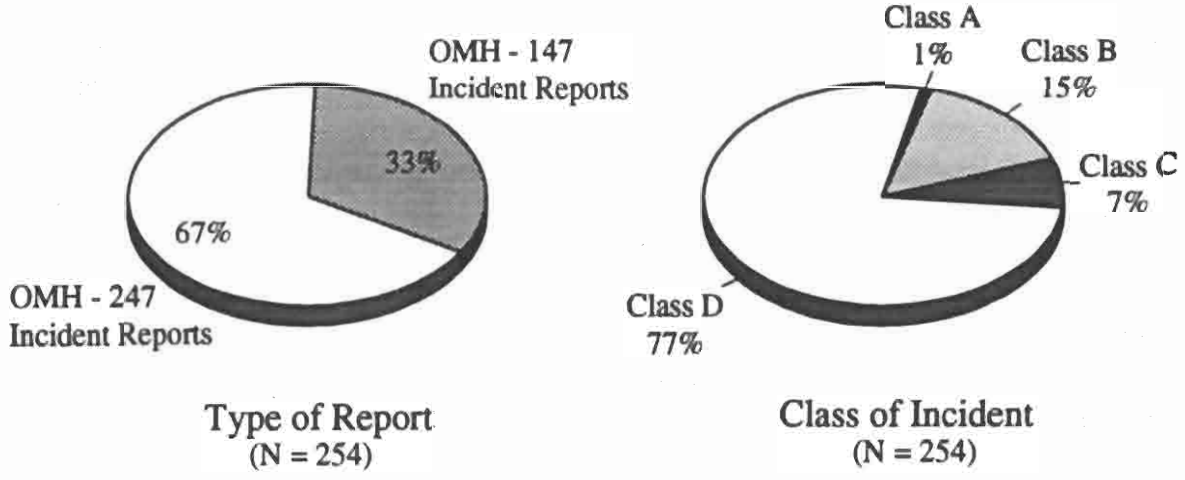
The routine reporting, review, and investigation of all untoward events and incidents at the facility, as well as the notification of certain external parties, including the Office of Mental Health's Central and Regional Offices, the Commission on Quality of Care, and law enforcement officials of certain "serious" incidents are specified in both OMH policy and regulations (NYS OMH Policy Manual QA-510; NYCRR Part 524). Like most state psychiatric centers, especially in New York City, Kingsboro generates a large number of incident reports each month. As noted above, for the 46-day period proximate with Mr. Allman's death, a total of 254 incident reports were filed by Kingsboro staff.

To assist center staff in appropriately triaging their attention to more and less serious untoward incident reports, the Office of Mental Health established a four-tier classification system for reported incidents—Class A, B, C, and D—with Class A incidents being the most serious and Class D incidents being the least serious. In the Commission's review of the 254 reports filed by Kingsboro in the 46-day period, 1% were classified as Class A incidents, 15% were classified as Class B incidents, 7% were classified as Class C incidents, and 76% were classified as Class D incidents. As allowed by OMH, the majority of Class D incidents (87%) were filed on the more abbreviated Incident Report Form 247, while all Class A, B, and C incidents (as well as the remaining Class D incidents) were filed on the standard Incident Report Form 147 (Figure 4).

Finding: OMH's classification system for incidents obscures the seriousness of many incidents, including assaults and elopements, which are often categorized as the least serious Class D incidents.

In this classification system, however, more and less serious incidents are defined somewhat subjectively, chiefly based on the seriousness of *actual patient injury,* and many patient-to-patient and patient-to-staff assaults are classified as the least serious Class D incidents. The classification system also defines most patient leaves without consent (not classified as escapes) as Class D incidents. Only homicides, homicide attempts, suicides, suicide attempts and other incidents which directly place a

Figure 4
Kingsboro Psychiatric Center Incident Reports
by Type and Class of Report
(November 1 - December 16, 1994)



patient's life in jeopardy are labeled Class A incidents. Similarly, Class B incidents are those, "which are not life threatening, but which require a swift investigation," including allegations of abuse or neglect, *aggravated* assaults involving a weapon and a serious injury, sexual assaults, escapes, and less serious suicide attempts.

Other incidents which may have seriously *threatened* the safety or well-being of patients, including those which may have resulted in injuries requiring some medical treatment beyond first aid, are classified as Class C incidents. Incidents which resulted in less serious injuries, bruises, abrasions, swollen eyes, etc., which do not threaten the safety or well-being of the patient, are classified as Class D incidents. In short, many incidents which may be very serious and/or which may reflect serious infringements of a patient's protection from harm may be classified as Class C or D incidents.

The Misclassification of Incidents

Perhaps in part because the definitions for the seriousness of incidents and their classifications appear subjective, the Commission noted that, for a large number of the incidents reported, classifications had changed many times. Most often Class D reports were reclassified as Class C reports; less often Class C reports were reclassified as Class B reports. Interviews with administrative staff responsible for these amended classifications indicated that ward staff, includ-

ing treatment team leaders and unit chiefs who review all incident reports before they are sent to Central Administration, may not always be aware that their initial classification had been changed or why.

The Commission also noted many incidents classified as Class D which *did in fact threaten the safety and well-being of patients.* In these incidents, unit chiefs and treatment team leaders, as well as center administrators, uniformly failed to consider the broader implications of the incidents in presenting serious threats to patients' safety and well-being. For example, many patient-to-patient assault incidents were classified as Class D incidents, although it was apparent that one or more of the patients' behaviors may have been potentially very threatening to the safety and well-being of other patients. Similarly, some reports of patients not determined dangerous to themselves or others who eloped, were inappropriately classified as Class D incidents, as staff negligence in supervising the patient and/or in leaving ward or building doors opened was clearly implicated and clearly threatened the safety and well-being of patients.

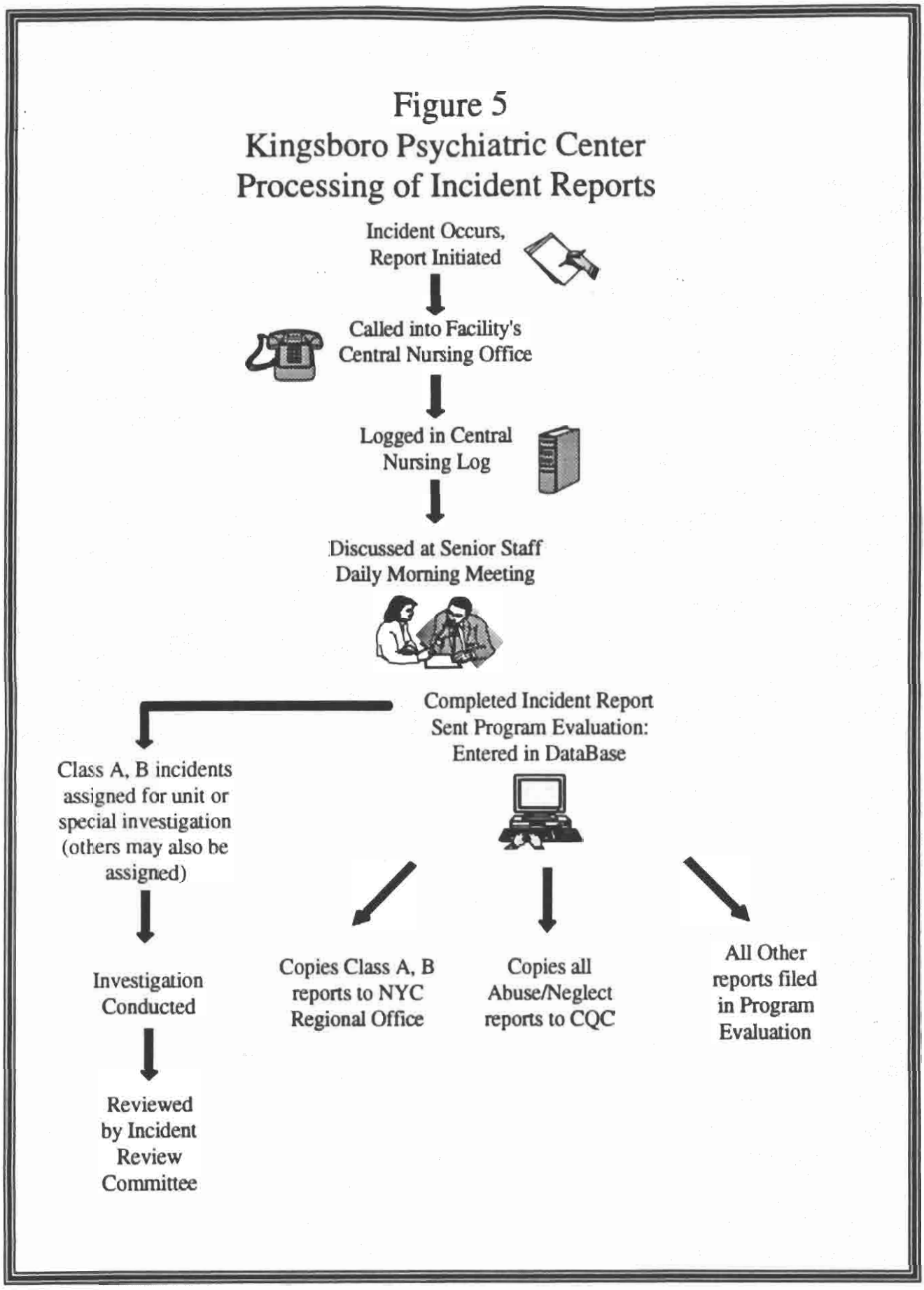
It is important to emphasize that Kingsboro's classification *or misclassification* of incidents determined the level of scrutiny that the reports received both by the center and by outside parties (Figure 5). Significantly, most Class C and Class D incidents are not subject to any formal investigation or review by senior center officials. Thus, serious issues in staff performance related to unauthorized patient departures, privileging decisions associated with these elopements, and clinical treatment issues associated with the high incidence of patient assaults on other patients and staff, classified as Class C and Class D incidents, often received little attention from center officials.

Additionally, according to both Kingsboro and OMH policy, only Class A and Class B incidents are assigned for a special independent or unit investigation; OMH Regional and Central Offices are only notified immediately of Class A incidents, while they are routinely routed copies of Class B incidents. Additionally, state psychiatric centers are only required to notify the Commission on Quality of Care of incidents

In the Matter of J.H.'s Elopement

In the case of J.H., who eloped from his treatment ward on 6/12/94, when staff went to get him medication for his anxious and pacing behavior, the investigation was promptly completed. The investigator determined that the patient, who returned several days later, had been able to elope through open front doors of the ward. The ward staff reported that the locks on the doors had been malfunctioning for several days prior to the elopement, but the investigator found no problem with locks in his assessment, and he also noted that there was no evidence that the doors had been forced open. The investigator concluded that there was staff neglect in leaving the front ward doors open, but that, "there is no evidence to prove who it was, among the staff, who failed to lock the door." *There is no indication in the investigation report or the attached staff statements that the investigator explored which staff had recently entered or left the ward, or even the whereabouts of all ward staff at the time of the patient's elopement. The investigator apparently also did not question staff about whether they had reported the malfunctioning locks to ensure their repair, although the investigation report and the staff's statements imply that they had* ***not*** *done so.*

Figure 5
Kingsboro Psychiatric Center
Processing of Incident Reports



of patient deaths and allegations of abuse and neglect. Thus, failure of the center to identify possible staff neglect in most incidents where staff compromised patient supervision or ward or building security, also resulted in these reports not being forwarded to the Commission, as required by state statute and regulations.[14]

Finding: Class D incidents receive little attention from center administrators or OMH officials. Some which may involve staff neglect, are also not appropriately reported to the Commission.

