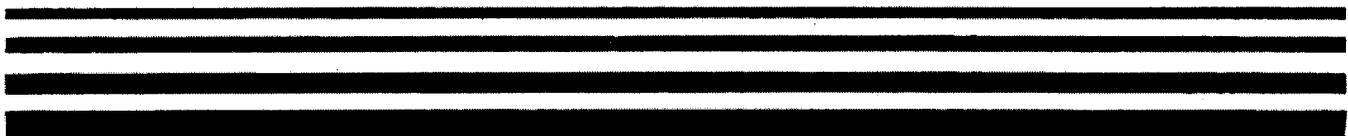




In the Matter of Timothy Smythe: A Patient at Central New York Psychiatric Center

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



In the Matter of Timothy Smythe: A Patient at Central New York Psychiatric Center

Clarence J. Sundram
CHAIRMAN

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James A. Cashen
COMMISSIONERS

August 1991



NYS COMMISSION
ON QUALITY OF CARE
FOR THE MENTALLY DISABLED

Preface

Protection from harm. Following a pivotal judicial decision on the rights of persons in institutions [*Youngberg v. Romeo*, 457 U.S. 307 (1982)], which articulated the responsibility of facilities to take reasonable measures to ensure that patients are kept safe, this phrase gained popular acceptance and has come to express succinctly the concept that institutions must undertake multiple tasks to promote patient safety. These tasks include, but are not limited to, such basic duties as the maintenance of sufficient numbers of appropriately trained staff to provide supervision and the issuance of policies to guide staff in carrying out their duties. It also includes the maintenance of an effective system of incident identification, reporting and review which ensures the implementation of remedial measures to reduce the likelihood of the recurrence of untoward events.

These systems of patient protection failed at Central New York Psychiatric Center (a forensic facility) in 1989, when inadequate supervision by direct care staff, and the failure to report and investigate incidents and take corrective measures in a timely manner, permitted two patients, Timothy Smythe* and D.C., to run an extortion ring, using physical and sexual assaults and threats thereof to gain compliance from fellow patients.

Although discovered in August 1989 when one of the two ringleaders wrote a letter detailing some of his activities because he had begun to fear his co-conspirator, the final written investigation report was not delivered to the director until February 12, 1990, six months later. The director took no action until May 23 when he forwarded it to the facility's Incident Review Committee.

The Commission's review of the facility investigation and the Commission's own investigation revealed that direct care staff were aware at least a year earlier that Mr. Smythe had over 500 packages of cigarettes in his locker, and that he "appear(ed) to be encouraging peers to act out, possibly paying them off with cigarettes (May, 1989 note in T. Smythe caserecord. Similar notes followed). Thus, the failure of the facility staff to report and to investigate the operation of this underground economy, its relation to Mr. Smythe's clinical status and its effect on the ward hindered the Administration in protecting patients from harm, including exploitation and, in its most serious form, assaults and rape.

Similarly, staff did not file incident reports on physical and sexual assaults perpetrated by D.C., although the Commission investigation confirmed that staff were aware of these incidents since they were referenced in D.C.'s treatment record, the records of his victims and the communication log.

These actions, clearly in violation of Office of Mental Health (OMH) incident reporting regulations, shielded the incidents from extensive investigation, prevented the incidents from receiving the level of administrative scrutiny they warranted, thwarted effective remediation and kept the information from external parties such as the Commission, Mental Hygiene Legal Services and the Board of Visitors, all of which must receive notice of specific types of incidents.

* A pseudonym.

The facility's Incident Review Committee acted expeditiously and made 11 additional recommendations, many centering around what the members identified as the main themes of the investigation — lax supervision and a need to "aggressively seek out and deal with problems in patient care and treatment."

In his memorandum to the Incident Review Committee accepting their recommendations and thanking them for their comprehensive and thorough review, the Director stated, "The time lapses in this case, including the time it took for my [Director's] review and actions, regardless of the circumstances, were intolerable." Indeed, the administration's failure to give this investigation and the subsequent review of causes and contributing factors the prominence and attention deserved, silently but effectively communicated that incident reporting and review was not a priority and, in effect, sanctioned the practice among staff of bypassing the OMH requirements to report and investigate untoward events and remediate their causes.

In response to their own and the Commission's findings, the facility undertook a number of corrective measures, including major revisions in the incident reporting and review policies and processes and in procedures for insuring enhanced supervision of patients, monitored by administrative rounds. A full description of the agency's corrective actions is appended to the report. The Central Office of OMH set up an information management system to monitor the investigation and review of serious incidents at forensic facilities and agreed to review the implementation of the new incident reporting system at Central New York Psychiatric Center by March 1992.

This report represents the unanimous opinion of the members of the Commission. A response to a draft of the report from OMH is attached as one of the appendices.


Clarence J. Sundram
CHAIRMAN


Irene L. Platt
COMMISSIONER

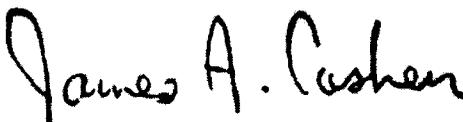

James A. Cashen
COMMISSIONER

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Introduction

The series of events described in this report illustrate what can happen when a facility loses sight of one of its most basic purposes — to provide a safe environment for its residents. Although accomplished by a variety of means, this end is substantially met through the provision of adequate supervision to residents and through a competent and timely review of untoward events and the implementation of corrective actions. Both of these systems failed in the case described herein, and the failure tainted direct care staff, ward supervisors, executive staff and the Executive Director.

This report contains, first, a description of what happened at Central New York Psychiatric Center around the care and treatment of Timothy Smythe* and those associated with him, followed by a discussion of the Commission's review of the facility's actions (and inactions), and offers at its conclusion recommendations for further corrective measures.

What Happened

At approximately 5:30 p.m. on Saturday, August 12, 1989, Ward 201 patient Timothy Smythe handed a two-page letter to a Senior Secure Hospital Treatment Assistant (SHTA). This letter described a ward in which Mr. Smythe exercised control over many aspects of the other patients' lives. Specifically, it contained 18 allegations that several patients on Ward 201 physically and/or sexually assaulted and extorted money, food and cigarettes from weaker patients. Mr. Smythe alleged that patient D.C. assaulted and/or extorted food and cigarettes from five patients, that he and O.R. extorted food and cigarettes from a sixth patient, and that O.R. physically assaulted a seventh.

In response, the Senior SHTA brought the letter immediately to the ward Supervisor and the Nurse Administrator. They began a preliminary investigation which included interviews of several patients, and a review of commissary "buy sheets." They also convened a special Therapeutic Community Meeting (TCM) informing patients that, "It has been brought to [our] attention that extortion, homosexual activity, and assaults are occurring and all of these happenings must stop immediately."

The next morning, at the direction of the Clinical Director, a special investigator was assigned to conduct an internal facility investigation, and the State Police Bureau of Criminal Investigation (BCI) was notified

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* A pseudonym.

and began an investigation. The facility investigation report was completed six months later on February 12, 1990 and was sent to the facility director. It revealed the following scenario.

