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

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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.

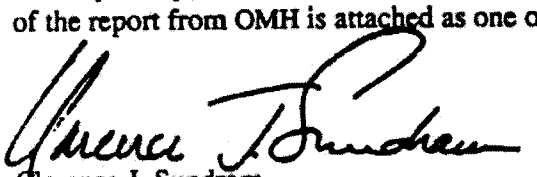
* A pseudonym.

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.



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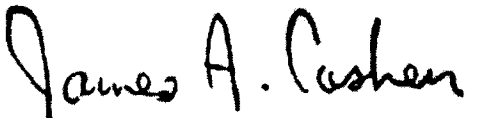

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Introduction

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

"It has been brought to [our] attention that extortion, homosexual activity, and assaults are occurring and all of these happenings must stop immediately."

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

* 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.

"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*."

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.

* 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

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.

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.

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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.

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.

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 victims'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

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.

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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.

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.

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.