Of note, despite the apparent critical role of an incident's classification in its review and attention by senior center staff and outside officials, there is no indication in any documentation provided by Kingsboro or the New York City OMH Regional Office that periodic audits of the appropriateness of incident classifications were conducted at Kingsboro Psychiatric Center. Although, as noted above, incident classifications of some incidents were periodically changed by center administrative staff, these

In the Matter of J.C.'s Elopement Out a Window

In the case of J.C., the patient escaped from his treatment ward by jumping out the visiting room window (with a sheet rope) on 6/13/94 at approximately 3:35 p.m. According to the report, J.C. was placed on escape status, because the psychiatrist felt he may have hurt himself during his escape. J.C. returned two days later with no injuries. Kingsboro provided no investigation report of this case, although three brief staff statements (all dated the day of the elopement) were attached. One staff statement indicated that J.C. had been in his group shortly before the incident; another stated that J.C. was found missing; and another stated that the staff person (from another ward) had told ward staff that he had seen a sheet hanging out of the window. *The "investigation" provided no commentary discussing how the window happened to be open or who was supposed to be supervising J.C. and/or the visiting area from which he escaped. In fact, there is nothing in the report about the window at all; nor is there any discussion of the whereabouts and activities of ward staff. The "investigation" also makes no reference of any review of the patient's record to determine if staff should have been more alert to his escape risk and need for greater supervision.*

[14] This issue of the misclassification of incidents and its effect in limiting external scrutiny has surfaced in several Commission on Quality of Care investigations—*Investigation into Allegations of Child Abuse and Neglect at Western New York Children's Psychiatric Center: Final Report*, NYS Commission on Quality of Care, April 1990; *In the Matter of Timothy Smythe: A Patient at Central New York Psychiatric Center*, NYS Commission on Quality of Care, August 1991; *Sexuality and Developmental Disabilities: An Investigation of Sexual Incidents at Bernard Fineson Developmental Center*, NYS Commission on Quality of Care, November 1991; and *Crossing the Line from Empowerment to Neglect: The Case of Project L.I.F.E.*, NYS Commission on Quality of Care, July 1994.

In the Matter of an Accusation of a Staff-Patient Sexual Relationship

L.S. alleged that a safety officer accused him of having a sexual relationship with another safety officer three days earlier on 7/23/94. Although L.S. initially reported the incident on 7/23/94 to the safety officer with whom he was accused of having a relationship, the incident was not ultimately reported until after L.S. reported the allegation for a second time to the treatment team leader three days later. The investigation report, dated 9/14/94, *nearly three months after the allegation was reported,* indicated that the safety officer denied having made this statement to L.S., but that he did admit to having had a confrontation with the patient over his being near Building 9. The second safety officer acknowledged that L.S. had made the report of the accusation to him on 7/23/94 and that he had told the patient that if the other safety officer says this again, he should tell him that the second safety officer had "f..... his mother." The second safety officer also confirmed L.S.'s report that he sometimes sent L.S. to the store and gave him cigarettes, but he denied any other relationship with L.S. L.S. also denied any relationship with the safety officer. *In addition to the delay in the final investigation report, L.S. was not interviewed until 8/8/94, almost two weeks after he filed his report, and the two safety officers were not interviewed until more than a month later, 9/7/94 and 9/13/94. Of note, no other safety officers were interviewed, although there is indication in the report (by the second safety officer) that such accusations had been made previously. In the final report, the safety officer alleged to have made the accusation was fully cleared; the second officer was counseled for not promptly reporting the incident, for his response to L.S., and for sending L.S. to the store for him. There is, however, no explanation for L.S.'s initial report, or that L.S.'s statement was likely to have been not credible due to a history of making false allegations or any acute symptoms of his illness. There is also no discussion of the appropriateness of the safety officer telling L.S. to stay away from Building 9; nor is there any indication that L.S. received any counseling in regard to the incident. Finally, the safety officer's ready report that the patient made purchases for him at local stores suggested that this was common practice, yet there is no indication that all staff were alerted (realerted) as to the inappropriateness of this behavior.*

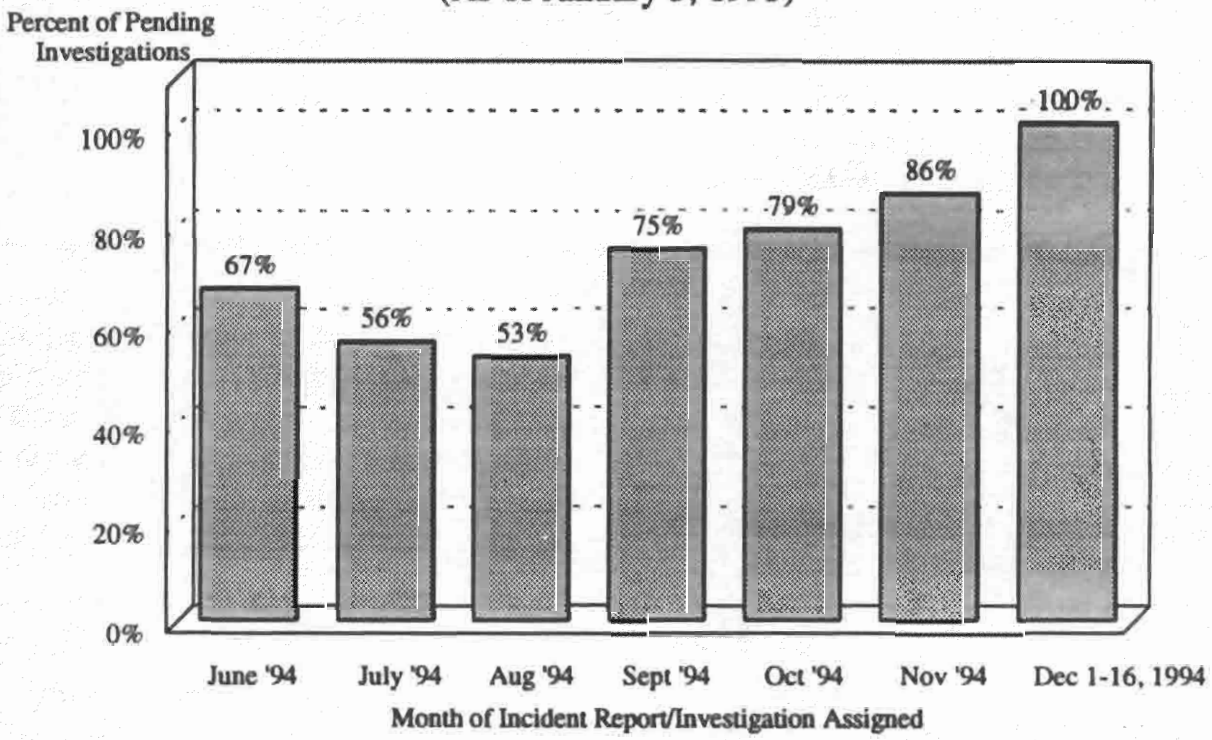
changes and their rationales were not usually communicated to unit chiefs and treatment team leaders. In many other cases, incidents which had serious implications for patient safety and protection from harm were left classified as the least serious Class D incidents and, in accordance with the established center procedures, described below, they were assigned little, if any, administrative staff attention.

Finding: Special investigations were usually not completed in a timely manner, and sometimes they were not initiated until several months after the incident was reported.

The Investigation of Serious Incidents

Documentation provided by Kingsboro officials, as well as the center's Director of Special Investigations indicated that investigations of untoward incidents are often not completed until several months after they were reported. At the time of the Commission's on-site review of Kingsboro Psychiatric Center in January 1995, 72% of the special investigations assigned as far back as June 1994 still were not completed (Figure 6).[15] The review of completed investigations found that most of these investigations were not completed until more than 60 days after the incident was initially reported.

Figure 6
Kingsboro Psychiatric Center
Special Investigations Pending
(As of January 5, 1995)



[15] Subsequently, in late January, 1995, Kingsboro reported having completed an additional 27 of the still pending 91 special investigations for the period June–December 1994, but it was apparent that this effort was spurred by both the Commission's and OMH's attention to the apparent long-term serious delays in the investigations of serious incidents at the center.

In the Matter of R.M.'s Request for an Aspirin

In the case of R.M., a patient on the Secure Services Ward, a report was filed on 8/20/94 which indicated that R.M. had assaulted a nurse with a broom. According to the report, R.M. had initially approached the nurses' station and asked for an aspirin for a headache. The nurse told R.M. that she could not give him an aspirin and would need to call a doctor. R.M. returned to the nurses' station a few minutes later to make his request again. When told again that he would have to wait, R.M. reportedly became hostile and threatening, and the nurse instructed staff restrain R.M. At this point, according to the report, R.M. became more upset, stating, "I will give you something to restrain me for," and he picked up a broom and hit the nurse in the face. *This investigation was extremely shortsighted and appeared to focus almost exclusively on the availability of the broom outside the locked utility closet. Some staff statements were not taken until 9/1/94 and 9/8/94; others were not taken until December, four months after the report was filed. Most notably, the investigation entirely ignored the nurse's role in contributing to the escalating incident by not being more attentive and responsive to the patient's complaint of a headache. Although she was not able to give him an aspirin, she could have indicated that she had called the doctor; she could have offered him a cold cloth to place on his forehead; she could have offered him the opportunity to sit in a quieter area of the ward; or she could have simply been more comforting to the patient. The investigation in this case also referenced no review of R.M.'s record to determine if he had a prior history of headaches which may have been overlooked and should have resulted in a PRN order for pain medication.*

Aside from the delays in completing special investigations, other serious problems were noted in most investigations reviewed by the Commission:

- issues of staff performance and neglect were often not thoroughly explored;
- patient witnesses were rarely, if ever, interviewed; and
- critical concerns cited in incident reports or referenced in witness statements were often entirely ignored.

Additionally, staff and patient witnesses were often not interviewed until long after the incident, and even then, in many cases, staff witness statements suggested that staff were not actually interviewed at all, but simply asked to record a statement of what happened. In many investigations, the similarity of staff witness statements (often to the extent of using the exact same language) suggested that some staff may have collaborated before writing their statements. As indicated in the case examples presented in this chapter, these problems in incident investigations laid a foundation for insufficient evidence documenting staff performance issues and misconduct—which in the final completed investigation reports—often ironically, but predictably, also became the rationale for no recommended corrective or disciplinary actions.