Mr. Smythe, the author of the letter, was running a "store" on the ward selling candy, cigarettes, and snack foods. Mr. Smythe supplied his store via friends who lived in Syracuse and shopped at the PX at the Air Force Base in Rome. They visited him on a weekly basis, making deliveries of goods bought at low PX prices. Patients would then buy from Mr. Smythe because his prices were cheaper than at the facility commissary and they could buy on credit. Additionally, Mr. Smythe allowed patients to use cigarettes in place of cash. Thus, a patient who was out of cigarettes could buy a pack on credit, paying for it later with two packs. Patients also sent money to Mr. Smythe through the Syracuse couple who then forwarded it to Mr. Smythe's cash account at Central New York. Interviews with facility staff assigned to the ward revealed that the operation of this patient-operated store was common knowledge, and a search of Mr. Smythe's locker produced over 500 packs of cigarettes.

Various sources of information supported these findings. Patient D.O. stated to the facility Special Investigator, "I was sending money to Smythe's friends on the outside. I was aware that his friends would then put the money in Smythe's account...." J.G. stated that he sent \$10.00 to the Syracuse couple to pay Mr. Smythe for cigarettes he had purchased. Additionally, a review of Ward 201 patient disbursement forms revealed that the Team Leader signed 18 disbursement forms for nine patients between March 17 and August 8, 1989, sending a total of \$267.90 to Mr. Smythe's Syracuse friends. In fact, during this period, the couple provided Mr. Smythe with \$874.44 worth of cigarettes and snack items and added \$898.50 to his cash account.

The "muscle" for this operation was D.C., who victimized several uncooperative patients by assaulting them physically or sexually. In his own words, D.C. described this activity. "Sometimes if the inmates didn't pay up I would collect. If they didn't pay their debt, I would punch them. I had to punch two or three inmates. One of those was inmate Martin*." Mr. Martin in a statement to the BCI accused D.C. of assault on several occasions, describing being punched in the eye, mouth, and groin. Mr. Martin further stated that on August 9, 1989 after verbally threatening to assault him, D.C. forced him into the bathroom, punched him, and sodomized him. D.C. was charged and later convicted of the rape of Mr. Martin.

"Sometimes if the inmates didn't pay up I would collect. If they didn't pay their debt, I would punch them. I had to punch two or three inmates. One of those was inmate Martin*."

* A pseudonym.

The facility's investigation report concluded that "extortion, beatings, and homosexual activity did occur" and offered recommendations in the areas of: updating facility policy regarding patient sexual contact; requiring the treatment team to determine whether a patient is capable of handling commissary privileges independently; alerting ward managers and cash office personnel to pay closer attention to disbursement forms; and strongly recommending that patient supervision be improved.

As the chronology (Appendix A) reveals, the Director was verbally briefed on the investigation's findings on August 17, 1989, five days after receipt of Mr. Smythe's letter containing the 18 charges. On February 12, 1990, six months after the investigation was begun, he received the written report and held it until May 23 when he forwarded it to the Special Review Committee (SRC). On June 19, 1990, the SRC returned the report to the Director with 11 additional recommendations (Appendix B).

Commission Actions

The serious nature of these charges and the fact that the incidents which had occurred several months earlier had not been reported to the Commission as required by the Office of Mental Health incident reporting regulations (14 NYCRR 524) led the Commission to conduct an investigation into the matter.

A May 21, 1990 call informed the Commission that Oneida County was preparing to bring to trial a former Central New York Psychiatric Center patient (D.C.) who had been indicted on charges of rape, sodomy, and extortion and alerted the Commission that the police investigation had revealed ongoing sexual and physical assaults resulting from improper supervision.

The serious nature of these charges and the fact that the incidents which had occurred several months earlier had not been reported to the Commission as required by the Office of Mental Health incident reporting regulations (14 NYCRR 524) led the Commission to conduct an investigation into the matter. At the onset, the Commission learned that the facility had conducted a special investigation and had identified some corrective actions.

CQC staff members reviewed a copy of the report of the special investigation conducted by the facility and made site visits to the facility on June 11, July 16, and July 20, 1990. During these visits, staff reviewed the special investigation file; read the clinical records of the patients named and those of eight other patients; read ward logs written between August 1, 1989 and May 1, 1990 and incident reports from the cited ward; and read the facility incident log from January 1, 1989 to September 30, 1989.

CQC staff also had conversations with the Clinical Director, the present Directors for Quality Assurance, Treatment Services, and Administration. Formal interviews were conducted with the Executive Director, the ward Team Leader, the Special Investigator, and the Senior SHTA.

To conclude the investigation, the CQC investigator met with the OMH Associate Commissioner for Forensic Services on October 3, and made one final site visit to the facility on October 25 to meet with both

the Facility Director and the present Director for Quality Assurance. This investigation concluded with the findings below.

Findings

- I. *Because staff repeatedly circumvented the incident reporting and review process, the facility missed signs that should have prompted an earlier investigation and the implementation of administrative and clinical interventions.*

Notes in Mr. Smythe's treatment record written by direct care staff verify that Mr. Smythe's store was common knowledge for at least several months before his letter. For example,

- patient appears to be encouraging his peers to act out, possibly paying them off with cigarettes (5/26/89);
- patient has been observed passing out packs of cigarettes to select patients usually after an incident involving another pt. (5/27/89);
- patient was overheard telling patients (D.C. and another patient) that they were not to give anyone anything unless he told them to. Stated "until these guys do as I say they get nothing." (8/6/89)

The failure of the facility staff to report and to critically evaluate the operation of the store, its relation to Mr. Smythe's clinical status and its effect on the ward hindered them from taking effective action to prevent exploitation of patients which in its most serious form resulted in assaults and rape. It also contributed to the facility's failure to review Mr. Smythe's need for treatment and continued stay. A brief summary of Mr. Smythe's admission and stay at Central New York will illustrate this point.

The failure of the facility staff to report and to critically evaluate the operation of the store, its relation to Mr. Smythe's clinical status and its effect on the ward hindered them from taking effective action to prevent exploitation of patients which in its most serious form resulted in assaults and rape.

Following his conviction on charges of grand larceny, Mr. Smythe was sentenced to one to three years in state prison. At the time of his admission to the Central New York Psychiatric Center on October 24, 1988, he was a "state ready" inmate of the county jail. (Mr. Smythe had been hospitalized in a psychiatric center in 1987 and 1988 after suicide attempts.)

He was admitted to Central New York from the county jail because of depression with an admitting diagnosis of Axis I, bipolar disorder, depressed, without psychotic features; Axis II, antisocial personality disorder. On February 9, 1989, he was discharged to Downstate Correctional Facility with a discharge diagnosis of Axis I, major depression, recurrent, without psychotic features; Axis II, no diagnosis.

One day later, a psychiatrist at Downstate's satellite clinic described Mr. Smythe as being in "an acute emotional stressful situation" and recommended his return to the psychiatric hospital. Although strongly disagreeing with the determination, Central New York readmitted him with a diagnosis of Axis I, panic disorder, without agoraphobia; Axis II, borderline personality disorder.