Finding: Many special investigations had serious flaws, including the failure to interview all staff witnesses or any patient witnesses and the failure to explore apparent staff performance problems.

The current acting center administrator confirmed the significant delays in the completion of special investigations and also their uneven quality. She stated that requests have been made to the Office of Mental Health Central Office for several years for additional special investigator items, but that they have never been approved. The acting center administrator also acknowledged, however, that with a staff of 1,100, the former administrator probably did have the discretion to reassign one or two currently authorized staff positions to this function.

Incident Review Committee

In accordance with the Office of Mental Health's and the center's incident reporting and review policies, Kingsboro has an Incident Review Committee which meets monthly to review serious incidents and their investigations and which is responsible for proposing needed recommendations for corrective and preventive actions. The Commission reviewed four sets of minutes of this Committee, reflecting its September, October, November, and December 1994 meetings.

Finding: The Incident Review Committee met monthly, but its reviews of serious incidents were usually very delayed, and they often overlooked needed corrective actions and/or effective process for their implementation.

Unfortunately, the format and content of these meeting minutes largely precluded any substantive evaluation of the Committee's deliberations or recommendations. In most cases, the incident was referenced by a number (sometimes there was no identification number), but no date, and in most references, the narrative was so abbreviated that it was not possible to discern the circumstances or nature of the inci-

In the Matter of M.C.'s Allegation of Staff Abuse

On 7/22/94, M.C. alleged that he was abused by staff who pulled him into the bathroom and closed the door and told him that he was "nothing and was always going to be in the hospital." M.C. further alleged that the staff were trying to provoke him into a fight—but he did not let himself be provoked. Kingsboro provided no investigation report of M.C.'s allegations of staff abuse, but the center did include M.C.'s statement and statements taken from several other staff. *Of note, M.C.'s statement was not taken until three days after he formally reported his allegation, no other patients were interviewed, and staff statements were not taken until much later—on 8/11/94, 9/14/94, 9/21/94, 9/23/94, 10/6/94, 10/21/94, 10/24/94, 11/1/94, and 12/2/94.* Most of the staff statements are not very informative. Most state that the staff person did not recall any incident that evening with M.C. Several did not even recall if they worked that night. The few staff who did recall the incident, which both M.C.'s and the staff's statements indicate started because staff told M.C. that he must remove the towel he was placing over his room light (to make the room dark), stated that they were very polite to M.C., but that they did try to move him to a smaller dormitory where he could be watched; but M.C. refused and was then told that he would be moved in the morning. Staff on duty in the morning also denied any untoward interaction with M.C. In short, it seems that center staff failed to take many appropriate immediate actions in response to M.C.'s initial serious allegation. Just as unfortunately, it seems that no one considered M.C.'s apparently reasonable request to be able to sleep in a darkened room at night.

dent. These limitations made an empirical assessment of the timeliness of the Committee's actions impossible; but senior Kingsboro staff reported that the Committee did not consider incidents until assigned special investigations were completed and, given delays in completing most investigations, most incident reviews by the Committee were not done until months after the serious untoward event had occurred. Similarly, although the Commission could not crosswalk many of the cases referenced in meeting minutes with the completed investigation reports, the limited narrative on all cases suggested that the Committee was no more thorough in its consideration of needed corrective and preventive actions than were the center's "investigators."

These limitations of Kingsboro's Incident Review Committee meeting minutes also appeared to have serious implications for any defined outcomes of the entire incident review process. Although the Commission was told that recommendations emanating from the Committee and approved by the facility administrator were formally shared with unit chiefs through memoranda from the Director of Treatment Services, the Commission's request for copies of this correspondence yielded very few documents, and it appeared that this process was not actually in operation for much of 1994.[16]

Safety and Risk Management Committee

Kingsboro's Safety and Risk Management Committee, which also meets monthly, reportedly has an overarching role in quality assurance by responding to concerns identified in incident investigations, problems detected by the Safety and Security Office, and identified deficiencies and plan of correction requirements by outside groups including HCFA and JCAHO. Commission staff interviewed the chair of this committee and reviewed the minutes of the Committee for 1994. Unlike the minutes of the Incident Review Committee, these minutes are well-organized, tracking logs of issues discussed and resolutions reached. Additionally, unresolved issues from previous meetings were carried over in subsequent meeting agendas and minutes. Thus, these minutes provided a better picture of the actual resolution of various quality assurance concerns (Figure 7).

Finding: The Safety and Risk Management Committee's minutes traced a year-long history of ineffectual administrative response to many critical patient safety and security issues.

This picture suggested repeated delays in the institution of recommended corrective actions, ranging from needed revisions in the facility's patient privileging procedures, to capital improvements, including security screens and double sally-port doors, to improve ward security. Known problems in the practices of ward staff being assigned to escort too many patients contributing to patient elopements went unaddressed for months. Similarly, repeatedly

[16] The Commission did receive a number of quality assurance related memoranda produced in 1994 by the Director of Clinical Services which addressed a number of medical, psychiatric, and other quality assurance matters—which were often directly linked to HCFA or other Commission on Quality of Care correspondence. These documents, however, did not appear to emanate from actions or recommendations of the center's Incident Review Committee. The one series of three pieces of correspondence from the Director of Treatment Services discussed new ward procedures regarding the safety and security of razors.

Figure 7

Keeping Track of the Master Key: Notes From the Safety Management Committee

March 1994 — Safety Management Coordinator reports staff are too careless with their keys and too many keys are lost, compromising patient and facility safety.

April 1994 — Chair of Safety Management sends memorandum to Director of Administration regarding patients using staff keys to elope.

May 1994 — 

Existing key policy is modified. Newly ordered keys will be numbered.

June/July 1994 — NO ACTION

August 1994 — Director establishes a workgroup to revise the key policy.

September 1994 — Key Control Policy revisions include:

1) Recall and tag all existing keys; and

2) Nondirect care staff's keys will be collected—new keys will be issued when they are available.

October 1994 — Policy for Issuance of Bit keys for KPC Employees submitted to Committee for review.

Facility receives 200 *new* MASTER KEYS.

November 1994 — Committee members agree with revised key policy.

December 1994 — Comments from Committee members incorporated into the Key Control Policy.

July 1995 — As of July 6, 1995 the Key Control Policy is still not finalized.

cited problems with contraband did not spur staff actions to ensure a more effective search policy for patients entering the ward until after Mr. Allman's death. And, recurring problems with lapses in ward and building security, while discussed month after month, were left unaddressed.

Although it appeared from the minutes that the Committee was diligent in tracking these needed improvements, it was largely incapable of ensuring their implementation. In many cases, delays were attributed to awaiting resource approvals from the Office of Mental Health, but in other cases, failure to implement corrective actions appeared to derive from less than aggressive administrative actions to communicate needed improvements to ward leadership, and especially unit chiefs.

In short, the minutes of this Committee documented the ineffectual administrative response to these critical issues.

Summary

In summary, despite the assignment of special investigations and regular monthly meetings of two quality assurance committees, each staffed with many senior clinical and program staff of the hospital, few constructive corrective actions were forthcoming from Kingsboro's quality assurance and risk management procedures. Additionally, the futility of special investigations conducted months late and often completed without attention to critical patient protection issues apparently escaped effective attention by the facility director. It is also important to highlight that the NYC Regional Office, which reportedly assigned a staff person to oversee both the program and quality assurance activities of Kingsboro Psychiatric Center, had also not effectively addressed these issues. In response to a Commission request for any and all 1994 NYC Regional Office correspondence related to untoward incidents, for example, only a small packet of documents was submitted, and most of these documents referenced the single issue of tardy reporting of serious incidents to the Regional Office. There was no correspondence referencing delays in special investigations, the quality of special investigations, the serious inadequacies of the minutes of the center's Incident Review Committee, nor the apparent inability of the center's Safety and Risk Management Committee to achieve any significant corrective action implementation in a timely manner.

Chapter VI
Conclusions and Recommendations

This is a report of a tragedy, but not an unpreventable tragedy. As illustrated in this report, the Commission's investigation identified a number of egregious errors in staff performance and judgment which contributed to Mr. Allman's death. Not only did this apparent homicide occur when most patients were awake and about, based on all staff interviews, but it also appears that no one was aware of any untoward interaction between Mr. Allman and Mr. Bishop the morning of Mr. Allman's death and that, in fact, staff did not become aware of the situation until they were alerted by Mr. Bishop himself, apparently some time after he allegedly had inflicted the fatal knife wounds on Mr. Allman.

Conclusion: A number of egregious errors in staff performance and judgment created the condition that contributed to Mr. Allman's death.

The different types of poor performance involved were also remarkable. They ranged from problems in clinical judgments and decision-making, including poor communication among team members of significant medication changes and largely absent psychiatrist progress notes; to staff inattention to Mr. Bishop's serious threatening and exploitative behavior toward other patients; to staff negligence in attending to appropriate standards for patient security and supervision, including intentionally relying on a patient to guard an open doorway, carelessly leaving a building exit door open, failing to ensure an adequate search of Mr. Bishop on his return to the ward, and most critically, neglecting to supervise Mr. Bishop carefully during his first few hours back on the ward. Although none of these events alone caused the death of Mr. Allman, the number of staff mistakes and the significance of staff performance problems uncovered in the investigation of his death contributed to the conditions that permitted the homicide to occur.

The Commission's further review revealed that these actions and inactions were not atypical of ongoing, known staff performance problems at Kingsboro Psychiatric Center, for at least many months before the homicide.

As reflected in the report, clinical team reviews of patients' medication decisions—and especially of the relationship of patients' violent and threatening behavior on the wards and the adequacy of their medication regimes—were not uniformly assured across many of the adult wards at Kingsboro. There was evidence of many patients routinely and/or periodically refusing medications *and simultaneously demonstrating hostile, assaultive, and threatening behavior*, where medication refusals were not consistently addressed by the clinical team, and where court orders for involuntary medication were not promptly considered. These problems were also known to and documented by the facility's Director of Clinical Services.

Patient assaultive and threatening behaviors toward one another and toward staff were also common occurrences on most of Kingsboro's

adult wards. Although many such events were reported on untoward incident reports, they were usually classified as the *least serious type of incident* and they were frequently not investigated by staff. There was also little evidence that the clinical implications of these incidents for individual patients and the hospital, as a whole, had been addressed adequately by clinical treatment teams or the hospital's senior management team. As a result, an unfortunate tolerance of a culture of violence persists on many adult wards at Kingsboro Psychiatric Center.

Conclusion: Dangerous incidents on patient wards, patient elopements, and the confiscation of dangerous contraband occurred with some frequency at Kingsboro in the months before the homicide.

As documented in many patient elopement and investigation reports reviewed by the Commission, lapses in ward and building security, including leaving ward and building doors unlocked, as well as particular problems in ensuring patient security during their transport to off-ward dining areas, have been ongoing at the center for at least the past year. Although the Kingsboro Psychiatric Center administration was aware of these problems and others—including inconsistent practices in awarding privileges to "high risk" patients and problems with security of the one master key which opens all doors in patient buildings—they did not effectively address or resolve these problems.

Although various search policies of the hospital specified that patients returning from escape status should be thoroughly searched, interviews with ward staff indicated that there were widespread misunderstandings of this mandate and how and where patient searches should be conducted. Review of patient elopements and escapes indicated that ward staff practices for patient searches varied both across and within wards, with very limited accountability. In particular, it appeared that senior clinical staff did not use consistent criteria in determining when patients returning from unauthorized departures would be asked to change into a hospital gown and be examined by a doctor allowing for a more comprehensive, if unobtrusive, search for dangerous contraband before returning to their treatment ward.

Although the confiscation of weapons occurred with some frequency at Kingsboro, as documented by safety officers in their reports and other incident reports filed by ward staff, metal scanners to search effectively and reasonably unobtrusively for this type of contraband had not been made available to most wards at Kingsboro until more than two months after Mr. Allman's death. And, as of February 9, 1995, although ward staff reported that they had been told to use metal scanners on all patients returning to the ward, the hospital's most current patient search policy (January 1995) continued to state that the use of the scanners in these situations was *discretionary.*

Finally, the decision to return Mr. Bishop to his previous ward rather than the Secure Services Ward—contrary to the request of the acting nurse administrator—based on a brief exam by an on-call psychiatrist who had not previously been treating Mr. Bishop, reflects the high-risk decision-making often left in the hands of on-call psychiatrists at Kingsboro Psychiatric Center, especially on weekends. Prior to Mr. Allman's death, the hospital had no clear guidelines that specified that all Criminal Procedure Law patients and all patients returning from escape status warranted special consideration either for placement on the hospital's Secure Services Ward or 1:1 staff supervision on their own ward for some specified period of time.

Review of other cases of patient elopements indicated that it was common for patients return-

ing from Escape and Leave Without Consent status to return to their previous ward. Although Commission staff were not able to check the clinical records of all these patients (many of whom had since been discharged from the hospital), incident reports documenting their returns rarely indicated that they were afforded 1:1 staff supervision or other intensive staff supervision for a defined period after their return. Rather, it was more common practice simply to reduce the returning patient's level on the hospital's privilege system, which typically denied him/her escorted or unescorted off-ward privileges.

In short, it appeared that most of the egregious staff errors and misconduct which contributed to Mr. Allman's death were not new problems to Kingsboro Psychiatric Center. As delineated in this report, these problems were well-known to most senior staff at Kingsboro Psychiatric Center, and presumably to at least some staff in the NYC Regional Office of the Office of Mental Health. The hospital's Central Nursing Log, untoward incident reports, and its Safety Log repeatedly referenced these concerns, as well as their serious implications for both patient and staff safety at the center.

Conclusion: Senior Kingsboro administrators were aware of ongoing staff performance problems similar to those associated with Mr. Bishop's escape many months prior to the homicide.

During the brief 46-day period surrounding Mr. Allman's death, 88 different patients were involved in 67 different patient fights or assaults, at least 17 staff were assaulted by patients, and 56 patients eloped from the center, usually by taking advantage of unlocked doors or limited staff supervision during escorted trips to programs or clinics or while attending off-ward activities. The Commission's observations on the wards at Kingsboro revealed that, even during these announced visits, when Commission staff were frequently escorted by other senior hospital personnel, incidents of hostile and threatening patient-to-patient interactions were relatively frequent. Approximately half of the adult patients who completed consumer surveys also reported that they were afraid of being hurt by other patients and/or that they had seen a patient hit or sexually hurt by other patients during their hospital stay.

* * *

In seeking explanations for the state of affairs at Kingsboro Psychiatric Center which contributed to the death of Mr. Allman, as well as the many other untoward and harmful events compromising patient and staff safety at the hospital for a much longer period of time, some explanations are readily apparent. Other explanations are more complex, intricately woven in the fabric of the emerging role of state psychiatric hospitals, especially in New York City, whereby these public institutions are called upon both to provide the treatment resource for all individuals needing intermediate and long-term psychiatric care and to be the treatment setting of last resort for individuals with the most intransigent psychiatric problems, often complicated by long histories of alcohol and drug abuse and interactions with the criminal justice system for their antisocial, violent, and other dangerous behaviors.

The Immediate Explanation

The most immediate explanation for this tragedy—*the evident mistakes, poor judgments and misconduct of staff*—first merits discussion. Notwithstanding the difficulties which have besieged Kingsboro Psychiatric Center over the last decade—or the acknowledged improvements noted in many aspects of custodial care, environmental maintenance, and programming at the center in the past five years—the number, nature, and seriousness of the staff performance problems which surrounded Mr. Allman's death

are striking. Yet, as the Commission discovered, they were not unfamiliar to staff working at Kingsboro Psychiatric Center.

Virtually all of these staff performance problems were well-known to senior staff at the hospital; most had also surfaced not on one or two, but most of the hospital's adult wards in the past year. Likewise, numerous reports confirmed that most of these issues were discussed frequently by the center's senior cabinet during its daily morning meetings. The center's Safety and Risk Management Committee minutes also frequently referenced most of these problems.

Conclusion: Frequent violent episodes on the Kingsboro wards adversely impacted on both patient and staff safety.

What soon became apparent was that although many staff—including many senior staff—were aware of and concerned about serious lapses in staff performance like those which contributed to Mr. Allman's death, the center's internal quality assurance mechanisms and its management team were not capable of effectively studying these problems, identifying reasonable corrective actions, or putting identified solutions into place. Instead, the center's senior staff, with some regularity, did discuss these problems, but either never identified reasonable corrective actions or failed to monitor their successful implementation. Several examples are instructive.

- In June 1994, the Kingsboro Senior Cabinet identified as a serious problem the frequency of elopements deemed to be patient "escapes," in view of the patients' dangerousness to themselves or others. They determined that all such elopements should be subject to special independent investigations. However, additional investigative resources were not made available to handle these added special investigations, and neither the center administrator, who reportedly had most strongly insisted on the recommendation, nor any other senior administrator apparently noticed or attended to the serious delays and backlogs in conducting these and other special investigations at the center since June 1994. Thus, the identified corrective action was not faithfully carried out; it had no discernible positive benefits for patient safety; and it may have actually led to negative outcomes in furthering the delay in the completion of *all* special independent investigations at the center.

- Throughout 1994, many reported patient elopements, several special investigations, and several monthly Safety and Risk Management Committee meeting minutes referenced problems with the center's procedures for awarding and handling "escorted" patient privileges. These references raised concerns about the maximum number of patients who should be assigned to a single staff escort, as well as minimum standards for the period of time for which patients should be deemed to be a low escape risk prior to their receipt of escorted privileges. Although senior staff also discussed these issues with Commission staff at the time of their January 1995 visit, they acknowledged that the issues had not yet been formally addressed.

- The Commission was told that all recommendations for corrective and preventive actions emanating from the incident reporting and investigation system were routed to the Director of Treatment Services for communication to the unit chiefs for ward implementation. Yet, when the

Commission solicited copies of all such documentation, memoranda addressing only a single recommendation, greater security for razors (used by patients to shave), were provided. This recommendation was issued by the hospital's Incident Review Committee on March 25, 1994; the Director of Treatment Services was notified on April 12, 1994; on July 7, 1994, nearly three months later, she issued a new "razor policy" to the unit chiefs indicating that they should establish a log to track the accountability of razors issued to patients and noting that she expected the new policy to be implemented by July 25, 1994. The Director of Treatment Services issued a more detailed follow-up procedure for shaving and accountability of razors by ward staff in a memo dated January 23, 1995.

There were other serious problems at the center, of which senior administrators apparently had knowledge, which were never addressed in the various senior cabinet and other quality assurance forums. For example, although patient-to-patient assaults were clearly the most frequent and the most threatening untoward incidents on adult wards at the center, this systemic problem was not referenced in the minutes

Conclusion: Although Kingsboro has various quality assurance systems, these systems have experienced great difficulties in implementing timely correction for known problems.

of the Safety and Risk Management Committee for the full 1994 calendar year; it received no attention in Incident Review Committee minutes for the last four months of 1994; and it was not addressed in any of the quality assurance documentation submitted by the center. Similarly, the high incidence of patient assaults on staff and the more than 2,000 staff workdays lost in 1994 to patient-related injuries were not apparently addressed in these forums. Finally, and not inconsequentially, the extraordinarily high overtime hours of the center's safety staff—despite the potentially serious consequences of these personnel working significantly extended work hours—were also not addressed.

Conclusion: Ongoing mistakes, poor judgments, and poor performance of clinical and direct care staff indicated serious problems in the management of Kingsboro and by OMH.

In short, Mr. Allman's death, apparently at the hands of another patient, was facilitated by a series of staff performance problems—ranging from acts of staff negligence to poor staff judgment to accidental, but careless staff misconduct. These staff failures—any one of which, if avoided, may have prevented the tragedy of Mr. Allman's death—unfortunately were not unique events. Documentation provided by Kingsboro Psychiatric Center, senior staff interviews, and the Commission staff's own observations well substantiated that virtually all of these problems had recurred many times in the course of the past year at the center, if not longer. Additionally, it appeared that most senior staff at Kingsboro were well aware of these problems, and in many cases, they had also directed some attention to their discussion and correction. Most tragically, however, these discussions rarely reached any constructive conclusions for corrective and preventive actions, and they even more rarely resulted in actual changes in center policy and practices to address the known and well-discussed problems.

Finally, although senior staff of the NYC Mental Health Regional Office and at least some staff of the OMH Central Office were routinely notified of many serious incidents at Kingsboro Psychiatric Center via a computer-networked communication system, this communication also did not trigger sufficient alarm or notable systemic corrective action to address apparent recurring problems. It appeared that although advances in technology have allowed the timely transmittal of information regarding protection-from-harm situations to state offices from state psychiatric centers, staff resources and responsibilities in regional offices and central office to address these reports have not been well identified, and clear expectations for the actual responses of these state officials to serious incidents have not been established or ensured.

Conclusion: Kingsboro and other NYC psychiatric centers continue to admit many acutely ill patients, contrary to the NYS Comprehensive Mental Health Plan, which reserves this role for better funded and staffed psychiatric services of general hospitals.

Underlying Problems

Notwithstanding the primary importance of the above problems in staff performance, together with the inadequacy of Kingsboro's and the Office of Mental Health's quality assurance systems to correct them, other more complex underlying issues and dilemmas are also critical to a full understanding of the continuing troubled role and performance of Kingsboro Psychiatric Center.

❑ Difficult Acute Service Role

The first of these problems is Kingsboro Psychiatric Center's most difficult acute psychiatric service role, whereby it admits approximately 1,750 patients annually, almost all of whom are in the acute phase of their illness and over 80% of whom are admitted on involuntary status, indicating that they have been deemed by two psychiatrists to be of danger to themselves or others. Additionally, Kingsboro officials estimate that almost all of its admitted patients have long psychiatric histories, marked by many previous hospitalizations and discharges, and that more than half of their adult patients have concomitant alcohol or substance abuse problems which both periodically trigger their psychiatric crises and contribute to their periodic episodes of violent and dangerous behaviors. Finally, a significant minority of Kingsboro's patients are admitted on Criminal Procedure Law status or upon release directly from a state correctional facility. Many others have prior criminal records, often for more than one offense.