On March 31, his Central New York physician wrote that Mr. Smythe had not shown "...any evidence of psychosis, depression, or panic disorder..." Similarly, on July 18, his physician wrote, "...he has been free of psychiatric symptoms...." Despite this lack of any documented psychosis or other serious mental illness, Mr. Smythe remained at the facility (which has an average length of stay of 76 days) for over one year.

It is clear from his case record and from staff's testimony that Mr. Smythe's minimally impaired functioning and his long length of stay enabled him to run his store and ensure the cooperation and participation of the other patients. A Security Hospital Therapy Aide (SHTSA) told CQC that Mr. Smythe was the only patient he knew of who would have been able to "pull this off" and that "none of this would have happened if they had gotten rid of him like staff suggested."

When questioned, the facility Director explained to CQC that there were a number of reasons for Mr. Smythe's lengthy stay. A forensic psychology intern was Mr. Smythe's primary therapist. This individual advocated strongly for the patient's continued stay at the hospital as he felt he was at a breakthrough point in therapy. Additionally, feeling "burned" by the aborted discharge attempt to Downstate, the treatment team was somewhat reluctant to try again as, according to the Clinical Director, panic attacks are difficult to predict. The treatment team also reportedly later believed it was not appropriate to send Mr. Smythe to prison when he had only five months before he was eligible for parole.

If these latter explanations are accurate, it is clearly appropriate to question whether Mr. Smythe's retention as a patient in this acute care psychiatric setting violated Central New York's admission/discharge policies.

Similarly, the facility also had in its possession sufficient evidence to indicate that D.C.'s behavior was a danger to other patients. Yet, because staff again failed to complete incident reports, the seriousness and frequency of his behavior was not assessed and effective and timely measures to intervene clinically and to safeguard other patients were not taken.

The CQC investigation revealed that in the two months prior to Mr. Smythe's August 12 letter, D.C.'s record documents six occasions when he physically or sexually assaulted other patients. In addition to documentation in D.C.'s case record, staff documented some of his behavior in the ward communication log, a commonly used vehicle for sharing information regarding ward events among shifts. For example, the log entry on June 24, 1989 stated that D.C. had punched another patient. In other instances, the incidents were recorded in the treatment records of the victims. An entry in one victim's record dated August 8, 1989 noted that he was struck by D.C. and treated for bruises.

The facility investigation also revealed that, according to several patients, staff witnessed serious incidents but did not document them in treatment records or on incident reports. As an example, in his statement during the investigation, D.C. testified that Mr. Smythe had jumped a patient who was running a smaller store and tried to choke him after the

The facility also had in its possession sufficient evidence to indicate that D.C.'s behavior was a danger to other patients. Yet, because staff again failed to complete incident reports, the seriousness and frequency of his behavior was not assessed and effective and timely measures to intervene clinically and to safeguard other patients were not taken.

patient threatened to expose his operation. He reported that staff intervened. An employee, in his statement taken during the investigation, admitted breaking up homosexual activity between patients and "informing other staff."

Despite the intervention of staff, these incidents were not reported and no investigations were conducted. Rather, D.C. was "counselled" about his behavior on three occasions by the Team Leader.

In summary, neither the Team Leader nor any staff member who saw, heard about, or documented the assaults in a case record or log filed an incident report. Since an incident report triggers the investigation and review process, this failure meant that the incidents were not investigated, were not reviewed by the facility director and the Incident Review Committee, and remedial actions were not recommended or implemented. The lack of an incident report also kept this information from coming to the attention of other bodies which have access to incident reports, including the Commission on Quality Care, Mental Hygiene Legal Services and the Board of Visitors. These actions clearly violate OMH incident reporting regulations, the intent of which is to ensure the uniform recording of untoward events within programs in order to "facilitate the identification of unfavorable trends by programs, and subsequently the implementation of preventive or corrective strategies." Incidents are defined to include any event which involves an injury; allegation of abuse (physical, sexual or psychological) or neglect; suicide attempt, or unexpected death of a client; involves a missing client; and/or is a possible crime.

Neither the Team Leader nor any staff member who saw, heard about, or documented the assaults in a case record or log filed an incident report. Since an incident report triggers the investigation and review process, this failure meant that the incidents were not investigated, were not reviewed by the facility director and the Incident Review Committee, and remedial actions were not recommended or implemented.

II. *The facility failed to conclude the special investigation promptly and failed to keep responsible parties informed.*

The incident giving rise to the allegations reported to the Commission occurred on Saturday, August 12, 1989 when Mr. Smythe handed the letter with the 18 charges of sexual and physical assault and extortion to staff. As noted, a facility investigation began almost immediately and the State Police BCI began its investigation within 48 hours. Contrary to OMH Incident Review Regulations (NYCRR 524.5), the Commission was not notified of these allegations.

The Special Investigator completed the investigation six months later, although he did orally report the bulk of the findings to the Director on August 17, five days after the letter. The investigator later advised CQC that several factors prevented him from completing a more timely report. Specifically, he was not relieved of his regular responsibilities to enable him to complete the investigation, and he was rewriting policy manuals in preparation for an upcoming JCAHO inspection. Outside of his control, the police investigation of the charges was ongoing, and the Assistant District Attorney handling the case had become ill and was unavailable for almost one month.

The facility Director confirmed this, adding that the investigator was under a deadline of October 11 to finish rewriting the policy manuals.

The failure to promptly complete the investigation of the serious allegations of assault and extortion, which at the very least suggested serious problems in the supervision and protection afforded to patients, and the failure to shepherd the investigation promptly to the Incident Review Committee paralyzed one of the central facility-wide systems in place to ensure the identification and remediation of serious problems.

In addition, he noted that in response to the violent death of a patient, the Special Investigator had been assigned to serve as a facility liaison to the State Police who were designing and installing a radio communication system with the facility.

Further CQC investigation revealed that the Director for Quality Assurance (DQA) at the time, who was the administrator responsible for supervising investigations, reportedly never gave the investigator a time frame for completion of the report. The investigator stated he never gave the DQA any information about the investigation, nor was he asked for any.

The indictment of D.C. was delivered shortly after January 1, 1990 and soon thereafter the DQA retired. The facility Director stated that the last thing the DQA gave him on his final day of work was the Special Investigator's report.

The facility Director forwarded the report to the Special Review Committee on May 23, 1990, three months after he received it on February 12, 1990 and nine months after Mr. Smythe delivered the letter containing the charges. Approximately three weeks later on June 19, the SRC returned the report to the Director with 11 additional recommendations.

The failure to promptly complete the investigation of the serious allegations of assault and extortion, which at the very least suggested serious problems in the supervision and protection afforded to patients, and the failure to shepherd the investigation promptly to the Incident Review Committee paralyzed one of the central facility-wide systems in place to ensure the identification and remediation of serious problems. Equally important, the administration's failure to give this investigation and the subsequent review of causes and contributing factors the prominence and attention deserved, silently but effectively communicated that incident reporting and review was not a priority and, in effect, sanctioned the practice among staff of by-passing the OMH requirements to report and investigate untoward events and remediate their causes.