Thus, although New York State's Comprehensive Mental Health Plan identifies the role of state psychiatric centers as treatment facilities for intermediate and long-term psychiatric care for nonacute patients, Kingsboro Psychiatric Center like many NYC state psychiatric centers is actually providing substantial acute psychiatric care—often to individuals with severe psychiatric illness and documented histories of both service and treatment resistance. Many of these patients are also dangerous—some as an apparent outcome of their mental illness, others in response to their abuse of illegal substances or alcohol, and still others as a result of volitional, antisocial, and criminal conduct.

- **Limited Physical Space**

Closely related to the above problem is Kingsboro's limited physical capacity. Although Kingsboro Psychiatric Center is less overcrowded than it was during 1988, when a state of emergency was called at the center, the center today is still seriously overcrowded. Most of the center's most troubled and difficult-to-manage intermediate care psychiatric wards are routinely more than ten patients over their reported design for a maximum census of 25 patients.

Conclusion: Many of Kingsboro's adult wards, especially those reserved for its most dangerous and treatment-resistant patients, remain seriously overcrowded.

These overcrowded wards leave little space for patients, especially during their waking hours—when the patients are often cramped into too small dayrooms. These overcrowded conditions contribute to the tense atmosphere on many wards and numerous patient skirmishes, and they preclude the kind of quiet, comfortable, and safe atmosphere that would reasonably help to calm and reassure the troubled men and women who come to Kingsboro for care and treatment.

Equally critically, the rush at Kingsboro's front door and its limited physical space have led routinely to the placement of dangerous and violent patients in wards with many other patients, most of whom are not dangerous, but who quite reasonably fear assaults and other threats on their safety. Although Kingsboro Psychiatric Center has maintained a small Secure Services Ward for its most dangerous patients, its census cap at 15 patients limits its capacity to address the needs of all violent patients at the center.

- **Inadequate Special Services for MICA Patients**

A third serious and well-recognized underlying problem affecting Kingsboro Psychiatric Center's performance is its limited services and specially trained staff to address the special problems of its many patients with concomitant drug and alcohol abuse problems. Although these services are more available today at Kingsboro than they have been in the past, they remain woefully inadequate.

At the time of the Commission's January 1995 review, only approximately 30 of the estimated 270 Kingsboro patients with these problems were attending the center's one treatment program addressing these addictions, and many of these patients were not participating in all components of the program. On-ward nursing groups, which attempt to teach patients the basics about these problems, especially as they relate to health issues, are an improvement. However, limited ward space often leads to nursing groups that are far too large and sometimes unruly, largely undoing the intended benefits of these activities. Frequent staff confiscation of contraband drugs from patients, only highlights the patients' serious problems with drug and alcohol abuse.

Although all staff—from senior psychiatrists to direct care staff—well appreciate the destructive role of drug and alcohol abuse for their patients, they also know that most patients, including those who may stay on at Kingsboro Psychiatric Center for more than 90 days, usually do not receive any significant treatment for their addictions during their hospital stay. Thus, staff are not surprised that most of these patients also return to Kingsboro Psychiatric Center within the 90-day window after their discharge, which the State-City, New York-New York Agreement targets as the interval for which

state centers must readmit patients who have not remained stable in the community.

- **Campus Versus Ward/Building Security**

Additionally, notwithstanding apparent staff performance problems which have regularly compromised ward and building security at Kingsboro, the challenge of maintaining the security of the center's 27-acre campus is well beyond the capabilities of the center's relatively small safety officer staff. Officials at the Office of Mental Health have already reported verbally to the Commission that Kingsboro has been authorized to hire several additional safety officers to reduce its overtime usage.

Yet, as the Commission further explored this problem, it also became apparent that, without substantial additional personnel services expenditures, significantly improved campus and perimeter security would not be possible. To staff even a single additional manned safety post 24 hours a day requires the hiring of five additional safety officers. Given the size of the campus, its 25 on-campus buildings, and its proximity to the local business district, it is clear that one or even two additional manned posts would not substantially increase campus surveillance.

Conclusion: Failure to address the treatment needs of the majority of Kingsboro's patients with drug and alcohol abuse problems contributes to their ongoing psychiatric problems and leads to their frequent readmissions.

Thus, the Commission came to agree with the safety officers at Kingsboro that primary security must be maintained at the ward and building level. Subsequent to Mr. Allman's death, a number of steps have been taken by Kingsboro administrators to ensure that staff are more accountable for locking both ward and building doors, to install double doors on wards to provide a secondary barrier to escapes, and to limit access to basement doors. Continued vigilance in these areas, with warranted progressive discipline to staff who fail to maintain security, is clearly needed. Similarly, requirements for staff to wear their identification badges and to be cautious with their master keys are sound corrective actions.

Conclusion: The most cost-efficient means of reducing patient elopements rests in better ward and building security, especially in those areas serving more dangerous, escape-risk patients.

The Commission also appreciated the center's efforts to begin to congregate patients admitted on Criminal Procedure Law status and who have evidenced dangerous behaviors toward others on two wards. The simple segregation of these patients, however, is inadequate action. Staff on these wards require additional training in the treatment of patients with histories of violence and criminal conduct, in the development of appropriate treatment goals and interventions to assist these patients, and in formulating appropriate criteria for the gradual awards of privileges and discharge of these patients to ensure public safety. Most critically, staff on these wards need to appreciate that standard processes and criteria which may be adequate for most psychiatric patients, may not be sufficient for these more dangerous patients.

Just as important, staffing on these wards should be augmented to reflect the patients' more difficult treatment and supervision needs. In achieving these enhanced staffing ratios, serious consideration should be directed toward substantially reducing the total patient census on these wards, rather than just placing more staff and patients together in an already very crowded space. Presently, in part because of their special role, these wards (especially Ward 3) often have the highest censuses of the center. This trend is ominous, and it risks more serious violent episodes among these patients.

Building 3, which houses these wards, as well as the hospital's three admission wards and its one Secure Services Ward, also warrants special security attention. Presently, this building is locked only during certain hours of the day, and its foyer is never staffed with a paid staff person. While the hospital is attempting to station a volunteer in this area several afternoons a week, this is not an adequate security response. At least during hours when most patients are awake, the Commission recommends that a staff person be stationed in the foyer of this building.

- **A More Realistic Approach to Safety and Security Issues**

There is a concurrent need to come to a more realistic approach to issues of safety and security in state psychiatric centers generally. The state has both the right and the obligation to securely confine patients who are believed to be seriously mentally ill and dangerous based on their past behavior, while they are treated in a psychiatric hospital. It has the right and the duty to ensure that they do not escape and do not harm either themselves or others. At the same time, the state has the obligation to ensure that patients who are *not* dangerous are also kept safe and are not needlessly deprived of their freedoms.

The manner in which state psychiatric centers are constructed, and their limited safety officer staff, makes it both difficult and undesirable to attempt to secure entire campuses. But, it is important to examine the feasibility of securing portions of the facility campus, including outdoor space, assigning patients with the highest security needs to these portions, and assigning adequate program and safety staff to these areas. This approach would permit attention to security needs of part of the patient population without unnecessarily restricting the rights and freedoms of all patients.

Conclusion: Wards designated to serve patients identified to be dangerous to others should have enhanced staffing, and staff should be trained in the special needs of these patients.

Finally, it is a significant and serious problem that a single master key opens not only all patient wards and buildings on the Kingsboro Clarkson Avenue campus, but almost all the buildings and wards of most psychiatric centers across the state. Although the Office of Mental Health recognizes the serious security risks associated with the handing out of this master key to literally tens of thousands of employees each year, it rightfully also notes that correcting this problem will be very expensive. It is imperative, however, that immediate attention be directed in ensuring more accountable locking systems at least for those wards and buildings, at Kingsboro and at other state psychiatric centers, serving the most dangerous patients.

- **Psychiatrist Training and Unrealistic Deference to Professional Judgment**

A final and critical problem underlying the tragedy of Mr. Allman's death centers on

the crucial role and responsibility assigned to treating psychiatrists at Kingsboro Psychiatric Center and indeed all state psychiatric centers. It is common knowledge, and a subject of some considerable discussion among clinical staff at Kingsboro, that the center is increasingly called upon to serve patients who present more difficult assessment problems and that, in particular, their addiction problems often result in behavior outside of the hospital which is not consistent with their drug- and alcohol-free conduct on the treatment wards.

Conclusion: Psychiatrists at Kingsboro and other state psychiatric centers would benefit from comprehensive training in assessing the dangerousness of patients with concomitant alcohol and drug abuse problems.

Although many of Kingsboro's psychiatrists have worked within the state system for many years, the Office of Mental Health has not offered its psychiatrists a comprehensive training program preparing them for the evaluation of the potential dangerousness of individuals with serious mental illness and concomitant drug and alcohol abuse histories; in fact, many treating psychiatrists at Kingsboro have had no significant formal clinical training in substance abuse or alcoholism. Many treating psychiatrists also have no formal training in forensic psychiatry, although they are asked to treat and assess criminal behavior for many of the patients. The Office of Mental Health has also not ensured that a smaller core group of psychiatrists at Kingsboro Psychiatric Center (or other state nonforensic psychiatric centers) receives this specialized training to assume these more difficult assessment assignments.

Concurrently, patient records—while usually referencing a summary of a patient's criminal history—are often sketchy in detailing the circumstances of these criminal episodes and, in many cases, they also do not provide a comprehensive, readily reviewable historical record of all past violent and dangerous behavior that the patient has demonstrated. Although Kingsboro has long had a "Checklist for Escape Risk, Suicide Risk, and Dangerousness to Others," the Commission's review indicated that the tool was irregularly used and filed idiosyncratically in patient records. This assessment tool also focused almost exclusively on process steps, alerting psychiatrists to what aspects of a patient's treatment record to review, rather than identifying key recent and past behaviors which signalled unusual risk for dangerous behaviors.

The more recently revised assessment tools for awarding patients home passes and other privileges at Kingsboro share similar limitations. Thus, although these tools assure three levels of psychiatrist review by the treating psychiatrist, the supervising psychiatrist, and the unit chief, they do not assure a more consistent and accountable criterion-based assessment of a patient's dangerousness. These tools also continue to rely heavily on the patient's behavior while in the hospital, which tends to obfuscate the obviously increased risks which may accompany the patient's activities in the community and especially likely abuse of alcohol or illegal drugs which may influence his or her behavior once outside the hospital's walls.

Further compromising these assessments, evening and weekend on-call assignments, as well as other vagaries of staff assignments and patient transfers in large public institutions, like Kingsboro, ensure that, with some frequency, psychiatrists will be asked to make critical decisions about patients about whom they have little personal knowledge.