III. Related to the first two findings, the facility failed to implement corrective action in a timely manner.

As noted previously, the findings of the Special Investigator concluded that "extortion, beatings and homosexual activity did occur" and detailed five recommendations: updating facility policy regarding patient sexual contact; requiring the treatment team to determine whether a patient is capable of handling commissary privileges independently; alerting ward managers and cash office personnel to pay closer attention to disbursement forms; and, strongly recommending that patient supervision be improved.

Although these recommendations were later accepted by both the Director and the Incident Review Committee, in February when they were presented to the Director, they were not implemented. Three and a half months later, the Director forwarded the investigation to the

Incident Review Committee. That body made 11 additional recommendations, many of them centering around what they identified as main themes of the investigation—a need to correct lax security and supervision and a need to “aggressively seek out and deal with problems in patient care and treatment.” Appendix B contains the full text of these recommendations. Among the most critical are the following:

- admonish management and supervisors that lax security and patient supervision will not be tolerated;
- conduct more supervisory rounds;
- comply with 14 NYCRR 524.5 requiring facilities to report incidents to outside control agencies including CQC;
- develop a policy regarding sexual activity;
- revamp the special investigation procedures;
- increase unannounced rounds by facility cabinet members; and,
- reinstruct all supervisors regarding incident reporting procedures.

After accepting the recommendations of the Special Review Committee and following the Commission’s initial site visit, the facility began the task of implementing the corrective actions, including the writing and revising of policies.

In his memorandum to the Incident Review Committee accepting their recommendations and thanking them for their comprehensive and thorough review (Appendix C), the Director stated, “The time lapses in this case, including the time it took for my [Director’s] review and actions, regardless of the circumstances, were intolerable.” This critique cannot be improved upon. The incidents under review were serious and, as identified by the Incident Review Committee, suggested a systemic failure to provide a safe environment. Yet, remediation was not begun for nearly a year and some corrective actions, including the designation of a Primary Investigator, were not implemented for 15 months.

The Director stated, “The time lapses in this case, including the time it took for my [Director’s] review and actions, regardless of the circumstances, were intolerable.”

IV. Failure to respond appropriately to the allegations extends beyond the facility to the OMH Bureau of Forensic Services’ lack of oversight of Central New York’s response to the serious allegations.

In conversation with the Associate Commissioner for Forensic Services, CQC staff learned that he was informed of the incident by telephone “very early,” but heard nothing further until the investigation was completed in February. The Associate Commissioner recalled asking the Director to be sure the police were notified and receiving the response that the call had already been made. He further noted that after being notified of the allegation, he would not routinely receive additional information until the case was completed. He recalled knowing that the case was going to the Grand Jury, but said he was not aware that the investigation was unnecessarily delayed.

The Associate Commissioner stated that he does not have program analysts (as are found in OMH regional offices) who are responsible for the review and analysis of incidents, and relies almost exclusively on Special Review Committee minutes for information about incident reporting and investigation at the forensic facilities. Further inquiry revealed that, although facilities are required to report serious incidents and the investigation results to the Quality Assurance Division at Central Office, this division does not query individual facilities regarding specific late investigations.

Thus, the Central Office oversight provided by the Bureau of Forensic Services failed to detect the facility's lack of responsiveness and consequently failed to address it. None of the corrective actions taken by OMH to date address this issue.

V. *The facility has undertaken corrective actions that touch many important aspects of facility life essential to the safety of patients.*

The facility has undertaken major revisions in the incident reporting and review process, has initiated staff training in responsibilities for the reporting and investigation of incidents, has increased administrative rounds to ensure adequate patient supervision, has tightened commissary rules and has written a policy regarding patients' sexual conduct.

Following the recommendations of the Special Review Committee and the initiation of the Commission's investigation, the facility has undertaken major revisions in the incident reporting and review process; including initiating training in responsibilities for the reporting and investigation of incidents; increasing administrative rounds to ensure adequate patient supervision; tightening commissary rules; and writing a policy regarding patients' sexual conduct.

Specifically, the facility revised its incident reporting policy to ensure its compliance with OMH incident reporting regulations, set a timetable for ensuring the expeditious completion of investigations and has addressed other major issues. Facility policy now requires that special investigations be concluded within thirty days. In addition, investigators must report the status of investigations to the DQA on a weekly basis. The final investigation report is now submitted to the Special Review Committee and not to the Director. Finally, the facility has established a position of "Primary Investigator" and had assigned this responsibility to an employee as of November 20, 1990. As a result of the CQC October 25, 1990 site visit when Commission staff reiterated Central New York's reporting obligation, the facility is now sending to CQC allegations of abuse as required by regulation.

The facility's revised incident reporting policy also requires that the Director or his designee inform the Bureau of Forensic Services by telephone (with written notification to follow) of alleged abuse and mistreatment of patients, serious injuries, escapes, homicide attempts, alleged crimes and deaths. Once completed, copies of investigations of all allegations of abuse, serious injury, death, suicides and homicides are to be sent to the Bureau. The facility and Bureau are refining this policy.

New policies written since the investigation forbid all sexual activity between patients and require that all such acts or attempted acts be prevented if possible and reported. In addition, the facility has written policies regarding shower and bathroom supervision.

The corrective actions implemented by Central New York, albeit not in a timely manner, address issues which form the fabric of the "civilization" of the institution — protection from harm, supervision, accountability, identification and review of untoward events, and sexuality.

Supervision at the facility has been improved due, in part, to the facility Director meeting with his cabinet and other senior staff and with all three shifts of direct care staff to "clearly articulate the expectations with regard to the preservation of the safety and well-being of patients." Written directives stating these expectations followed. Rounds by all levels of administrative/supervisory staff have been increased. In addition, all supervisory staff were reminded in writing of their responsibilities to report incidents, to make reports to the police and to request the initiation of a special investigation.

The facility has also developed a policy (effective September 21, 1990) regarding the trading or exchange of commissary items or personal property. The policy states, in part, "Patients shall not request or solicit commissary items and/or other personal property items without the consent and approval of the Team Leader/designee."

In addition, the Director has informed CQC that the facility is developing a system by which the Team Leader, primary therapist, visiting room staff and patient cash office personnel will ensure that unusual or excessive disbursements and deposits are flagged.

The corrective actions implemented by Central New York, albeit not in a timely manner, address issues which form the fabric of the "civilization" of the institution — protection from harm, supervision, accountability, identification and review of untoward events, and sexuality. The present challenge lies in maintaining the momentum for change by ensuring the aggressive implementation of these policies and procedures.

Additional Recommendations

In addition to the corrective actions already identified, the Commission recommends that the following measures be undertaken:

- Central New York Psychiatric Center and the Bureau of Forensic Services review the treatment of Mr. Smythe to determine whether his lengthy stay was clinically appropriate and to critique the efficacy of the treatment provided to him. If this review reveals that Mr. Smythe remained a patient in violation of the admission/discharge standards, the review team should take whatever steps are necessary to ensure stricter compliance with these policies;
- The Bureau of Forensic Services develop written procedures for the review of investigations of serious allegations, including a system for ensuring the timely completion of these investigations and for monitoring the implementation of corrective actions. These procedures need to provide a method whereby the findings of these reviews are communicated to the facility in a timely manner and to the OMH Division of Quality Assurance; and,

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- The OMH Division of Quality Assurance review the implementation of the facility's revised incident reporting system and share this report with the facility and CQC by March 1992. This should include, but not be limited to, a review of whether incidents are being reported as required, whether investigations are skillfully performed and completed in a timely manner, whether appropriate law enforcement and oversight agencies are notified, whether IRC review occurs promptly, and whether the facility's mechanism for ensuring the effectiveness of corrective actions functions well.

OMH Response

As is customary, the Commission shared the draft of this report with Central New York Psychiatric Center and with the Office of Mental Health. Their response, included as Appendix D, details the corrective actions already taken by the facility and the office and those actions proposed. In addition, in its response, OMH offers assurances that Central Office will monitor incident reporting and investigation reforms at the facility and provide a report on the functioning of this system to CQC by March, 1992. Attachments referenced in the OMH response are available by contacting the Commission.

Appendix A

Chronology of Events

- 8/12/89 Patient Smythe hands a two-page letter to Senior SHTA. This letter contained 18 separate allegations that several patients on the ward physically and/or sexually assaulted and/or extorted money, food and cigaretes from weaker patients.
- 8/12/89 Unit level investigation began.
- 8/13/89 Clinical Director informed.
State Police informed.
Special investigation begins.
- 8/14/89 State Police BCI begin investigation.
- 8/17/89 Facility Special Investigator reports preliminary findings to Director.
- 10/17/89 Mr. Smythe discharged from Central New York.
- 1/90 Patient D.C. indicted.
- 2/12/90 Special investigation concluded. Report given to Director.
- 5/21/90 Commission alerted to allegations.
- 5/23/90 Director forwards report to Special Review Committee.
- 6/11/90 CQC site visit to the facility.
- 6/19/90 Special Review Committee returns report to the Director.
- 6/28/90 Director accepts Special Review Committee recommendation.
- 7/16/90 CQC site visit to the facility.
- 7/20/90 CQC site visit to the facility.
- 10/3/90 CQC interview with Associate Commissioner for Forensic Services
- 10/25/90 CQC site visit to facility to meet with the Executive Director and Director of Quality Assurance.
- 11/90 Recommendations of Special Review Committee implemented.

Appendix B

CONFIDENTIAL

MEMORANDUM

TO: H. E. Smith, Executive Director

FROM: Bruce Bradigan, Chairperson, *Bruce Bradigan*
Special Review Committee

RE: [REDACTED] Special Investigation

DATE: June 19, 1990

Attached please find the Special Investigation Report and recommendations of Mr. Henry Michalczyk, Supervising SHTA, and the transcript of the interview with [REDACTED] and the draft proposal for the new Special Investigator Program.

After reviewing Mr. Michalczyk's report, the clinical records of former patient [REDACTED] and other patients, the other evidence gathered during the investigation including the statements of staff and patients, and interviewing Mr. Michalczyk, this committee finds that there is substantial corroboration of the allegations of former patient [REDACTED] including those of extortion, sexual assaults, and physical (non-sexual) assaults. Corroborating evidence includes incident reports, progress notes, statements of patients and staff, and ward logs. As you know, these allegations have led to one or two Grand Jury indictments.

Following patient [REDACTED] statement several measures were taken to protect the patients and to prevent further recurrences of identified problems. These measures included:

- o Patients from the unit were transferred from the unit described in the statements.
- o A ward meeting held by the Supervising SHTA and Nurse Administrator and ward staff and patients to make it clear to all that neither extortion nor sexual acts (either consensual or assaultive) were allowed.
- o The allegedly primary assaultive patient was restricted from situations where some of the behavior was alleged to have occurred, and was observed more closely.

- o The Bureau of Criminal Investigation was called in to investigate the possibility of criminal charges.

We of the committee believe that additional measures need to be taken. We believe that a revitalization of one principle of our organizational behavior is required; specifically, we need to re-inculcate an organizational attitude that is stated positively as one of promoting the highest standards of patient care and treatment, and includes the stated intention to aggressively seek out and deal with problems in patient care and treatment. In particular, we are referring to lax security and supervision, which were the main themes coursing throughout the allegations and corroborated in the other documentation.

The following are our recommendations:

- 1) The committee recommends that a session be held with management and supervisors to deliver the message, in the strongest terms possible, that lax security and patient supervision will be not be tolerated in this facility.
- 2) The Committee recommends that there be increased rounds by the supervisors including the AOD, Sr. TAs, Supervising TAs and Treatment Team Leaders and that security supervision examine the feasibility of the facility increasing the frequency of the day rooms being empty of all personnel and locked with special locks controlled by supervisors between the hours of 10:30 p.m. and 6:30 a.m. Additionally, the Committee recommends that the staff should be required to periodically tour the bathrooms, shower rooms and other areas where patients are located, and that a written policy for shower supervision be established.
- 3) In conjunction with recommendations 1) and 2) above, if evidence of enhanced ward safety and security is not readily apparent, then the committee recommends that DETEX Stations be installed on the wards and frequent rounds of the patient areas be enforced via the system. Similarly, a separate DETEX system would also be adopted by the AOD and Sr. TA staff to insure acceptable supervision of the wards.
- 4) We recommend that we seek legal advice as to whether we can pursue disciplinary actions at this time. Specifically, the contract agreement between the State and Council 82 contains a prohibition against personnel action except where a crime has taken place, when more than 9 months has passed since the "conduct giving rise to discipline". We recommend seeking the advise of counsel as to whether; a) any of the staff behavior or neglect rises to the level of criminal activity, and b) whether any

personnel action can be taken for the activities and neglect that do not rise to the level of criminal activity.