At the same time that these special unmet training needs for psychiatrists have contributed to problems in care and treatment, as well as problems in patient and staff safety at Kingsboro, documentation provided by Kingsboro Psychiatric Center, as well as other Commission investigations of patient deaths and quality of care complaints at the center (and other state psychiatric centers), indicates that more comprehensive and accountable supervision of psychiatrist performance in basic practice standards is also essential. Regularly charting progress notes, making sound medication decisions, documented with clear rationales, reading the notes of other ward staff as an important component of assessing a patient's progress or possible decompensation, and attending to untoward incidents with which the patient has been involved, are critical performance standards which must be met by all psychiatrists. In the case of Mr. Bishop, psychiatrist performance in all of these areas was deficient. Greater accountability for psychiatrist performance is also needed to ensure that psychiatrists are meeting with all patients on their caseloads at least two or three times a week and that psychiatrists are participating in daily rounds, working closely with medical physicians treating their patients. It was apparent from the Commission's review that these basic practice standards for inpatient psychiatry were not always ensured at Kingsboro.

Recommendations

A. Systemic Reforms for State Psychiatric Centers in New York City

1. Notwithstanding the initiatives which the Office of Mental Health has put forward in the past several weeks to address the patient and facility security problems, as well as the accountability problems in psychiatrists' patient privileging assessments, other efforts to ensure long-term accountability for both patient and public safety at all state psychiatric centers are critical.

   - Patients with known histories of violence and criminal behavior should be adequately supervised on the wards. OMH should consider whether placing these patients on special wards, with enhanced staffing ratios and staff trained in managing violent patients, would be a better alternative to the commingling of these patients with other nonviolent patients who are often victims of aggressive and violent behavior.
   - The Office of Mental Health should consider other steps which can enhance its ability to protect patient and public safety, especially for patients who have long histories of violent, dangerous, and/or criminal behavior in the community. The option of discharging these patients for the balance of their involuntary commitment period on conditional release status, whereby the state's obligation to monitor their receipt of appropriate aftercare services and their safety in the community is more explicit, should be given especially serious consideration.[17]
   - The new patient privileging review system recently implemented by the Office of Mental Health should be subject to a six-

[17] This recommendation is discussed in greater detail in the report, *In the Matter of R.H. A Case of Elopement, Lapsed Security, and Tragedy at Manhattan Psychiatric Center*, NYS Commission on Quality of Care, April 1995.

month and a twelve-month evaluation. This evaluation should target outcome indicators, including the rate of unauthorized patient departures, the appropriate versus unduly restrictive awards of patient privileges, and its impact on discharge planning and successful patient discharges. Attention should also be directed toward the consistency of psychiatrist assessments and privileging decisions both within and across state psychiatric centers.

- The Office of Mental Health should develop a short- and long-term plan to address the apparent security limitations of relying on the same master key to maintain ward and building security on almost all state psychiatric centers. The most immediate efforts should be directed to providing enhanced security to secure services wards, admission wards, and other wards specially targeted to serving patients with known histories of violent and criminal behavior.

2. The Office of Mental Health should develop an effective system for monitoring the operation and quality of care offered by the five psychiatric centers in New York City. Almost all of the most serious problems identified in this report had persisted for many months, if not much longer, yet existing OMH monitoring apparently failed either to identify these problems as serious and warranting action or to ensure timely corrective action. As a part of this effort, OMH should evaluate the need to replicate the recommended evaluation of psychiatric practice at Kingsboro Psychiatric Center, at other New York City state psychiatric centers, and, if needed, ensure comparable evaluations and psychiatric training programs at other centers.

3. The Office of Mental Health should take steps to reduce the significant role of all New York City state psychiatric centers in providing acute versus intermediate and long-term psychiatric services as prescribed in the NYS Comprehensive Mental Health Plan. State centers, not afforded Medicaid reimbursement for most of their adult patients, are not funded or staffed comparably with psychiatric services of general hospitals to provide this level of care. In this effort, the Office of Mental Health should also seriously consider establishing ward census caps of 25-30 patients at all state psychiatric centers, which is more comparable to most accredited psychiatric services, to improve the ability of staff to provide a safe, secure and therapeutic environment for patients.

4. The Office of Mental Health should provide a specialized training program for clinical and direct care staff in meeting the needs of patients with concomitant alcohol and drug abuse problems, who now reportedly comprise approximately 50% of all patient admissions to state psychiatric centers in New York City. In addition to this training program, all centers should have access to a qualified core team of clinicians who can both direct the development of appropriate programs and individualized treatment plans for this population, and who are available to provide ongoing staff training. The long-term goal should be for the establishment of such teams at each center; however, priority for the short term

should be to make at least one such team available to the New York City region by the end of 1995.

5. Recognizing that state psychiatric centers will continue to be the treatment setting of last resort for most patients committed to psychiatric facilities in New York pursuant to Criminal Procedure Law, and for other patients with very dangerous behaviors, the Office of Mental Health should develop a comprehensive assessment tool which will assist psychiatrists and other clinicians at state centers to more accurately and uniformly assess a patient's risk of dangerousness toward others. The development of this tool and the aggregate data generated will also facilitate the Office's ability to monitor the treatment and safety needs of patients with high risk of criminal and/or violent behavior, as well as the experiences of these patients upon discharge to the community.

B. Immediate Actions to Improve Patient Safety and Services at Kingsboro

1. As soon as possible, the Office of Mental Health should appoint an experienced permanent director and key cabinet members for Kingsboro Psychiatric Center.

2. The Office of Mental Health should take steps to reduce the overcrowding at Kingsboro Psychiatric Center. Particular attention should be directed toward eliminating the hospital's direct admission catchment areas, diverting admissions to other available psychiatric services of general hospitals which are better staffed to provide acute psychiatric services. Additionally, serious consideration should be given to establishing census caps of no more than 25-30 patients per ward, which is consistent with standard practice of most accredited psychiatric services and hospitals.

3. Immediate efforts should be taken by the Office of Mental Health and the new hospital leadership to address the problems affecting patient safety and security at Kingsboro Psychiatric Center identified in this report, including, but not necessarily limited to:

   - the high incidence of patient assaults on other patients and on staff members;
   - consistent locking of ward and building doors, as required;
   - clear and reasonable staffing standards for escorting patients to dining areas, to off-ward programs, and to clinic and other appointments; and
   - consistent staff compliance with the new hospital policies governing the handling of patient elopements, patient and ward searches, and the awarding of patients' unescorted and escorted privileges.

4. The Office of Mental Health and the new hospital leadership should ensure an effective system for the reporting, investigation, and review of untoward incidents which affect the safety, welfare, and care of patients at Kingsboro Psychiatric Center. Readily identifiable problems with the appropriate classification of the seriousness of reported incidents, the availability of well-trained and capable special investigators, and the quality and timeliness of special investigations and the hospital's Incident Review Committee's review of serious incidents should be initial priorities of this effort.

5. The Office of Mental Health should evaluate the quality of psychiatric services at Kingsboro Psychiatric Center, with attention to basic practice standards in conducting intake and risk assessments, in preparing appropriate individualized treatment plans, in providing regular progress notes, and in ensuring sound psychotropic medication-prescribing practices, including but not limited to the provision of clear written rationales for all medication decisions. Additionally, actions should be taken immediately to ensure that all patients have *a scheduled appointment* with their psychiatrist at least one or two times weekly and that all psychiatrists are aware of their obligation to routinely (but at least weekly) review the progress notes for all patients on their caseload.

6. Based on the findings of the above evaluation, the Office of Mental Health and facility management should identify key training needs of the current psychiatric staff and ensure that appropriate training programs are offered in a timely manner. Identified unsatisfactory practices of individual psychiatrists should be addressed in their annual performance evaluations and, when warranted, through ongoing progressive supervision and/or discipline.

7. Over the coming year, the Office of Mental Health should maintain an ongoing monitoring presence at Kingsboro Psychiatric Center, which continues to review and ensure improvements in all areas of substandard performance identified in this report. A formal monitoring plan with quarterly progress reports should be developed for this purpose. This plan should include a focused evaluation and assessment of the hospital's newly established review and approval process for awarding patients off-ward escorted and unescorted privileges, as well as home leaves.

Appendix

Response of the New York State Office of Mental Health to the Commission's Draft Report

NEW YORK STATE
OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229

Joel A. Dvoskin, Ph.D., Acting Commissioner

June 28, 1995

Clarence J. Sundram, Chairman
Commission on Quality of Care For The Mentally Disabled
99 Washington Avenue
Suite 1002
Albany New York 12210-4090

Dear Mr. Sundram: Clarence

Our comments regarding the Commission's investigation of the November 1994 death of [redacted] are enclosed.

Our observations are presented in three sections:

1. An overview of Kingsboro's recent history, including some of the management and program improvements completed or in progress at the Brooklyn facility.

2. The Agency's reactions to the [redacted] investigation.

3. A summary of corrective action plans, addressing the Commission's principal conclusions and recommendations.

By and large, OMH agrees with the Commission's findings. There are, however, two key areas where we differ.

Despite its serious and long-standing problems, Kingsboro has many important strengths, encompassing its people, programs, physical plant and surrounding medical community. While fully recognizing the problems, we find that these positive elements are understated in the draft Commission report.

As noted in the commentary, we concur with the Commission's principal finding that [redacted] death may have been preventable, based on the combination of circumstances which surrounded the tragedy. We do not agree, however, with the assignment of primary accountability for those circumstances.

The thrust of the Commission's findings is that Kingsboro's on-site administrative staff failed to properly inform senior management of critical events associated with [redacted] escape and return, and/or did not respond properly to the advice and directives they were given.

We reach a markedly different conclusion. Significant responsibility for the succession of problems associated with the response to this incident must rest with the senior facility management, who were unavailable and/or unresponsive to repeated requests for assistance and guidance from the on-site administrators. Our corrective actions are based on this premise.

We support the Commission's recommendation that various innovations in security and treatment planning realized at Kingsboro be replicated at other OMH facilities in New York City.

Thank you for the opportunity to comment on this report.

Sincerely,

Joel

Joel Dvoskin. Ph.D.
Acting Commissioner

JD:ma
Enclosure

cc: Billy Jones, M.D.

"PATIENT SAFETY AND SERVICES AT KINGSBORO PSYCHIATRIC CENTER"

A Confidential Report By

Commission On Quality of Care
for the Mentally Disabled
Albany New York

April 1995

RESPONSE AND COMMENTARY

by

New York State Office of Mental Health
44 Holland Avenue
Albany New York 12229

June 1995

INTRODUCTION

By letter dated April 10, 1995 Commission Chairman Clarence Sundram transmitted to Acting OMH Commissioner Joel Dvoskin a 70-page draft report concerning the November 1994 death of Kingsboro patient George Allman*. The report includes a comprehensive evaluation of overall patient programming and security at the Brooklyn facility.

The Office of Mental Health has evaluated the Commission's report in the context of on-going Agency activities involving Kingsboro staff, management and programs. The Agency's reactions are summarized in the following three sections:

* An overview of Kingsboro's recent history.
* A critique of the Allman homicide.
* Corrective action plans addressing the Commission's conclusions and recommendations.