- 5) The Committee recommends that Central New York Psychiatric Center restructure its policies in keeping with the incident reporting regulations, specifically 14 NYCRR Part 524.5 (2), (6), and (7), which require written reports to the Regional Office of allegations of abuse, potential crimes, and injuries which do not jeopardize a client's life, require prompt reports to the CQC on allegations of patient abuse or neglect, and require prompt (within 3 days) reports to MHLS and our Board of Visitors of client abuse or neglect.
- 6) The Committee recommends that we define a policy on sexual activity and train all staff on that policy. This Committee recommends that the policy be essentially that all sexual acts are banned and that all acts or attempted acts be prevented if possible and be reported. Furthermore, that when evidence of any sexual activity has taken place, the patients must be examined by a physician and a determination of consent or non-consent be obtained and the possibility of a charge of sexual assault be explored.
- 7) The Committee recommends that the Special Investigation System be revamped along the lines of the attached proposal. Furthermore, that the Special Investigator be required to report to the Special Review Committee monthly until the investigation is completed, and that an additional investigator or investigators will be assigned to incomplete cases after the first 30 days.
- 8) The Committee recommends that the facility increase the frequency of unannounced rounds by Cabinet, Clinical Cabinet and other facility managers, on all shifts to reinforce supervision of patients.
- 9) The Committee recommends that a formal policy which addresses trading or selling patient commissary, food, cigarettes, etc., be devised and implemented. The Committee recognizes that informal procedures are presently in place but recommends that the procedures be reviewed and formalized. Procedures also need to be developed to help those patients who need assistance in controlling their commissary.
- 10) The Committee recommends that through all levels of supervision staff be reminded and policies be reinforced as to when an incident report must be initiated, when a special investigation should be initiated, when the police should be notified, and on who else should be notified for the various

types of incidents.

- 11) The Committee recommends that the Executive Director first be included in the Special Investigation process at the point of completion of the Special Review Committee findings.

We hope that you find these recommendations useful. We are available at your convenience to discuss the investigations, the general situation, and these recommendations with you at your convenience.

BB:saf

cc: Bob Welton
Dick Stevenson

Appendix C

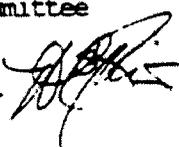
CONFIDENTIAL

RECEIVED

JUN 29 1990

DIRECTOR FOR
ASSURANCE
OFFICE CENTER

MEMO TO: Mr. Bruce Bradigan, Chairperson
Special Review Committee

FROM: Mr. H. E. Smith
Executive Director 

DATE: June 28, 1990

RE:  Special Investigation

I would firstly like to thank the Committee for a comprehensive and thorough review of this extremely troublesome and complex incident. I have again reviewed all documentation provided by Mr. Michalczyk which includes the statement taken from  on August 13, 1989.

I agree that beyond the steps taken thus far by the facility and the Oneida County District Attorney's Office, additional measures must be taken. Therefore, I concur with the recommendations in total, and I am ordering that the following specific steps be taken in conjunction with the enumerated recommendations:

Recommendation #1: At the July 18, 1990 meeting of the Clinical Cabinet, I will review the highlights of this case and inform the committee of my endorsement of the recommendations as well as specify the details of the recommended meeting. In brief, along with the other members of the Cabinet, the Director of Nursing and the Security Hospital Treatment Chief, I will conduct meetings on all three shifts with SHTA Supervisors, Nurse Administrators, Treatment Team Leaders, and Senior Treatment Assistants. The nature of this incident will be discussed and clear articulation of our expectations with regard to the preservation of the safety and well being of our patients will be strongly emphasized. Following the meetings there will be a written directive from me to each shift management team reinforcing these imperatives.

Recommendation #2: The directive referenced above will include notice to increase facility rounds by the stated individuals and I will require that the Director of Nursing, the Clinical Director, Unit Chiefs and Security Hospital Treatment Chief ensure that rounds on all three shifts are accelerated and that frequent tours of the bathroom and shower areas are conducted. Additionally, I request that the Security Hospital Treatment Chief, through the Clinical Director, draft a written policy for shower and bathroom supervision which is to be presented to the Clinical Cabinet by August 1st for review and/or approval.

Recommendation #3: I concur with this recommendation and will periodically review our practices at the Clinical Cabinet to determine whether or not we need to adopt the DETEX system.

Recommendation #4: I shall personally contact Mr. Louis Patack of OMH Counsel's Office, who specializes in labor management issues. If indicated, I will ask Mr. Stevenson, Personnel Director, to meet with Mr. Patack to review the elements of this case and to gain his advice and direction for any appropriate action.

Recommendation #5: I concur with this recommendation in its entirety and refer this issue to the Director for Quality Assurance to restructure our policy in accordance with the recommendation and to present them to me as soon as possible for adoption.

Recommendation #6: I concur that we need to articulate a policy on sexual activity of patients and train all staff on this policy. I appoint Mr. Fenton, Director of Nursing, as Chairman of a committee which will include the Security Hospital Treatment Chief, two designated Senior Treatment Assistants, the Infection Control Nurse, the Director of Education & Training, a designated SHTA Supervisor, and Nurse Administrator to develop such a policy for presentation to the Medical Staff and Clinical Cabinet by August 15, 1990.

Recommendation #7: As discussed, I have previously reviewed the attached proposal with regard to restructuring the Special Investigation System, and accordingly will take steps to refocus the system with the inclusion of a 30 day limit on investigations and including a weekly report by the assigned special investigator to the Director for Quality Assurance to determine the status of the case. In turn, the DQA will keep me apprised weekly of any pending SI's.

Recommendation #8: I also concur with this recommendation and will include my proposal at the July 25th Clinical Cabinet Meeting.

Recommendation #9: In tandem with the committee formed to address the issue in Recommendation #6, I charge the same committee, within the same timeframe, to draft a policy which addresses the trading or selling of patient commissary, food, cigarettes, etc.

Recommendation #10: I concur that all levels of supervision be reminded of policies and procedures with regard to SI's or other unusual events which may require notification of law enforcement. Together with the DQA and in consultation with the Cabinet, I will draft a formal notice to the Executive Committee and line supervisors. The draft will be completed by August 1, 1990.

Recommendation #11: The current practice concerning SI's, which includes my receipt of the investigation from the special investigator, review, pass on to Special Review Committee for recommendation, will be discontinued, and we will adopt recommendation #11 which calls for the SI's submittal to the Special Review Committee for comment and recommendation and then to the Executive Director for final recommendations and approval. I also request that specific timeframes be adopted for the Special Review Committee's response to the Executive Director, as well as a timeframe for the Executive Director to arrive at final conclusions before presentation to the Incident Review Committee by a Special Review Committee member and, if appropriate, forwarding to the Bureau of Forensic Services and all other persons or agencies delineated in our policy.

Mr. Bruce Bradigan

-3-

June 28, 1990

The time lapse in this case, including the time it took for my review and actions, regardless of circumstances, were intolerable. However, I sincerely believe that the above steps will remediate and prevent this inordinate delay from occurring in the future. As discussed, there are far-reaching consequences to both the factual findings and allegations surrounding this case. I believe that perhaps we have become lax in a number of areas which could jeopardize patient, as well as staff safety and security, and we must rectify the situation immediately.

HES:jjb
Att.

Appendix D



NEW YORK STATE
OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229

RICHARD C. SURLES, Ph.D., Commissioner

May 29, 1991

Clarence J. Sundram, Chairman
Commission on Quality of Care
for the Mentally Disabled
One Commerce Plaza, Suite 1002
Albany, New York 12210

Dear Mr. Sundram:

Thank you for the opportunity to respond to the Commission's confidential draft report "The Case of Timothy Smythe: Patient Extortion at Central New York Psychiatric Center and Related Issues". The findings contained within your report clearly demonstrate that, in the case described therein, Central New York Psychiatric Center failed to provide a safe environment for its patients. Both CNYPC and OMH recognize that the provision of a safe environment is, indeed, one of our most basic obligations. Clearly, the adequate supervision of patients and the comprehensive management of untoward incidents are critical vehicles for ensuring such an environment. CNYPC and OMH acknowledge that in this case both of these systems failed to function properly. This failure directly contributed to the tragic events described in your report.