For more than a year OMH has been working intensively with Kingsboro concerning various clinical, quality assurance and management issues, providing leadership, consultation and technical assistance. George Allman's death occurred at about the time that these initiatives were beginning to have measurable impact. Since that tragedy, the Agency has redoubled its efforts to address the serious program and administrative problems previously identified and discussed in the draft Commission report.

The results to date are encouraging. As outlined in the following pages, a number of Agency and Commission concerns have already been addressed, in whole or in part. More importantly there is a genuine sense of momentum, potential and promise, as the hospital's new leadership continues to work constructively with OMH central management to forge viable service delivery and program plans for Kingsboro. The facility's place in the surrounding medical community also seems assured, based on new linkages being formed and fostered as this response is written. Finally, there is a developing framework for addressing the needs and concerns of Kingsboro's program and clinical staff, who have labored far too long without adequate recognition for their efforts.

This Agency appreciates the opportunity to comment on the Commission's findings, and invites reactions to the various developments outlined here.

* The Commission's psuedonyms for the victim and his alleged assailant are used throughout this commentary.

KINGSBORO PSYCHIATRIC CENTER: A BLEND OF PROBLEMS AND PROMISE

The Commission report notes that Kingsboro Psychiatric Center has experienced some difficulty over the past decade. A consistently high census, difficulties with an aging physical plant and a predominantly acute care, high risk population have severely strained the facility's limited fiscal, program and human resources.

As discussed by Commission staff, some 85% of Kingsboro's nearly 2,000 admissions during calendar year 1994 were involuntary in status, coming directly from hospital emergency rooms without benefit of stabilization or other intervention. Many of these patients have histories of poly-substance abuse, which complicates their in-hospital treatment and frequently impedes their successful return to the community. The facility has thus been required to act de facto as an acute care hospital, despite having few of the resources and supports normally found in such settings.

These problems have been compounded by repeated rapid turnover among senior management staff. A succession of CEO's and other top officials has come and gone over the past 10 years, often changing before any significant benefit could be derived from an individual's expertise or competence.

Offsetting these difficulties are a number of important strengths, some of long-standing, others associated with gains achieved in recent years. In many respects, Kingsboro's glass should really be seen as "half full" rather than "half empty", in the context of its progress to date and future potential.

Inherent Strengths and Resources

While often severely stressed by the problems outlined above, Kingsboro's line staff generally display a remarkable level of dedication and competence, consistently applied in a variety of situations and settings. The hospital's physical plant is essentially sound, well-constructed and attractive. The facility is located in the midst of a major medical community, including Kings County Hospital Center and SUNY Health Sciences Center. Opportunities abound for collaborative health care and research initiatives.

The developments and plans discussed below are designed to build on this reservoir of strength and positive resources.

Recent Trends

The Office of Mental Health considers Kingsboro to be on a path of steady improvement, rebounding from the systemic problems outlined earlier. Obviously many serious problems remain. However, the Agency is pleased and appreciative of the Commission's citation of some of the more important upward trends:

* Marked improvements in patient environmental conditions since the late 1980's, including major gains in ward cleanliness, safety, clothing, equipment and supplies.

* Concomitant reductions in facility census.

* Encouraging clinical practice standards, including timely attention to patients' medical needs; cautious, conservative use of medication and restraints; and generally good patient access to psychiatric services.

* High-quality programs for substance abuse patients.

Current Initiatives

From an Agency perspective, the list of positive changes planned or in place for Kingsboro is substantially broader. Recent developments include the following:

* **New facility leadership.** In April 1995 Billy Jones, M.D., former President of the New York City Health & Hospitals Corporation, was appointed Executive Director at Kingsboro. Other recent Cabinet appointees include the Director For Quality Assurance, Director of Nursing and Associate Director. The new team brings an excellent balance of clinical and management expertise. In the few weeks since his appointment, Dr. Jones has moved aggressively to forge and strengthen collaborative ties with other health care providers in the surrounding community. He has also taken strong steps to improve the facility's management systems and clinical care strategies.

* **Revised patient care staffing.** In recent months the facility has extensively reorganized its policies and procedures governing deployment of professional nursing and other direct-care staff, achieving significant gains in effectiveness and efficiency. The principal outcomes to date include consistent uniform coverage from shift to shift and day to day; sharply reduced overtime among direct care staff; enhanced nursing coverage; and reduced reliance on contractual staffing.

* **Revised search procedures for drugs and other contraband.** A new policy, issued May 8, 1995, addresses the principal search protocol issues identified by Commission and OMH staff.

* **Short and long-term security plans.** Substantial capital improvements enhanced personal identification procedures and other changes represent significant gains in meeting the safety and security needs of patients, staff and the community.

* **Revised system for patient supervision.** A new policy, issued in February 1995, markedly strengthens the process for management of individual patients. Six "levels" of supervision are defined in the policy, ranging from continuous one to one observation to unescorted off-grounds privileges. A three-tier system is used to determine the individual's level of supervision at a particular point in time:

1. An assessment and recommendation by the treatment team.
2. Consultation among the Unit Chief, Treatment Team Leader, Supervising Psychiatrist and Unit Psychiatrist.
3. A written physician's order.

Provision is made for on-going assessment of each patient's changing needs and behaviors.

* **Program space renovation.** Capital improvements nearing completion in Kingsboro's Building Two directly address many of the environmental concerns expressed by Commission and OMH staff. When finished, this completely renovated plant will have 160 beds, distributed equally among two secure units and six admissions wards (20 beds each). Sleeping rooms will be limited to four beds or less, with 10% of each ward's capacity devoted to single rooms. Scheduled for completion this Fall, this $18 million project represents a major gain in the quality of available program space,

particularly for "high risk" patients.

* **Incident reporting and risk management.** Policies and procedures in this critical area of hospital management have been completely revised. Incident classifications, in particular, are receiving close scrutiny and management. The facility's Incident Review Committee has been strengthened and given new leadership. A separate Special Review Committee receives and acts on all serious incident investigations, providing rapid management consideration of high-risk issues. Staff have been trained in the revised incident reporting procedures.

* **Incident investigations.** This parallel function has also been completely revamped. A full-time Director of Investigations and Incident Management provides day to day oversight for the system, assisted by a second full-time special investigator. Off-shift, weekend and holiday coverage is provided through a rotating roster, ensuring that a trained investigator is available at all times.

THE GEORGE ALLMAN HOMICIDE

The Office of Mental Health concurs with the Commission's overall finding that Mr. Allman's November 1994 death was a preventable tragedy. This homicide resulted from simultaneous break-downs in several critical systems, policies and procedures. Chief among them were:

* Serious failures in building and perimeter security, permitting CPL patient John Bishop to leave the facility without challenge.

* An inadequate personal search protocol following Mr. Bishop's return to the campus, enabling him to conceal the murder weapon on his person.

* Inappropriate evaluation, housing and supervision of this patient following his return.

* Inadequate management oversight and response.

The Agency disagrees with certain specific findings concerning the Bishop-Allman incident:

CQC Finding: Senior staff were not kept reasonably informed of the escape and subsequent events (Report, p.15).

OMH Finding: Failures in the management response protocol were due to the inaction and/or unavailability of senior staff during critical phases of this incident.

Like other OMH facilities, Kingsboro uses a two-tier system to provide supervisory and management coverage during off-shifts, weekends and holidays. On-site supervision is handled by an **Administrator-On-Duty (AOD)** who is normally stationed in the Central Nursing Office. AOD's typically handle a variety of situations requiring supervisory intervention and/or reporting, such as emergency staffing shortages, equipment problems and patient-related incidents. By payroll title, the AOD is typically a Nurse Administrator.

Management-level oversight is concurrently provided by an **Administrator-On-Call (AOC)**, an off-site assignment which rotates among the facility's senior executives. As noted in the Commission's report, the AOC is expected to be available by phone or beeper throughout his or her tour. The AOC provides management guidance, support and direction during emergency situations, by phone and/or in person. The

assignee is expected to report to the facility in case of a serious or sensitive incident, and to advise the Executive Director of such emergencies.

Staff assigned as Administrators-On-Duty following Mr. Bishop's escape made repeated attempts to report and obtain assistance with the unfolding situation. Unfortunately, the response they received was markedly inadequate and untimely.

Mr. Bishop's elopement triggered a number of internal and external notifications, including the police, District Attorney's Office, the psychiatrist on duty and the Unit Chief for Bishop's service. The Administrator-on-Call should have been among those immediately notified, but was not contacted until approximately 11:00 p.m. on Saturday, November 19, 1994. With this exception, the notification protocol was correctly followed.

The AOC assignment for that evening (4:00 p.m. to midnight) and for Sunday morning, November 20, 1994 (midnight to 8:00 a.m.) was carried by the facility's **Director of Nursing**. As indicated above, she was notified of the escape at approximately 11:00 p.m. on the 19th. Approximately an hour later, staff attempted to update her concerning the police search, media presence and other events. The Nursing Director was unreachable by telephone or beeper, and remained so for most of the balance of her AOC tour. Various messages left on her answering machine were not returned until approximately 4:30 a.m., when the patient had returned to the campus and the police search had ended.

In the interim, staff tried unsuccessfully to contact the **Executive Director**, in light of the escalating police and media activity, and concerns about the escapee's status should he return (see following discussion).

The AOD next tried to phone the **Director For Treatment Services** (DDTS), second in command of the facility. The DDTS was reached shortly before 3:00 a.m. She instructed the AOD to contact the **Director For Quality Assurance** concerning any subsequent developments in the case, and to consider the Director of Nursing relieved of AOC duties for the balance of the night shift. The Treatment Services Director indicated that she would personally advise the Executive Director of the Bishop situation.

The next significant event was Mr. Bishop's return to the Kingsboro campus, at about 4:30 a.m. As instructed, the AOD notified the Quality Assurance Director. In this conversation, the AOD explained that the on-duty psychiatrist

had overruled the recommendation of the nursing staff that Mr. Bishop be housed initially on the secure unit. The AOC did not question the psychiatrist's decision to return the patient to his home unit.

The on-site administrators heard nothing further from the various senior managers until approximately 10:30 a.m., when the DDTS phoned to follow up on her early morning contact.

The Commission's report (p. 15) correctly observes that the AOC is responsible for coming to the facility in a major emergency to provide senior management oversight. In this case, the escape of an extremely dangerous patient had triggered a major all-night police search. The media were pressing to know the facility's plans for this dangerous escapee. The on-site Administrators needed guidance in dealing with Bishop clinically and administratively in the event he returned. Under those circumstances, the fact that three senior officials failed to report to the facility, and took no other substantive action to deal with the situation, represented a very serious break-down in the management response system.

CQC Finding: The Executive Director was not promptly notified of Mr. Bishop's escape because center staff had the wrong telephone number.

OMH Finding: The incorrect numbers had no significant bearing on the situation. Primary responsibility for notifying the Executive Director rested with the off-grounds senior managers who were advised of the escape.

The Director of Nursing, in her capacity as AOC, was told of the escape at approximately 11:00 p.m. on Saturday, November 19, 1994. She should have notified the Executive Director but did not.

The Director For Treatment Services, second-in-charge of the facility, was told of the escalating Bishop situation at approximately 3:00 a.m. on Sunday, November 20, 1994. She told the AOD that the Executive Director's phone numbers on record in the Central Nursing Office were out of date, and promised to call the CEO herself.

The Director For Quality Assurance designated as alternate AOC for the midnight to 8:00 a.m. shift was advised of the patient's return, and questionable placement status, at approximately 4:30 a.m. on Sunday, November 20, 1994. She, too, failed to contact the Executive Director.

The incorrect phone numbers in the nursing office represented a minor administrative problem. Three senior officials had timely knowledge of the Bishop situation, but failed to notify the Executive Director. Responsibility for doing so rested with those officials, not with the on-site administrators.

CQC Finding: The Executive Director issued an administrative order for Mr. Bishop's transfer to the secure unit; however, there was confusion about how to effect the order.

OMH Finding: There was no confusion, or substantive delay, in the execution of the transfer order. The transfer procedure had no material bearing on the outcome of the case.

While on the phone with the AOD at about 10:30 a.m. on Sunday, November 20, 1994 the Director For Treatment Services received a call from the Executive Director. The CEO wanted to know why she had not been informed about the escape of a dangerous patient, and directed that Bishop be transferred immediately to the Kingsboro secure care unit. The DDTS got back on the line with the AOD and instructed her to have the on-call physician arrange the transfer.

The AOD immediately phoned the doctor and requested a transfer order. The doctor went at once to Mr. Bishop's unit, spoke briefly with the patient and wrote the order. Moments later Bishop told staff, including a Safety Department escort, that he had killed a man and that the body was in the ward dorm. Rushing to the scene, staff discovered Mr. Allman lying on his bed with multiple stab wounds to the chest. Medical staff responding to the code blue emergency noted that the blood on and around the patient's wounds did not appear fresh.

In summary, the Agency agrees that Mr. Allman 's death stemmed from a number of clinical and administrative problems, including errors in judgment, security break-downs, an inadequate patient search procedure and a seriously flawed psychiatric evaluation of Allman's attacker. Most serious, however, was the failure of senior management to intervene in any substantive way in the tragic scenario leading to Mr. Allman's death.

CORRECTIVE ACTION PLANS

The Agency appreciates the Commission's careful and thorough consideration of the serious clinical and management issues affecting Kingsboro and other State-operated psychiatric centers in New York City. As indicated earlier, these problems are continuing to receive focused attention based on various internal initiatives. Following is a summary of Agency plans for addressing the principal concerns raised in the draft report.

Kingsboro Psychiatric Center

Management Oversight: As previously noted, a new senior management team has just been appointed at Kingsboro, with additional upper and mid-level management changes anticipated over the next three to six months. The Agency will be working closely and collaboratively with the new team to build on the various program initiatives planned and in progress.

Staff Performance: Kingsboro's clinical and direct-care staff deserve considerable credit for dealing in a competent, supportive and caring manner with an extremely difficult patient population. Concerted efforts are being made to improve the morale and self-confidence of the facility's rank and file staff in the context of the various program changes. The Executive Director is playing a major role in this initiative maintaining regular and frequent contact with staff at all levels and setting a tone of support, collaboration, esprit de corps and mutual respect throughout the hospital.

Quality Assurance and Risk Management: Since the Bishop - Allman incident, the Quality Assurance Department has been extensively reorganized as indicated earlier in this commentary. Incident management and internal investigations are under new leadership and have undergone extensive changes in policies and practices.

All Kingsboro investigators will receive refresher training in the near future helping to ensure that the goals of speed, objectivity and thoroughness are uniformly met in the conduct of critical incident investigations. The Incident Review and Special Review Committees are structured and managed so as to ensure prompt, decisive follow-through on the results of these investigations.

These program and leadership changes will be closely monitored over the next several months, both internally and

by the Agency.

Psychiatric Services: There are several key developments in this area. Dr. Jones, Kingsboro's new Executive Director is a highly qualified psychiatrist himself and has taken a strong personal interest in the development, delivery and management of psychiatric services. Dr. Jones is currently leading an effort to recruit three additional supervisory staff in this field to provide enhanced guidance, training and program oversight.

The OMH Bureau of Health Services is providing on-going consultative services and training to the facility's medical staff, dealing with psychopharmacology, medication practices, and related matters.

Finally, Dr. Jones met recently with the President of SUNY Health Sciences Center to discuss collaborative programs in research and treatment services with that facility. A similar initiative is under way with Kings County Hospital Center, Kingsboro's other major health services neighbor. These are very encouraging and important developments, pointing up the facility's renewed commitment to becoming a full partner in the fields of psychiatric research and service delivery.

Treatment Accountability: The Agency and facility concur that tighter procedures are needed to ensure timely and regular assessment of conditions on Kingsboro's various wards and services. A new Daily Rounds Procedure implemented in January 1995, directly addresses this issue. On each ward, the Team Leader and Treating Psychiatrist conduct daily team meetings, covering all significant clinical and administrative issues arising in the preceding 24 hours.

Programming for Polysubstance Abuse Patients: This area has also seen several key developments, some occurring since the Commission's report, others stemming from the earlier Agency initiatives. They include:

* Enhanced training for clinical and direct-care staff in the treatment and management of "MICA" cases. This will include collaborative participation by psychiatric faculty from SUNY Health Sciences Center.

* Establishment of a Substance Abuse Group on each of the facility's adult wards, excluding geriatric services.

* Expansion of "Double Recovery" and "Fresh Start" Programs.

* Enhanced training opportunities for development of Alcoholism Peer Counselors and Certified Addictive Counselors, from among Kingsboro staff.

* Increased case management services for MICA patients.

* Teleconference presentations by leading experts in the poly-substance abuse field.

Care and Management of High Risk Patients: The Agency concurs with the Commission's comment that simply congregating patients with histories of violent and/or criminal behavior does not adequately address their safety and treatment needs. Several of the initiatives previously outlined are aimed in whole or in part at the needs of this population. Following is a summary of developments affecting Kingsboro's patients and staff:

* Enhanced training for staff assigned to MICA and other multiply disabled patients.

* Improved building and perimeter security systems.

* Revised procedures for assignment of patient privileges and for patient supervision.

* Renovated program space, specifically designed to address the security, and treatment needs of difficult patients.

* A substantially strengthened contraband search policy.

* Improved staffing for secure care and other high-risk patient programs.

Physical Plant and Census: The renovated Building Two space will directly and substantially address the concerns expressed in this report and in various Agency reviews of Kingsboro's physical plant needs. The new space is specifically designed to enhance patient privacy, programming and security.

More immediate steps have also been taken to control census. Kingsboro's acute service role is being rapidly reduced and phased out, through admissions management agreements with other providers in the service area. Such agreements are in place or being negotiated with Kings County Hospital, Catholic Medical Center, Brookdale and Interfaith

Hospital. Acute admissions from three of Kingsboro's Community Planning Districts will be completely absorbed by these other facilities.

NEW YORK CITY-BASED PSYCHIATRIC CENTERS

The Office of Mental Health is taking steps to ensure that the foregoing and other program and management improvements are replicated throughout the New York City Region. As the Commission report indicates, mental health service needs in the metropolitan area are acute and growing. OMH will ensure that the State is as fully prepared as possible to meet those needs, in cooperation with other service providers.

The following comments address the Commission's specific recommendations (Report, pp. 67-69).

Secure Care Units: For many years, OMH has wrestled with the advantages and disadvantages of segregating violent and other difficult patients from the rest of the population. There are numerous internal and external studies purporting to show the efficacy of one approach over the other. The Agency will continue to evaluate available options for dealing with the special needs of this population.

Conditional Discharge of Involuntary Patients: This option will also be considered in the context of an overall plan for meeting the needs of special populations.

Security Systems: Earlier this year, each OMH facility was directed to develop immediate and long-range plans for safety and security enhancement. Those plans are now complete and have received Agency approval. Currently, their implementation is being audited jointly by the Bureaus of Inspection & Audit, Capital Operations, and Quality Assurance.

Patient Privileging Policies: The patient assessment and privileging procedures now in place at Kingsboro (see earlier discussion) will be augmented shortly by a region-wide policy governing evaluation of behavioral risk factors. Developed by a task force of Clinical Directors from State-operated facilities in New York City, the policy will provide for a comprehensive assessment of each patient's risk history at the time of admission. Factors such as violent and/or criminal behavior, substance abuse or CPL status will trigger a prompt, multi-level evaluation of the patient's behavioral

The revised assessment program will be introduced in July 1995, as indicated below.

Risk Assessment and Treatment Planning: As part of its comprehensive realignment of patient assessment practices, OMH has developed a training program designed to aide clinicians at all levels in making optimum use of historical data. Participants will learn to obtain and apply this information on a collaborative basis, working with the patient to develop an effective treatment plan. To be presented in July 1995 for approximately 500 clinical staff from New York City-based OMH facilities, the program will include an introduction of the risk-based assessment protocol outlined above.

Management of New York City Facilities: Many of the other initiatives discussed here have been replicated in other New York City-based Psychiatric Centers. Of particular note in the context of this report are the new safety and security plans; new procedures for reporting escapes, locating absent patients and accounting for their whereabouts within specified time periods; and the on-going internal audit of facility security programs. Additional funding in the amount of $3 million has been allocated Agency-wide for these initiatives.

Acute Care Services: The admissions management program recently undertaken at Kingsboro is being evaluated in the context of a region-wide plan for acute psychiatric admissions. This approach is expected to significantly reduce the current over-reliance on State-operated psychiatric centers for the provision of acute care services.

MICA Case Management Programs: All of the measures being implemented at Kingsboro will be replicated at other OMH facilities in New York City, consistent with local resources, staffing and patient needs.

The OMH Bureau of Psychiatric Services regularly provides continuing medical education programs and on-site clinical consultations concerning difficult or specialized cases. Over the past two years, these programs have included several MICA-related initiatives, dealing with cocaine abuse and treatment; substance abuse among women; cocaine use and psychopathology; and screening and drug interventions for patients with alcohol problems.

The Bureau also provides State-wide psychopharmacology training programs twice annually for Clinical Directors, Chief Pharmacists and Psychopharmacologists. The Spring 1995

program, held June 5-6 in Albany, focused exclusively on psychopharmacologic issues in the evaluation and management of MICA patients. This topic was also treated during each of the Bureau's 1994 pharmacology training programs, where case discussions focused exclusively on New York City-based patients.

The Agency is encouraged by the increasing availability of training and case conference resources in this field, and will continue to explore additional alternatives.

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The Commission on Quality of Care for the Mentally Disabled is an independent agency responsible for oversight in New York State's mental hygiene system. The Commission also investigates complaints and responds to requests concerning patient/resident care and treatment which cannot be resolved with mental hygiene facilities.

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