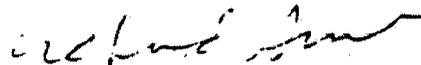
Recognizing these failures within the system, CNYPC and the Bureau of Forensic Services, in cooperation with the Quality Assurance Division, have taken actions both to correct the immediate problems related to this case and to reduce the potential for any future such occurrence. These actions are detailed in the enclosed report. They address the paramount issues of safety, patient supervision, accountability and management of untoward incidents.

Your report acknowledges the progress that has been made toward corrective actions in these critical areas. As you state, the present challenge now lies in maintaining our momentum and ensuring the aggressive implementation of the changes in policy and procedure. Both CNYPC and OMH feel confident that we can

meet this objective and continue our efforts toward ensuring a secure and safe environment for the patients of this facility.

I hope that the attached response provides you with sufficient information on the status of your recommendations. If any additional information is needed, please do not hesitate to contact Dr. Sandra L. Forquer, Deputy Commissioner for Quality Assurance and Information Systems.

Sincerely,



Richard C. Surles, Ph.D.
Commissioner

Attachment

CQC FINDINGS

FINDING #1. Because staff repeatedly circumvented the incident reporting and review process, the facility missed signs that should have prompted an earlier investigation and the implementation of administrative and clinical interventions.

FINDING II. The facility failed to conclude the special investigation promptly and failed to keep responsible parties informed.

FINDING III. Related to the first two findings, the facility failed to implement corrective action in a timely manner.

Findings number I,II,III of the Commission's Report relate primarily to deficiencies in the areas of patient supervision, incident reporting/investigation and follow up. The following information details the corrective actions that have been initiated in each of these areas in response to the Commission's findings.

PATIENT SUPERVISION

Central New York PC recognizes that there were serious shortcomings in the supervision of patients which allowed Mr. Smythe's activities to go unchecked for a significant period of time. Although cognizant of some of Mr. Smythe's activities, staff failed to take effective actions to prevent exploitation of other patients.

In order to address the issue of patient supervision, CNYPC's Executive Director issued immediate changes in facility policy regarding the supervision of patients (Attachment A "Immediate Changes in Policy and Practice"). This policy directive clearly outlined the procedures to be followed regarding sexual activities between patients, increased supervision and documentation of supervision by staff, accelerated supervisory rounds and the issue of coercion/extortion among patients. In order to reinforce this

directive, the Executive Director, together with the Director of Nursing, Treatment Team Leaders and all facility supervisors, conducted a series of staff meetings over a three-day period with all shifts. This included addressing all Security Hospital Treatment Assistants at their pre-shift briefings and repeating these meetings as necessary to account for staff who were on pass day or leave. Similarly, nursing staff and members of the multi-disciplinary treatment teams were advised of the gravity of the situation and alerted to the changes in policy regarding patient supervision.

Following the issuance of this preliminary policy on supervision and sexual practices of patients, a committee was formed and developed a formal policy on sexual activities of patients which was implemented in September 1990 (Attachment B, "Sexual Activities of Patients"). A new policy for shower and bathroom supervision was also implemented in September 1990. (Attachment C.)

Immediately following the incident, the facility increased (and has maintained) the frequency of unannounced rounds by Cabinet, Clinical Cabinet and other facility managers on all shifts in order to reinforce supervision of patients. Nursing rounds are logged in the Daily Nursing Log and Administrator On Duty Log. Rounds by Supervisory Security Hospital Treatment Assistants and Cabinet are documented in the Supervisors Log. (Attachment D, Cabinet Rounds Schedule, Updated Version 01/29/91 - 06/02/91).

Additionally, CNYPC formally addressed the issue of the trading or selling of patient commissary food, cigarettes, etc. The current policy on trading or exchange of commissary items/personal property was implemented in September 1990. (Attachment E). Although not specifically referenced in the recommendations, the facility also felt it appropriate to develop a policy regarding employees receiving gifts from patients. (Attachment F).

It was also agreed that Central New York PC should develop mechanisms for a system of checks and balances to record and track cash disbursements and gifts. The

memo of August 23, 1990 from the Business Officer to the Director for Administrative Services (Attachment G) outlines the issues discussed by an ad hoc committee consisting of support and clinical managers as well as the "Policy on Patient Cash Disbursements and Receipts and Gifts". (Attachment H).

INCIDENT REPORTING AND INVESTIGATION

CNYPC recognizes that their incident reporting and review process was functioning inadequately at the time of this incident. In order to address this problem, the facility responded on both an immediate and long-term basis. CNYPC's immediate response was to clarify the incident reporting policy and procedure with all levels of staff. During the staff meetings which were held by the Executive Director to reinforce the new policies on patient supervision, the requirement to report incidents of all types was strongly reinforced with supervisory and direct care staff.

In addition to this immediate response and as a result of the facility's Special Investigation and the recommendations of the Special Review Committee, CNYPC completely revised its Incident Reporting Policy. The revised policy explicitly addresses the following components of incident reporting and review:

- Definitions of incidents
- Classification of incidents
- Notification procedures for the different classes of incidents
- Documentation of incidents
- Function and responsibilities of the Incident Review Committee
- Internal and external notification requirements.

The revised policy and procedure was implemented and shared with the Commission on Quality Care in November, 1990. (Attachment I, "Revised Incident Reporting Policy").

CNYPC also acknowledges that in this case the special investigation was not completed in a timely and efficient manner. As stated by CNYPC's Executive Director to the Incident Review Committee, "The time lapses in this case, including the time it took for my [Director's] review and actions, regardless of the circumstances, were intolerable." In order to ensure the prompt completion of special investigations and the subsequent implementation of corrective action, specific responsibilities and timeframes have been incorporated into the revised Incident Reporting/Special Investigation process. These include the following:

- completion of the special investigation within 30 days of the incident.
- weekly status reports by the assigned special investigator to the Director for Quality Assurance.
- weekly status reports by the Director for Quality Assurance to the Executive Director regarding special investigations in progress and any corrective actions that need to be taken immediately.

Since the implementation of this policy at CNYPC, all special investigations have been completed within the 30 day timeframe. Additionally, the revised Incident Reporting Policy has been restructured in keeping with OMH incident reporting regulations and contains specific timelines and external reporting requirements to the following agencies:

- Office of Mental Health Board of Visitors
- Commission on Quality of Care for the Mentally Disabled
- Mental Hygiene Legal Services
- Medical Examiner/Coroner
- Next of Kin/Legal guardian
- Law Enforcement Authorities
- OMH Bureau of Forensic Services
- Department of Corrections

In addition to changes in policy and procedure, a unique Special Investigator Program has been developed at CNYPC. The highlights of this program include the position of Principal Investigator which is presently filled by an individual who was formerly an investigator for a law enforcement agency and also a private investigator. In addition to the position of Principal Investigator, there are also three Associate Principal Investigators, including one who was formerly a physical evidence expert for a law enforcement agency. The Principal Investigators, in turn, have trained a cadre of eight additional Special Investigators. This enhanced Special Investigation Program has significantly strengthened CNYPC's ability to conduct prompt and comprehensive special investigations in follow-up to serious incidents.

CLINICAL ISSUES

The Commission's report also raises the issue of the clinical appropriateness of Mr. Smythe's continued stay at CNYPC. While, as the report states, there are statements in the record to the effect that Mr. Smythe was free of psychotic symptoms at times, his case presented a number of complex clinical features which contributed to his length of stay at CNYPC:

- o Mr. Smythe had undergone two previous hospitalizations for suicidal behavior at another psychiatric center and was in outpatient treatment at the time of his arrest and incarceration. On his previous hospitalizations, he was diagnosed as having a panic disorder. With this disorder, Mr. Smythe's ability to function in the correctional environment was questionable and was one of the issues involved in keeping him at CNYPC. During a specialized treatment planning session on 08/21/89, attended by the Clinical Director and 17 other staff, it was recommended that Mr. Smythe remain in CNYPC until his parole date on 10/17/89. This recommendation was in large part based on the fact that he had been unable to adjust to the correctional environment on his previous discharge from CNYPC. At the time of that discharge, Mr. Smythe had remained in prison

less than 24 hours before deteriorating and being returned to CNYPC.

- o Mr. Smythe was being prescribed medication (Nardit) to treat his panic disorder. This medication requires a specialized diet which the correctional facility claimed difficulty in providing and in monitoring compliance. CNYPC has a full array of clinical and dietary services through which they were able to provide the specialized diet and monitor compliance and reactions to this medication.

- o Mr. Smythe was delusional and often presented symptoms of grandiosity and paranoia. For example, he claimed that "... more than 4,600 people were sent to prison because of his undercover police work". He wrote notes claiming that he had written a novel and a screenplay, was a Green Beret in Vietnam for four years, seventeen days and fifteen hours during which he was a prisoner of war "for 22 months", etc. None of these events actually occurred.

In summary, there were times when Mr. Smythe was free of psychiatric symptomatology while at CNYPC, but there were times when such symptomatology was clearly displayed. This, along with his history of hospitalizations, outpatient treatment, and specialized medication regimen, were all contributing factors to his length of stay at CNYPC.

FINDING IV. Failure to respond appropriately to the allegations also falls outside of the facility to the OMH Bureau of Forensic Services' lack of oversight of Central New York's response to the serious allegation.

Since December, 1989, the Central Office Quality Assurance Division has been in the process of improving OMH's ability to monitor serious incidents within State Psychiatric Centers and local programs. As a result, an incident management process has been developed which includes enhanced procedures for the intake, screening, follow up and evaluation of serious incidents by the Central Office Quality Assurance Division.

Presently, the systemic response immediately following serious incidents at forensic facilities is as follows:

- A. Facility notifies the Central Office Bureau of Forensic Services who, in turn, communicates the information to the Bureau of Data/Incident Management of the Central Office Quality Assurance Division.
- B. Simultaneously, the Bureau of Forensic Services and the Bureau of Data/Incident Management evaluate the information available from the initial incident report.
- C. Based on established criteria, the Bureau of Data/Incident Management makes a determination in regard to the patient's immediate safety and the appropriateness of the facility actions initiated in response to the incident. If the determination is negative in relation to either patient safety or appropriateness of facility actions, Bureau staff then make immediate recommendations directly to the facility.
- D. The facility is then requested to forward copies of all pertinent information (i.e., Special Investigation reports, plans of corrective action) to the Bureau of Data/Incident Management. This information is then evaluated for appropriateness and comprehensiveness of the facility's response to the incident. If any issues or problems are identified in terms of the facility's management of the incident, staff from both Bureaus then work cooperatively with facility staff to address and resolve these issues. Since the time of the CNYPC incident, the Bureau of Data/Incident Management has developed a manual system for tracking facility responses to requests for incident-related documentation. Plans are presently underway for the development of a computerized tracking system through which the timeliness of facility responses will be monitored. Any responses that are overdue will be tracked until all of the needed information has been received.

ADDITIONAL RECOMMENDATIONS

Central New York Psychiatric Center and the Bureau of Forensic Services should review the treatment of Mr. Smythe to determine whether his lengthy stay was clinically appropriate and to critique the efficacy of the treatment provided to him. If this review reveals that Mr. Smythe remained a patient in violation of the admission/discharge standards, the review team should take whatever steps are necessary to ensure stricter compliance with these policies.

The OMH and CNYPC will move forward immediately to implement this additional recommendation. In order to complete a comprehensive clinical review of the treatment provided to Mr. Smythe at CNYPC and determine whether his stay was clinically appropriate, a consultant who is an expert in forensic psychiatry has been retained by the Bureau of Forensic Services. He will conduct a thorough review of the clinical care provided to Mr. Smythe during his stay at CNYPC and the appropriateness and efficacy of treatments and interventions provided to him. Upon completion of this review, the consultant's report will be shared with the Commission.

The Bureau of Forensic Services should develop written procedures for the review and investigation of serious allegations, including a system for ensuring the timely completion of these investigations and for monitoring the implementation of corrective actions. The procedures need to provide a method whereby the findings of these reviews are communicated to the facility in a timely manner and to the OMH Quality Assurance Division.

The OMH Quality Assurance Division and the Bureau of Forensic Services have worked cooperatively to develop procedures for the review and follow-up of serious incidents. These procedures include a system for monitoring the timely completion of investigations and the monitoring of corrective actions and are outlined in our response to Finding IV. In addition, procedures for the reporting of serious incidents involving

forensic patients are delineated in the attached "Handbook for Regional Offices and Facility Staff (Attachment J.)

The OMH Quality Assurance Division should review the implementation of the facility's revised incident reporting system and share this report with the facility and CQC by March 1992. This should include, but not be limited to, a review of whether incidents are being reported as required, whether investigations are skillfully done and completed in a timely manner, whether appropriate law enforcement and oversight agencies are notified, whether IRC review occurs promptly and whether the facility's mechanism for ensuring the effectiveness of correction actions functions well.

OMH agrees that a thorough review of CNYPC's revised incident reporting and incident management system is in order. The Quality Assurance Division will conduct this review which will include all of the components listed in the Commission's recommendation. A report will be developed and shared with the facility and the Commission by March, 1992.

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Copies of this report are available in large print, braille, or voice tape. Please call the Commission for assistance in obtaining such copies at 518-473-7538.

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.

The Commission's statewide toll-free number is for calls from patients/residents of mental hygiene facilities and programs, their families, and other concerned advocates.

Toll-free Number:

1-800-624-4143 (Voice/TDD)

